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
	AL0103	A. BUILDING: ______ B. WING ______	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT HAMMONTON	**308 SOUTH WHITE HORSE PIKE HAMMONTON, NJ 08037**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 09/19/2023 to 09/20/2023 and New Standard Senior Living at Hammonton was found to be in compliance with the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. TYPE OF SURVEY: Initial pre-operational survey conducted on 9/19/2023 & 9/20/2023 for the Newly Constructed two-story Assisted Living (AL) facility licensed for 174 AL beds. This AL facility has a total 162 apartments/residential units. CENSUS: N/A The outbreak response plan was reviewed. 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.	A 000		
A1113	8:36-16.10(a)(1) Physical Plant (a) Each residential unit shall contain, at a minimum, a small refrigerator, a wall cabinet for food storage, a small bar-type sink, and a counter with work space and electrical outlets suitable for small cooking appliances, for example, a microwave, a two-burner cooktop, or a toaster-oven. 1. Upon entering the assisted living facility,	A1113		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE
11/13/23

New Jersey Department of Health

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A1113	Continued From page 1 the resident and the resident's family or representative shall be asked if they wish to have a cooking appliance. If so, the appliance shall be provided by the facility, in accordance with facility policies. If the resident and resident's family or representative wish to provide their own cooking appliance, it shall meet the facility's safety standards. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide a small refrigerator inside of 162 facility apartments/residential units as required by regulations for an assisted living facility. This deficient practice was evidenced by the following: On 9/19/2023 at 10:30 a.m., surveyors toured the facility's two-story building with the facility's Executive Director (ED). During the tour, surveyors randomly enetered the following apartment #'s: NJ EX Order. 264b1 NJ EX Order. 264b1 and NJ EX O. The surveyors observed that each unit did not have a refrigerator inside the apartment: During an interview with the ED at 11:55 a.m., she confirmed that none of the apartments had refrigerators at the time of survey but that the facility had ordered the refrigerators.	A1113		

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A1113	Continued From page 2 Later at 2:00 p.m., the ED provided surveyors with a documentation that indicated an order for refrigerators. Upon review of the quote/invoice, the surveyor noted that the facility ordered 161 refrigerators. Surveyors made the ED aware that the facility has 162 apartments/residential units and was required to provide a refrigerator for each residential unit. The ED stated that she would order enough refrigerators for all apartments. On 9/20/23 at 11:35 a.m., the ED stated that refrigerators were expected to be delivered at the facility on 9/29/2023.	A1113		

October 3, 2023

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the Statement of Deficiencies (SOD).**

   Vendor contacted and resourced partial items in order to ensure delivery as soon as possible.

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

   We are not open to residents therefore no residents affected or have the potential to be affected.

3. **What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.**

   All rooms are equipped with brand new refrigerator.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change.**

   Executive Director ensured, and inspected, 162 refrigerators were delivered on September 28th, 2023 and placed in each room. Pictures and delivery receipt provided to DOH Inspector. Executive Director will check 10 random rooms per month and report to QA that refrigerators are in the rooms,

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
AL0103	A. Building B. Wing	9/28/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT HAMMONTON	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 A1113 Reg. # 8:36-16.10(a)(1) LSC	Correction Completed 09/28/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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
9/20/2023

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