STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHINGTON	339 GREENTREE ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00171443; NJ00173742; NJ00173883 CENSUS: 101 SAMPLE SIZE: 6 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/05/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00171443; NJ00173742; NJ00173883

Based on interview, record review, and review of pertinent facility documents, it was determined that the Executive Director (ED) failed to ensure the implementation and enforcement of five facility policies and procedures for 5 of 6 residents reviewed, Residents #1, #2, #3, #4, and #5. This deficient practice was evidenced by the following:

On 5/31/24 at 9:56 a.m., the surveyor interviewed the Assistant Resident Care Director (ARCD) to inquire about an [NJ Exec Order 26.4] that took place on [NJ Exec Order 26.4]. The ARCD stated Residents #1 and #3 were transferred to a [NJ Exec Order 26.4] unit at a local hospital following the [NJ Exec Order 26.4]. The ARCD stated Resident #1 sustained a [NJ Exec Order 26.4b1], had [NJ Exec Order 26.4] and then had an [NJ Exec Order 26.4b1] [NJ Exec Order 26.4] to his/her [NJ Exec Order 26.4]. Additionally, the ARCD stated Resident #3 was monitored at the hospital for [NJ Exec Order 26.4b1] in his/her [NJ Exec Order 26.4] for a few days, however, was later discharged (on [NJ Exec Order 26.4]) with [NJ Exec Order 26.4] (a [NJ Exec Order 26.4b1]).

At 10:20 a.m., the surveyor observed Resident #1 and Resident #3 sitting together in the common area. The surveyor observed Resident #1 sitting in a chair with an [NJ Exec Order 26.4b1] to his/her [NJ Exec Order 26.4] and a [NJ Exec Order 26.4] nearby, and Resident #3 sitting in his/her [NJ Exec Order 26.4b1]. The surveyor interviewed

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A 310	Continued From page 2 Resident #3 to inquire about any NJ Exec Order 2 sustained from the NJ Exec Order 26.4 that took placed on NJ Exec Order 2. Resident #3 stated he/she was not NJ Exec Order 2 in the NJ Exec Order 26.4 however, the resident stated his/her NJ Exec Order 26 Resident #1, NJ Exec Order 26.4b1 and sustained a "NJ Exec Order 26.4b1 ". At 11:10 a.m., the surveyor reviewed the Medical Record (MR) of Resident #3, which revealed the resident was admitted to the "NJ Exec Order 26 Center" on NJ Exec Order 26. at 2:47 p.m. and discharged on NJ Exec Order 2. The surveyor noted that the latest nursing assessment in the resident's MR was dated NJ Exec Orde. At 11:18 a.m., the surveyor reviewed the MR of Resident #1, which revealed the resident was admitted to "NJ Exec Order 26.4b1 " on NJ Exec Order 2 at 3:06 p.m., with a diagnosis of NJ Exec Order 26.4b1 (and discharged on NJ Exec Order 2). The surveyor noted that the last nursing assessment in the resident's MR was dated NJ Exec Orde. At 11:28 a.m., the surveyor reviewed the closed MR of Resident #2, which revealed a Progress Notes (PN) written by LPN #1, dated NJ Exec Orde, which indicated that the LPN found Resident #2 on the NJ Exec Order 26.4b1, with "NJ Exec Or to the NJ Exec Order 26.4b1 ". The surveyor then reviewed three PNs dated NJ Exec Orde. The first was written by LPN #2 which indicated Resident #2 was found NJ Exec Order 26.4b1, and the resident stated he/she NJ Exec Order 26.4b1. The second PN written by LPN #1, indicated Resident #2 was sent out to a local hospital after he/she had NJ Exec Order 26.4b1 and did not NJ Exec Order 26.4b1 The third PN written by LPN #1, indicated Resident #2 was admitted to a local hospital for NJ Exec Order 26.4b1.	A 310		

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A 310	Continued From page 3	A 310		

Additionally, the surveyor's review of LPN #1 note dated [NJ Exec Order 2], documented that Resident #2's [NJ Exec Order 26.4] notified the facility that the resident [NJ Exec Order 26.4b1] on NJ Exec Order 26.4b1 r the resident's [NJ Exec Order 26.4b] The surveyor noted that the laststt nursing assessment on resident's MR was dated [NJ Exec Order 2].

At 11:57 a.m. and 12:44 p.m., the surveyor interviewed the Resident Care Director (RCD) to inquire as to when residents should be assessed. The RCD was asked to confirm that Resident #'s 1 and #3 were assessed upon their return from the hospital. The surveyor also asked the RCD if Resident #2 was assessed post [NJ Ex] with a [NJ Exec O]. The RCD stated assessments were done every six months and with change in functionality. The RCD also stated that Resident #1 and Resident #3 were assessed upon their return from the hospital, she satetd however, that she "didn't get the assessments into the system." In addition, the RCD stated that she was not sure if she assessed Resident #2, following the resident's [NJ Exec O] with [NJ Exec Order 26.4b1] on [NJ Exec Orde] and [NJ Exec Orde].

At 1:26 p.m., the surveyor interviewed the ED to inquire as to when assessments should be completed. The ED stated that assessments should be completed prior to move-in and then every six months. Additionally, the ED stated assessments were not completed upon resident return from the hospital, unless there was a change in condition.

On 6/4/24 at 10:50 a.m., the surveyor reviewed the [NJ Exec Orde] MR of Resident #4, which revealed a PN written by a LPN at the facility, dated [NJ Exec Order 2]. The PN indicated an aide at the facility observed Resident #4 NJ Exec Order 26.4b1 ."

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A 310	Continued From page 4 At 11:04 a.m. on 6/4/24, the surveyor interviewed the RCD to inquire about the NJ Exec Order 26.4b1 that took place on NJ Exec Order 26 involving Resident #4, and to cclarify if the incident was reported to the DOH. The RCD stated she could not recall the incident and stated she would have to review her PN. At 11:50 a.m., the surveyor reviewed the MR of Resident #5, which revealed another PN written by the same LPN, dated NJ Exec Order 26. The PN indicated, an aide in the NJ Exec Order 26.4b1 unit at the facility observed Resident #5 being NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1. At 12:00 p.m., the RCD stated she was not able to locate an incident report or reportable event record for the NJ Exec Order 26.4b1 that took place on NJ Exec Order 26 between Residents #4 and #5. The surveyor reviewed the facility policy titled, "Upon return from the ER or Hospital," revised in September of 2019, which indicated that the procedure was to take a full set of vital signs, update the care plan/service plan if indicated, the nurse was to perform an assessment and write a nurse's note, the nurse was to add the resident to the acute tracker list, the nurse was to email all department heads and concierge that the resident returned, and the nurse was to review and process any new orders. The surveyor also reviewed the facility policy titled, "Fall Procedure," revised in March of 2019, which indicated, "... 6. When a resident falls, the resident will not be moved until he/she is assessed by a nurse. The nurse will determine if the resident requires medical attention. 7. If there is not a RN on site: If the resident has a visible	A 310		

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A 310	Continued From page 5 injury- call 911. Stay with the resident until EMS arrives then call the RCD/ on-call RN..." The surveyor reviewed the facility policy and procedure titled, "Abuse Reporting" revised in March of 2019, which indicated, "... The Executive Director will complete an Incident Report in Eldermark ...." The surveyor also reviewed the facility policy and procedure titled, "Reportable Events," revised in March of 2019, which indicated, "The community will report all reportable events as required by law and regulations." Further, the surveyor reviewed the facility policy titled, "Executive Director Responsibilities," which indicated, "... The Executive Director will be responsible for, but not limited to, the following: Ensuring the implementation and enforcement of all Policies and Procedures-including Resident Rights." Reference 8:36-5.10(a)(3) A-0565; 8:36-7.2(f) A-0745	A 310		
A 565	8:36-5.10(a)(3) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 3. Any suspected cases of resident abuse or exploitation which have been reported to the State Long-Term Care Ombudsman.	A 565		

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A 565	Continued From page 6	A 565		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00171443; NJ00173742; NJ00173883

Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to notify the Department of Health (DOH) immediately by telephone or in writing within 72 hours of NJ Exec Order 26.4b1 for 2 of 6 residents reviewed, Resident #4 and Resident #5. This deficient practice was evidenced by the following.

On 6/4/24 at 10:50 a.m., the surveyor reviewed the NJ Exec Order Medical Record (MR) of Resident #4, who was admitted to the facility in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 The surveyor reviewed a Progress Note (PN) dated NJ Exec Order 26.4b which indicated an aide at the facility observed Resident #4 " NJ Exec Orde another NJ Exec Order 26 on the NJ Exec Orde

At 11:04 a.m., the surveyor interviewed the Resident Care Director (RCD) to inquire about the NJ Exec Order 26.4b1 that took place on NJ Exec Order 26. involving Resident #4, and to inquire if the incident was reported to the DOH. The RCD stated she could not recall the incident, or the other resident involved, and stated she would have to review her PN.

At 11:50 a.m., the surveyor reviewed the MR of Resident #5, who was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1

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A 565	Continued From page 7 NJ Exec Order 26 and NJ Exec Order 26 The surveyor reviewed a PN dated NJ Exec Order 26, which indicated that an aide in the NJ Exec Order 26.4b1 unit at the facility observed Resident #5 being NJ E on the NJ Exec by another NJ Exec Order 26.4 At 12:00 p.m., the RCD confirmed that she was not able to locate an incident report or reportable event record for the NJ Exec Order 26.4b1 that took place on NJ Exec Order 26 between Residents #4 and #5. The surveyor reviewed the facility policy titled, "Reportable Events," which indicated, "The community will report all reportable events as required by law and regulations."	A 565		
A 745	8:36-7.2(f) Resident Assessments and Care Plans (f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00171443; NJ00173742; NJ00173883 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure residents were assessed in accordance with Chapter 8:36-7.2 and facility policies and procedures for 3 of 6 residents reviewed,	A 745		

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A 745	Continued From page 8	A 745		

Residents #1, #2, and #3. This deficient practice was evidenced by the following:

On NJ Exec Order 26, the Department of Health (DOH) received a Reportable Event Survey (RES) from the Executive Director (ED) at the facility. The RES indicated, on NJ Exec Order 26, Resident #3 NJ Exec Order 26 his/her NJ Exec Order 26.4b1. The RES also indicated Resident #3's NJ Exec Order 26 Resident #1, was in the NJ Exec Order 26.4b1 of the NJ Exec Order 26 at the time of the NJ Exec Order 26.4b and NJ Exec Order 26.4b1 were taken to the hospital.

On 5/31/24 at 9:03 a.m., the surveyor arrived at the facility and observed NJ Exec Order 26.4b1 around the area of the NJ Exec Order 26 that was NJ Exec Order 26 Resident #3's NJ Exec Order 26

At 9:56 a.m., the surveyor interviewed the Assistant Resident Care Director (ARCD) to inquire about the NJ Exec Order 26.4 that took place on NJ Exec Order 26. The ARCD stated Residents #1 and #3 were transferred to a NJ Exec Order 26 unit at a local hospital following the NJ Exec Order 26.4b The ARCD stated Resident #1 sustained a NJ Exec Order 26.4b1 , had NJ Exec Order 26 and then had an NJ Exec Order 26.4b1 NJ Exec Order 26 to his/her NJ Exec Order 26. Additionally, the ARCD stated Resident #3 was monitored at the hospital for NJ Exec Order 26.4b1 in his/her NJ Exec and was later discharged (on NJ Exec Order 26.4 with NJ Exec Order 26.4b1).

At 10:20 a.m., the surveyor observed Resident #1 and Resident #3 sitting together in the common area. The surveyor observed Resident #1 sitting in a chair with an NJ Exec Order 26.4b1 to his/her NJ Exec Order 26 with a NJ Exec Order nearby, and Resident #3 sitting in his/her NJ Exec Order 26.4b1. The surveyor interviewed Resident #3 to inquire about any NJ Exec Order 26 sustained from the NJ Exec Order 26.4 that took placed on

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A 745	Continued From page 9	A 745		

NJ Exec Order 2[redacted]. Resident #3 stated he/she was not NJ Exec Order 2[redacted] in the NJ Exec Order 26.4[redacted] however, the resident stated his/her NJ Exec Order 26[redacted] Resident #1, NJ Exec Order 26.4b1 [redacted] and sustained a NJ Exec Order 26.4b1 [redacted] "

At 11:10 a.m., the surveyor reviewed the Medical Record (MR) of Resident #3, who was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 [redacted] The surveyor observed a Progress Note (PN) written by Licensed Practical Nurse (LPN) #1 at the facility dated NJ Exec Order 26. The PN indicated Resident #3 was admitted to a local hospital for NJ Exec Order 26.4b1 , and observed at the hospital to rule out NJ Exec Order 26.4b1 [redacted] in his/her NJ Exec Order 26.4b1. The surveyor also observed a PN written by LPN #2 dated NJ Exec Order 2[redacted], which indicated Resident #3 returned from the hospital and the resident's NJ Exec O[redacted] [redacted]. Additionally, the surveyor reviewed another PN written by the Resident Care Director (RCD) dated NJ Exec Order 2[redacted], which was a late entry for NJ Exec Order 26. The PN indicated Resident #3 had NJ Exec O[redacted] to his/her NJ Exec Order 2[redacted] and NJ Exec Order 26.4 on his/her NJ Exec Order following a NJ Exec Order 26.4b1. The PN indicated Resident #3 was admitted to the hospital with NJ Exec Order 26.4b1. The surveyor reviewed Resident #3's hospital record, which confirmed the resident was admitted to the "NJ Exec Order 26.4b1" on NJ Exec Order 2[redacted] at 2:47 p.m. and discharged on NJ Exec Order 2[redacted]. The surveyor observed the latest nursing assessment was dated NJ Exec Orde[redacted].

At 11:18 a.m., the surveyor reviewed the MR of Resident #1, who was admitted to the facility in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 [redacted]. The surveyor observed a PN written by LPN #1 at the facility dated NJ Exec Order 26.4b [redacted] The PN indicated, Resident #1 was admitted to a local

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A 745	Continued From page 10	A 745		

hospital with a NJ Exec Order 26.4b1 The surveyor also observed a PN written by the RCD dated [redacted], which indicated the note was a late entry for [redacted]. The PN indicated the RCD responded to the scene of a NJ Exec Order 26.4b1, at which time, Resident #1 "had complaint of [redacted] to [his/her [redacted]," and was [redacted] The surveyor reviewed Resident #1's hospital record, which indicated the resident was admitted to "NJ Exec Order 26.4b1" on [redacted] at 3:06 p.m., with a diagnosis of [redacted] (and discharged on [redacted]). The surveyor observed the latest nursing assessment was dated [redacted]

At 11:28 a.m., the surveyor reviewed the closed MR of Resident #2, who was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1. The surveyor observed a PN written by LPN #1 dated [redacted], which indicated the LPN found Resident #2 on the NJ Exec Order 26.4b1, with [redacted] to the [redacted]". The surveyor then reviewed three PN dated [redacted]. The first was written by LPN #2 at the facility, which indicated Resident #2 was found NJ Exec Order 26.4b1 [redacted] and the resident stated he/she [redacted] his/her [redacted] The second PN written by LPN #1, indicated Resident #2 was sent out to a local hospital after he/she had NJ Exec Order 26.4b1 and did not NJ Exec Order 26.4b1. The third PN written by LPN #1, indicated Resident #2 was admitted to a local hospital for [redacted]. Lastly, the surveyor reviewed a PN written by LPN #1 dated [redacted], which indicated Resident #2's [redacted] notified the facility that the resident [redacted] on NJ Exec Order 26.4b1 the resident's

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A 745	Continued From page 11 NJ Exec Order 26.4b1. The surveyor observed the latest nursing assessment was dated NJ Exec Order 26.4b1. At 11:57 a.m. and 12:44 p.m., the surveyor interviewed the Resident Care Director (RCD) to inquire when residents should be assessed, if Residents #1 and #3 were assessed upon their return from the hospital, and if Resident #2 was assessed post NJ Exec Order 26.4b1. The RCD stated assessments were done every six months and with change in functionality. The RCD also stated Resident #1 and Resident #3 were assessed upon their return from the hospital, however, she "didn't get the assessments into the system". In addition, the RCD stated she was not sure if she assessed Resident #2 following the resident's NJ Exec Order 26.4b1 At 1:26 p.m., the surveyor interviewed the ED to inquire when assessments should be completed. The ED stated assessments should be completed prior to move-in and then every six months. Additionally, the ED stated assessments were not completed upon resident return from the hospital, unless there was a change in condition. The surveyor reviewed the facility policy titled, "Upon return from the ER or Hospital," revised in September of 2019, which indicated, the procedure was to take a full set of vital signs, update the care plan/service plan if indicated, the nurse was to perform an assessment and write a nurse's note, the nurse was to add the resident to the acute tracker list, the nurse was to email all department heads and concierge that the resident returned, and the nurse was to review and process any new orders. The surveyor also reviewed the facility policy	A 745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHINGTON	339 GREENTREE ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 745	Continued From page 12 titled, "Fall Procedure," revised in March of 2019, which indicated, "... 6. When a resident falls, the resident will not be moved until he/she is assessed by a nurse. The nurse will determine if the resident requires medical attention. 7. If there is not a RN on site: If the resident has a visible injury- call 911. Stay with the resident until EMS arrives then call the RCD/ on-call RN."	A 745		
A 751	8:36-7.3(b) Resident Assessments and Care Plans (b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00171443; NJ00173742; NJ00173883 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop, review, and revise the Health Service Plan (HSP) for 3 of 6 residents reviewed, Residents #1, #2, and #3. This deficient practice was evidenced by the following: On 5/31/24 at 9:56 a.m., the surveyor interviewed the Assistant Resident Care Director (ARCD) to inquire about a NJ Exec Order 26.4b1 that took place on [redacted]. The ARCD stated Residents #1 and #3 were transferred to a [redacted] unit at a local hospital following the [redacted] The ARCD	A 751		

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ALL AMERICAN ASSISTED LIVING AT WASHINGTON	339 GREENTREE ROAD SEWELL, NJ 08080

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A 751	Continued From page 13	A 751		

stated Resident #1 sustained a NJ Exec Order 26.4b1 [redacted], and then had an NJ Exec Order 26.4b1 NJ Exec Order 2[redacted] to his/her NJ Exec Order 26[redacted]. Additionally, the ARCD stated Resident #3 was monitored at the hospital for NJ Exec Order 26.4b1 [redacted] in his/her NJ Ex[redacted] for a few days, however, was later discharged (on NJ Exec Order 26[redacted] with NJ Exec Order 26.4b1 [redacted].

At 11:10 a.m., the surveyor reviewed the Medical Record (MR) of Resident #3, who had a diagnosis of NJ Exec Order 26.4b1 [redacted]. The surveyor observed a Progress Note (PN) written by Licensed Practical Nurse (LPN) #1 at the facility dated NJ Exec Order 2[redacted]. The PN indicated Resident #3 was admitted to a local hospital for NJ Exec Order 26.4b1 [redacted], and observed at the hospital to rule out NJ Exec Order 26.4b1 in his/her NJ Exec Order 26.4b1. The surveyor also observed a PN written by LPN #2 dated NJ Exec Order 2[redacted], which indicated Resident #3 returned from the hospital and the resident's NJ Exec Order 26.4b1. Additionally, the surveyor reviewed another PN written by the Resident Care Director (RCD) dated NJ Exec Order 2[redacted], which was a late entry for NJ Exec Order 26[redacted] The PN indicated Resident #3 had NJ Exec O[redacted] to his/her NJ Exec Order[redacted] and NJ Exec Order 26.4[redacted] on his/her NJ Exec Order[redacted] following a NJ Exec Order 26.4b1. The PN indicated Resident #3 was admitted to the hospital with NJ Exec Order 26.4b1 The surveyor reviewed Resident #3's "Transfer Report" from the resident's NJ Exec Order 26[redacted] admission at the hospital, which indicated the resident had a NJ Exec Order 26.4b1 [redacted]. The surveyor did not observe a HSP for Resident #3.

At 11:18 a.m., the surveyor reviewed the MR of Resident #1, which revealed a PN written by LPN #1 at the facility dated NJ Exec Order 2[redacted]. The PN indicated, Resident #1 was admitted to a local hospital for a

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A 751	Continued From page 14	A 751		

NJ Exec Order 26.4b1 The surveyor also observed a PN written by the RCD dated NJ Exec Order 26, which indicated the note was a late entry for NJ Exec Order 2. The PN indicated the RCD responded to the scene of a NJ Exec Order 26.4b1, at which time, Resident #1 "had complaint of NJ Exec Order 2 [his/her NJ Exec Order 26.4b1," and was NJ Exec Order The surveyor reviewed Resident #1's hospital record, which indicated the resident was admitted to "NJ Exec Order 26.4b1" on NJ Exec Order 2 at 3:06 p.m., with a diagnosis of NJ Exec Order 26.4b1 (and discharged on NJ Exec Order 2). The surveyor did not observe a HSP for Resident #1.

At 11:28 a.m., the surveyor reviewed the NJ Exec Order MR of Resident #2, who was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1. The surveyor observed a PN written by LPN #1 dated NJ Exec Order 2 which indicated the LPN found Resident #2 on the NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1". The surveyor then reviewed three PN dated NJ Exec Orde. The first was written by LPN #2 at the facility, which indicated Resident #2 was found NJ Exec Order 26.4b1, and the resident stated he/she NJ Exe his/her NJ Exec Orde The second PN written by LPN #1, indicated Resident #2 was sent out to a local hospital after he/she had NJ Exec Order 26.4b1 and did not NJ Exec Order 26.4b1. The third PN written by LPN #1, indicated Resident #2 was admitted to a local hospital for NJ Exec Order 26. Lastly, the surveyor reviewed a PN written by LPN #1 dated NJ Exec Order 2, which indicated Resident #2's NJ Exec Order 26.4b notified the facility that the resident NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b. The surveyor observed Resident #2's

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A 751	Continued From page 15 HSP, started on NJ Exec Order 26, which indicated the resident was a NJ Exec Order 26 due to NJ Exec Order 26.4b1 in NJ Exec Order 26. Resident #2's HSP indicated the resident would be NJ Exec Order 26.4b1, however, the GSP did not list any services or interventions to NJ Exec Order 26.4b1. Resident #2's HSP did not indicate that any review or revisement of the HSP was completed following the resident's NJ Exec Order 26.4b1 on NJ Exec Order 26 and NJ Exec Order 26. At 1:51 p.m., the RCD provided the surveyor with the HSP for Residents #1, #2, and #3. The GSP for Resident #1 and #3 revealed the HSP was started on NJ Exec Order 26, the day of survey. Resident #2's HSP was started on NJ Exec Order 26, however, it did not list any services or interventions to NJ Exec Order 26, and did not reveal any revisions to the HSP after Resident #2's NJ Exec Order 26.4b1 on NJ Exec Order 26 and NJ Exec Order 26. The surveyor reviewed the facility policy titled, "Upon return from the ER or Hospital," revised in September of 2019, which indicated, the procedure was to take a full set of vital signs, update the care plan/service plan if indicated, the nurse was to perform an assessment and write a nurse's note, the nurse was to add the resident to the acute tracker list, the nurse was to email all department heads and concierge that the resident returned, and the nurse was to review and process any new orders. Reference: 8:36-7.2(f) A-0745	A 751		

All American ASSISTED LIVING

All American Assisted Living at Washington
339 Greentree Road
Sewell, NJ 08080
NJ Exec Order 26.4b1
NJ Exec Order 26.4b1

RE: Complaint #: NJ00173742

To this may concern,

The following is to serve as the Plan of Correction in response to the Statement of Deficiencies received on 8/23/24 stemming from an onsite visit on 6/4/24. There were found to be four deficiencies related to New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Livings.

A 310

8:36-3.4 (a) (1) Administration

1. Residents 1,2,3,4 and 5 were found to be affected by the deficient practice. The Executive Director, Resident Care Director and Assistant Resident Care Director were in serviced on policies and procedures related to NJ Administrative Code 8:36 on September 12th 2024 by regional nurse NJ Exec Order 26.4b1 RN. The in service included NJ Exec Order 2 polices related to assessments, reporting NJ Exec Order 2 resident rights, and policies and procedures for notifying the Division of Health and the State Long Term Care Ombudsman.
2. All residents have the potential to be affected by the deficient practice.
3. To ensure the deficient practice will not recur the Executive Director will daily review assessments, recent hospitalizations and incident reports to ensure the deficient practice is being corrected.
4. To Monitor that the deficient practice will not recur the executive director or designee review assessments, recent hospitalizations and incident reports during monthly QA to ensure the deficient practice is being followed. The completion date is September 30th, 2024.

accepted 10/16/24

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Sewell, NJ 08080
NJ Exec Order 26.4b1
NJ Exec Order 26.4b1

A 565

8:36-5.10(a)(3) General Requirements

1. Residents 4 and 5 were found to be affected by the deficient practice. Resident 4 NJ Exec Order 26.4b1 [redacted] All staff will be in serviced by the Executive Director or designee on reporting NJ Exec Order and completing incident reports by October 23rd 2024. All incident reports will be completed in a timely manner. The executive director and Resident Care Director will also ensure that all state reportable events are reported within state compliance guidelines.
2. All residents have the potential to be affected by the deficient practice.
3. To ensure the deficient practice will not recur in services for the RCD and nurses will be completed by the executive director or designee by October 23rd 2024. In services will be on our policy "NJ Exec Order Reporting General Policies" The administration and clinical team will review incident reports daily to ensure significant events are reported in a timely manner.
4. To monitor that the deficient practice is being corrected and will not recur a monthly audit will be conducted by the Executive Director or designee to review recent incident reports and state reportable. In services and training will be completed by October 23rd 2024.

accepted 10/16/24 EB

A 745

8:36-7.2(f) Resident Assessments and Care Plans

1. Residents 1, 2, and 3 were found to be affected by the deficient practice. Resident # 2 is NJ Exec Order 26.4b1. The residents affected by the deficient practice all have current assessments completed as well as updated care plans by 5.31.24.
2. All residents have the potential to be affected by the deficient practice.
3. The Executive Director or designee will review hospitalizations, assessments, and care plans to monitor that the deficient practice is being corrected. Executive Director or designee will in service the RCD and nurses on when an assessments need to completed. This will be completed by October 23rd 2024.
4. To monitor that the deficient practice is being corrected the Executive Director or designee will review hospitalizations, assessments, and care plans and include results in monthly QA. This will be completed by October 23rd 2024.

accepted 10/16/24 EB

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339 Greentree Road
Sewell, NJ 08080
NJ Exec Order 26.4b1
NJ Exec Order 26.4b1

A 751

8:36-7.3(b) Resident Assessments and Care Plans

1. Residents 1, 2, and 3 were found to be affected by the deficient practice. Resident # 2 is NJ Exec Order 26.4b1. The residents affected by the deficient practice all had current assessments completed as well as updated health service plans by 5.31.24.
2. All residents have the potential to be affected by the deficient practice.
3. An in-service will be completed by the Executive Director or designee for the RCD and nurses to ensure each resident is assessed for a need to have a health service plan. Also included will be how to identify if a health service plan is needed. This will be completed by October 23rd 2024.
4. To monitor that the deficient practice is being corrected and will not recur routine audits will be conducted by the Executive Director or designee to review residents receiving outside services. Continuing audits will be completed monthly and included in QA.

Accepted 10/16/24 SB

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08A012 Y1	A. Building B. Wing Y2	10/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHINGTON TOWNSHI	339 GREENTREE ROAD SEWELL, NJ 08080

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0565	Correction	ID Prefix A0745	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.10(a)(3)	Completed	Reg. # 8:36-7.2(f)	Completed
LSC	10/16/2024	LSC	10/16/2024	LSC	10/16/2024
ID Prefix A0751	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-7.3(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/16/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/4/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO