

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2025
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NAME OF PROVIDER OR SUPPLIER ALL AMERICAN ASSISTED LIVING AT WASHIN	STREET ADDRESS, CITY, STATE, ZIP CODE 339 GREENTREE ROAD SEWELL, NJ 08080
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A 000	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #: NJ180498, NJ182626, NJ188325</p> <p>Census: 90</p> <p>Sample Size: 10</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administrator's Responsibilities</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/30/25

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ 182626</p> <p>Based on interview and record review, it was determined that the facility failed to ensure their administrator or designee implemented their NJ Ex Order 26 reporting policy by not conducting a complete and thorough investigation for an NJ Ex Order 26. 4B1. This deficient practice was identified for 1 of 2 NJ Ex Order 26. 4B1 reviewed, and was evidenced by the following:</p> <p>The surveyor reviewed the medical record for Resident #10.</p> <p>A review of the Resident Face Sheet (admission record) indicated that Resident NJ Ex Or was admitted to the facility NJ Ex Order 26. 4B1 [REDACTED]</p> <p>A review of the Progress Notes included The following notes:</p> <p>A note dated 11/8/24 at 8:47 PM, written by the Licensed Practical Nurse (LPN #1), that this writer was called to help at the front desk. Resident's [family member redacted] called building stating that [the resident] had called [them] stating that another resident (Resident #3) had come to [their] room and NJ Ex Order 26. 4B1 "</p>	A 310		
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A 310	<p>Continued From page 2</p> <p>NJ Ex Order 26. 4B1 [redacted]. Upon interviewing the resident (Resident #10) with another nurse, the resident stated that [they] were sitting in [their] living room when another resident (Resident NJ Ex) NJ Ex Order 26. 4B1 in [their] wheelchair NJ Ex Order 26. 4B1. The resident stated [they] told the resident to NJ Ex Order 26. 4B1 and called [their family member redacted]. NJ Ex Order 26. 4B1."</p> <p>A note dated 11/8/24 at 9:33 PM, written by LPN #2, indicated that this nurse received a call from Resident #10's [family member redacted] very upset stating [the resident] called [them] stating there was an NJ Ex Order 26. 4B1 [redacted] room with another nurse and asked what happened. [Resident #10] stated while sitting on [their] couch, another resident (Resident #3) NJ Ex Order 26. 4B1 [themselves] into [the resident's] room NJ Ex Order 26. 4B1 [redacted]. [Resident #10] stated [they] asked [Resident #3] to NJ Ex Order 26. 4B1 and called [their family member redacted]. NJ Ex Order 26. 4B1."</p> <p>The surveyor reviewed the closed medical record for Resident #3.</p> <p>A review of Resident #3's Resident Face Sheet revealed the resident was admitted to the facility NJ Ex Order 26. 4B1 [redacted].</p> <p>A review of Resident #3's most recent Service</p>	A 310		
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A 310	<p>Continued From page 3</p> <p>Plan (SP) dated effective [redacted] and last modified [redacted], indicated the resident was able to [redacted] and [redacted], did not have [redacted] and was [redacted]. The plan also included under the [redacted] category that the resident had [redacted] and did not have a current or [redacted].</p> <p>A review of Resident #3's Progress Notes included a note dated [redacted] at 9:09 PM, written by LPN #1, that this writer received a complaint from another resident (Resident #10), that [Resident #10] [redacted]. Upon investigation with another nurse, [Resident #3] was sitting in a wheelchair in [their] own room using [their] phone. Upon asking, [Resident #3] stated that [they] were on [their] way back to [their] room when they [redacted] [Resident #10's] room. [Resident #3] stated that [Resident #10's] living room door was propped open and [Resident #10] was sitting in living room area. [Resident #3] stated that [they] said hi from the hallway through the doorway [and Resident #3] was invited into the room by [Resident #10] where they made small talk, and [Resident #3] left for [their] own room. [Resident #3] [redacted] going into [Resident #10] [redacted]. [Resident #3] was advised per Executive Director to remain out of [Resident #10's] room and to [redacted] [Resident #10].</p> <p>On 10/6/25 at 10:37 AM, the surveyor requested from the Executive Director (ED #1) a list of [redacted] or [redacted] investigations from [redacted] until present.</p>	A 310		
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A 310	<p>Continued From page 4</p> <p>On 10/6/25 at 11:36 AM, ED #1 provided one investigation: the investigation for an NJ Ex Order 26. 4B1, involving Resident #3 and other residents. There was no investigation provided for the NJ Ex Order 26. 4B1.</p> <p>On 10/6/25 at 1:15 PM, the surveyor interviewed ED #1, who stated that neither she nor the Resident Care Director (RCD) were employed in their roles at the facility on NJ Ex Order 26. 4B1, and they were doing their best to look through the previous administration's files to find the investigations. ED #1 stated that she was unable to locate an NJ Ex Order 26. 4B1 report for the NJ Ex Order 26. 4B1.</p> <p>At that time, the RCD stated she had been looking through files and the electronic medical record and also could not find any additional investigations. Both ED #1 and the RCD acknowledged that the facility should have completed an investigation for the NJ Ex Order 26. 4B1.</p> <p>A review of the facility's "Abuse Reporting" policy with a revision date of 3/2019, revealed All employees are mandatory reporters, meaning they MUST report abuse and suspected abuse to the Executive Director Immediately ... The Executive Director shall immediately report the suspected abuse to Older Adult Protective Services ... Abuse is defined as ...Sexual: contact or interaction of a sexual nature involving a resident without his or her informed consent...</p> <p>A review of the facility's "Incident/Accident Reports" dated revised 3/2019, revealed ...reports need to be completed for all of the following ... Abuse-alleged and actual ...Follow your state regulations regarding reportable</p>	A 310		
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A 310	Continued From page 5 incidents ...	A 310		
A 565	<p>8:36-5.10(a)(3) Reportable Events</p> <p>(a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 or (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following:</p> <p>3. Any suspected cases of resident abuse or exploitation, which have been reported to the State Long-Term Care Ombudsman.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ 182626</p> <p>Based on interview and record review, it was determined that the facility failed to report an NJ Ex Order 26. 4B1 to the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 2 NJ Ex Order 26 reviewed, and was evidenced by the following:</p> <p>The surveyor reviewed the medical record for Resident #10.</p>	A 565		

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A 565	<p>Continued From page 6</p> <p>A review of the Resident Face Sheet (admission record) indicated that Resident #10 was admitted to the facility NJ Ex Order 26. 4B1 [REDACTED].</p> <p>A review of the Progress Notes included The following notes:</p> <p>A note dated NJ Ex Order 26.4 at 8:47 PM, written by the Licensed Practical Nurse (LPN #1), that this writer was called to help at the front desk. Resident's [family member redacted] called building stating that [the resident] had called [them] stating that another resident (Resident NJ Ex) had come to [their] room and NJ Ex Order 26. 4B1 [REDACTED]. Upon interviewing the resident (Resident #10) with another nurse, the resident stated that [they] were sitting in [their] living room when another resident (Resident #3) rolled up in [their] NJ Ex Order 26. 4B1 [REDACTED]. The resident stated [they] told the resident to NJ Ex Ord and called [their family member redacted]. NJ Ex Order 26. 4B1 [REDACTED]."</p> <p>A note dated NJ Ex Order 26 at 9:33 PM, written by LPN #2, indicated that this nurse received a call from Resident #10's [family member redacted] very NJ Ex Ord stating [the resident] called [them] stating there was an NJ Ex Order 26. 4B1 [REDACTED]. This nurse went in this resident's (Resident #10) room with another nurse and asked what happened. [Resident #10] stated while sitting on [their] couch, another resident (Resident #3) wheeled [themselves] into [the resident's] room NJ Ex Order 26. 4B1 [REDACTED].</p>	A 565		
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A 565	<p>Continued From page 7</p> <p>NJ Ex Order 26. 4B1 [Redacted]. [Resident #10] stated [they] asked [Resident #3] to [Redacted] and called [their family member redacted].</p> <p>NJ Ex Order 26. 4B1 [Redacted].</p> <p>The surveyor reviewed the closed medical record for Resident #3.</p> <p>A review of Resident #3's Resident Face Sheet revealed the resident was admitted to the facility</p> <p>NJ Ex Order 26. 4B1 [Redacted]</p> <p>A review of Resident #3's most recent Service Plan (SP) dated effective [Redacted], and last modified [Redacted], indicated the resident was able to NJ Exec Order 26.4b1 and [Redacted], did not have NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1. The plan also included under the NJ Ex Order 26. 4B1 category that the resident had [Redacted] issues and did not have a current or history of [Redacted] or [Redacted].</p> <p>A review of Resident #3's Progress Notes included a note dated [Redacted] at 9:09 PM, written by LPN #1, that this writer received a complaint from another resident (Resident #10), that [Resident #3] had gone into [Resident #10's] room NJ Ex Order 26. 4B1 [Redacted]. Upon investigation with another nurse, [Resident #3] was sitting in a wheelchair in [their] own room using [their] phone. Upon asking, [Resident #3] stated that [they] were on [their] way back to [their] room when they rolled past</p>	A 565		
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A 565	<p>Continued From page 8</p> <p>[Resident #10's] room. [Resident #3] stated that [Resident #10's] living room door was propped open and [Resident #10] was sitting in living room area. [Resident #3] stated that [they] said hi from the hallway through the doorway [and Resident #3] was invited into the room by [Resident #10] where they made small talk, and [Resident #3] left for [their] own room. [Resident #3] going into [Resident #10's] room</p> <p>[Resident #3] was advised per Executive Director to of [Resident #10's] room and to [Resident #10].</p> <p>On 10/6/25 at 10:37 AM, the surveyor requested from the Executive Director (ED #1) a list of investigations from until present.</p> <p>On 10/6/25 at 11:36 AM, ED #1 provided one investigation: the investigation for an , involving Resident #3 and other residents. There was no investigation provided for the .</p> <p>On 10/6/25 at 1:15 PM, the surveyor interviewed ED #1, who stated that neither she nor the Resident Care Director (RCD) were employed in their roles at the facility on , and they were doing their best to look through the previous administration's files to find the investigations. ED #1 stated that she was unable to locate an report for the , or a confirmation that the NJDOH had been notified of the .</p> <p>At that time, the RCD stated she had been looking through files and the electronic medical record and also could not find any additional investigations or confirmation the NJDOH had</p>	A 565		
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A 565	<p>Continued From page 9</p> <p>been notified of the NJ Ex Order 26. 4B1. Both ED #1 and the RCD acknowledged that the facility should have completed an investigation for the NJ Ex Order 26. 4B1 and notified the NJDOH of the NJ Ex Order 26. 4B1.</p> <p>A review of the facility's "Abuse Reporting" policy with a revision date of 3/2019, revealed All employees are mandatory reporters, meaning they MUST report abuse and suspected abuse to the Executive Director Immediately ... The Executive Director shall immediately report the suspected abuse to Older Adult Protective Services ... Abuse is defined as ...Sexual: contact or interaction of a sexual nature involving a resident without his or her informed consent...</p> <p>A review of the facility's "Incident/Accident Reports" dated revised 3/2019, revealed ...reports need to be completed for all of the following ... Abuse-alleged and actual ...Follow your state regulations regarding reportable incidents ...</p>	A 565		
A 625	<p>8:36-5.18(a)(3) Managed Risk Agreements</p> <p>(a) The choice and independence of action of a resident may need to be limited when a resident's individual choice, preference and/or actions are identified as placing the resident or others at risk, lead to adverse outcome and/or violate the norms of the facility or program or the majority of the residents. When the resident assessment process identified in N.J.A.C. 8:36-7 indicates that there is a high probability that a choice or action of the resident has resulted or will result in any of the preceding, the assisted living residence, comprehensive personal care, home or assisted living program shall:</p>	A 625		

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A 625	<p>Continued From page 10</p> <p>3. Seek to negotiate a managed risk agreement with the resident (or legal guardian) that will minimize the possible risk and adverse consequences while still respecting the resident's preferences; and</p> <p>This STANDARD is not met as evidenced by: Complaint # NJ 182626</p> <p>Based on interview and record review, it was determined that the facility failed to develop and implement a Managed Risk Agreement for a resident upon the initial identification of NJ Ex Order 26. 4B1. This deficient practice was identified for 1 of 3 residents reviewed (Resident #3), and was evidenced by the following:</p> <p>The surveyor reviewed the closed medical record for Resident #3.</p> <p>A review of Resident #3's Resident Face Sheet (an admission summary) revealed the resident was NJ Ex Order 26. 4B1 .</p> <p>A review of the Progress Notes included the following notes:</p> <p>A note dated NJ Ex Order 26 at 9:09 PM, written by the</p>	A 625		
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A 625	<p>Continued From page 11</p> <p>Licensed Practical Nurse (LPN #1), included that this writer received a complaint from another resident (Resident #10), that [Resident #3] had [Resident #10's] [Resident #10's] room. Upon investigation with another nurse, [Resident #3] was sitting in a wheelchair in [their] own room using [their] phone. Upon asking, [Resident #3] stated that [they] were on [their] way back to [their] room when they [Resident #10's] room. [Resident #3] stated that [Resident #10's] living room door was propped open and [Resident #10] was sitting in living room area. [Resident #3] stated that [they] said hi from the hallway through the doorway [and Resident #3] was invited into the room by [Resident #10] where they made small talk, and [Resident #3] left for [their] own room. [Resident #3] going into [Resident #10's] room.</p> <p>[Resident #3] was advised per Executive Director (ED #2) to of [Resident #10's] room and to [Resident #10]. Hourly checks also initiated per [ED #2].</p> <p>A note dated at 9:28 PM, written by LPN #2, included that this nurse received a complaint from a family member and another resident (Resident #10) that this resident (Resident #3) went into that resident's (Resident #10) room. When speaking to this resident (Resident #3), [they] stated that when [they] were going by the other resident's (Resident #10) room, they said hi from the hallway and was invited into the other resident's (Resident #10) room where they shared small talk before leaving for [their] own room. [Resident #3]. [Resident #3] advised per [ED #2] to of other</p>	A 625		
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A 625	<p>Continued From page 12</p> <p>resident's (Resident #10) room and to [redacted] other resident (Resident #10). Hourly checks also initiated per [ED #2].</p> <p>A note dated 1/16/25 at 10:44 PM, written by the Resident Care Director (RCD), indicated that staff reported witnessing [Resident #3] act in an NJ Ex Order 26.4B1 with a [gender redacted] resident. During this event, the resident [Resident #3] was separated immediately from the [gender redacted] resident. Investigation into the report was initiated, it was discovered that [Resident #3] had been NJ Ex Order 26.4B1 with several [gender redacted] residents in the community. [ED #2] had discussion with resident with Director of Nursing (DON) witness. Resident was notified any future NJ Ex Order 26.4b1 would not be tolerated and family would be made aware. Physician made aware and ordered NJ Ex Order 26.4B1 for [Resident #3]. [Resident #3] refused offer for NJ Ex Order 26.4B1 and/or NJ Ex Order 26.4B1 support. Nursing team aware to NJ Ex Order 26.4b1.</p> <p>A review of Resident #3's most recent Service Plan (SP) dated effective NJ Ex Order 26.4b1, and last modified NJ Ex Order 26.4b1 indicated the resident was able to NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 did not have NJ Ex Order 26.4b1 and was NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1. The plan also included under the NJ Ex Order 26.4B1 category that the resident had NJ Ex Order 26.4b1 and did not have a current or history of NJ Ex Order 26.4b1 NJ Ex Order 26.4B1 behavior.</p> <p>A further review of Resident #3's closed medical record did not include a Managed Risk Assessment (MRA), a formal, written plan negotiated between a care facility and a resident to address potential risks to the resident's safety</p>	A 625		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2025
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NAME OF PROVIDER OR SUPPLIER ALL AMERICAN ASSISTED LIVING AT WASHIN	STREET ADDRESS, CITY, STATE, ZIP CODE 339 GREENTREE ROAD SEWELL, NJ 08080
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A 625	<p>Continued From page 13</p> <p>and well-being that arise from the resident's choices.</p> <p>On 10/7/25 at 1:34 PM, the surveyor interviewed ED #1, who stated she was not the ED at the time of NJ Ex Order 26. 4B1. ED #1 stated she had double checked with the Regional Director of Wellness (RDW), who reviewed Resident #3's medical record, and stated Resident #3 did not have a MRA. When asked if this resident should have had a MRA in place for their NJ Ex Order 26. 4B1, ED #1 stated, "For [the resident], absolutely!"</p> <p>On 10/7/25 at 3:05 PM, the surveyor interviewed the RDW, who confirmed Resident #3 did not have a MRA, and acknowledged a MRA should have been initiated after the first NJ Ex Order 26. 4B1.</p> <p>A review of the facility's "Managed Risk Agreement/Informed Consent Process" policy with a revised date of January 2019, revealed ... The community may implement a managed risk agreement to decrease the probability of a negative outcome when a resident's choice, preference, or action may place the resident or others at risk ... A copy of all notifications will be retained in the resident's medical record.</p>	A 625		
A 709	<p>8:36-7.2(d)(1-18) Health Care Assmnt. and Health Service Plan</p> <p>(d) Each health care assessment by the registered professional nurse shall include, at a minimum, evaluation of the following:</p> <p>1. Need for assistance with "activities of daily living";</p>	A 709		

New Jersey Department of Health

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A 709	Continued From page 14 2. Cognitive patterns; 3. Communication/hearing patterns; 4. Vision patterns; 5. Physical functioning and structural problems; 6. Continence; 7. Psychosocial well-being; 8. Mood and behavior problems; 9. Activity pursuit patterns; 10. Disease diagnoses; 11. Health conditions and preventive health measures, including, but not limited to, pain, falls, and lifestyle; 12. Oral/nutritional status; 13. Oral/dental status; 14. Skin conditions; 15. Medication use; 16. Special treatment and procedures; 17. Restraint use; and 18. Outside service utilization.	A 709		

New Jersey Department of Health

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A 709	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ188325</p> <p>Based on review of the closed medical record and interview, it was determined that the facility Registered Nurse (RN) failed to assess an NJ Ex Order 26. 4B1 immediately upon identification. This deficient practice was identified for 1 of 10 residents, Resident #1, reviewed for NJ Ex Order 26. 4B1 and was evidenced by the following:</p> <p>A review of Resident #1's Resident Face Sheet (an admission record) revealed that the resident was admitted to the facility NJ Ex Order 26. 4B1 [REDACTED]</p> <p>A review of a physician's Progress Note (PN) dated NJ Ex Order 26, revealed NJ Ex Order 26. 4B1 [REDACTED]</p> <p>A review of a PN dated NJ Ex Order at 11:51 AM, revealed NJ Ex Order 26. 4B1 [REDACTED]</p> <p>Further review of a PN dated NJ Ex Order 26 at 10:30 PM, revealed NJ Ex Order 26. 4B1 [REDACTED]</p>	A 709		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/07/2025
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A 709	<p>Continued From page 16</p> <p>NJ Ex Order 26. 4B1</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED] nurse last visited on [REDACTED] and provided [REDACTED] care to the resident's NJ Ex Order 26. 4B1. Writer reached out to [REDACTED] concerning the matter at about 10 PM and was informed that a case manager, RN, would visit tomorrow, [REDACTED] to assess the resident. Writer contacted the DON (Director of Nursing) and PCP (Primary Care Physician) about NJ Ex Order 26. 4B1. Writer will reach out to the ED (Executive Director) and Corporate Nurse (Director of Wellness) to follow up on immediate concerns of the resident's needs of proper [REDACTED] care. This report from med-tech tonight is the first time residents NJ Ex Order 26. 4B1 has been reported and brought to writer's attention. Nursing will continue to monitor resident for any further changes in status."</p> <p>A review of the 24 Hour Communication Log revealed an entry dated [REDACTED], which indicated, NJ Ex Order 26. 4B1</p> <p>[REDACTED]</p> <p>[REDACTED]"</p> <p>A review of a PN dated [REDACTED] at 6:04 PM, revealed "...transport called this shift to confirm resident [REDACTED] (P/U) to new facility. P/U time will be at 2 PM via wheelchair. Will let next shift know as well as written in 24 hour communication log."</p> <p>A review of the final PN dated [REDACTED] at 1:41 PM, revealed NJ Ex Order 26. 4B1</p>	A 709		
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New Jersey Department of Health

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A 709	<p>Continued From page 17</p> <p>...transport and transporting to new facility. All medications were signed off by their ^{NJ Ex Order 26.4B1} and the nurse." There was no documented evidence within the PN that the resident was seen by the ^{NJ Ex Order 26.4B1} RN Case Manager as previously indicated in a PN dated ^{NJ Ex Order 26.4} at 10:30 PM, and on the 24 Hour Communication Log for the 3 PM to 11 PM shift on ^{NJ Ex Order 26.4}</p> <p>A review of the resident's Service Plan Detail effective ^{NJ Ex Order 26.4}, revealed that it was not updated to include the care of the resident's ^{NJ Ex Order 26.4B1} upon the initial identification.</p> <p>A review of a ^{NJ Ex Order 26.4B1} Flow Sheet indicated that on ^{NJ Ex Order 26.4} the resident had a ^{NJ Ex Order 26.4B1}</p> <p>^{NJ Ex Order 26.4B1}</p> <p>^{NJ Ex Order 26.4B1}</p> <p>^{NJ Ex Order 26.4B1}. Further review of the ^{NJ Ex Order 26.4B1} documentation revealed a Patient Care Order (Verbal Order) dated ^{NJ Ex Order 26.4} at 11:44 EST (Eastern Standard Time), to ^{NJ Ex Order 26.4} with ^{NJ Ex Order 26.4b1} (^{NJ Ex Order 26.4}) ^{NJ Ex Order 26.4}, pack with ^{NJ Ex Order 26.4B1} and cover with ^{NJ Ex Order 26.4B1} dressing 3 (three) x week. Facility to provide ^{NJ Ex Order 26.4} care when ^{NJ Ex Order 26.4B1} not visiting.</p> <p>On 10/6/25 at 1:33 PM, the surveyor interviewed the Executive Director (ED) who stated that neither herself or the corporate nurse (Regional Director of Wellness (RDW)) were informed of the resident's ^{NJ Ex Order 26.4} status until after the resident was ^{NJ Ex Order 26.4B1} from the facility. The ED stated</p>	A 709		
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New Jersey Department of Health

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A 709	<p>Continued From page 18</p> <p>that the facility Licensed Practical Nurse (LPN) #2 notified us that the receiving facility called and was upset because they did not know about the [redacted] NJ Ex Order 26. The ED explained that was why the facility was in possession of a [redacted] NJ Ex Order 26. treatment order dated [redacted] NJ Ex Order 26. 4B, after the resident had already been [redacted] NJ Ex Order 26. 4B1 from the facility. The ED further explained that she was unsure if the [redacted] NJ Ex Order 26. 4B agency had communicated with the former Resident Care Director (RCD)/ DON or to LPN #2 regarding the resident's [redacted] NJ Ex Order 26. status while the resident was here at the facility, as she was not always advised of clinical information.</p> <p>On 10/7/25 at 10:03 AM, the surveyor requested a copy of the facility [redacted] NJ Ex Order 26. 4B1 policy. The ED stated that the facility did not have a [redacted] NJ Ex Order 26. 4B1 policy, but used a Significant Change Policy instead.</p> <p>On 10/7/25 at 1:29 PM, the surveyor requested documented evidence that the resident's [redacted] NJ Ex Order 26. was assessed by the facility RN on [redacted] NJ Ex Order 26. 4B, after the LPN #1 documented the presence of a [redacted] NJ Ex Order 26. above the [redacted] NJ Ex Order 26. 4B1. The RDW was present and stated that the LPN needed to write a description of the [redacted] NJ Ex Order 26., not a staging, and notify the DON in accordance with her scope of practice. The RDW stated that the DON should have written a PN to indicate notification. The RDW further stated that there should have been an [redacted] NJ Ex Order 26. 4B report, investigation, and an update of the Health Service Plan which were not completed as required.</p> <p>At that time, the ED stated that she was unable to provide the surveyor with documented evidence that an RN assessment was completed as required.</p>	A 709		

New Jersey Department of Health

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A 709	Continued From page 19 A review of the facility policy, "Significant Change" revised June 2020, included: "Significant changes will be documented and reflected in the care plan/service plan. Resident significant changes will be assessed by the nurse. The resident's immediate needs will be met with the significant change...The care plan/service plan will be updated with the significant change."	A 709		
H 000	Initials Comments Type of Survey: Complaint Complaint #: NJ180498, NJ182626, NJ188325 Census: 90 Sample Size: 10 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.	H 000		
H5770	8:43E-13.4(c) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall send a completed, paper copy of the Universal	H5770		

New Jersey Department of Health

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H5770	<p>Continued From page 20</p> <p>Transfer Form with a patient when a patient is transferred.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ188325</p> <p>Based on closed record review, and interview, it was determined that the facility failed to send a completed copy of the Universal Transfer Form (a mandatory form used by New Jersey's licensed healthcare facilities to communicate essential patient care information during a transfer to another facility, ensuring continuity of care) with a patient upon transfer to another facility for a resident who was previously identified with a NJ Ex Order 26. 4B1 [REDACTED].</p> <p>This deficient practice was identified for 1 of 10 residents, Resident #1, reviewed for NJ Ex Order 26. 4B1 [REDACTED] and was evidenced by the following:</p> <p>A review of Resident #1's Resident Face Sheet (an admission record) revealed that the resident was admitted to the facility NJ Ex Order 26. 4B1 [REDACTED].</p> <p>A review of a Progress Note (PN) dated NJ Ex Order 26. 4B1 [REDACTED] at 10:30 PM, revealed Med-tech called writer (Licensed Practical Nurse, LPN #1) to resident's</p>	H5770		

New Jersey Department of Health

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H5770	<p>Continued From page 21</p> <p>room at about 9:30 PM. Resident has ^{NJ Ex Order 26. 4B1} [REDACTED]. Just above the ^{NJ Ex Order 26. 4B1} [REDACTED].</p> <p>Further review of the PN included a PN dated ^{NJ Exec Order 26. 4B1} [REDACTED] at 1:41 PM, revealed that the Resident has been picked up by ...transport and transporting to new facility. All medications were signed off by ^{NJ Ex Order 26. 4B1} [REDACTED] and nurse. Further review of the PN failed to indicate that the facility phoned the receiving facility to provide the resident's current clinical status and estimated time of departure.</p> <p>On 10/6/25 at 1:16 PM, the surveyor reviewed Resident #1's closed record in the presence of the Resident Care Director (RCD) and noted that a Universal Transfer Form was not found.</p> <p>At that time, the RCD also reviewed the closed record and confirmed that the Universal Transfer Form was not found.</p> <p>On 10/6/25 at 3:58 PM, the RCD stated that there was no documented evidence to indicate that the Universal Transfer Form was completed and the receiving facility was informed of the resident's condition prior to transfer. The RCD further stated that there was no documented evidence to indicate that the receiving facility was called before the resident left the facility to relay the resident's condition prior to transfer.</p> <p>A review of the facility's policy "Transfer to another Healthcare Facility" revised June 2020, included: ...When a resident is being discharged to another facility: Verify the receiving facility has</p>	H5770		
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New Jersey Department of Health

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H5770	Continued From page 22 all of the necessary paperwork...Complete the transfer sheet from the resident's chart and send it and the POLST (Physician Orders for Life Sustaining Treatment)...	H5770		

Received
Acceptable POC # 3
11/18/25



DEFICIENCY TAG#: A 310

- (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;
- HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
 - Resident #3 **NJ Ex Order 26. 4B1.**
 - Resident #10 still resides within the community and is **NJ Exec Order 26.4**, however resident #3 **NJ Ex Order 26. 4B1.**
 - HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
 - All residents have the potential to be affected.
 - WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
 - Executive Director (ED) and/or designee in-serviced all staff on facility policies and procedures for abuse, dangerous and violent residents, incident and accident reporting, resident rights, and reportable events. Started October 9, 2025, and will be completed by November 30, 2025.
 - Investigations will be initiated timely by the Executive Director (ED) and/or designee for all allegations of abuse.
 - Director of Business Administration and/or designee pulls Relias every Monday to audit completion of all in-services.
 - All new residents are given a copy of resident rights prior to moving in.
 - Resident rights are reviewed at orientation, annually through Relias training, and as needed.
 - HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
 - Resident Care Director (RCD), and/or designee audits progress notes, charting and documenting daily and relays significant findings to the management team in morning meeting.
 - COMPLETION DATE: 11/30/2025

**DEFICIENCY TAG#: A 565**

- (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at **NJ Ex Order 26. 4B1** if after business hours, followed with 72 hours by written confirmation of the following: 3. Any suspected cases of resident **NJ Ex Order 26** or exploitation, which have been reported to the State Long-Term Care Ombudsman.
- HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
 - Resident #10 still resides within the community, however resident #3 **NJ Ex Order 26. 4B1**.
 - HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
 - All residents have the potential to be affected.
 - WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
 - Executive Director (ED) and/or designee to report any suspected cases of resident abuse or exploitation to the New Jersey Department of Health by phone immediately and by written confirmation within 72 hours.
 - Executive Director (ED) and/or designee in-serviced all staff on facility policies and procedures for abuse, incident and accident reporting, and reportable events. Started October 9, 2025, and will be completed by November 30, 2025.
 - HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
 - Resident Care Director (RCD), and/or designee audits progress notes, charting and documenting weekly and relays significant findings to the management team in morning meeting and will report any suspected allegations of abuse immediately.
 - COMPLETION DATE: 11/30/2025

11/18/25
Acceptable PIC



DEFICIENCY TAG#: A 625

- (a) The choice and independence of action of a resident may need to be limited when a resident's individual choice, preference and/or actions are identified as placing the resident or others at risk, lead to adverse outcome and/or violate the norms of the facility or program or the majority of the residents. When the resident assessment process identified in N.J.A.C. 8:36-7 indicates that there is a high probability that a choice or action of the resident has resulted or will result in any of the preceding, the assisted living residence, comprehensive personal care, home or assisted living program shall: 3. Seek to negotiate a managed risk agreement with the resident (or legal guardian) that will minimize the possible risk and adverse consequences while still respecting the resident's preferences;
- HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
 - Resident #3 **NJ Ex Order 26. 4B1**
 - HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
 - All residents have the potential to be affected.
 - WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
 - Executive Director (ED) in-serviced Resident Care Director (RCD) upon **NJ Ex Order 26. 4B1** on facility policies and procedures for managed risk assessment/agreements.
 - Regional Nurse audited compliance 6/26/2025 and Executive Director (ED) and Regional Nurse initiated a managed risk agreement for all residents who were non-compliant with treatment and facility policy and procedures.
 - HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
 - Resident Care Director (RCD), and/or designee to monitor compliance through quality assurance audits quarterly. This deficient practice had already been identified prior to the 10/7/25 survey and auditing had already been put into place.
 - COMPLETION DATE: 11/03/2025

Acceptable POC
11/18/25



DEFICIENCY TAG#: A 709

- (d) Each health care assessment by the registered professional nurse shall include, at a minimum, evaluation of the following: 1. Need for assistance with "activities of daily living", 2. Cognitive patterns; 3. Communication/hearing patterns; 4. Vision patterns; 5. Physical functioning and structural problems; 6. Continence; 7. Psychosocial well-being; 8. Mood and behavior problems; 9. Activity pursuit patterns; 10. Disease diagnoses; 11. Health conditions and preventive health measures, including, but not limited to, pain, falls, and lifestyle; 12. Oral/nutritional status; 13. Oral/dental status; 14. Skin conditions; 15. Medication use; 16. Special treatment and procedures; 17. Restraint use; and 18. Outside service utilization.
- HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
 - Resident #1 **NJ Ex Order 26. 4B1**
 - HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
 - All residents have the potential to be affected.
 - WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
 - Regional Nurse in-serviced Executive Director (ED) and Resident Care Director (RCD) on facility policies and procedures for updating the residents' service plan.
 - Executive Director (ED) and/or designee in-serviced all staff on facility policies and procedures for abuse, incident and accident reporting, and reportable events. Started October 9, 2025, and will be completed by November 30, 2025.
 - Resident Care Director (RCD), and/or designee in-serviced Licensed Practical Nurses (LPN's), Medication Technicians (MT), and aides on facility policies and procedures for notification to the Registered Nurse (RN), scope of practice, and significant change. Started October 9, 2025, and will be completed by November 30, 2025.
 - Resident Care Director (RCD), and/or designee in-serviced Licensed Practical Nurses (LPN's) on facility policies and procedures for change in condition assessments, including skin assessments, changes to skin integrity, and reporting to the Registered Nurse promptly. Started October 9, 2025, and will be completed by November 30, 2025.
 - Resident Care Director (RCD), and/or designee to assess skin integrity for all residents who have been determined to be more compromised or at risk for skin breakdown.
 - HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
 - Resident Care Director (RCD) and/or designee to monitor chart audit compliance of Health Service Plan (HSP) through quality assurance. This deficient practice had already been identified prior to the 10/7/25 survey and auditing had already been put into place.

Acceptable POC
11/18/25



DEFICIENCY TAG#: A 709 continued

- Resident Care Director (RCD), and/or designee audits progress notes, charting and documenting weekly to identify any significant changes to skin integrity.
- COMPLETION DATE: 11/30/2025

DEFICIENCY TAG#: H 5770

- (a) A licensed healthcare facility or program shall send a completed, paper copy of the Universal Transfer Form with a patient when the patient is transferred;
- HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
 - Resident #1 **NJ Ex Order 26. 4B1**.
 - HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
 - All residents have the potential to be affected.
 - WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
 - Resident Care Director (RCD), and/or designee in-serviced Licensed Practical Nurses (LPN's) and Medication Technicians (MT) on facility policies and procedures for transferring a resident to another healthcare facility, including the mandatory use of the universal transfer form.
 - Resident Care Director (RCD), and/or designee in-serviced Licensed Practical Nurses (LPN's) and Medication Technicians (MT) on facility policies and procedures for documenting progress notes, charting and documenting, and discharging residents.
 - Resident Care Director (RCD), and/or designee in-serviced Licensed Practical Nurses (LPN's), Medication Technicians (MT), and aides on facility policies and procedures for notification to the Registered Nurse (RN), scope of practice, and significant change.
 - Resident Care Director (RCD), and/or designee in-serviced Licensed Practical Nurses (LPN's) on facility policies and procedures for change in condition assessments, including skin assessments.
 - HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
 - Resident Care Director (RCD), and/or designee to monitor compliance by auditing all resident transfer/discharge charts weekly x 4 weeks, then monthly x 2 months, then through quality assurance quarterly.
 - Resident Care Director (RCD), and/or designee audits progress notes, charting and documenting daily and relays significant findings to the management team in morning meeting.
 - COMPLETION DATE: 11/30/2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 08A012 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/18/2025 Y3
NAME OF FACILITY ALL AMERICAN ASSISTED LIVING AT WASHINGTON TOWNSHI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 H5770	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43E-13.4(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2025	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	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/7/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 08A012	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 11/18/2025	Y3
NAME OF FACILITY ALL AMERICAN ASSISTED LIVING AT WASHINGTON TOWNSHI			STREET ADDRESS, CITY, STATE, ZIP CODE 339 GREENTREE ROAD SEWELL, NJ 08080		

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0565	Correction	ID Prefix A0625	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.10(a)(3)	Completed	Reg. # 8:36-5.18(a)(3)	Completed
LSC	11/30/2025	LSC	11/30/2025	LSC	11/03/2025
ID Prefix A0709	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-7.2(d)(1-18)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2025	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/7/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		