STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18A113	A. BUILDING: _____ B. WING _____	C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT HILLSBOROUG	351 ROUTE 206 HILLSBOROUGH, NJ 08844

(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: COMPLAINT #: NJ00141850, NJ00142668, NJ00147404, NJ00168414, NJ00169932 CENSUS: 78 SAMPLE SIZE: 10 TYPE OF SURVEY: Standard Survey of 112 residential units, Complaint, and Life Safety Code The facility is not in substantial compliance with all 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 Life Safety Code Survey was conducted by the State Agency on 02/05/2024 - 02/07/2024. The facility was in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.	A 000		
A 235	8:36-2.4(d) Licensure Procedures (d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and resident records and conferences with residents.	A 235		

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

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 235	Continued From page 1	A 235		

This REQUIREMENT is not met as evidenced by:
Based on record and document review and interview, the facility failed to ensure all incident report forms were completed for 1 resident (Resident #6) of 3 sampled residents reviewed for incident reports completed related to [redacted].

Findings included:

A review of Resident #6's "Face Sheet" revealed the facility admitted the resident on [redacted]

A review of Resident #6's "Master LOC [Level of Care] Assessment," dated [redacted], revealed Resident #6 [redacted]

A review of Resident #6's "Progress Notes" revealed Resident #6 [redacted] on [redacted], [redacted] and [redacted].

A review of Resident #6's incident reports revealed the facility lacked [redacted] reports for the following dates: [redacted], and [redacted]

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A 235	Continued From page 2 During an interview on 02/07/2024 at 11:45 AM, Certified Medical Assistant (CMA) #3 stated Resident #6 NJ ex order 26.4b1. CMA #3 stated when a resident [redacted] the procedure was to call the nurse. CMA #3 stated if a nurse was in the building, they would arrive to conduct an assessment of the resident, but if the nurse were not in the building, the nurse on-call would walk the CMAs through what to do over the phone. CMA #3 stated that NJ Exec Order 2 required an incident report to be filled out. During an interview on 02/07/2024 at 2:11 PM, the Director of Nursing (DON) stated when a resident NJ Exec [redacted] the aide should let the CMA know and the CMA should notify the DON. The DON stated if she were in the building then she assessed the resident, but if she was not in the building, she directed the CMAs regarding how to assess the resident, such as looking for obvious NJ Exec Order 2 or if the resident NJ Exec Order 26.4b1. The DON stated an incident report should be filled out and a progress note written in resident's chart. During an interview on 02/07/2024 at 6:01 PM, the Executive Director was unable to provide a facility policy on NJ Exec [redacted] but stated his expectation was for an incident report to be filled out for resident NJ Exec C	A 235		
A 549	8:36-5.7(a)(7) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at	A 549		

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A 549	Continued From page 3 all times. The manual(s) shall include at least the following: 7. Policies and procedures, including content and frequency, for physical examinations and immunizations and tuberculin testing upon employment and subsequently for employees and individuals providing direct resident care services in the facility through contractual arrangements or written agreement; This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility document review, and interview, the facility failed to maintain personnel files for 2 (Certified Nursing Assistant #1 and Certified Nursing Assistant #6) of 5 personnel files reviewed. Findings included: A review of a facility policy titled, "Records, Employee," revised in 01/2019, revealed, "2. The following information will be kept in each employee's confidential medical file: Health Examination, Mantoux Tuberculin Skin Test-PPD [purified protein derivative]." A review of Certified Nursing Assistant (CNA) #1's employee record revealed no evidence of a [redacted] examination for CNA #1. The facility was unable to provide a current [redacted] examination for CNA #1. A review of CNA #6's employee record revealed no evidence of a [redacted] examination or a current [redacted] test for CNA #6. The facility was unable to provide a [redacted] examination or [redacted] test for CNA	A 549		

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 549	Continued From page 4 #6. During an interview on 02/07/2024 at 6:01 PM, the Executive Director (ED) confirmed CNA #1 did not have a [NJ Exec Orde] assessment or an annual PPD on file and confirmed CNA #6 did not have a [NJ Exec Orde] assessment on file. The ED said staff should have a [NJ Exec Orde] assessment completed before hire and that an annual [NJ Exec O] should be completed.	A 549		
A1193	8:36-17.3(a)(4) Housekeeping-Sanitation-Safety-Maintenance (a) The housekeeping and sanitation conditions in paragraphs 1 through 12 below shall be met. Application of this requirement with respect to the individual living environment shall take into consideration residents' personal preferences for style of living: 4. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Items which are broken or worn to the extent that they may cause discomfort or present danger to residents shall be repaired, replaced, or removed promptly; This REQUIREMENT is not met as evidenced by: Based on observation, document review, interview, and facility policy review, the facility failed to:	A1193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1193	Continued From page 5 1. ensure a resident washing machine on the second floor was in good repair and free of foul odors; and 2. conduct 2 of 4 required quarterly fire sprinkler tests during 2022 and 2023. Findings included: 1. During an initial tour of the facility conducted on 02/05/2024 at 10:50 AM, a foul odor from a second-floor left wing laundry room was detected in the air and a black substance was observed around the base of a washer. During an interview on 02/06/2024 at 3:00 PM, Certified Nursing Assistant (CNA) #1 stated she had been aware of a foul odor coming from the second-floor resident laundry area for a while. CNA #1 stated she was alerted of an odor coming from that laundry room by some of the residents who did their laundry on her assigned wing of the facility. CNA #1 stated she went to the second-floor laundry area to determine if an odor was present and stated there was a foul smell present at that time and noted residents on the wing verified it had smelled bad for a long time. CNA #1 stated that housekeeping mopped around the washers, but it smelled bad and a black substance was around the base of a washer. CNA #1 stated she reported this finding to the Maintenance Director but did not fill out an official work order. A review of facility work orders provided on 02/06/2024 at 5:00 PM revealed that no work orders were turned in or completed for the second-floor laundry room related to a foul odor, a black substance around a washing machine, or water pooling.	A1193		

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A1193	Continued From page 6 During an interview on 02/07/2024 at 10:38 AM, Housekeeper #5 stated it was housekeeping's responsibility to ensure all areas of the facility were cleaned and the laundry areas were mopped and cleaned by the housekeeping department. Housekeeper #5 stated he was aware that the laundry room smelled, but did not report the smell, reiterating that housekeeping just kept that area cleaned. During an interview on 02/07/2024 at 10:38 AM, the Maintenance Director stated that, on 02/06/2024, the smell in the laundry area in question was bought to his attention, and the washer mentioned was taken apart and cleaned and that is when he found that there was water pooled at the bottom of the machine. The Maintenance Director stated that once the washer was cleaned, the smell disappeared but then the smell came back again, so the issue needed to be investigated further to determine where the smell was coming from. During an interview on 02/07/2024 at 1:20 PM, the Executive Director (ED) stated his expectation was for all facility equipment to be kept clean and in good repair. The ED stated that, when a smell was identified coming from a washer in the laundry room, it should have been fixed. Review of an undated facility policy titled "Work Orders" revealed "Policy: Our community will maintain a system for residents and employees to request for work to be performed by the maintenance team. Procedure: 1. Reports of items in need of repair will be brought to the concierge. Concierge will complete the work order form." 2. A review of forms provided by the facility, which	A1193		

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A1193	Continued From page 7 were titled "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems," with dates of 02/23/2022, 11/07/2022, 02/27/2023, and 12/12/2023, revealed that these were the only dates on which fire sprinkler tests were conducted at the facility. During an interview on 02/06/2024 at 5:40 PM, the Maintenance Director stated quarterly sprinkler tests should have been conducted by contract services every quarter, but the tests had only been conducted twice a year. The Maintenance Director stated that he had started in the maintenance position six months prior and, going forward, he would ensure the testing was completed timely. A policy regarding facility maintenance and equipment upkeep was requested on 02/07/2024 at 2:00 PM, but no policy was provided by the facility prior to exit.	A1193		

POC #3- accepted. MP

All American ASSISTED LIVING

3/7/2024

HFEL.POCAL@doh.nj.gov

Please find the proposed Plan of Corrections for the Standard Survey, Complaint, and Life Safety Code that was conducted by the State Agency on 2/5-7/2024 at All American Assisted Living in Hillsborough NJ.

A235 8:36-2.4(d) Licensure Procedures

1. Resident #6 was identified as NJ ex order 26.4b1
2. All residents have the potential to be impacted by this alleged deficient practice.
3. All Nurses and Medication Aides in the Nursing Department will be reeducated on Falls Policy and Procedure and given a copy by the Executive Director or designee by 4/12/2024.
4. All staff will follow policy and procedure for new Incidents including completing incident reporting and all new incidents will be audited for completion 1 x week x 4 weeks then periodically thereafter by Resident Care Director or designee to verify compliance by 4/12/2024.

A549 8:36-5.7(a)(7) General Requirements

1. No residents were identified as impacted by this alleged deficient practice.
2. All residents have the potential to be impacted by this alleged deficient practice.
3. All current personnel files will be audited for completion by the Executive Director or designee by 4/7/2024. All current employee files will be compliant by 6/7/2024.
4. All personnel files will be audited upon new hire and annually for completion by the Director of Business Administration or designee.

A1193 8:36-17.3(a)(4) Housekeeping-Sanitation-Safety-Maintenance

(1)

1. No residents were identified as impacted by this alleged deficient practice.
2. All residents have the potential to be impacted by this alleged deficient practice.
3. All staff will be reeducated on Work Orders policy and procedure such as: reporting odors, non-working equipment, or other items which require a work order, by the Executive Director or designee by 4/7/2024.
4. All new facility work orders will be audited for completion 1 x week x 4 weeks then periodically thereafter by Maintenance Director or designee.

A1193 8:36-17.3(a)(4) Housekeeping-Sanitation-Safety-Maintenance

(2)

1. No residents were identified as impacted by this alleged deficient practice.
2. All residents have the potential to be impacted by this alleged deficient practice.
3. First quarter maintenance of Wet Pipe Fire Sprinkler Systems completed on 3/11/2024 and 2024 future maintenance appointments are scheduled for 6/11/2024, 9/9/2024, and 12/9/2024. ED and Director of Maintenance reeducated on requirements of wet pipe fire sprinkler system maintenance.
4. Maintenance Director or designee will audit maintenance of Wet Pipe Fire Sprinkler System completion 3/11/2024 and quarterly thereafter.

Sincerely,

NJ Exec Order 26.4b1 3/7/2024

NJ Exec Order 26.4b1 CALA- Executive Director

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
18A113 Y1	A. Building B. Wing Y2	4/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT HILLSBOROUGH	351 ROUTE 206 HILLSBOROUGH, NJ 08844

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 A0235 Reg. # 8:36-2.4(d) LSC	Correction Completed 04/11/2024	ID Prefix A1193 Reg. # 8:36-17.3(a)(4) LSC	Correction Completed 04/11/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
2/7/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
18A113		4/11/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix A0235 Reg. # 8:36-2.4(d) LSC	Correction Completed 04/11/2024	ID Prefix A0549 Reg. # 8:36-5.7(a)(7) LSC	Correction Completed 04/11/2024	ID Prefix A1193 Reg. # 8:36-17.3(a)(4) LSC	Correction Completed 04/11/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
2/7/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO