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
	35A002	A. BUILDING: ______ B. WING ______	C 08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON TOWNSHIP SENIOR LIVING	**600 MEDICAL CENTER DRIVE** **SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00145752 CENSUS: 76 SAMPLE SIZE: 3 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 625	8:36-5.18(a)(3) General Requirements (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:	A 625		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/27/21

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A 625	Continued From page 1 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; This STANDARD is not met as evidenced by: Complaint #: 00145752 Based on interview and record review it was determined that the facility failed to negotiate a NJ Ex Order 26.4(b)(1) Agreement with 1 of 3 residents, Resident #1, who had history of NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). The deficient practice was evidenced by the following: On 8/2/21 at 11:30 a.m., during the entrance conference with the Executive Director (ED), the surveyor inquired if the facility had any residents with a NJ Ex Order 26.4(b)(1) Agreement. The ED stated that there was no resident with a NJ Ex Order 26.4(b)(1) Agreement. At 11 a.m., the surveyor reviewed Resident's #1's medical record which revealed that the resident was admitted to the facility in NJ Ex Or of NJ Ex Orde with diagnoses which included NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). According to the "Resident Review Tool" (RRT) dated NJ Ex Order 26.4, completed by a Licensed Practical Nurse (LPN), the resident was NJ Ex Ord with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) In addition, the LPN documented that the resident was NJ Exec Order to	A 625		

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A 625	Continued From page 2 NJ Ex Order 26.4(b)(1) that the resident NJ Ex Order 26.4(b)(1) and had NJ Ex Order 26.4(b)(1) in the refrigerator in the resident's apartment. Further surveyor review of the resident's medical record revealed a Physician's "Office Visit" dated NJ Ex Order 26.4(b)(1), prior to the resident's admission to the facility. The "Progress Notes" indicated, "Pt [patient] still NJ Ex Order 26.4(b)(1) or more NJ Ex Order 26.4(b)(1) per day." In addition, the "Patient Active Problem List" indicated, "NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) without complication." During interview with the ED and the Director of Nursing (DON), both stated they were aware that the resident was a NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The ED confirmed that after the NJ Ex Order 26.4(b)(1) incident on NJ Ex Order 26.4(b)(1) that started in the Resident #1's room, she then took away the resident's NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Also, the DON confirmed that she observed the resident in his/her apartment, by the window, NJ Ex Order 26.4(b)(1) but could not recall the date and time. Despite this, there was no documented evidence in the medical record that the facility worked with the resident to develop a NJ Ex Order 26.4(b)(1) agreement for NJ Ex Order 26.4(b)(1) so as to minimize the danger to Resident #1, other residents and staff. According to the Facility Reportable Event (FRE) documentation, on NJ Ex Order 26.4(b)(1) at approximately 8:14 [a.m.] the NJ Ex Order 26.4(b)(1) sounded and NJ Ex Order 26.4(b)(1) was observed coming into the hallway from NJ Ex Order 26.4(b)(1) Resident #1's NJ Ex Order 26.4(b)(1). During interview with the ED, she stated that 76 residents were NJ Ex Order 26.4(b)(1) from their apartments and 15 residents were later NJ Ex Order 26.4(b)(1)	A 625		

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A 625	Continued From page 3 Refer to 8:36-6.1(a)(8)	A 625		
A 657	8:36-6.1(a)(8) Resident Care Policies (a) Written resident care policies and procedures shall be established, implemented, and reviewed at intervals specified in the policies and procedures. Each review of the policies and procedures shall be documented. Policies and procedures shall include, but not be limited to, the following: 8. The control of smoking in the facility, in accordance with N.J.S.A. 26:3D-55 et seq. and the rules promulgated thereunder; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00145752 Based on observation, interview and record review it was determined that the facility Administrator failed to ensure that the "Smoking" policy was implemented for 2 of 3 residents reviewed for [NJ Ex Order 26.4(b)] Resident #1 and Resident #2. This deficient practice was evidenced by the following: Facility Smoking Policy: According to the facility's policy and guidelines titled, "Smoking," "Residents who smoke are reviewed for his or her ability to smoke safely and must agree to, and honor the terms and conditions for smoking which include designated smoking times and locations." In addition, the "Provision(s) And Procedures(s)" revealed, "On admission, residents who smoke have a Safe	A 657		

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A 657	Continued From page 4 Smoking Evaluation completed as part of the overall admission process. The Safe Smoking Evaluation is completed annually and at a significant change in condition." On 5/28/21, the Department of Health (DOH) received a Facility Reportable Event (FRE) regarding a NJ Ex O that occurred at the facility on NJ Ex Order 26.4. According to the FRE dated NJ Ex Order 26.4, completed by the facility's Executive Director (ED) at approximately 8:14 [a.m., or p.m., not specified], the NJ Ex Order 26.4(b)(1) sounded and the NJ Ex Order 26.4(b)(1) were released. The ED documented that a Licensed Practical Nurse (LPN) responded down the hallway and observed NJ Ex Order 26.4(b)(1) around the NJ Ex Ord of room #... and NJ Ex Order 26.4(b)(1) to the hallway from NJ Ex Order 26.4(b)(1)." According to the ED's documentation, the NJ Ex Order 26.4(b)(1) and Emergency Medical Service arrived at 8:18 a.m. and NJ Ex Order 26.4(b)(1). Also, the ED documented that the Building Inspector concluded that the building was safe and 15 residents were NJ Ex Order 26.4(b) within the community due to NJ Ex Order 26.4(b)(1) in the vicinity to the NJ Ex O On 8/2/21 at 10:20 a.m., the surveyor toured the NJ Exec Order 2 floor of the Assisted Living unit and observed Resident #1 in bed in his/her apartment. The resident was NJ Ex Order and NJ Ex Order 26.4(b)(1) and told the surveyor to NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1), back to where the resident NJ Ex Order 26.4(b)(1) During the interview regarding the above mentioned NJ Ex O Resident #1 stated that the facility NJ Ex Order 26.4 him/her for NJ Ex Order 26.4 the NJ Ex and stated, NJ Ex Order 26.4(b)(1)." The resident admitted that he/she NJ Ex Order 26.4 about NJ Ex O in the apartment on the day of the NJ Ex O incident and explained that he/she disposed of the NJ Ex Order 26.4 of the NJ Ex Order 26.4(b)(1) in a NJ Ex O	A 657		

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A 657	Continued From page 5 and there was no NJ Ex O Further, Resident #1 stated that he/she was not in the apartment at the time of the incident and was not sure how the NJ Ex O started. The resident stated that only NJ Ex Order 26.4(b)(1) would start a NJ Ex O and reiterated, "NJ Ex Order 26.4(b)(1) does not start NJ Ex Order 26. The resident then informed the surveyor that he/she was no longer in possession of the NJ Ex Order 26.4(b)(1) and that the facility took everything away from the resident, including the resident's NJ Ex Order 26 At 11 a.m., the surveyor reviewed Resident's #1's medical record which indicated that the resident was admitted to the facility in NJ Ex Or of NJ Ex Orde with diagnoses which included NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). According to the "Resident Review Tool" dated NJ Ex Order 26.4, completed by a Licensed Practical Nurse (LPN), LPN #1 documented that the resident was NJ Ex Ord with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and was unsafe to NJ Ex Order 26 and unsafe to NJ Ex Order and had NJ Ex Order in the refrigerator in the resident's apartment. LPN #1 was not available for interview at the time of the survey. At 10:45 a.m., the surveyor interviewed LPN #2, the LPN that was on duty the day of the above NJ Ex O incident and she stated that at approximately 7:45 a.m., she was notified by LPN #3, the LPN in charge of Resident #1's care, that he [LPN #3] NJ Ex Order 26.4(b)(1) in the hallway of the resident's apartment. LPN #2 stated that she went up to the resident's room with LPN #3 and asked the resident if he/she was NJ Ex Order 26.4(in the apartment. LPN #2 told the surveyor that the resident first denied NJ Ex Order 26.4(and later admitted to having been NJ Ex Order 26.4(b) LPN #2 stated that she	A 657		

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A 657	Continued From page 6 confiscated the remaining NJ Ex Order 26.4(b)(1 and NJ NJ from the resident. LPN #2 explained that she told the resident that he/she was not allowed to NJ Ex Order 26 in the apartment. LPN #2 stated that the resident informed the two LPNs that he/she was not aware that NJ Ex Order 26.4(was not allowed in the apartment. At 2:25 p.m., the surveyor NJ Ex Order 26.4(b)(1) an interview with LPN #3 regarding the NJ Ex incident. LPN #3 stated that a few days prior to the incident [could not recall date/time], he was notified by a Certified Nursing Assistant (CNA) that Resident #1 was NJ Ex Order 26.4(in his/her apartment. LPN #3 stated that he immediately informed the DON that the resident was NJ Ex Order 26.4(in the apartment. LPN #3 stated that he accompanied the DON to speak to the resident and the resident was reminded that NJ Ex Order 26.4(was not allowed in the apartment or inside of the building. LPN #3 stated that the NJ Ex Order 26.4(b)(1 and NJ Ex Order 26. were never removed from the resident's apartment and that it was not the first time the resident was observed NJ Ex Order 26.4(in the apartment. LPN #3 further stated that on NJ Ex Order 26.4 at approximately 7:30 a.m., he smelled NJ Ex Order 26.4(b coming from the resident's apartment so he called LPN #2 to accompany him to the resident's apartment since he did not want to get NJ Ex Order 26.4(b)(1) with the resident. He stated that the resident had NJ Ex Order 26.4(b)(1) in a Styrofoam cup with NJ Ex Order next to his/her recliner chair. LPN #3 stated that when confronted the resident admitted to NJ Ex Order 26.4(in the apartment. LPN #3 stated that they [LPN #2 and LPN #3] confiscated the resident's NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4 LPN #3 thought that the problem was solved. LPN #3 stated that a few minutes later, the resident came to him at the opposite hallway to	A 657		

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A 657	Continued From page 7 ask for NJ Ex Order 26.4(b)(1) LPN #3 explained that he gave the resident NJ Ex Order 26.4(b)(1) and a NJ Ex Order 2 and put the resident in the elevator to go down and outside to NJ Ex Order 26. LPN #3 stated that approximately 15 minutes later, he [LPN #3] then heard the NJ Ex Order go off with a loud "pop pop" sound. LPN #3 stated that he observed NJ Ex Order the resident's apartment and NJ Ex Order 26.4(b)(1). At 2:30 p.m., the surveyor conducted an interview with CNA #2 who stated that about the same week of the NJ Ex O [could not recall date/time], she alerted LPN #3, who then alerted the DON, that Resident #1 was observed NJ Ex Order 26.4(b in his/her apartment. CNA #2 stated that the DON and LPN #3 went into the resident's apartment and told the resident that the facility had a designated area and chair for NJ Ex Order 26.4(b) At 11:30 a.m., the surveyor interviewed the ED and requested for review the facility's NJ Ex Order 26.4(b policy. The ED stated that on NJ Ex Order 26.4 at approximately 8:16 a.m., she received multiple phone calls from staff that there was a NJ Ex at the facility and that the NJ Ex started in Resident #1's apartment. The ED stated that when she arrived at the facility, the residents were already NJ Ex Order 26.4(b)(1) from their apartments and the NJ Ex had been contained by the NJ Ex Order 26.4(b)(1). During interview with the ED the surveyor inquired if Resident #1 was a NJ Ex Order 26.4 and NJ Ex Order 26.4 in the apartment. The ED stated that she was aware that Resident #1 was a NJ Ex Order 26.4 but was not aware that the resident NJ Ex Order 26.4 in his/her apartment. The ED explained that she educated the resident and the resident's Power of Attorney (POA) regarding the facility's NJ Ex Order 26.4(b policy. The ED added that based on the education, she	A 657		

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A 657	Continued From page 8 allowed the resident to keep his/her own NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) in the apartment. The surveyor then requested the NJ Ex Order 26.4(b)(1) assessment completed for Resident #1 that deemed the resident safe to NJ Ex Order 26.4(b)(1) and to keep his/her own NJ Ex Order 26.4(b)(1). At 4 p.m., the surveyor interviewed the DON regarding Resident #1. The DON stated that she was alerted by a staff member, [could not recall the staff member], that the resident was NJ Ex Order 26.4(b)(1) in his/her apartment. The DON stated that she could not recall the date/time when she observed the resident by the window NJ Ex Order 26.4(b)(1) The DON stated that she reminded the resident that he/she could not NJ Ex Order 26.4(b)(1) in the apartment and that there was a designated area to NJ Ex Order 26.4(b)(1) outside of the building. The surveyor asked the DON if a NJ Ex Order 26.4(b)(1) assessment was completed on the resident. The DON replied, "No" and stated that she was not aware that there was a NJ Ex Order 26.4(b)(1) assessment form until after the NJ Ex Order 26.4(b)(1) occurrence on NJ Ex Order 26.4(b)(1). There was no documented evidence in the medical record that the resident was assessed for NJ Ex Order 26.4(b)(1) to ensure that the resident had the ability to NJ Ex Order 26.4(b)(1) safely in a designated area. Also, there was no documented evidence in the resident's medical record that the resident and his/her POA were educated regarding the NJ Ex Order 26.4(b)(1) policy. 2. On 8/2/21 at 10:45 a.m., the surveyor requested from LPN#2 a list of residents who NJ Ex Order 26.4(b)(1). LPN #2 stated that Resident #1 and Resident #2 were the only two NJ Ex Order 26.4(b)(1) at the facility and added that Resident #2 NJ Ex Order 26.4(b)(1) outside in the NJ Ex Order 26.4(b)(1). Resident #2 was not available for interview.	A 657		

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A 657	Continued From page 9 At 12:15 p.m., the surveyor reviewed Resident #2's medical record which revealed that the resident's move-in date was [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4(b)(1)] and the resident had diagnoses which included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). According to the "General Service Plan" dated [NJ Ex Order 26.4(b)(1)], the resident was [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] and required assistance with the [NJ Ex Order 26.4(b)(1)] to get NJ Ex Order 26.4(b)(1). Upon review of the resident's medical record there was no documented evidence that Resident #2 had been assessed for safe [NJ Ex Order 26.4(b)(1)] ability until [NJ Ex Order 26.4(b)(1)], after the occurrence of the [NJ Ex Order 26.4(b)(1)] fire. At 1:50 p.m., the surveyor informed the ED about the aforementioned concerns and she acknowledged that there was no [NJ Ex Order 26.4(b)(1)] assessments completed on Resident #2 until after the [NJ Ex Order 26.4(b)(1)] on [NJ Ex Order 26.4(b)(1)]. The facility failed to implement its "Smoking" policy prior to the fire on [NJ Ex Order 26.4(b)(1)] which threatened the safety of residents and staff in the facility.	A 657		
A 693	8:36-7.1(a) Resident Assessments and Care Plans (a) Upon admission, each resident shall receive an initial assessment by a registered professional nurse to determine the resident's needs. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00145752	A 693		

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A 693	Continued From page 10 Based on interview and record review it was determined the facility failed to ensure that an initial assessment was completed by a Registered Nurse (RN) upon admission in order to determine a resident's ability to safely NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) so as not to pose a harm to the resident or others for 1 of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following: On 8/2/21 at 11 a.m., the surveyor reviewed Resident's #1's medical record which revealed that the resident was admitted to the facility in NJ Ex Ord of NJ Ex Orde with diagnoses which included NJ Ex Order 26.4(b)(associated with NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The "Resident Review Tool" (RRT), dated NJ Ex Order 26.4 and completed by a Licensed Practical Nurse (LPN) documented that the resident was NJ Ex Ord with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Further surveyor review of the RRT identified that the initial assessment was completed and signed by an LPN. According to the RRT, the LPN documented that the resident was NJ Ex Orde NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 . Additionally, the LPN documented that the resident had NJ Ex Ord in the refrigerator and NJ Ex Order 26.4(b)(1 and a NJ Ex Order 2 in his/her apartment,and that the resident was unsafe to NJ Ex Order 26. At 4 p.m., the surveyor interviewed the Director of Nursing (DON)/RN, via telephone regarding Resident #1's initial assessment and inquired who performed the assessment. The DON confirmed that the resident's initial assessment was completed by an LPN. The DON explained that she was not aware that a resident's initial assessment had to be completed by a Registered Nurse.	A 693		

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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
A 693	Continued From page 11 Refer to 8:36-6.1(a)(8)	A 693		
A 703	8:36-7.2(a) Resident Assessments and Care Plans (a) Within 30 days prior to admission to the assisted living residence, comprehensive personal care home, or assisted living program, a physician, advanced practice nurse or physician assistant shall specify in writing that the resident is appropriate for this level of care. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00145752 Based on interview and record review it was determined that the facility failed to ensure that a resident received a physical and medical certification from a Physician, Nurse Practitioner or Physician's Assistant certifying that the resident was appropriate for Assisted Living (AL) for 1 of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following: On 8/2/21 at 11 a.m., the surveyor reviewed Resident's #1's medical record which revealed that the resident was admitted to the facility in NJ Ex Ord of NJ Ex Orde with diagnoses which included NJ Ex Order 26.4(b)(associated with NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). According to the "Resident Review Tool" (RRT) dated NJ Ex Order 26.4(, completed by a Licensed Practical Nurse (LPN), the resident was NJ Ex Or with NJ Ex Order 26. and NJ Ex Order 26.4(b)(1) In addition, the LPN documented that the resident was NJ Exec Order to NJ Ex Order 26. NJ Ex Order and had NJ Ex Order in the refrigerator of	A 703		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35A002	A. BUILDING: ______ B. WING ______	C 08/02/2021

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WASHINGTON TOWNSHIP SENIOR LIVING	600 MEDICAL CENTER DRIVE SEWELL, NJ 08080

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A 703	Continued From page 12 the resident's apartment. Upon continued review of the resident's medical record the surveyor found no documented evidence by a Physician, Nurse Practitioner or Physician's Assistant certifying that Resident #1 was appropriate for AL. At 12:45 p.m., the surveyor informed the Executive Director (ED) that there was no documented evidence of medical certification for Resident #1's in the resident's medical record. The ED stated that the resident's history and physical, including the certification, had been completed. The ED stated that she would contact the resident's Physician to obtain a completed and signed certification form. Throughout the survey, the ED failed to provide the surveyor with documented evidence that Resident #1 had been examined by a Physician and evaluated to be appropriate for admission to the AL on NJ Ex Order 26.4. Refer to 8:36-6.1(a)(8)	A 703		
A 753	8:36-7.3(c) Resident Assessments and Care Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced	A 753		

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
	35A002	A. BUILDING: ______ B. WING ______	C 08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON TOWNSHIP SENIOR LIVING	600 MEDICAL CENTER DRIVE SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 753	Continued From page 13 by: Based on interview and record review it was determined that the facility failed to develop and/or update the General Service Plan (GSP) for 1 of 3 residents reviewed for NJ Ex Order 26.4(b) Resident #2. This deficient practice was evidenced by the following: On 8/2/21 at 11:30 a.m., during the entrance conference with the Executive Director (ED) the surveyor asked the ED to identify the current residents that NJ Ex Order 26.4(b) The ED confirmed that Resident #2 NJ Ex Order 26.4(b) She added that Resident #2 had been NJ Ex Order 26.4(b)(1) since admission over NJ Ex and that there were no NJ Ex Order 26.4(b) concerns with this resident. At 12:15 p.m., the surveyor reviewed Resident #2's medical record which revealed that the resident's move-in date was NJ Ex Order 26.4(of NJ Ex Order and the resident had diagnoses which included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) According to the "General Service Plan" dated NJ Ex Order 2, the resident was NJ Ex Ord and NJ Ex Order 26.4(to NJ Ex Order 26.4 NJ Ex Order and NJ Ex Ord and required assistance with the NJ Ex Order 2 Surveyor review of the resident's GSP dated NJ Ex Order 2 provided no documented evidence that the GSP contained intervention(s) to reflect Resident #2's NJ Ex Order 26.4(b) behavior. The "Resident NJ Ex Order 26.4(b)(1) Evaluation" revealed, "If all questions in sections B and C are answered YES and there are no indications of NJ Ex Order 26.4(b)(1) on the resident's NJ Ex Order 26.4(b) the resident can NJ Ex Order 26 independently. A NJ Ex Order 26.4(b)(1) care plan or service plan is required." The resident's, "Resident NJ Ex Order 26.4(b)(1) Evaluation (paper version)," which was completed by the ED on NJ Ex Order 26.4(indicated that Resident #2 required a	A 753		

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
	35A002	A. BUILDING: ______ B. WING ______	C 08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON TOWNSHIP SENIOR LIVING	**600 MEDICAL CENTER DRIVE** **SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 753	Continued From page 14 NJ Ex Order 26.4(b) care plan. There was no documented evidence that the GSP was updated with intervention(s) to reflect the resident's NJ Ex Order 26.4(b) behavior as required on the "Resident NJ Ex Order Evaluation (paper version)" During interview at 1:05 p.m., with the ED, the surveyor informed her of the above concern, the ED stated that she would have the GSP updated. In addition, the facility's policy and guidelines titled, "Smoking" indicated, "Based on the outcome of the Safe Smoking Review, community staff develops a smoking care plan, ... The Care Plan is reviewed and revised periodically as needed."	A 753		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
35A002 (Y1)	A. Building B. Wing (Y2)	9/2/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON TOWNSHIP SENIOR LIVING	600 MEDICAL CENTER DRIVE 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 A0625 Reg. # 8:36-5.18(a)(3) LSC	Correction Completed 09/15/2021	ID Prefix A0657 Reg. # 8:36-6.1(a)(8) LSC	Correction Completed 08/05/2021	ID Prefix A0693 Reg. # 8:36-7.1(a) LSC	Correction Completed 08/10/2021
ID Prefix A0703 Reg. # 8:36-7.2(a) LSC	Correction Completed 08/10/2021	ID Prefix A0753 Reg. # 8:36-7.3(c) LSC	Correction Completed 08/05/2021	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/2/2021	☐ ☐ YES ☐ NO