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 _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW STANDARD SENIOR LIVING AT HAMMON	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: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00 184327 CENSUS: 138 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 05/03/25

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This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00184327

Based on observation, interview and record review, it was determined that the facility Executive Director (ED) failed to develop a comprehensive [NJ Exec Order 26.4b] policy to include [NJ Exec Order 26.4b] guidelines and failed to enforce its [NJ Exec Order 26.4b] '[NJ Exec Order 26.4b1]' policy for 1 of 3 residents reviewed, Resident #3. The deficient practice was evidenced by the following:

On 4/10/25 at 10:30 a.m., Resident #3, was observed with a [NJ Exec Order 26.4b1] and about to exit the apartment. The resident granted the surveyor permission to enter the apartment. Upon entering the apartment, the surveyor was [NJ Exec Order 26.4b] with [NJ Ex Order 26. 4B1]. The surveyor also observed a [NJ Ex Order 26. 4B1] on the resident's table. The surveyor then asked the resident if he/she [NJ Ex Order 26. 4B1]. The resident [NJ Exec Order 26.4b1] [NJ Ex Order 26. 4B1] at the time however, [NJ Exec Order 26.4b1] [NJ Ex Order 26. 4B1] at other times. The resident proceeded to leave the unit.

At 10:56 a.m., the surveyor asked the Certified Medication Assistant (CMA) on duty at the time to inspect Resident #3's apartment. The CMA walked into the apartment and immediately said, '[NJ Ex Order 26. 4B1]." The CMA stated that it had been an [NJ Exec Order 26.4b1] with Resident #3 [NJ Ex Order 26. 4B1].

On [NJ Exec Order] at 5:02 p.m., a Licensed Practical Nurse (LPN) documented that she received a call

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A 310	Continued From page 2	A 310		

from the resident's responsible party that Resident #3 was in his/her apartment with another resident, Resident #1, possibly [NJ Ex Order 26. 4B1] and looked as though he/she was [NJ Ex Order 26. 4B] out on the bed. Resident #3 was sent to the [NJ Ex Order 26. 4B1] as a result of [NJ Exec Order 26.4b1] on his/her bed after NJ Exec Order 26.4b1 in the apartment.

At 12:58 p.m., the surveyor interviewed the Executive Director (ED) and inquired about Resident #3 and other residents *NJ Ex Order 26. 4B1* [redacted]. The ED stated that residents *NJ Ex Order 26. 4B1* [redacted] had been an on-going concern, and the residents were informed to only *NJ Ex Order 26. 4B1* [redacted]. She added that some residents still *NJ Ex Order 26. 4B1* [redacted] and would [NJ Exec Order 26.4b] [redacted] to remove the [NJ Ex Order 2] [redacted].

The facility failed to follow their [NJ Exec Order 26.4b] [redacted] policy, Residents Right and also to investigate the reason Resident #3 *NJ Ex Order 26. 4B1* [redacted] after the facility received a call from the resident's responsible party regarding the resident *NJ Ex Order 26. 4B1* [redacted].

The surveyor reviewed the policy provided by the ED titled, "Smoking Prohibition Policy" which revealed under Procedure, "... 3. Special outdoor areas may be designated as Resident smoking area."

Surveyor review of the "Residents Rights" provided by the ED revealed, "... 22. The right to live in safe and clean conditions in a community..."

Refer to 8:36-4.1(a)(22)

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A 401	Continued From page 3	A 401		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00184327 Based on observation, interview and record review, it was determined that the facility failed to ensure that residents lived in a safe environment and did not [NJ Exec Order 26.4b] in their apartments for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 4/10/25 at 10:30 a.m., Resident #3, was observed with a [NJ Exec Order 26.4b1] and about to exit his/her apartment. The resident granted the surveyor permission to enter the apartment. Upon entering the apartment, the surveyor was [NJ Exec Order 26.4b] with [NJ Ex Order 26. 4B1]. The surveyor also observed a [NJ Ex Order 26. 4B1] on the resident's table. The surveyor then asked the resident if he/she [NJ Ex Order 26. 4B1]. The resident [NJ Exec Order 26.4b] [NJ Ex Order 26. 4B1] at the time however, [NJ Exec Order 26.4b] [NJ Ex Order 26. 4B1].	A 401		

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A 401	Continued From page 4 The resident proceeded to leave the unit. At 10:50 a.m., the surveyor observed two staff members in the hallway and the surveyor asked Staff Member #2 to inspect Resident #3's apartment. Staff member #2 confirmed that she [redacted]. At 10:56 a.m., the surveyor asked a Certified Medication Assistant (CMA) on duty at the time to inspect Resident #3's apartment. The CMA walked into the apartment and immediately said, '[redacted]." The CMA informed the surveyor that it had been an [redacted] with Resident #3 [redacted]. At 11:20 a.m., the surveyor reviewed Resident #3's electronic medical record which revealed that the resident's move in date was [redacted] with diagnoses of [redacted], The "Pre-Admission Medical Certification for Assisted Living" dated [redacted] completed by a physician indicated that the resident was [redacted]. The above CMA stated that the resident was [redacted] with Activity of daily Living. Surveyor continued review of Resident #3's electronic medical record observed that on [redacted] at 7:43 p.m., a Licensed Practical Nurse (LPN) documented that she [redacted] and it appeared that the resident had been [redacted]. The LPN documented that she reminded the resident about not [redacted], which the resident acknowledged and stated that he/she would not [redacted]. On [redacted] at 7:43 p.m., the same	A 401		

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A 401	Continued From page 5	A 401		

LPN documented that she NJ Ex Order 26. 4B1 in the nearby hallway and the resident denied NJ Ex Order 26. 4B1.

Additionally, the same above LPN documented that on NJ Exec Order 26 at 5:02 p.m., she received a call from the resident's responsible party that Resident #3 was in his/her apartment with another resident, Resident #1, possibly NJ Ex Order 26. 4B1 and looked as though he/she was NJ Ex Order 26. 4B NJ Ex O on the bed. Resident #3 was sent to the NJ Ex Order 26. 4B1 as a result of NJ Ex Order 26. 4B1 .

At 12:38 p.m., the surveyor interviewed the above LPN who confirmed that the resident did NJ Ex Order 26. 4 on NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b . The LPN also confirmed that Resident #1, was observed by Resident #3's apartment on NJ Ex Order 26.4 and "believed" that Resident #1 had just come out of Resident #3's apartment.

In addition, the surveyor reviewed the resident's "Managed Risk Agreement" (MRA) dated NJ Ex Order 26.4(b)(1 completed by a Registered Nurse (RN) which indicated that Resident #3's NJ Ex Order 26. 4B1 would be NJ Exec Order 26.4b1 . The RN documented that NJ Ex Order 26. 4B1 would also be given to the resident from the front desk and the resident would go to NJ Ex Order 26. 4B1 . However, the resident continued to NJ Ex Order 26. 4B1

At 12:58 p.m., the surveyor interviewed the Executive Director (ED) and inquired about Resident #3 and other residents NJ Ex Order 26. 4B1 . The ED stated that although Resident #3's NJ Ex Order 26. 4B1 were NJ Exec Order 26.4b1 but appeared that the resident was getting NJ Ex Order 26. 4B1 from other sources. The ED explained that residents NJ Ex Order 26. 4B1 had

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been an on-going concern, and were informed to only [NJ Ex Order 26. 4B1 redacted]. She added that some residents still [NJ Ex Order 26. 4B1 redacted] and would [NJ Ex Order 26.4(b)(1) redacted] to [redacted].

In addition, the surveyor inquired about the incident that occurred on [redacted], in Resident #3's apartment when the resident's responsible party notified the facility of Resident #3 [NJ Ex Order 26. 4B1 redacted] on the bed after possibly [NJ Ex Order 26. 4B1 redacted]. During the interview, the ED stated that she was present in the facility at time of the incident and only had conversation with Resident #3 regarding [NJ Ex Order 26. 4B1 redacted].

At 1:55 p.m., the surveyor interviewed the front desk concierge who showed the surveyor Resident #3's [NJ Ex Order 26. 4B1 redacted] [NJ Exec Order 26.4b1 redacted]. She informed the surveyor that the resident was also getting [NJ Ex Order 26. 4B1 redacted] from other residents.

On 4/16/25, post survey, the surveyor reviewed Resident #3's [NJ Ex Order 26. 4B1 redacted] summary dated [NJ Ex Order 26. 4B1 redacted]., provided by the ED via email which revealed, "Diagnosis: [NJ Ex Order 26. 4B1 redacted]."

Review of the "Residents Rights" provided by the ED revealed, "... 22. The right to live in safe and clean conditions in a community..."

The surveyor reviewed the smoking policy titled, "Smoking Prohibition Policy" which revealed, "Smoking is prohibited in any building of the Community, including dwelling units, because of health and safety hazards." Procedure 3. "Special outdoor areas may be designated as Resident smoking areas."

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A 401	Continued From page 7 The facility failed to follow their [NJ Exec Order 26.4b] policy, and the resident [NJ Ex Order 26.4(b)(1)] the apartment placed the resident and other residents at risk for safety. Pt has a managed risk agreement that [NJ Ex Order 26. 4B1] will be NJ Exec Order 26.4b1; however, the resident was getting [NJ Ex Order 26. 4B1] from other sources. On 4/10/25 at 3:40 p.m., the surveyor met with the Executive Director and requested a removal plan regarding the above [NJ Ex Order 26. 4B1]. On 4/14/25, the facility submitted an acceptable removal plan for the above concern.	A 401		
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 by: Complaint #: NJ 00184327 Based on interview and record review, it was determined that the facility failed to ensure that resident's Service Plan (SP) was developed and/or updated for [NJ Ex Order 26.4(b)( ] for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following.	A 753		

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A 753	Continued From page 8 On 4/10/25 at 10:30 a.m., Resident #3, was observed about to exit his/her apartment. The resident granted the surveyor permission to enter the apartment. Upon entering the apartment, the surveyor was [NJ Exec Order 26.4b] with [NJ Ex Order 26. 4B1] [redacted]. The surveyor also observed a [NJ Ex Order 26. 4B1] on the resident's table. The surveyor then asked the resident if he/she [NJ Ex Order 26. 4B1] [redacted]. The resident [NJ Exec Order 2] [NJ Ex Order 26. 4B1] at the time however, [NJ Exec Order 26.4b] [NJ Ex Order 26. 4B1] [redacted] at other times. At 10:56 a.m., the surveyor asked a Certified Medication Assistant (CMA) on duty at the time to inspect Resident #3's apartment. The CMA went into the apartment and immediately confirmed that Resident #3 [NJ Ex Order 26. 4B1] [redacted] and informed the surveyor that it had been an [NJ Exec Order 26.4b1] with the resident [NJ Ex Order 26. 4B1] [redacted]. Surveyor continued review of Resident #3's electronic medical record observed that on [NJ Ex Order 26.4(b)(] at 7:43 p.m., a Licensed Practical Nurse (LPN) documented that she [NJ Ex Order 26. 4B1] coming from the resident's apartment and it appeared that the resident had been [NJ Ex Order 26. 4B1] [redacted]. The LPN documented that she reminded the resident about not [NJ Ex Order 26. 4B1] [redacted], which the resident acknowledged and stated that he/she would not [NJ Ex Order 26. 4B1] [redacted]. On [NJ Ex Order 26.4(] at 7:43 p.m., the same LPN documented that she [NJ Ex Order 26. 4B1] in the nearby hallway and the resident [NJ Exec Order 2] [NJ Ex Order 26. 4B1]. Additionally, the same above LPN documented on [NJ Ex Order 26.4] at 5:02 p.m., that she received a call from the resident's responsible party that the resident was in his/her apartment with another resident, Resident #1, possibly [NJ Ex Order 26. 4B1] and	A 753		

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A 753	Continued From page 9 looked as though he/she was [NJ Ex Order 26. 4B1] on the bed. Resident #3 was sent to the [NJ Ex Order 26. 4B1] as a result of [NJ Ex Order 26.4(b)(1)] on his/her bed after [NJ Ex Order 26. 4B1] [redacted]. The surveyor reviewed Resident #3's "Managed Risk Agreement" (MRA) dated [NJ Ex Order 26.4(b)(1)], completed by a Registered Nurse (RN) which indicated that the resident's [NJ Ex Order 26. 4B1] would be [NJ Exec Order 26.4b1 redacted]. The RN documented that [NJ Ex Order 26. 4B1] would also be given to the resident from the front desk and the resident would go to [NJ Ex Order 26. 4B1 redacted]. At 12:58 p.m., the surveyor interviewed the Executive Director (ED) and inquired about Resident #3 and other residents [NJ Ex Order 26. 4B1 redacted]. The ED stated that residents [NJ Ex Order 26. 4B1 redacted] had been an on-going concern, and the residents were reminded to only [NJ Ex Order 26. 4B1 redacted]. She added that some residents still [NJ Ex Order 26. 4B1 redacted] and [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4(b)(1)] the [NJ Ex Order 26.4(b)(1)]. The surveyor reviewed Resident #3's SP which was initiated on [NJ Ex Order 26.4(b)(1)], and did not observe documented evidence that the SP had been revised to include intervention(s) to address the resident's continued [NJ Ex Order 26. 4B1]. Despite the MRA, the resident continued to [NJ Ex Order 26. 4B1 redacted]. At 1:10 p.m., the surveyor interviewed the Director of Wellness (DOW) regarding Resident #3's SP not been updated to include the resident's [NJ Ex Order 26. 4B1]. The DOW stated that she was new to the facility and would review the SP.	A 753		

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A 753	Continued From page 10 On 4/16/25, post survey, the surveyor reviewed Resident #3's NJ Ex Order 26. 4B1 summary dated NJ Ex Order 26. 4B1., provided by the ED via email which revealed, "Diagnosis: NJ Ex Order 26. 4B1 [redacted]."	A 753		

NEW STANDARD
Senior Living

New Standard Senior Living at Hammonton
308 S. White Horse Pike
Hammonton, NJ 08037
P (609) 541-7718

April 29, 2025

Plan of Correction

A310 - 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;

1. All residents who smoke were educated on the smoking policy and consequences of smoking in their apartments or undesignated areas on 4/10/25. Resident # 3 were affected by the deficient practice. No smoking signs and smoking in designated area signs were placed in front of the building and across the parking lot leading to the designated smoking area on 4/11/25.
2. All residents have the potential to be affected by the deficient practice.
3. A detailed smoking policy was put into place outlining resident expectations and consequences regarding smoking on 4/10/25. All residents were advised that they can and will ultimately receive 30-day notice if they continue to smoke in their apartment and that the facility will help with finding placement. Staff were educated on the smoking policy and to report resident smoking in undesignated areas. 4/11/25
4. . The Executive Director and or designee will monitor and review monthly quality assurance during the morning meeting. Completion date 4/17/25

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A401 - 8:36-4.1(a)(22) Resident Rights

(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:

22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;

1. All residents were re-educated on the residents' rights to live in a safe and clean environment on 4/11/2025. All residents were educated about the seriousness of smoking in the apartment and undesignated areas on 4/11/2025. No smoking signs and smoking in designated area signs were put in place at the front entrance of the facility, in the circle, and across the parking lot to the far right of the parking lot on 4/11/2025. Residents acknowledged the potential danger of smoking in the apartment and undesignated areas. Resident #3 were affected by the deficient practice.
2. All residents have the potential to be affected by the deficient practice.
3. A detailed smoking policy was put into place outlining resident expectations and consequences regarding smoking on 4/10/2025. All residents were advised that they can and will ultimately receive 30-day notice if they continue to smoke in their apartment and that the facility will help with finding placement on 4/11/2025. Staff will conduct random room checks weekly on all smokers to make sure they are not smoking in their apartments for one month and then at least once quarterly thereafter. Staff will perform random checks daily to ensure residents are not smoking in undesignated areas for one month and then at least quarterly thereafter. Residents were re-educated during our monthly resident council meeting on residents' rights regarding smoking. Staff were in-serviced on smoking policy and residents' rights. 4/11/25
4. The Executive Director and or designee will monitor and review monthly quality assurance during the morning meeting. Completion date 4/17/25

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A753 - 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.

1. The DON reviewed documentation and updated all SPs for residents who NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 assessment on 4/11/2025. Resident #3 were affected by the deficient practice and service plan updated immediately. 4/10/25

2. All residents have the potential to be affected by not completing a risk assessment for smoking.

3. The DON and the Executive Director developed an excel spread sheet to track the Risk Assessment to ensure timely updates on 4/11/2025.

4. DON will conduct a Risk Assessment upon admission and assess semi-annually as well as whenever there are a significant change in condition to ensure they remain current. Completion date 4/17/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
AL0103		5/8/2025

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 04/17/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 04/17/2025	ID Prefix A0753 Reg. # 8:36-7.3(c) LSC	Correction Completed 04/17/2025
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	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	
4/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO