New Jersey Department of Health

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 ____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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: COMPLAINT #: NJ00183957 and NJ00188941 CENSUS: 60 SAMPLE SIZE: 8 TYPE OF SURVEY: Standard Survey of 90 residential units 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. CENSUS: 59 A Life Safety Code Survey was conducted by the State Agency on 11/03/2025. The facility was not 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 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/05/26

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 ____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 935	Continued From page 1	A 935		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, facility document review, and review of manufacturer's guidelines, the facility failed to ensure nursing staff administered NJ Ex Order 26 in accordance with manufacturer's guidelines. Specifically, Licensed Practical Nurse (LPN) #2 failed to NJ Exec Order 26.4b1 prior to administration of NJ Exec Order for 2 (Resident #7 and Resident #8) of 5 residents observed during medication administration.

Findings included:

LPN #2's competency evaluation titled, "Demonstrate Proper NJ Ex Order 26.4(b)(1) with NJ Ex Order dated 10/01/2025, revealed, "7. Prime NJ Ex Or with 2 units or as instructed by RN [Registered Nurse]." The competency evaluation revealed LPN #2 received an "acceptable" rating during an observation by the Director of Nursing (DON).

A resident demographic record indicated the facility admitted Resident #7 on NJ Exec Order 26.4b1. According to the demographic record, the resident had a medical history that included a diagnosis of NJ Exec Order 26.4b1 .

Resident #7's "Individual Service Plan," dated NJ Ex Order 26.4(b)(1), included an undated goal that

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 ___	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 935	Continued From page 2 indicated the resident would receive necessary care to manage NJ Exec Order 26.4b1 Interventions directed staff to provide assistance with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 as prescribed. Resident #7's "Current Medications" report for the timeframe from NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 included an order started on NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Ex three times a day. During an observation of medication administration for Resident #7 on NJ Exec Order 26.4b1 at 11:02 AM, LPN #2 removed Resident #7's NJ Exec Order from the medication cart, cleansed the top of the NJ Exec Order 26.4b1 with alcohol, applied a NJ Exec Order 2 to the NJ Ex of the NJ Exec O and NJ Exec Order the NJ Exec Or . LPN #2 then administered the NJ Exec Order to the resident. LPN #2 did not NJ Exec Orde the NJ Exec Order 2 of the NJ Exec Order 26.4b1 prior to administration of the NJ Exec Order to Resident #7. The manufacturer's guidelines for Resident #7's NJ Exec Order 26.4b1 pen, titled, NJ Exec Order 26.4b1 " revealed, "Before each NJ Ex Order 26.4(b) small amounts of air may collect in the cartridge during normal use. To avoid NJ Ex Order 26.4(b)(1) and to ensure proper dosing: E. Turn the dose selector to select 2 units (see diagram E). F. Hold your NJ Ex Order 26.4(b)(1) with the NJ Ex Order 26.4 pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge (see diagram F). G. Keep the NJ Ex Order 26.4 pointing upwards, press the push-button all the way in (see diagram G). The dose selector returns to 0. A drop of NJ Ex Order 26 should appear at the NJ Ex Order 26.4(b)(1). If not, change the NJ Ex Order 26.4 and repeat the procedure no more than 6 times." A resident demographic record indicated the	A 935		

New Jersey Department of Health

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 ________	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 935	Continued From page 3 facility admitted Resident #8 on NJ Exec Order 26.4b1 According to the demographic record, the resident had a medical history that included a diagnosis of NJ Exec Order 26.4b1 . Resident #8's "Individual Service Plan," dated NJ Exec Order 26.4b1, included an undated goal that indicated the resident would receive necessary care to manage NJ Exec Order 26.4b1 Interventions directed staff to provide assistance with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 as prescribed. Resident #8's "Current Medications" report for the timeframe from NJ Exec Order 26.4b1 included an order started on NJ Exec Order 26.4b1 for NJ Exec Orde twice a day. During an observation of medication administration for Resident #8 on NJ Exec Order 26.4b1 at 11:18 AM, LPN #2 removed Resident #8's NJ Exec Order from the medication cart, cleansed the top of the NJ Exec Order 26.4b1 with alcohol, applied a NJ Exec Order to the NJ Ex of the NJ Exec O and NJ Exec Order the NJ Exec Or . LPN #2 then administered the NJ Exec Order to the resident. LPN #2 did not prime the NJ Exec Order of the NJ Exec Order 26.4b1 prior to administration of the NJ Exec Order to Resident #8. The manufacturer's guidelines for Resident #8's NJ Exec Order 26.4b1, titled, NJ Exec Order 26.4b1 " revealed, "Priming your NJ Exec Order 26.4b1: Step 7: Turn the dose selector to select 2 units (See Figure H). Step 8: Hold the NJ Ex Ord with the NJ Ex Order 26.4 pointing up. Tap the top of the NJ Ex Ord gently to let any air bubbles rise to the top (See Figure I). Step 9: Hold the NJ Ex Ord with the NJ Ex Order 26.4 pointing up. Press and hold in the dose button until the dose counter shows "0.' The '0' must line up with the dose pointer. A drop of NJ Ex Order 26 should be seen at the needle tip (See Figure J). If you do not see a drop of NJ Ex Order 26.4	A 935		

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 ______	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 935	Continued From page 4 repeat steps 7 to 9, no more than 6 times. If you still do not see a drop of NJ Ex Order 26.4 change the NJ Ex Order 26.4 and repeat steps 7 to 9." During an interview on 10/31/2025 at 11:23 AM, LPN #2 stated she was not aware that an NJ Exec Order 26.4b1 needed to be NJ Exec Order 26.4b1 prior to administering NJ Exec Order 26.4b1 to a resident During an interview on 10/31/2025 at 2:51 PM, the DON stated they conducted quarterly observations of medication administration. The DON stated she would expect the staff administering NJ Exec Order 26.4b1 via a NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 prior to administering the NJ Exec Order 26.4b1 During an interview on 10/31/2025 at 3:28 PM, the Executive Director stated she would expect staff who administered medications to follow what was taught during their competency training, and she would expect staff to NJ Exec Order 26.4b1 before administration.	A 935		
A1041	8:36-14.3(a) Emergency Services and Procedures (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb	A1041		

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 ____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
A1041	Continued From page 5	A1041		

threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills.

This REQUIREMENT is not met as evidenced by:
Based on interview and facility document and policy review, the facility failed to conduct monthly fire drills for 3 of 12 months reviewed and failed to ensure complete documentation of the drills to include the time and description of the drill.

Findings included:

An undated facility policy titled, "[Corporate Name] Fire Drill Policy and Procedure" indicated, "The purpose of this policy is to ensure the safety of all residents, staff, and visitors by maintaining readiness and preparedness in the event of a fire emergency." The policy continued, "[Corporate name] is committed to conducting fire drills on a monthly basis in compliance with state and local regulations. Fire drills will be conducted on a rotating shift schedule to ensure that all shifts (Day, Evening, and Overnight) receive annual training and experience in proper fire response and evacuation procedures."

Facility documents titled, "Training/In-Service Documentation" revealed fire drills were conducted on the following dates: 02/27/2025, 03/12/2025, 04/30/2025, 05/19/2025, 06/20/2025, 07/18/2025, 08/07/2025, 09/27/2025, and 10/15/2025. The documents revealed no evidence of the time of the drill or description of the drill. There was no evidence to indicate which

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 ______	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
A1041	Continued From page 6 shift schedule (Day, Evening, or Overnight) the fire drills were conducted. There was no documented evidence of the staff in charge of the drill on 02/27/2025, 07/18/2025, or on 10/15/2025. There was no evidence of fire drills conducted for the months of November 2024, December 2024, and January 2025. During an interview on 11/03/2025 at 1:38 PM, the Director of Maintenance (DOM) acknowledged that there was no evidence a fire drill was conducted during the months of November 2024, December 2024, and January 2025. He stated that the fire drill documentation that was completed on 02/27/2025, 03/12/2025, 04/30/2025, 05/19/2025, 06/20/2025, 07/18/2025, 08/07/2025, 09/27/2025, and 10/15/2025 did not have the hour the drill was completed or a description of the fire drill. He stated that there was no signature of the staff in charge of the drill on 02/27/2025, 07/18/2025, or 10/15/2025. He stated he was aware of the life safety code requirement to conduct monthly fire drills. The DOM stated he was not aware of the requirements to include the description of the fire drill, the time the drill was conducted, and the signature of the staff in charge. He stated he expected fire drills to be completed monthly and to have complete documentation of the fire drills. During an interview on 11/03/2025 at 2:16 PM, the Executive Director (ED) stated there was no evidence that fire drills were conducted during the months of November 2024, December 2024, and January 2025. She stated the fire drill documentation did not contain the time the drill was conducted or a description of the fire drill on 02/27/2025, 03/12/2025, 04/30/2025, 05/19/2025, 06/20/2025, 07/18/2025, 08/07/2025, 09/27/2025, or 10/15/2025. She stated that the fire drills	A1041		

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 ______	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
A1041	Continued From page 7 lacked the signature of the person in charge of the drill on 02/27/2025, 07/18/2025, and 10/15/2025. The ED stated she expected fire drills to be conducted monthly and to have all the required evidence of information documented, including the time the fire drill was conducted, the description of the fire drill, and the signature of the staff in charge of the fire drill.	A1041		
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 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 interview and facility document review, the facility failed to exercise their emergency generator monthly under load for at least 30 minutes according to National Fire Protection Association (NFPA) 110, Standard for Emergency and Standby Power Systems, for 12 of 12 months reviewed and failed to conduct weekly inspections of the generator for 52 weeks of 52 weeks. Findings included:	A1249		

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 ______	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
A1249	Continued From page 8 During an interview on 11/03/2025 at 2:16 PM, the Executive Director (ED) stated she had no policy on inspecting, testing, or maintaining the generator. On 11/03/2025 at 10:47 AM, a review of the life safety code inspection book provided by the facility contained no evidence of weekly or monthly inspections, testing, or maintenance of the generator for the prior 12 months. An annual generator inspection document titled, "NJ Ex Order 26.4(b)(1) dated 01/29/2025, for "NJ Ex Order 26.4(b)(150 KW Preventative Maintenance Check List" was provided but did not included evidence of weekly or monthly inspections, testing, or maintenance of the generator for the prior 12 months. During an interview on 11/03/2025 at 11:10 AM, and after a second request for weekly and monthly inspections, testing, or maintenance of the generator for the prior 12 months, the Director of Maintenance (DOM) stated he had never performed any load tests, weekly or monthly inspections, testing, or maintenance of the generator since he began working at the facility in NJ Exec Order 26.4b1 He stated he had no documentation of any weekly or monthly inspections, testing, maintenance, or monthly load testing of the generator for the prior 12 months. During the interview on 11/03/2025 at 2:16 PM, the ED further stated she was not aware of the requirement to inspect the generator weekly or perform load testing monthly. She stated she expected all New Jersey Administrative Code (NJAC) and the life safety code (LSC) regulations to be followed.	A1249		

POC Received 1/21/2026
Accepted

The Heritage Assisted Living 45 Route 206 Hammonton, NJ 08037

Revised Plan of Correction

January 21, 2026

Tag A935 8:36-11.4(b) Pharmaceutical Services

Insulin Administration Not in Accordance with Manufacturer's Guidelines

1. Corrective action for residents found to have been affected by the deficient practice

Immediately upon identification of the deficient practice on **10/31/2025**, the Director of Nursing (DON) provided **one-on-one re-education** to LPN #2 regarding prope NJ Exec Order 26.4b1 administration, including mandatory priming of NJ Exec Order 26.4b1 per manufacturer's guidelines prior to each NJ Exec Order 26.4b1 The education included a return demonstration, which LPN #2 successfully completed. The DON reviewed proper administration with all other nursing staff on 11/4/2025.

Residents #7 and #8 were assessed by nursing staff for any adverse outcomes related to insulin administratior NJ Exec Order 26.4b1 were reviewed, and NJ Exec Order 26.4b1 were identified. Ongoing monitoring of NJ Exec Order 26.4b1 for both residents continued per physician orders, and no further issues were noted.

On 10/31/2025 the DON reviewed manufacturer instructions for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with nursing staff to reinforce correc NJ Exec Order 26.4b1 technique and ensure safe and accurate NJ Exec Order 26.4b1 administration

2. How the facility will identify other residents having the potential to be affected by the same deficient practice

The DON conducted an immediate audit of **all residents currently prescribed insulin via pen devices** to identify those potentially affected by the deficient practice. Medication Administration Records (MARs) and insulin administration practices were reviewed for all residents receiving insulin on 10/31/2025.

The Heritage Assisted Living 45 Route 206 Hammonton, NJ 08037

Revised Plan of Correction

Additionally, on 11/4/2025 the DON conducted **direct observation** of insulin administration by all licensed nursing staff to verify correct technique, including priming of insulin pens prior to administration. Any staff found to require reinforcement were immediately re-educated.

3. Measures put into place for systemic changes to ensure the deficient practice will not recur

To prevent recurrence, the facility implemented the following systemic changes:

The DON revised on 10/31/2025 the **Medication Administration Policy** to explicitly state that insulin pens must be primed prior to each use in accordance with manufacturer guidelines.

On 10/31/2025 the DON updated the **nursing competency checklist** for insulin administration to clearly include insulin pen priming as a required step.

On 11/4/2025 the DON provided **mandatory in-service education** for all licensed nursing staff on proper insulin pen administration, including manufacturer-specific instructions.

Required **annual and new-hire competencies** for insulin administration to include direct observation and return demonstration of insulin pen priming was implemented on 11/4/2025.

On 10/31/2025 the DON posted **manufacturer priming instructions** in medication rooms and medication carts as a visual reminder for nursing staff

4. How the facility will monitor corrective actions to ensure compliance and prevent recurrence

The DON or designee will conduct **monthly medication administration audits** for a minimum of **three months**, with a focus on insulin pen administration and priming technique. These audits will include direct observation and documentation of compliance.

The Heritage Assisted Living 45 Route 206 Hammonton, NJ 08037

Revised Plan of Correction

Results of audits will be reviewed during **Quality Assurance and Performance Improvement (QAPI)** meetings managed by the DON. Any identified noncompliance will result in immediate re-education and follow-up monitoring. The next meeting is scheduled for 3/2/2026.

The insulin administration observations will continue **quarterly** as part of the facility's ongoing quality monitoring program to ensure continued adherence to safe medication administration practices. Quarterly observations may be concluded at the community's discretion when Quality Assurance findings indicate full compliance. The next Quality Assurance meeting will be on 3/2/2026.

Date of Completion: 11/4/2025
Responsible Party: Director of Nursing / Executive Director

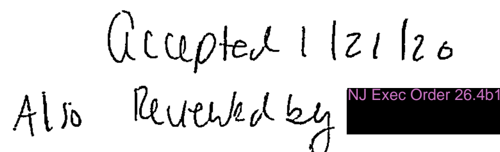
accepted 1/21/26

Tag A1041 8:36-14.3(a) Emergency Services and Procedures

Emergency Services and Procedures – Fire and Disaster Drills

1. Corrective action for residents found to have been affected by the deficient practice

Although no actual emergency events occurred during the period of noncompliance, all residents were considered potentially affected due to the facility's failure to conduct required monthly fire drills and maintain complete documentation. Upon identification of the deficiency, the facility conducted a **fire drill** on 11/1/2025 that included staff participation and resident safety measures appropriate to the drill scenario. Staff were re-educated on fire response procedures, including RACE and PASS protocols, to ensure resident safety in the event of an emergency.



The Heritage Assisted Living 45 Route 206 Hammonton, NJ 08037

Revised Plan of Correction

2. How the facility will identify other residents having the potential to be affected by the same deficient practice

All residents residing in the facility during the period in which required fire drills were not conducted or were inadequately documented were identified as potentially affected. The facility reviewed its emergency preparedness plan to ensure that all current residents are included in future drills as appropriate. Selected residents will continue to participate in drills based on cognitive and physical ability, and all residents will be protected by staff trained through routine emergency preparedness activities.

3. Measures put into place for systemic changes to ensure the deficient practice will not recur

The facility implemented the following systemic changes:

Assigned **primary responsibility** for scheduling, conducting, and documenting all emergency drills to the **Director of Maintenance (DOM)**, with oversight by the **Executive Director (ED) on 11/1/2025.**

The Maintenance Director developed and implemented a **standardized Fire Drill Documentation Form** that requires completion of all mandated elements, including:

- Date and time of drill
- Description and type of drill
- Shift conducted (Day, Evening, Overnight)
- Participating staff
- Signature of the staff member in charge

On 11/1/2025 the Maintenance Director established a **monthly emergency drill calendar** to ensure drills are conducted every month and rotate across all shifts annually.

The Maintenance Director provided education to leadership staff on **NJAC 8:36-14.3(a)** requirements, including documentation standards and annual disaster drill requirements on 11/1/2025.

The Heritage Assisted Living 45 Route 206 Hammonton, NJ 08037

Revised Plan of Correction

On 11/11/2025 the Maintenance Director implemented a requirement that **at least one non-fire disaster drill** be conducted and documented annually.

4. How the facility will monitor corrective actions to ensure compliance and prevent recurrence

The ED or designee will review emergency drill documentation **monthly** to verify completeness, accuracy, and compliance with regulatory requirements. Drill compliance will be tracked on a **master log** and reviewed during **Quality Assurance and Performance Improvement (QAPI)** meetings. The next meeting is scheduled for 3/2/2026.

After six months of sustained compliance, ongoing monitoring will continue quarterly as part of routine life safety oversight. Quarterly observations may be concluded at the community's discretion when Quality Assurance findings indicate full compliance

Responsible Parties: Executive Director, Director of Maintenance
Date of Completion: 11/11/2025

accepted 1/21/26
Also reviewed by NJ Exec Order 26.4b1

The Heritage Assisted Living 45 Route 206 Hammonton, NJ 08037

Revised Plan of Correction

Tag A1249 8:36-17.7

Housekeeping–Sanitation–Safety–Maintenance: Emergency Generator Testing and Maintenance

1. Corrective action for residents found to have been affected by the deficient practice

All residents were considered potentially affected due to the facility's failure to perform required weekly inspections and monthly load testing of the emergency generator. Immediately upon identification of the deficiency, the facility contacted a **licensed generator service vendor on 11/3/2025** to evaluate the emergency generator and confirm operational readiness. The generator was assessed to ensure it would function properly in the event of a power outage, thereby protecting resident health and safety on 11/18/2025. The load testing was completed on 11/18/2025.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice

All residents residing in the facility during the period of noncompliance were identified as potentially affected. A licensed generator service vendor on 11/18/2025 reviewed emergency power coverage areas to ensure critical resident care systems are supported by the generator. This review ensures all current and future residents are protected in the event of a power failure.

3. Measures put into place for systemic changes to ensure the deficient practice will not recur

The facility implemented the following systemic corrective actions:

The Maintenance Director developed and implemented a **Generator Inspection, Testing, and Maintenance Policy** consistent with **NFPA 110** requirements on 11/19/2025.

The Heritage Assisted Living 45 Route 206 Hammonton, NJ 08037

Revised Plan of Correction

Assigned responsibility for generator oversight to the **Director of Maintenance**, with oversight by the **Executive Director**.

The Maintenance Director established a **weekly inspection log** and **monthly load testing log** to document on 11/19/2025:

- Weekly visual inspections
- Monthly load testing under load for at least 30 minutes
- Any corrective actions taken

On 11/3/2025 the Maintenance Director contracted with a **qualified generator service company** to perform annual preventive maintenance and support monthly load testing as needed.

The licensed generator service technician provided education to the DOM and ED on NFPA 110 requirements and New Jersey Life Safety Code regulations 11/18/2025.

4. How the facility will monitor corrective actions to ensure compliance and prevent recurrence

The ED will review generator inspection and testing logs **monthly** to ensure all required inspections and load tests are completed and documented. Compliance will be monitored through routine **QAPI reviews**. Quarterly observations may be concluded at the community's discretion when Quality Assurance findings indicate full compliance. The next review is scheduled for 3/2/2026.

On 1/19/2025 the Maintenance Director and Executive Director created a calendar with scheduled audits and corrective action will be documented. Generator compliance will be included in ongoing life safety audits to ensure sustained adherence to regulatory requirements.

The Heritage Assisted Living 45 Route 206 Hammonton, NJ 08037

Revised Plan of Correction

Responsible Parties: Executive Director, Director of Maintenance
Date of Completion: 11/19/2025

Accepted 1/21/26
reviewed by NJ Exec Order 26.4b1

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
1a006 Y1	A. Building B. Wing Y2	1/21/2026 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 A0935 Reg. # 8:36-11.4(b) LSC	Correction Completed 11/04/2025	ID Prefix A1041 Reg. # 8:36-14.3(a) LSC	Correction Completed 01/11/2026	ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 01/19/2026
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	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

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 11/3/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

EVENT ID: NKPX12