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 02/16/2024

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 #: NJ00158708 CENSUS: 82 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 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
C# NJ00158708
Based on interview and review of facility policy, it was determined that the Administrator failed to implement and enforce the facility's policy and procedure titled, "MECHANICAL LIFTING DEVICES PROGRAM," to ensure safe transfers of residents that required a Hoyer lift for transfers. This deficient practice was evidenced by the following:

At 11:00 a.m., the surveyor interviewed a Hospice Aide (HA) who stated she cared for residents that used a Hoyer lift and was not trained at the facility on the use of Hoyer lifts. The HA stated that she had previous experience with the use of a Hoyer lift.

At 11:30 a.m., the surveyor interviewed a Home Health Aide (HHA) who had been employed with the facility for [redacted NJ Exec Order 26.4], and confirmed she did not receive training at the facility for the use of Hoyer lifts.

On 2/16/2024 at 12:40 p.m., the surveyor interviewed the DON and was informed that the facility had residents that required transfers with a Hoyer lift. At this time, the surveyor asked the DON for the facility's policy on mechanical lift devices.

At 1:50 p.m., the surveyor reviewed the facility's policy titled, "MECHANICAL LIFTING DEVICES PROGRAM" which revealed, "Program Components ...iv. Arranging for team members

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A 310	Continued From page 2 ...to receive training and competency review, and in-service training (including demonstration), regarding use of mechanical lifts; training is to occur for each team member ...5. Maintenance ...iii. Performing monthly preventative maintenance inspections of lift equipment using the Mechanical Lift Monthly Inspection Checklist." At 2:10 p.m., the surveyor interviewed the Executive Director (ED) and requested documentation of staff training, review of competency, and monthly preventive maintenance inspections of the Hoyer lift checklist. At 2:30 p.m., the ED was unable to provide documented staff training on the use of Hoyer lifts and unable to provide the Hoyer lift monthly inspection checklist. The ED stated she was not aware of such a checklist and will reach out to the corporate office. At 3:00 p.m., the DON confirmed that he had not provided staff any trainings for the use of a Hoyer lift. The facility failed to implement its policy on the use of Hoyer lifts to ensure staff utilized the mechanical lift safely and that the equipment was maintained in good working order in accordance with manufacturer's instructions.	A 310		
A1057	8:36-15.4 Resident Records All records shall be maintained for a period of 10 years after the discharge of a resident from the assisted living residence, comprehensive personal care home or assisted living program.	A1057		

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A1057	Continued From page 3 This REQUIREMENT is not met as evidenced by: C# NJ00158708 Based on interview and closed medical record review, it was determined that the facility failed to maintain and/or retain complete medical records for residents that were discharged from the facility for 2 of 2 residents reviewed, Resident #2 and Resident #4. This deficient practice was evidenced by the following: 1. On 2/16/2024 at 10:45 a.m., the surveyor requested the closed medical records of Resident #2 and Resident #4 for review. At 11:40 a.m., the Director of Nursing (DON) provided the surveyor with Resident #2 and Resident #4 closed medical record. During surveyor review of the closed medical record, the surveyor observed that Resident #'s 2 and 4 closed medical record were incomplete. At 12:00 p.m., the surveyor informed the DON that the closed medical record for Resident #2 and Resident #4 was incomplete. Surveyor's review of Resident #2's closed medical record revealed that the resident, moved in on NJ ex order 26.4b1 and was discharged on NJ ex order 26.4b1 Surveyor review of Resident #4's closed medical record revealed that the resident, moved in NJ ex order 26.4b1 and was discharged on NJ ex order 26.4b1 At 12:05 p.m., the DON informed the surveyor that he would continue to look for the closed medical record of Resident #'s 2 and 4. At 2:00 p.m., the DON confirmed that he was not	A1057		

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A1057	Continued From page 4 able to locate the complete medical file of Resident #'s 2 and 4, and that he was only able to locate the residents thinned medical records which included the electronic medical record of the service plan and the face sheet. The facility failed to maintain Resident #'s 2 and #4 medical record for the period of 10 years after discharge in accordance with State regulations.	A1057		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
35A002		4/23/2024

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 03/01/2024	ID Prefix A1057 Reg. # 8:36-15.4 LSC	Correction Completed 03/01/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 2/16/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			