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HERITAGE ASSISTED LIVING, THE	45 ROUTE 206 HAMMONTON, NJ 08037

(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: Census: 72 Sample Size: 6 TYPE OF SURVEY: Standard Survey of 96 residential units 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 359	8:36-4.1(a)(3) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 3. The right to have his or her independence and individuality; This REQUIREMENT is not met as evidenced by:	A 359		

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

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A 359	Continued From page 1	A 359		

Based on observations and staff and resident interviews, it was determined that the facility failed to allow residents' access to their personal space and belongings for 1 of 6 sampled residents, Resident #1. This had the potential to affect 8 residents locked out of their unit on the NJ Ex Order 26.4b1 unit.

Findings include:

1. Resident #1 was admitted to the facility on NJ Ex Order 26.4b1. Diagnoses included NJ Ex Order 26.4b1 and NJ Ex Ord There was no documentation indicating that Resident #1 was NJ Ex Order 26.4b1.

On 07/07/2021 at 11:00 AM, an interview was completed with Resident #1. Resident #1 told the surveyor that staff NJ Ex Order 2 residents from the NJ side of the NJ Ex Order 26.4b1 unit onto the NJ side of the NJ Ex Order 26.4b1 unit from after breakfast until after the evening meal, usually about 7:00 PM. The units were separated by a dining room. Resident #1 also reported being NJ Ex Order and having to NJ Ex Order 26.4b1 because NJ Ex Order was not available. Resident #1 did say that liquids were provided if staff were asked for them.

An observation of the NJ Ex Order 26.4 units was made on 07/07/2021 at 11:10 AM. There were two hallways separated by a dining room. The 'NJ E side consisted of resident rooms. The 'NJ E side had resident rooms and an open common area next to the dining room. NJ Ex Order residents were observed on the 'NJ E side of the unit. The other NJ Ex O NJ E side residents were observed in the 'NJ E side common area. The door to go from the common area into the dining room was NJ Ex Order 26. Residents could go from the 'NJ E side to the 'NJ E side, but once they were on the 'NJ E side, they could not go back to the 'NJ E side to their room. A

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A 359	Continued From page 2	A 359		

large water dispenser was noted to be on a table in the dining room that was not accessible to residents.

On 07/07/2021 at 10:35 AM, an interview was completed with Certified Medication Aide (CMA) #7. CMA #7 said that residents were taken from the '[NJ E] side to the '[NJ E] side for the day each morning. The door to the dining room on the '[NJ E] side was locked to keep all residents but [NJ Ex Orde] who were allowed to stay on the '[NJ E] side. "It's to keep them from [NJ Ex Order 26.4b1] in and out of rooms. If they want to go back to their room, they ask the aide and they will get let back in."

On 07/07/2021 at 10:45 AM, an interview was completed with Certified Nursing Assistant (CNA) #1. CNA #1 said that residents from the '[NJ E] side were brought over to the '[NJ E] side unit after breakfast. [NJ Ex Ord] residents were allowed to stay on the '[NJ E] side because there were no concerns about them [NJ Ex Order 26.4b1] The other '[NJ E] side residents were not allowed to go back to their rooms. "Some of them want to go back over there, but they can't because we have to see what they are doing." CNA #1 said that if residents want to lie down and nap, "they can do that over here on a couch. There is a bucket of cold water in the dining room. Residents cannot get to it, but if they ask for water, I get it for them." There was no scheduled time for fluids. Fluids will be provided just if they say they are thirsty. CNA #1 reported being familiar with Resident #1 and that Resident #1 was not allowed to go back to the '[NJ E] side of the unit. Resident #1, "does [NJ Ex O] [redacted], but [Resident #1] knows he/she [NJ Ex Order 26.4b]." CNA #1 said that Resident #1 was [NJ Ex Ord] and [NJ Ex Order 26.4b1] "I think [Resident #1] has to stay over here because he/she is a [NJ Ex Order 26]. Residents who need [NJ Ex Order 26.4b1] get taken

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A 359	Continued From page 3 into the general [NJ Ex Order 26.4b1] on this side and we [NJ Ex Order 26.4b1]." An interview was completed with the Director of Nurses (DON) on 07/07/2021 at 11:17 AM. The DON said, "The morning aides bring the '[NJ E] side residents into the dining room with residents from the [NJ] side. After breakfast, all the residents go to the '[NJ E] side. They watch TV or listen to music and activities comes in. Staff check them to see if they need to be [NJ Ex Order 26.4b] then they have lunch. The aides take the '[NJ E] side residents back to their rooms to [NJ Ex Order 26.] them and takes them back to the '[NJ E] side living room. There are a couple of residents who can stay on the '[NJ E] side. They are not at risk to [NJ Ex O] themselves. (Residents in the '[NJ E] side common area) can nap in their chairs. There is a big 5-gallon container of water that the aides can get for them. It's in the dining room. We have talked about moving it to living room since it's summertime." The DON said that Resident #1 had to stay on the '[NJ E] side because Resident #1 would NJ Ex Order 26.4b1 and had [NJ Ex Order 26.4b1] .	A 359		
A 901	8:36-10.5(c)(4) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes,	A 901		

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A 901	Continued From page 4 shall be kept on file in the facility for at least 30 days; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, it was determined the facility failed to: 1. Post meal menus with portion sizes and any changes in the menu in the food preparation area, and post in a conspicuous place in the residents' area, and/or provide a copy to the residents; 2. Post changes or substitutions of the menu; and keep a 30-day log of meal changes or substitutions. This had the potential to affect 72 residents who received meals served from the facility's kitchen. Findings include: On 07/07/2021 at 8:32 AM, observations were made of the facility's kitchen. A weekly menu, posted in the food plating area, was observed to have no portion sizes listed. It was observed that the menu indicated chicken barley soup would be served at lunch later that day. On 07/07/2021 at 11:20 AM, observations were made of the lunch service. It was observed that tomato soup was served instead of the barley soup as listed on the menu. The wax beans were portioned with an unmeasured spoon. On 07/07/2021 at 11:28 AM, Dietary Aide (DA) #8, who was plating portions of food, was asked	A 901		

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A 901	Continued From page 5	A 901		

how she knew the correct portion sizes to serve residents as portions were not listed on the menu. She stated she had many years of experience and knew what portions were appropriate. She stated she knew what 4 ounces (oz.) looked like.

On 07/07/2021 at 12:25 PM, the Dietary Manager was asked if menus included portion sizes. He stated it had been "quite some time" since he had included portion sizes on the menus and the dietician had approved the menus without portion sizes for at least "a year." He stated he made "reasonable substitutions" without communicating with the dietician. He stated the logbook where substitutions had been logged at one time was now "empty" as he had not kept the log in a "long time."

On 07/08/2021 at 10:31 AM, the Dietary Manager was asked if menus were provided to residents. He stated the residents were provided with the menu as staff reviewed the menu with residents daily and took the resident's menu orders for the next day. Menus were not observed posted in the dementia care unit or the main dining room.

On 07/08/2021 at 12:30 PM, observations were made of the plating of the lunch meal in the dementia unit. It was observed there was no weekly menu posted in the serving area. It was observed that the food delivered from the kitchen included noodles. A poster listing food portions was observed on the wall in the kitchenette area of the dementia unit. The poster indicated that 6 ounces of pasta should be provided to residents for one serving.

On 07/08/2021 at 12:45 PM, DA #9 was observed serving one 4 oz. scoop of noodles per plate in the dementia unit. DA #9 was asked how they

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A 901	Continued From page 6 knew what portion sizes of food to serve to the residents. DA #9 stated she did not know. She was asked if she had been provided any education on plating food in the dementia unit or serving lunch, and she said, "No." On 07/08/2021 at 12:50 PM, Certified Nurse Assistant (CNA) #9 stated at times she plated meal portions in the dementia unit. She was asked if she had received training in serving food portions, and she said, "No." She was asked if she would know if a portion required more than one scoop, and she said, "No." On 07/08/2021 at 12:50 PM, Certified Home Health Aide (CHHA) #2 stated at times she plated meal portions in the dementia unit. She was asked if she had received training in serving food portions, and she said, "Not really." On 07/08/2021 at 1:30 PM, the Dietary Manager was asked what the correct portion size was for pasta, and he stated 4 oz. He was informed of the incorrect portion size indicated on the poster in the dementia unit. Two attempts were made to call the dietician, but they were unsuccessful. On 07/08/2021 at 1:45 PM, during the exit visit, the Administrator acknowledged the concerns.	A 901		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.	A 935		

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A 935	Continued From page 7	A 935		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, and record review, it was determined that the facility failed to ensure medications were given in accordance with prescriber's order for 1 of 3 observed residents, Resident #6, by failing to ensure Resident #6 received [redacted] with meals in accordance with the prescriber's orders.

Findings include:

1. Resident #6 was admitted to the facility on [redacted]. Diagnoses included [redacted] and [redacted].

A review of the prescriber's orders dated [redacted] indicated Resident #6 was to receive an [redacted] "with meals." [redacted] is a [redacted].

An observation of medication pass was completed on 07/07/2021 at 10:40 AM with Certified Medication Aide (CMA) #7. CMA #7 administered the [redacted] to Resident #6. During an interview, CMA #7 told the surveyor that lunch would be served around noon but it was okay to give Resident #6 [redacted] early because Resident #6's [redacted]." The [redacted] completed just prior to the [redacted] was

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A 935	Continued From page 8 NJ Ex Order 26.4b at NJ Ex Order 26.4b1 . On 07/07/2021 at 11:42 AM, the surveyor interviewed the Director of Nurses (DON). The DON said that medications ordered to be given with meals should be given at 11:30 AM or 12:00 PM, and that the lunch meal was delivered about 12:30 PM. The DON also said that the medication times were set "or the staff would be on the floor giving medications all day." Lunch was delivered to Resident #6 on 07/07/2021 at 12:32 PM almost 2 hours after the resident received the NJ Ex Order 26.4b1 .	A 935		
A1227	8:36-17.4(a) Housekeeping-Sanitation-Safety-Maintenance (a) All solid or liquid waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey State Department of Environmental Protection and this chapter. Solid waste which is stored within the building shall be stored in insect-proof, rodent-proof, fireproof, nonabsorbent, watertight containers with tight fitting covers and collected from storage areas regularly so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was	A1227		

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determined that the facility failed to store waste in a sanitary manner by failing to have lids on 1 of 1 garbage dumpsters and by placing garbage bags on the ground instead of inside the dumpster. This had the potential to affect all residents.

Findings include:

Reference: Chapter 24 of the New Jersey Sanitary Code section 8:24-5.5 Refuse, recyclables, and returnables, indicates:
(e) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the retail food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.

1. On 07/06/2021 at 1:00 PM, an observation of the outside garbage dumpster was completed with the Maintenance Director (MD). There were no lids on the dumpster and the bin was noted to be nearly empty. There were approximately 25 large bags of garbage lying on the ground beside the dumpster. The MD said that the dumpster probably had been full so staff would have left the garbage bags on the ground. After the dumpster was emptied, no one picked up the bags off the ground and placed them into the dumpster. The MD reported having to pick up bags of garbage off the ground and put them in the dumpster, "about every week." The MD also said that the plastic lids break off the dumpster and the lids had not been in place for a long time. He indicated the dumpsters were emptied twice a week.

On 07/08/2021 at 9:20 AM, an interview was completed with the Food Service Director (FSD). The FSD said that maintenance staff dealt with

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A1227	Continued From page 10 the dumpster and picking up bags that were left on the ground and would communicate with the vendor if there were issues with the dumpster, such as the lids not being in place. The FSD did not know if there had been lids present on the dumpster. The kitchen had been using, and was still using, disposable dinnerware throughout the COVID-19 pandemic and that resulted in a large increase in the amount of garbage generated.	A1227		
A1243	8:36-17.6(b) Housekeeping-Sanitation-Safety-Maintenance (b) The temperature of the hot water used for bathing and handwashing shall be at least 105 degrees and shall not exceed l20 degrees Fahrenheit. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain safe water temperatures within the acceptable temperature range of 105-120 degrees Fahrenheit (F). Temperatures were noted over 120 degrees F at 3 of 10 sinks tested in resident accessible areas. This had the potential to affect 28 residents. Findings include: 1. On 07/06/2021 at 10:15 AM, an interview was completed with the Maintenance Director (MD) The MD said that water temperatures were not monitored at sinks in residents' rooms or	A1243		

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A1243	Continued From page 11 common areas. The MD said that the hot water heaters had thermometers and that the facility did not use cold water mixing valves. The MD said that the water temperatures were kept under 120 degrees F. On 07/06/2021, an environmental observation was completed throughout the facility with the MD. The MD did not have access to a thermometer. Water temperatures were taken by the surveyor and verified with the MD. The water temperature in Room A202 was identified to be 121.3 degrees F. The second-floor television lounge had a common sink that had a water temperature of 123 degrees F. This sink was inside the locked memory unit that housed cognitively impaired residents. Room D205 had a water temperature of 124.3 degrees F. On 07/06/2021 at 2:25 PM, an observation of the facility water heaters was completed with the MD. There were three hot water heaters observed, each with its own thermometer attached. One thermometer showed a temperature of 150 degrees F, one showed a temperature of 124 degrees F, and the third one could not be read by the surveyor or MD. The facility did not have a policy for maintenance to monitor water temperatures.	A1243		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against	A1249		

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A1249	Continued From page 12 deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure the building was kept free of fire hazards and kept in good condition to ensure an attractive appearance and pleasant atmosphere. This was evidenced by exit and fire doors failing to self-close, improper storage of oxygen tanks, and failure to clean and/or repair a black substance on a wall from a water leak. This had the potential to affect 72 residents. Findings include: 1. During an observation on 07/06/2021 at 10:40 AM, the exit door by Room A212 failed to self-close. The Maintenance Supervisor demonstrated that a flap screwed onto the bottom of the door was preventing the door from self-closing. The Maintenance Supervisor stated he thought the flap had been added to block light from coming in from under the bottom of the door. During an observation on 07/06/2021 at 2:08 PM, the fire exit door by Room C108 failed to self-close. The Maintenance Supervisor acknowledged the issue. 2. On 07/06/2021 at 11:23 AM, two oxygen tanks	A1249		

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(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
A1249	Continued From page 13 were observed in the corner of the second-floor conference room. The tanks were not in carts, stands, or securely chained to the wall. The Maintenance Supervisor stated the tanks should have been stored in a closet on the "B" wing of the facility, and he said, "They are supposed to be chained." On 07/06/2021 at 11:43 AM, a biohazard storage room by Room C208 was observed to contain nine oxygen tanks which were not stored securely in carts, stands, or chained to the wall. The Maintenance Supervisor acknowledged the situation. 3. On 07/06/2021 at 1:30 PM, the storage closet by Room D105 was observed to have a black substance on the wall near the floor measuring approximately 12 inches by 20 inches. The black substance adhered to the wall. The Maintenance Supervisor stated the black substance was the result of a recent water leak. The Administrator was informed of the issues prior to survey exit on 07/08/2021 at 1:45 PM.	A1249		
A1307	8:36-18.4(a)(1) Infection Prevention and Control Services (a) Each new employee upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment	A1307		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1a006	A. BUILDING: _____ B. WING _____	07/08/2021

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HERITAGE ASSISTED LIVING, THE	45 ROUTE 206 HAMMONTON, NJ 08037

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A1307	Continued From page 14	A1307		

for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:

1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.

This REQUIREMENT is not met as evidenced by:
Surveyor: Bigham, Aletha

Based on record review and interviews, it was determined that the facility failed to ensure 5 of 5 sampled employees (Certified Nurse Assistants [CNAs] #5 and #6, Licensed Practical Nurse [LPN] #3, Activity Aide #3, and Maintenance Supervisor) completed required NJ Ex Order 26.4b1 with a NJ Ex Order 26.4b1 upon hire. This had the potential to affect 72 residents who resided in the facility.

Findings include:

On 07/08/2021 at 8:00 AM, five randomly selected employee files were reviewed for required NJ Ex Order 26.4b1 upon hire. Records for CNAs #5 and #6, LPN #3, Activity Aide #3, and the Maintenance Supervisor were reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1a006	A. BUILDING: _____ B. WING _____	07/08/2021

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(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
A1307	Continued From page 15 A review of all five employee records indicated no appropriate exceptions for [redacted]. A review of the employee records indicated none of the sampled employees had completed the required [redacted] upon hire. On 07/08/2021 at 10:30 AM, the Administrator (ADM) was informed of the missing records, and he stated he would investigate. On 07/08/2021 at 11:35 AM, the Director of Nurses (DON) stated some records were missing, including the [redacted]. The DON provided no new information regarding [redacted]. The DON had no explanation for the missing records and could not confirm [redacted] had been completed.	A1307		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
1a006 Y1	A. Building B. Wing Y2	8/6/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING, THE	45 ROUTE 206 HAMMONTON, NJ 08037

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 A0359	Correction	ID Prefix A0901	Correction	ID Prefix A0935	Correction
Reg. # 8:36-4.1(a)(3)	Completed	Reg. # 8:36-10.5(c)(4)	Completed	Reg. # 8:36-11.4(b)	Completed
LSC	08/04/2021	LSC	08/04/2021	LSC	08/04/2021
ID Prefix A1227	Correction	ID Prefix A1243	Correction	ID Prefix A1249	Correction
Reg. # 8:36-17.4(a)	Completed	Reg. # 8:36-17.6(b)	Completed	Reg. # 8:36-17.7	Completed
LSC	08/04/2021	LSC	08/04/2021	LSC	08/04/2021
ID Prefix A1307	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-18.4(a)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/04/2021	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	
7/8/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO