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 12/10/2025

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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: Standard with Complaint COMPLAINT #: NJ00182373 and NJ00185106 CENSUS: 90 SAMPLE SIZE: 16 The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 461	8:36-5.1(d)(5) General Requirements (d) The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of providing nursing services to maintain residents, including residents who require nursing home level of care. However, the resident may be, but is not required to be moved from the facility or program if it is documented in the resident record that a higher level of care is required, as demonstrated by one or more of the following characteristics: 5. The resident requires treatment of a stage three or four pressure sore or multiple stage two pressure sores. However, a resident who	A 461		

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A 461	Continued From page 1 requires treatment of a single stage two pressure sore shall be retained and a plan of care developed and implemented to stabilize the pressure sore and the condition which caused it; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00182373 Based on facility policy review, record review, and interview, the facility failed to provide documentation related to the determination of discharging a resident from the facility for 1 (Resident #1) of 7 residents reviewed for residents' care levels being appropriate for the assisted living facility. Findings included: A facility policy titled, "Discharge/Move-Out Policy & Procedure," dated December 2023, revealed the "Purpose" was "To determine the ability of the Community and team to meet the resident's ongoing needs and preferences, in concert with the [the Facility's Parent Company] Residency Agreement as well as the State regulations." The policy revealed, "Definitions of Move-Out Reasons and Procedures" included, "Level of Care- the resident's clinical needs can no longer be met and all efforts to engage ancillary support have not been successful. Health and Wellness Director will notify CCO [Chief Clinical Officer] before level of care notice may be issued." The policy revealed, "Involuntary Move-Out," which included, "If [the Facility's Parent Company], in consultation with the Resident, family and	A 461		

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A 461	Continued From page 2 physician, that it is inappropriate or unsafe for a Resident remain in his/her Suite, determinations concerning temporary or permanent transfers will be made as applicable to state regulations." Resident #1's "Move In Record" revealed the facility originally admitted the resident on NJ Exec Order 26.4b1 and readmitted the resident on NJ Exec Order 26.4b1 According to the Move In Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. Per the Move In Record, the facility discharged the resident on NJ Exec Order 26.4b1. Resident #1's "Service Plan Report" included a focus area that indicated that the resident had NJ Exec Order 26.4b1 on NJ Exec O of their NJ Exec Order Interventions directed staff to administer medications and treatments as ordered, and to report any NJ Exec Order 26.4b1 to a nurse. The Service Plan Report included a focus area regarding "Wellness Services." Interventions indicated that the resident received NJ Ex Order 26. care services. Resident #1's physician "Progress Notes," dated NJ Exec Order 26.4b1, revealed the resident was seen by an advance nurse practitioner (APN) for a follow-up after an emergency room (ER) visit. The note revealed diagnoses that included an NJ Exec Order 26.4b1 on the NJ Exec Order 26.4. During a telephone interview on 12/09/2025 at 8:32 AM, Resident #1's Responsible Party (RP), RP #9, stated that they believed Resident #1 was discharged from the facility NJ Exec Order 26.4 RP #9 stated that the NJ Exec Order 2 care the resident received was NJ Exec Order 26.4b1 and the resident should have been able	A 461		

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A 461	Continued From page 3 to [NJ Exec Or] Resident #1's record revealed that the resident was treated by an outside third-party provider for [NJ Ex Order 26.] care services. "Visit Note Report" records indicated that the [NJ Exec Order 2] care visits dates were NJ Exec Order 26.4b1 [redacted] Resident #1's "Physicians Progress Note Detail," dated [NJ Exec Order 26.4b1], included assessments of [NJ Exec O] [redacted]. The Physicians Progress Note Detail included treatment orders for the [NJ Exec Order 26.4b] Resident #1's "Progress Notes" revealed a note, dated [NJ Exec Order 26.4b1] and electronically signed by the current Assistant Director of Health and Wellness (ADHW), that indicated that the resident moved out of the facility that day with their family member present. The note indicated that the resident was transported via a facility bus to another facility. The note indicated that the resident's primary care physician was notified Resident #1's record revealed no formal documentation of the determination to discharge the resident or documentation of discharge planning. During an interview on 12/09/2025 at 4:04 PM, the ADHW stated that Resident #1 was receiving [NJ Exec Order 2] care from an outside provider a couple of times per week. The ADHW stated that the Director of Health and Wellness (DHW) or the Executive Director (ED) were responsible for discharge planning. The ADHW stated that the facility did not have a DHW at the time of Resident #1's discharge.	A 461		

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A 461	Continued From page 4 During an interview on 12/09/2025 at 3:45 PM, the ED stated she was not employed with the facility during the time Resident #1 was a resident at the facility. The ED stated that due to the change in ownership on NJ Ex Order 26.4(b)(1), she may not have access to all the information related to Resident #1's discharge. The ED stated that she had tried to reach out to former management from the previous ownership about documentation of Resident #1's discharge. The ED stated that for a resident discharge, there should be documentation of case coordination notes between facility nursing staff and the resident's family. The ED stated that once there was a determination made that a resident's level of care exceeded the facility's scope, the information was presented to the facility's CCO. She stated that she had no documentation of the determination being made for Resident #1.	A 461		
A 477	8:36-5.1(i) General Requirements (i) An existing assisted living residence or comprehensive personal care home which increases its number of licensed beds on or after September 1, 2001, shall occupy at least 10 percent of the additional beds with Medicaid-eligible persons and shall maintain this level of Medicaid occupancy thereafter. This REQUIREMENT is not met as evidenced by: Based on interview and facility document review, the facility failed to maintain a population of Medicaid eligible residents of at least 10 percent.	A 477		

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A 477	Continued From page 5 Findings included: The facility's "Resident Roster Report," dated 12/08/2025, revealed the facility had a census of 90 residents. During an interview on 12/09/2025 at 9:58 AM, the Executive Director (ED) stated that the facility had [redacted] residents on Medicaid. During an interview on 12/09/2025 at 10:53 AM, the ED stated that the facility would normally maintain a population of Medicaid-eligible residents of at least 10 percent, but recent resident discharges and [redacted] caused the population to decrease. During an interview on 12/10/2025 at 9:29 AM, the ED stated the facility did not have a policy related to ensuring the facility maintained a population of Medicaid-eligible residents of at least 10 percent. The ED stated the facility followed the regulatory requirements, which stated the facility must maintain a population of Medicaid-eligible residents of at least 10 percent.	A 477		
A 571	8:36-5.10(a)(6) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 6. Termination of employment of the administrator, and the name and qualifications of his or her replacement.	A 571		

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A 571	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on facility document review, a review of the New Jersey Department of Health website, and interview, the facility failed to provide documentation that the facility notified the state survey agency when the Administrator's employment was [NJ Exec Order 26.4b1] in [NJ Exec Order 26.4b1] and replaced with the facility's current Executive Director (ED). The deficiency had the potential to affect all residents residing in the facility. Findings included: An entrance conference was conducted on 12/08/2025 at 9:06 AM with the ED. The ED stated she had been in the position since [NJ Ex Order] [redacted] The ED's personnel file revealed an "Executive Director" job description signed by the ED and dated [NJ Ex Order 26.4(b)(1)] The New Jersey Department of Health's website revealed the ED was not listed as the facility's Administrator. During an interview on 12/08/2025 at 11:15 AM, the ED stated that the previous Administrator did email the state survey agency to inform of the change in Administrator, but she did not have access to that email due to the change in ownership on [NJ Ex Order 26.4(b)(1)] During an interview on 12/10/2025 at 1:30 PM, the ED stated that the facility failed to provide documentation related to notifying the state survey agency of change in Administrator.	A 571		

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A 767	8:36-7.4(c)(2) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 2. Monitoring of the condition of all residents on an as needed basis; This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and interview, the facility failed to ensure they implemented their "Wound Care Policy" for 1 (Resident #1) of 3 residents reviewed for resident care. Findings included: A facility policy titled, "Wound Care Policy," dated December 2023, indicated, "Documentation of resident skin condition in any applicable treatments." The policy revealed, "Purpose: [Facility Parent Company] partners with ancillary support agencies and services provide oversight and care for resident wounds and other skin breakdown. The purpose of the policy is to outline documentation and establish the roles of each involved entity." The policy revealed, "Procedure" included, "A. Skin checks/observations," which revealed, "Skin assessments and updates should be tracked weekly using the Weekly Wound Observation tool in the EHR [electronic health record]." The policy revealed, "B. Documentation" included, "The Weekly Wound Observation Tool should include updates of treatment orders, measurements, staging (if applicable), the	A 767		

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A 767	Continued From page 8	A 767		

condition of the wound in general, and a reference to the overseeing provider."

Resident #1's "Move In Record" revealed the facility originally admitted the resident on NJ Exec Order 26.4b1 and readmitted the resident on NJ Exec Order 26.4b1. According to the Move In Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 Per the Move In Record, the facility discharged the resident on NJ Exec Order 26.4b1.

Resident #1's "Service Plan Report" included a focus area that indicated that the resident had NJ Exec Order 26.4b1 on NJ Exec O of their NJ Exec Order Interventions directed staff to administer medications and treatments as ordered, and to report any NJ Exec Order 26.4b1 to a nurse. The Service Plan Report included a focus area regarding "Wellness Services." Interventions indicated that the resident received NJ Exec Order 2 care services.

Resident #1's physician "Progress Notes," dated NJ Exec Order 26.4b1, revealed the resident was seen by an advance nurse practitioner (APN) for a follow-up after an emergency room (ER) visit. The note revealed diagnoses that included an NJ Exec Order 26.4b1 on the NJ Exec Order 26.4.

Resident #1's record revealed that the resident was treated by an outside third-party provider for NJ Exec Order 2 care services. "Visit Note Report" records indicated that the NJ Exec Order 2 care visits dates were NJ Exec Order 26.4b1.

Resident #1's record revealed no documentation of "Weekly NJ Exec Order 26 Observation Tool" records for

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A 767	Continued From page 9 the resident. During an interview on 12/10/2025 at 10:07 AM, the Assistant Director of Health and Wellness (ADHW) stated that Resident #1 received [NJ Exec Order 2] care from an outside provider a couple of times per week. The ADHW stated that the facility's registered nurses were responsible for assessing and monitoring the resident to determine if the third party's [NJ Exec Order 2] care treatment was working. The ADHW stated that the information should be documented in the resident's clinical record. During an interview on 12/10/2025 at 10:15 AM, the Executive Director (ED) stated that the "Weekly [NJ Exec Order 26] Observation Tool" was a tool used for case coordination and ensured the interventions provided by the third party wound care provider was were effective. The ED acknowledged that facility could not provide the Weekly [NJ Exec Order 26] Observation Tool related to Resident #1's [NJ Exec Order 2] care.	A 767		
A 939	8:36-11.5(b)(1)(i-ii) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 1. A unit-of-use/unit dose drug distribution system shall be developed and implemented whenever the administration of medication is delegated by the registered professional nurse to a certified medication aide; i. Over-the-counter (OTC) solid and liquid dosage forms may be dispensed in a non	A 939		

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A 939	Continued From page 10 unit-of-use or non unit-dose medication distribution system. ii. Prescription liquid medications (that is, conventional bottles, concentrates) may be dispensed in a non unit-of-use, non unit-dose, or conventional medication distribution system. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00185106 Based on interview, observation, and record review, the facility failed to ensure a unit-of-use/unit dose drug distribution system was developed and implemented for medication administration by certified medication aide staff, which affected 4 (Residents #8, #9, #11, and #12) of 8 residents reviewed for medication administration. Specifically, medications in pill bottles were administered by medication technicians (MTs). Findings included: 1. A "Move In Record" revealed the facility admitted Resident #8 on NJ Exec Order 26.4b1. According to the Move In Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 [redacted]. Resident #8's "Service Plan Report" included a focus area initiated on NJ Exec Order 26.4b1 that indicated the resident needed staff assistance for medication administration or medication program	A 939		

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A 939	Continued From page 11 services. Interventions directed staff to administer medications to the resident (initiated NJ Exec Order 26.4b1); and to monitor for effectiveness, side effects, and interactions (initiated NJ Exec Order 26.4b1). An observation of a medication cart on 12/09/2025 at 1:53 PM with Licensed Practical Nurse (LPN) #4 revealed the cart included the following prescription medications in medication pill bottles for Resident #8: - NJ Exec Order 26.4b1 -NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1) - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 During an interview on 12/09/2025 at 1:53 PM, at the time of the observation, LPN #4 stated that Resident #8's nurses and MTs administered the medications.	A 939		

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A 939	Continued From page 12 Resident #8's NJ Ex Order 26.4(b)(1) Medication Administration Report (MAR)" revealed MT #1, MT #5, MT #6, MT #7, or MT #8 documented that they administered the medications observed in the medication cart to Resident #8 on NJ Exec Order 26.4b1 . During an interview on 12/09/2025 at 12:22 PM, MT #1 stated that she had been working at the facility as an MT for NJ Exec Order 26.4b1. MT #1 stated that Resident #8 had several prescription pill bottles in the medication cart, and technically they were not supposed to be administered by MTs. MT #1 stated they had to administer Resident #8's medications from a pill bottle because that was the way they came from Resident #8's pharmacy. During a telephone interview on 12/10/2025 at 8:00 AM, MT #6 stated that MT staff were not supposed to administer prescription medications out of pill bottles to residents. MT #6 stated she mostly worked on the 11:00 PM to 7:00 AM shift and had administered NJ Ex Order 26.4(b)(1) to Resident #8 out of a pill bottle. During a telephone interview on 12/10/2025 at 12:41 PM, MT #7 stated that MT staff were not allowed to administer prescription medications out of pill bottles to residents, but Resident #8 had a medication that she was required to administer on the 11:00 PM to 7:00 PM shift. 2. A "Move In Record" revealed the facility admitted Resident #9 on NJ Exec Order 26.4b1. According to the Move In Record, the resident had a medical history that included diagnoses of the NJ Exec Order 26.4b1 .	A 939		

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A 939	Continued From page 13 Resident #9's "NJ Exec Order 26.4b1 Management Evaluation," dated NJ Exec Order 26.4b1, revealed Resident #9 required assistance with NJ Exec Order 26.4b1 [redacted]. An observation of a medication cart on 12/09/2025 at 2:02 PM with LPN #2 revealed the cart included NJ Exec Order 26.4b1 [redacted] in a medication pill bottle for Resident #9. Resident #9's "NJ Exec Order 26.4b1 Medication Administration Report (MAR)" revealed MT #8 documented that she administered NJ Exec Order 26.4b1 [redacted] to Resident #9 on NJ Exec Order 26.4b1. 3. A "Move In Record" revealed the facility admitted Resident #12 on NJ Exec Order 26.4b1. According to the Move In Record, the resident had a medical history that included diagnosis of NJ Exec Order 26.4b1 [redacted] Resident #12's "Service Plan Report" included a focus area initiated on NJ Exec Order 26.4b1 that indicated the resident needed staff assistance for NJ Exec Order 26.4b1 [redacted] or NJ Exec Order 26.4b1 [redacted] Interventions directed staff to administer medications to the resident (initiated NJ Exec Order 26.4b1). An observation of a medication cart on 12/09/2025 at 2:13 PM with MT #1 revealed the cart included a prescription medication pill bottle containing NJ Exec Order 26.4b1 [redacted] for Resident #12. Resident #12's "NJ Exec Order 26.4b1 Medication Administration Report (MAR)" revealed MT #1 or MT #3 documented that they administered	A 939		

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A 939	Continued From page 14 NJ Ex Order 26.4(b)(1) to Resident #12 on NJ Exec Order 26.4b1 [redacted] 4. A "Move In Record" revealed the facility admitted Resident #11 on NJ Exec Order 26.4b1. According to the Move In Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 [redacted]. Resident #11's "Service Plan Report" included a focus area initiated on NJ Exec Order 26.4b1, that indicated the resident needed staff assistance for NJ Exec Order 26.4b1 [redacted]. Interventions directed staff to coordinate medication refills with the resident's pharmacy or family (initiated NJ Exec Order 26.4b1). An observation of a medication cart on 12/09/2025 at 2:13 PM with MT #1 revealed the cart included the following prescription medications in medication pill bottles for Resident #11: - NJ Exec Order 26.4b1 [redacted]) - NJ Exec Order 26.4b1 [redacted] - NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 [redacted] Resident #11's "NJ Exec Order 26.4b1 Medication Administration Record" revealed MT #1, MT #3, MT #5, MT #6, or MT #8 documented that they administered the medications observed in the medication cart to Resident #11 on NJ Exec Order 26.4b1 [redacted]	A 939		

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A 939	Continued From page 15 During an interview on 12/09/2025 at 12:22 PM, MT #1 stated that Resident #11 had prescription medications in the medication cart that were administered from pill bottles. During an interview on 12/10/2025 at 8:39 AM, MT #3 stated that MTs were technically not supposed to administer prescription medications from pill bottles to residents, but they did. MT #3 stated that usually only nurses administered prescription medications out of pill bottles to residents. During an interview on 12/09/2025 at 4:27 PM, MT #5 stated that sometimes residents were administered prescription medications from pill bottles because the medications were only provided in bottles from the resident's pharmacy. During an interview on 12/09/2025 at 1:12 PM, LPN #2 stated that MTs were not allowed to administer prescription medications to residents out of a pill bottle, but some residents' medications came from the pharmacy in bottles instead of in a prepacked container. LPN #2 stated that only nurses were supposed to administer prescription medications from pill bottles to residents. During an interview on 12/09/2025 at 2:21 PM, the Assistant Director of Health and Wellness (ADHW) stated that facility nurses were able to administer bottled prescription medications to residents in the facility, but MTs were not allowed to. During an interview on 12/09/2025 at 3:49 PM, the Executive Director (ED) stated that MT staff were not supposed to administer prescription medications from pill bottles to residents; only	A 939		

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A 939	Continued From page 16 facility nurses should administer prescription medications from pill bottles to residents. During an interview on 12/10/2025 at 9:29 AM, the ED stated that the facility did not have a policy related to certified medication aides (CMAs) or MTs administering prescription medications out of a pill bottle. The ED stated the facility followed regulations related to medication administration conducted by MTs, and an MT could not administer prescription medications out of a pill bottle; only nurses could administer prescription medications out of bottles.	A 939		
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 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:	A1041		

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A1041	Continued From page 17 Based on interview and record review, it was determined that the facility failed to conduct one drill per year for emergencies due to a disaster other than fire, such as storm, flood, or other natural disaster, bomb threat or nuclear accident. Additionally, documentation that the facility requested a joint drill of the local fire department, or notified first aid and civil defense agencies of this drill could not be produced. This deficient practice was evidenced by the following: On 12/03/25 in the presence of the Executive Director (ED), the surveyor reviewed the emergency drills and test documentation provided by the ED which revealed that none of the drills conducted were for emergencies due to disasters other than fire. The surveyor interviewed the ED regarding the emergency drills, The ED confirmed that none of the drills were for emergencies other than fire. The surveyor then asked the ED if the local fire department, first aid or civil defense agencies were invited to participate in a community-wide disaster drill, and if so to provide evidence of the invitation and the drill. The ED stated that they would not be able to provide evidence of the emailed invitations or the drill because they just changed ownership and no longer have access to the emails.	A1041		
A1089	8:36-16.3(b) Physical Plant (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by	A1089		

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A1089	Continued From page 18 mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that a means of ventilation was provided either by a window with an openable area or by mechanical ventilation for every bathroom or water closet. This deficient practice was evidenced by the following: On 12/03/25 from 10:43 to 11:58 a.m., in the presence of the Maintenance Tech (MT), the surveyor observed that the bathroom ventilation in resident rooms NJ Exec Order 26.4b1 was not functioning when tested by the MT. During surveyor interviews with the MT regarding the ventilation, the MT acknowledged and confirmed that the ventilation was not functioning.	A1089		
A1095	8:36-16.5(b) Physical Plant (b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented.	A1095		

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A1095	Continued From page 19 National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance (ITM) of all fire detection systems were in accordance with N.J.A.C 5:23, N.J.A.C. 5:70 and NFPA 72. This deficient practice was evidenced by the following: On 12/03/25 in the presence of the Executive Director (ED), the surveyor reviewed the fire alarm system (FAS) inspections report which revealed that the fire alarm system was not inspected semi-annually. The inspection report was dated 4/23/25, which indicated that the last date the system had any service performed was 3/1/24, a year later. The FAS report had no indication of the annual testing of elevator recall, electro-mechanical door holder release or access-controlled exit door unlocking. And also there was no indication of smoke detector sensitivity testing. During surveyor interview with the ED regarding the above concerns, the ED confirmed and acknowledged the above concerns and stated that there was over a years' time between FAS inspections.	A1095		
A1097	8:36-16.6 Physical Plant	A1097		

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A1097	Continued From page 20 All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the wet/dry sprinkler system, kitchen fire suppression system and fire pumps were Inspected, Tested and Maintained (ITM) in accordance with N.J.A.C 5:23. This deficient practice was evidenced by the following: On 12/3/25 in the presence of the Executive Director (ED) and Maintenance Director (MD), the surveyor reviewed the quarterly wet/dry sprinkler system ITM provided by the ED and MT which revealed that (quarterly) ITM was conducted on 4/22/25 (Q2) and 7/11/25 (Q3). However, the facility was unable to provide the surveyor with ITM reports for January (Q1) and October (Q4). Additionally, documentation of 10- year dry sprinkler head sampling or 5-year internal pipe inspections was not provided. The surveyor interviewed the ED and MT regarding the wet and dry sprinkler system and the ED stated that they were able to provide Q2 and Q3 ITM reports but were unable to find or	A1097		

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A1097	Continued From page 21 provide quarterly wet/dry sprinkler system ITM for Q1 or Q4 of 2025. Additionally, the MD stated that dry sprinkler head sampling was conducted and that he was unable to provide the documentation. On 12/3/25 in the presence of the ED and MD, the surveyor requested semi-annual ITM reports for the kitchen suppression system and weekly/annual ITM of the fire pump from the ED and MD. During continued interview with the ED and MD regarding the kitchen suppression system and fire pumps, the ED stated that they would not be able to provide ITM for the kitchen suppression system. The MD stated that the facility do not conduct weekly/annual fire pump testing. At 11:45 a.m. and 12:02 p.m., in the presence of the Maintenance Tech (MT), the surveyor observed that 2 sprinkler heads in the activities dining room and one sprinkler head in the medication room on the first floor were missing escutcheons. During surveyor interviews with the MT regarding the sprinkler heads, he confirmed that the sprinkler heads were missing escutcheons.	A1097		
A1169	8:36-16.15(a) Physical Plant (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101.	A1169		

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A1169	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) of the fire extinguishers comply with NFPA 10. This deficient practice was evidenced by the following: On 12/03/25 from 10:37 to 11:20 a.m., in the presence of the Maintenance Tech (MT), the surveyor observed that the fire extinguishers on floors 1- 3 were not provided with a means to readily identify their location from a distance. Additionally, the monthly inspection tag on the fire extinguisher outside of resident room [NJ Exec] was last signed on 6/12/25 and the fire extinguisher in the [NJ Exec Of] therapy gym was missing an inspection signature for the month of August. The surveyor interviewed the MT regarding the fire extinguishers and he confirmed that the fire extinguishers were not provided with a way to readily indicate their locations. Additionally, the MT confirmed that signatures were missing on the monthly inspection tags for 2 fire extinguishers.	A1169		
A1187	8:36-17.3(a)(1) Housekeeping-Sanitation-Safety-Maintenance (a) The housekeeping and sanitation conditions in paragraphs 1 through 12 below shall be met. Application of this requirement with respect to the individual living environment shall take into consideration residents' personal preferences for style of living:	A1187		

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A1187	Continued From page 23 1. The facility and its contents, including all surfaces such as tables, floors, walls, beds and dressers, shall be clean to sight and touch and free of dirt and debris; This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that an electrician licensed in accordance with N.J.A.C 13:31 inspected and provided a written statement that the electrical circuits and wiring in the facility were satisfactory and in a safe condition on an annual basis. This deficient practice was evidenced by the following: During surveyor interview on 12/03/25 in the presence of the Executive Director (ED), the surveyor asked the ED for documentation regarding an annual electrical inspection. The ED stated that an annual electrical inspection was not conducted and that they would not be able to provide the surveyor documentation of an annual electrical inspections..	A1187		
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.	A1243		

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A1243	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that the temperature of the hot water used for bathing and hand-washing was maintained between 105 degrees and 120 degrees. This deficient practice was evidenced by the following: On 12/3/25 in the presence of the Maintenance Tech (MT), the surveyor observed the following: At 10:43 a.m., in resident room (RR) NJ Exec O the water temperature was 129.4-degrees Fahrenheit. At 10:58 a.m., in RR NJ Exec O the water temperature was 144-degrees Fahrenheit. At 11:13 a.m., in RR NJ Exec O the water temperature was 131-degrees Fahrenheit. At 11:58 a.m., in RR NJ Exec O the water temperature was 134-degrees Fahrenheit. During surveyor interview with the MT regarding the water temperatures in rooms NJ Exec Order 26.4b1 and NJ Exec O the MT acknowledged that the water temperatures were above normal.	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 deterioration. The building and grounds shall be	A1249		

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A1249	Continued From page 25 kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure that the building and grounds were kept free from fire hazards and other hazards to resident's health and safety. This deficient practice was evidenced by the following: On 12/03/25, in the presence of the Executive Director (ED) and Maintenance Director (MD), the surveyor reviewed the generator Inspection, Testing and Maintenance (ITM) logs provided by the MD which revealed that load tests of the generator for at least 30 minutes at 30% of the nameplate rating were not conducted every month. Additionally, the documentation was incorrectly recorded. The Hour meter reading did not change, the Kilowatt (kW) rating is marked as 250 kw when it is 35 kW, "transfer switch functional?" is marked as "NO", and "90 min battery powered lighting at generator and transfer switch" is marked as "YES" and there is no battery powered lighting at the generator transfer switch as required. During surveyor interview with the MD regarding Generator ITM, he confirmed that 30-minute monthly load test were not being conducted; that	A1249		

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A1249	Continued From page 26	A1249		

the documentation of the testing was not recorded properly and that there was no battery powered emergency lighting at the transfer switch.

Further, the surveyor reviewed the generator ITM which revealed that the generator testing by the facility's vendor dated 2/21/25 indicated "Found genset making voltage but the voltage and frequency gauges are inoperable." "Does not want quote at this time to diagnose" "MD is interested to replace the genset for a larger one, after their main refrigeration unit has been replaced, Currently the genset only handles some lighting, 1 outlet and the kitchen refrigerator. No elevators are on the ATS either."

During surveyor interview with the MD regarding the above concerns, he stated that the generator gauges were inoperable and confirmed that at least one elevator was not hooked up to the generators automatic transfer switch.

At 10:47 a.m., in the presence of the Maintenance Technician (MT), the surveyor observed that Stair-1 exit stairway enclosure door on the third floor did not positively latch when tested by the MT.

During surveyor interview with the MT regarding the exit door, he confirmed that the stairway enclosure door did not positively latch when tested.

At 11:02 a.m., in the presence of the MT, the surveyor observed that the medical storage room on the third floor did self-close but did not positive latch when tested.

During surveyor interview with the MT regarding

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A1249	Continued From page 27 the medical storage room, the MT confirmed that the storage room door did not positively latch. At 11:09 a.m,. and 11:30 a.m., in the presence of the MT, the surveyor observed that the door to the electrical rooms on the second and third floors were unlocked. Additionally, the electrical room on the third floor contained 2 unprotected penetrations for the pass-through of wire in the ceiling. During surveyor interview with the MT regarding the electrical rooms, he confirmed that the doors were unlocked and that the penetrations in the electrical room on the third floor were not protected by a system or materials capable of restricting the transfer of fire and smoke. At 11:18 a.m., in the presence of the MT, the surveyor observed that a 2 ft x 2 ft ceiling tile was missing in the [redacted] therapy gym storage closet. During surveyor interview with the MT regarding the storage closet, he confirmed that the ceiling tile was removed and that he would replace it. At 11:40 a.m., in the presence of the MT, the surveyor observed that the exit door from the stairway enclosure on floor #1 did not positively latch when tested by the MT. And also, the space under the stairs was used to store approximately 10 tables and chairs. During surveyor interview with the MT regarding the exit stairway enclosure, he confirmed that the door did not positive latch when he tested it, and that the stairway enclosure was being used to store tables and chairs. At 11:58 a.m., in the presence of the MT, the	A1249		

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 12/10/2025

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
A1249	Continued From page 28 surveyor observed that an illuminated exit sign was not provided over the smoke barrier doors leading into the lobby area on the first floor. During surveyor interview with the MT, he confirmed that there was no exit sign over the smoke barrier doors. At 12:08 p.m., in the presence of the MT, the surveyor observed that the door to the commercial laundry room on the first floor did not self-close and positively latch. The door was held open with a doorstop, when the doorstop was removed by the MT, the door did not self-close and positively latch. The surveyor observed that a cardboard was wedged in the top edge of the door. During surveyor interview with the MT regarding the above concerns, he confirmed that the door to the laundry room was not being held open by a code compliant automatic hold-open device. The surveyor informed the MT that doors to hazardous areas must remain closed, or if held open, only by code compliant automatic hold-open devices that are connected to and release with activation of the fire alarm system.	A1249		

POC #3 received 1/30/26
Accepted 1/30/26

Washington Township Senior Living
Provider Identification Number: 35A002
Survey Completion Date: December 10th, 2025

Responses to the cited deficiencies do not constitute an admission or agreement by the community to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state regulation.

A461 General Requirements

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: Resident #1 no longer lives in the community

2. ELEMENT 2: All residents have the potential to be affected by this deficient practice.

3. ELEMENT 3: With respect to what the facility will do to PREVENT the same deficiency from recurring:

All clinical leadership and Executive Director will be re-educated by the Chief Clinical Officer on level of care and involuntary discharge protocols. Training will be completed on 1/14/2026 and documented on an in-service sign in sheet.

4. ELEMENT 4: ED or designee will review all move outs and their associated move out reason in electronic recording system to pull the move out report in each system. This will be done for the month prior at the beginning of each month, no later than the 7th of each month.

This will all be completed by 1/14/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

cupproved 1/30/26

A477-General Requirements

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: The community will conduct a review on or before January 31st, 2026 of all Medicaid eligible residents to obtain the 10% threshold requirement.

Washington Township Senior Living
Provider Identification Number: 35A002
Survey Completion Date: December 10th, 2025

2. ELEMENT 2: All residents have the potential to be affected by this deficient practice.

3. ELEMENT 3: With respect to what the facility will do to PREVENT the same deficiency from recurring:

A. To maintain 10% Medicaid eligible residents we will have 10% in house. Will create a wait list to ensure if one moves out, we will have another ready to occupy that apartment. Director of Sales or designee created current waitlist for Medicaid pending residents as on January 26, 2026.

4. ELEMENT 4: Director of Sales and Executive Director will maintain a resident roster created on the first Monday of each month of all residents with Medicaid eligible residents and reconcile it monthly to ensure we are tracking our Medicaid eligible residents and keeping to our 10% requirement.

Completion date 1/31/26 approved 1/30/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A571-General Requirements

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: The current administrator is now reflected as the facility administrator of record. The state was notified on December 8, 2025.

2. ELEMENT 2: This deficient practice had the potential to affect all residents.

B. ELEMENT 3: With respect to what the facility will do to PREVENT the same deficiency from recurring:

1. Chief Clinical Officer will ensure any future changes in administrator of record via the NJ internal portal for licensing and administrator changes. Chief Clinical Officer received this information from state of NJ and was educated on this rule on January 15, 2025.

Washington Township Senior Living
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Survey Completion Date: December 10th, 2025

2. ELMENT 4: Chief Clinical Officer will complete a review each month of administrator of record and ensure it is accurate and up-to-date. The review of the employee roster for administrators will be used to review.

Completion Date 1/15/26 approved 1/30/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A767-Resident Assessments and Care Plans

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT1: Resident #1 no longer resides in the community.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

3. ELEMENT 3: With respect to what the facility will do to PREVENT the same deficiency from recurring:

A. Health and Wellness Director, or designee conducted a 100% audit of all existing residents for wounds, skin breakdown, and wound prevention measures / treatments completed on December 16, 2025.

B. Clinical Leadership and Executive Director will be re-educated on wound care and third-party care coordination documentation policies. Such training will take place on January 14th, 2026. This training was completed by the Chief Clinical Officer.

4. ELEMENT 4: Health and Wellness Director will review all residents with wounds every week. To include review of any outside provider notes ie home health, hospice providers. This review will include measurements, treatment orders, is the wound progressing.

Completion Date 1/28/26 approved 1/30/26

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ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A939-Pharmaceutical Services

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: Resident #8, 9 11 and 12 will have their medications converted to unit dose packaging on or before January 31st, 2026.

2. ELEMENT 2: All other residents have the potential to be affected by this deficient practice.

3. ELEMENT 3: With respect to what the facility will do to PREVENT the same deficiency from recurring:

A. HWD or designee will conduct a 100% audit of all medication carts for medication bottles. All residents found to have medications NOT in compliance with unit-dose packaging requirements will be converted to such. This audit will be completed on or before January 31st, 2026.

B. Executive Director or designee will provide re-training to medication techs on their scope and service on medication administration. Such training will take place before January 31st, 2026.

4. ELEMENT 4: Health and Wellness Director or designee will conduct a med cart audit each month using the med cart audit form to ensure all medications are in the correct packaging. This audit will be documented on the med cart audit form indicating each med cart in the community.

Completion Date 1/31/26 approved 1/30/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A041-Emergency Services and Procedures

Washington Township Senior Living
Provider Identification Number: 35A002
Survey Completion Date: December 10th, 2025

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: The Maintenance Director scheduled and completed an unannounced disaster drill on 12/29/25. It was a Facility based functional test for a weather emergency. The Executive Director invited both local fire department and civil defense agency on December 19, 2025 and retained such documentation.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

3. ELEMENT 3: With respect to what the facility will do to PREVENT the same deficiency from recurring:

A. Maintenance Director was educated by Executive Director on the new process for scheduling drills on December 19, 2025 by verbal communication. One Disaster drill will be scheduled annually in our internal electronic system.

4. ELEMENT 4: Maintenance Director or designee will schedule annual disaster drills annually in the internal electronic system. Executive Director will then review monthly all scheduled tasks within the electronic system to ensure compliance.

Completion date 1/31/26 approved 1/30/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A1089-Physical Plant

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: Apartments NJ Exec Order 26.4b1 will have their ventilation fan in bathrooms repaired and operational on or before January 15st, 2026. Maintenance Director of designee will ensure repair is done by said date.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

Washington Township Senior Living
Provider Identification Number: 35A002
Survey Completion Date: December 10th, 2025

3. ELEMENT 3: With respect to what the facility will do to PREVENT the same deficiency from recurring:

A. All staff are re-educated on identifying and reporting work orders issues for malfunctioning or broken equipment or systems by Executive Director on January 8, 2026.

B. The Maintenance director completed a facility wide audit on January 26, 2026, there were no concerns noted. Maintenance director is also educated by Executive Director on January 26, 2026 on auditing ventilation systems routinely to ensure they are operational and in good repair.

4. ELEMENT 4: Maintenance Director or designee will schedule quarterly checks in internal electronic system on a sampling of resident apartments to ensure ventilation systems are operational and in good repair.

Completion date 1/26/26 approved 1/30/26

A1095-Physical Plant

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: Fire Alarm System inspection is scheduled for February 2, 2026.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

B. With respect to what the facility will do to PREVENT the same deficiency from recurring:

ELEMENT 3: Maintenance Director or designee will identify a vendor and schedule regular and recurring Fire Alarm System testing and inspection semi-annually and schedule those pre-determined dates in the internal electronic system. Maintenance Director was educated on January 26,2026 on new process of following regulations for scheduling inspections for Fire alarm systems, as well as fire extinguisher tags and signage checks for monthly compliance by Executive Director.

ELEMENT 4: Executive Director or designee will review scheduled tasks in internal electronic system monthly to ensure substantial compliance.

Washington Township Senior Living
Provider Identification Number: 35A002
Survey Completion Date: December 10th, 2025

Completion Date 2/3/26

approved 1/30/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A1097-Physical Plant-Fire Suppression System

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: Fire Suppression in the kitchen, Wet/Dry Sprinkler system and fire pump system inspections have been scheduled for February 2, 2026. Sprinkler heads were repaired in the activity room on December 16, 2025 by maintenance director.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

B. With respect to what the facility will do to PREVENT the same deficiency from recurring:

3. ELEMENT 3: Maintenance Director or designee identified a vendor and scheduled regular and recurring sprinkler testing and inspection, fire suppression system inspection and fire pump system inspection and testing as required and scheduled those pre-determined dates in the internal electronic monitoring system. Executive director educated maintenance director on proper scheduling to comply with regulations and safety on December 16, 2025.

4. ELEMENT 4: Executive Director or designee will review scheduled tasks in internal electronic system monthly to ensure substantial compliance.

Completion Date: 2/3/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

approved 1/30/26

A1169-Physical Plant-Fire Extinguishers

Washington Township Senior Living
Provider Identification Number: 35A002
Survey Completion Date: December 10th, 2025

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: All Fire Extinguishers have had signage placed indicating their location and all tags are up to date w th signatures from monthly inspection. This was completed by the maintenance director on December 22, 2025.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

B. With respect to what the facility will do to PREVENT the same deficiency from recurring:

3. ELEMENT 3: Maintenance Director or designee will schedule this inspection of both the fire extinguisher tags and compliance with required monthly signage in internal electronic system. Maintenance director was educated by Executive Director on regulatory compliance and ensuring fire extinguishers have proper signage and are checked and signed off properly monthly on December 22, 2025.

4. ELEMENT 4: Executive Director or designee will review scheduled tasks in internal electronic system monthly to ensure substantial compliance.

Completion Date 12/22/25 approved 1/30/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A1187-Houskeeping-Sanitation-Safety-Maintenance

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: An electrical inspection was completed December 11, 2025 and a written statement from the licensed electrician will be retained.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

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Provider Identification Number: 35A002
Survey Completion Date: December 10th, 2025

B. With respect to what the facility will do to PREVENT the same deficiency from recurring:

3. ELEMENT 3: Maintenance Director or designee will schedule the electrical systems inspection annually in internal electronic system. Maintenance director was educated by executive director on new process of scheduling annual Electrical inspections on December 11, 2025.

4. ELEMENT4 : Executive Director or designee will review scheduled tasks in internal electronic system monthly to ensure substantial compliance.

Completion Date 12/11/25 approved 1/30/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A1243-Houskeeping Sanitation Safety and Maintenance.

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: Hot water temps in apartments NJ Exec Order 26.4b1 have all been corrected and are within range as of December 12, 2025. Current hot water temperatures are all noted as the following – NJ Exec Order 107degree Fahrenheit , NJ Exec Ord- 110 degree Fahrenheit, NJ Exec Ord- 108 degree Fahrenheit, and room NJ Exec Ord- 115 degree Fahrenheit.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

B. With respect to what the facility will do to PREVENT the same deficiency from recurring:

3. ELEMENT 3: Maintenance Director or designee will schedule routine checks weekly of water temperatures for compliance with the 105-120 degree Fahrenheit requirement in internal electronic system and document the temperatures. Facility wide audit completed on January 26, 2026 by maintenance director and all water temperatures were noted to be within range. Executive Director educated maintenance director on January 26, 2026 on new process for water temperature checks.

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Survey Completion Date: December 10th, 2025

4. ELEMENT 4: Executive Director or designee will review scheduled tasks in electronic system monthly to ensure substantial compliance.

Completion Date 1/31/26 approved 1/30/26

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

A1249-Housekeeping-Sanitation-Safety-Maintenance

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. ELEMENT 1: Generator Testing is scheduled for January 31,2026 and documentation will be uploaded into internal electronic system in accordance with the Generator testing requirements. All doors noted that were malfunctioning and not latching or closing properly have been fixed as of January 29,2026. Electrical room locks have been changed to ensure they are secure and wiring concerns in those rooms have been corrected as of December 11, 2025.

2. ELEMENT 2: All residents had the potential to be affected by this deficient practice.

B. With respect to what the facility will do to PREVENT the same deficiency from recurring:

3. ELEMENT 3: Maintenance Director or designee will schedule this Generator testing in internal electronic system monthly with the 30 minute load test. Maintenance director was educated by executive director on new process and schedule of regulatory generator testing, as well as regulations on all doors and the importance of auditing and ensuring compliance on 12/23/25. Building wide audit was completed by maintenance director to ensure compliance with all functioning doors on January 15, 2026. Generator service company was out January 29, 2026 to provide education to maintenance director on testing generator monthly properly.

4. ELEMENT 4: Executive Director or designee will review scheduled tasks in internal electronic system monthly to ensure substantial compliance.

Completion Date: 1/31/26 approved 1/30/26

Washington Township Senior Living
Provider Identification Number: 35A002
Survey Completion Date: December 10th, 2025

ED or designee will bring all audits and trainings to the community's Quality Assurance meeting monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.

All Deficient practices will be corrected on or before Feb 3, 2026.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
35A002 Y1	A. Building B. Wing Y2	1/30/2026 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 A0461	Correction	ID Prefix A0477	Correction	ID Prefix A1041	Correction
Reg. # 8:36-5.1(d)(5)	Completed	Reg. # 8:36-5.1(i)	Completed	Reg. # 8:36-14.3(a)	Completed
LSC	01/14/2026	LSC	01/31/2026	LSC	01/31/2026
ID Prefix A1089	Correction	ID Prefix A1095	Correction	ID Prefix A1097	Correction
Reg. # 8:36-16.3(b)	Completed	Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-16.6	Completed
LSC	01/26/2026	LSC	02/03/2026	LSC	02/03/2026
ID Prefix A1169	Correction	ID Prefix A1187	Correction	ID Prefix A1243	Correction
Reg. # 8:36-16.15(a)	Completed	Reg. # 8:36-17.3(a)(1)	Completed	Reg. # 8:36-17.6(b)	Completed
LSC	12/22/2025	LSC	12/11/2025	LSC	01/31/2026
ID Prefix A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/31/2026	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	
12/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
35A002 Y1	A. Building B. Wing Y2	1/30/2026 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 A0461	Correction	ID Prefix A0477	Correction	ID Prefix A0571	Correction
Reg. # 8:36-5.1(d)(5)	Completed	Reg. # 8:36-5.1(i)	Completed	Reg. # 8:36-5.10(a)(6)	Completed
LSC	01/14/2026	LSC	01/31/2026	LSC	01/15/2026
ID Prefix A0767	Correction	ID Prefix A0939	Correction	ID Prefix A1041	Correction
Reg. # 8:36-7.4(c)(2)	Completed	Reg. # 8:36-11.5(b)(1)(i-ii)	Completed	Reg. # 8:36-14.3(a)	Completed
LSC	01/28/2026	LSC	01/31/2026	LSC	01/31/2026
ID Prefix A1089	Correction	ID Prefix A1095	Correction	ID Prefix A1097	Correction
Reg. # 8:36-16.3(b)	Completed	Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-16.6	Completed
LSC	01/26/2026	LSC	02/03/2026	LSC	02/03/2026
ID Prefix A1169	Correction	ID Prefix A1187	Correction	ID Prefix A1243	Correction
Reg. # 8:36-16.15(a)	Completed	Reg. # 8:36-17.3(a)(1)	Completed	Reg. # 8:36-17.6(b)	Completed
LSC	12/22/2025	LSC	12/11/2025	LSC	01/31/2026
ID Prefix A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/31/2026	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	
12/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO