

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AL0103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/22/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NEW STANDARD SENIOR LIVING AT HAMMON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 SOUTH WHITE HORSE PIKE HAMMONTON, NJ 08037</b>
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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 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ189010 CENSUS: 132 SAMPLE SIZE: 6 SURVEY DATE: 10/22/2025 - 10/22/2025</p> <p>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, based on this Complaint Survey.</p> <p>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.</p>	A 000		
A 753	<p>8:36-7.3(c) Resident Assessments and Care Plans</p> <p>(c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan.</p> <p>This REQUIREMENT is not met as evidenced by: NJ189010</p> <p>Based on observation, record review, and</p>	A 753		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/15/25

New Jersey Department of Health

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A 753	<p>Continued From page 1</p> <p>interview, the facility failed to update the service plan for 1 (Resident #2) of 3 residents reviewed.</p> <p>Findings included:</p> <p>An "Admission Record" revealed the facility admitted Resident #2 on [redacted]. According to the Admission Record, Resident #2 had a medical history that included [redacted].</p> <p>A quarterly "Level of Care Assessment/Support/Individualized Service Plan," dated [redacted], revealed Resident #2 required [redacted] and [redacted] every hour, exhibited [redacted] and was very [redacted] with [redacted].</p> <p>A "Behavior Note," dated [redacted], revealed Resident #2 [redacted] throughout the facility "all shift as per usual routine" and was unable to be [redacted] to their apartment for [redacted]. The [redacted] Note revealed staff observed Resident #2 [redacted] and staff offered an activity to the resident, which was declined.</p> <p>A "Health Status Note," dated [redacted], revealed Resident #2 [redacted] through the facility while [redacted] of other resident rooms. The note also revealed Resident #2 [redacted] another resident's room [redacted] and [redacted].</p> <p>A "Health Status Note," dated [redacted] revealed Resident #2 was seen [redacted] in the facility. Per the note, staff successfully [redacted] Resident #2 to their apartment.</p>	A 753		

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A 753	<p>Continued From page 2</p> <p>A "Behavior Note," dated [redacted] revealed Resident #2 was up [redacted] around the unit and going [redacted] and [redacted] of other residents' [redacted]</p> <p>A "Behavior Note," dated [redacted], revealed Resident #2 was observed wandering the halls and [redacted]</p> <p>Resident #2's undated "Service Plan Detail" report lacked a service plan that addressed Resident #2's [redacted] and [redacted] or attempting to enter other resident rooms.</p> <p>During an interview on 10/22/2025 at 1:47 PM, Resident #1 stated Resident #2 [redacted] around the facility and [redacted] as they walked past resident rooms. Resident #1 stated they informed the Assistant Director of Nursing (ADON) of Resident #2's [redacted] and the ADON responded they were unable to stop Resident #2 from [redacted] Resident #2 stated staff [redacted] Resident #2 to the activities room when they saw Resident #2 [redacted] other resident rooms. Resident #1 stated they met with the Director of Nursing (DON) and informed them of Resident #2's [redacted] Resident #1 stated the DON told them the facility could not do anything about Resident #2's [redacted] and [redacted] resident doors. Resident #1 stated they [redacted] in the facility with Resident #2.</p> <p>During an interview on 10/22/2025 at 2:55 PM, Resident #4 stated Resident #2 [redacted] around the facility and [redacted]. Resident #4 stated they had seen Resident #2 try to [redacted]. Resident #4 stated the residents in the facility kept their doors</p>	A 753		

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A 753	<p>Continued From page 3</p> <p>locked and the Executive Director (ED) had been notified of Resident #2's [redacted].</p> <p>During an interview on 10/22/2025 at 3:05 PM, the ADON stated Resident #2 [redacted] and was not [redacted]. The ADON said Resident #2 attempted to [redacted] into other residents' spaces and was observed [redacted] handles as they [redacted]. The ADON stated Resident #2 started the [redacted] behavior within the [redacted].</p> <p>During an interview on 10/22/2025 at 3:16 PM, Licensed Practical Nurse (LPN) #1 stated Resident #2 [redacted] noting the LPN had observed the resident [redacted] as they [redacted]. She stated interventions for residents that [redacted] included [redacted] with snacks, meals, or encouragement to attend activities.</p> <p>During an interview on 10/22/2025 at 3:24 PM, Certified Nursing Assistant (CNA) #1 stated Resident #2 [redacted]. CNA #1 stated they [redacted] the resident when they observed the resident [redacted]. CNA #1 stated other residents did [redacted] Resident #2 to [redacted]. CNA #1 stated they told residents who complained about Resident #2 that Resident #2 was [redacted] and the staff were watching Resident #2. The CNA stated some residents were [redacted] Resident #2 was going to [redacted].</p> <p>During an interview on 10/22/2025 at 3:37 PM, Caregiver #1 stated Resident #2 [redacted] noting they had observed Resident #2 trying to [redacted] by [redacted] the [redacted]. Caregiver #1 stated residents in the</p>	A 753		

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A 753	<p>Continued From page 4</p> <p>facility had complained of Resident #2 [redacted] their [redacted].</p> <p>During an interview on 10/22/2025 at 3:47 PM, the ED stated a town hall meeting was held with residents in the facility on [redacted]. During the meeting, one resident [redacted] about Resident #2 [redacted] and [redacted] on resident doors. The ED stated the facility was working on placing the resident in a more suitable environment.</p> <p>On 10/22/2025 at 4:03 PM, Resident #2 was observed in the facility playing a game with other residents.</p> <p>During an interview on 10/22/2025 at 4:06 PM, Resident #6 stated Resident #2 [redacted] in the facility, [redacted]. Resident #6 stated Resident #2 [redacted]. Resident #6 stated staff [redacted] the resident back to their room when they saw them [redacted]. Resident #6 stated it made them [redacted] just knowing there was [redacted]. Resident #6 stated they were [redacted] they might [redacted] Resident #2 in their [redacted].</p> <p>During an interview on 10/22/2025 at 4:23 PM, Activity Assistant (AA) #1 stated that, when Resident #2 [redacted] staff [redacted] the resident to the activities room to engage the resident in activities and [redacted] games. AA #1 stated residents complained about Resident #2 [redacted].</p> <p>During an interview on 10/22/2025 at 4:26 PM, the DON stated she expected staff to [redacted] and engage Resident #2 with activities when they [redacted] or if the resident was causing [redacted].</p>	A 753		

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A 753	<p>Continued From page 5</p> <p><b>NJ Ex Order 26.4(b)(1)</b> The DON stated residents who <b>NJ Exec Order 26.4b1</b> but were not <b>NJ Exec Order 26.4b1</b> were entitled to <b>NJ Exec Order 26.4b1</b> around the facility because it was their home. The DON stated Resident #2 <b>NJ Exec Order 26.4b1</b> and, if the resident did not have a service plan for the <b>NJ Exec Order 26.4b1</b>, they should have one. She stated two residents had complained to the DON about Resident #2 <b>NJ Ex Order 26.4(b)(1)</b>. The DON stated she was responsible for updating service plans and confirmed they should have updated Resident #2's service plan when the resident began displaying <b>NJ Exec Order 26.4b1</b> of <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/22/2025 at 4:53 PM, the ED stated she expected staff to redirect and engage Resident #2 in activities when the resident <b>NJ Exec Order 26.4b1</b>. The ED stated residents who <b>NJ Exec Order 26.4b1</b> should have a service plan for <b>NJ Exec Order 26.4b1</b>. The ED stated residents had reported Resident #2 had attempted to <b>NJ Exec Order 26.4b1</b>. The ED informed those residents that staff were monitoring Resident #2 and encouraged the residents to <b>NJ Exec Order 26.4b1</b>.</p>	A 753		
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## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL0103	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 12/23/2025	Y3
NAME OF FACILITY NEW STANDARD SENIOR LIVING AT HAMMONTON			STREET ADDRESS, CITY, STATE, ZIP CODE 308 SOUTH WHITE HORSE PIKE HAMMONTON, NJ 08037		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0753	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-7.3(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/30/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/22/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		