	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MUUTU	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
		IDENTIFICATION NUMBER:	A. BUILDIN		COMPLETED
		315506	B. WING		02/06/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
MANORC	ARE HEALTH SERVICES	-WASHINGTON TOWNSHIP		378 FRIES MILL ROAD SEWELL, NJ 08080	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLET THE APPROPRIATE DATE
E 000	Initial Comments		EO	00	
E 037	Appendix Z-Emergen Provider and Supplier Guidance 483.73, Re Care (LTC) Facilities. EP Training Program	equirements for Long Term	EO	37	3/14/20
SS=D	Hospitals at §482.15, at §484.102, "Organiz OPOs at §486.360, R Training program. The following: (i) Initial training policies and procedur staff, individuals provi arrangement, and vol expected roles. (ii) Provide emer at least every 2 years (iii) Maintain doc preparedness training (iv) Demonstrate emergency procedures (v) If the emerge and procedures are s [facility] must conduct policies and procedur *[For Hospices at §41 hospice must do all o (i) Initial training	unteers, consistent with their gency preparedness training aumentation of all emergency g. staff knowledge of es. ncy preparedness policies ignificantly updated, the t training on the updated res. 18.113(d):] (1) Training. The f the following: in emergency preparedness res to all new and existing			
	expected roles.	gement, consistent with their staff knowledge of			
30RATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				02/24/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/03/2021

FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/03/2021 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION 01	(X3) DATE	
		315506	B. WING			02/	06/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICES	-WASHINGTON TOWNSHIP			378 FRIES MILL ROAD SEWELL, NJ 08080		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 037	at least every 2 years (iv) Periodically r emergency prepared employees (including special emphasis play procedures necessar others. (v) Maintain docu preparedness training (vi) If the emerge and procedures are s hospice must conduc policies and procedur *[For PRTFs at §441. program. The PRTF r (i) Initial training policies and procedur staff, individuals prov arrangement, and vol expected roles. (ii) After initial tra preparedness training (iii) Demonstrate emergency procedure (iv) Maintain doc preparedness training (v) If the emerge and procedures are s PRTF must conduct t policies and procedur *[For LTC Facilities at Program. The LTC fac following: (i) Initial training	es. rgency preparedness training eview and rehearse its hess plan with hospice nonemployee staff), with ced on carrying out the y to protect patients and umentation of all emergency g. ency preparedness policies ignificantly updated, the t training on the updated res. 184(d):] (1) Training must do all of the following: in emergency preparedness res to all new and existing iding services under unteers, consistent with their unteers, consistent with their staff knowledge of es. umentation of all emergency g every 2 years. staff knowledge of es. umentation of all emergency g. ncy preparedness policies ignificantly updated, the raining on the updated res. t §483.73(d):] (1) Training cility must do all of the in emergency preparedness res to all new and existing	E	03			

If continuation sheet Page 2 of 6

PRINTED: 03/03/2021

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					/I APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315506	B. WING			02/	06/2020
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MANORC	ARE HEALTH SERVICES	-WASHINGTON TOWNSHIP			78 FRIES MILL ROAD SEWELL, NJ 08080		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 037	expected role. (ii) Provide emergent at least annually. (iii) Maintain docu preparedness training (iv) Demonstrate emergency procedured *[For CORFs at §485. CORF must do all of t (i) Provide initial t preparedness policies and existing staff, indi- services under arrange consistent with their en- (ii) Provide emergency consistent with their en- (iii) Maintain docu (iv) Demonstrate emergency procedured be oriented and assign responsibilities re- emergency plan within workday. The training instruction in the location systems and signals and (v) If the emergency and procedures are sist CORF must conduct the policies and procedured *[For CAHs at §485.6] The CAH must do all (i) Initial training in policies and procedured and extinguitation and extinguitation (i) Initial training in policies and procedured (i) Initial training in policies and procedures (ii) Initial training in policies and procedures (iii) Initial training in policies and procedures (iii) Initial training in policies and procedures (iii) Initial training in (iii) Initial training in (iiii) Initial	unteers, consistent with their gency preparedness training umentation of all emergency l. staff knowledge of es.	E	037			

Facility ID: NJ08004

If continuation sheet Page 3 of 6

PRINTED: 03/03/2021

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MI II T	IPLE CONSTRUCTION		NO. 0938-039
		A. BUILDI			(X3) DATE SURVEY COMPLETED	
		315506	B. WING			02/06/2020
NAME OF PF	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY,	STATE, ZIP CODE	
MANORCA	ARE HEALTH SERVICES	-WASHINGTON TOWNSHIP		378 FRIES MILL ROAD SEWELL, NJ 08080		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE EENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page	• 3	E	37		
	authorities, to all new individuals providing s and volunteers, o roles. (ii) Provide emergent at least every 2 years (iii) Maintain door (iv) Demonstrate emergency procedure (v) If the emergen	and existing staff, services under arrangement, consistent with their expected gency preparedness training umentation of the training. staff knowledge of es. ency preparedness policies ignificantly updated, the aining on the updated				
	CMHC must provide i preparedness policies and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff kno procedures. Thereaff emergency preparedr years. This REQUIREMENT by: Based on interview a preparedness training	training. The CMHC must weledge of emergency er, the CMHC must provide ness training at least every 2 is not met as evidenced and a review of emergency documentation on		PRACTICE:		
	2/5/2020, in the prese it was determined tha staff on the Emergence annually. This deficie 31 of 144 active staff following:	ence of facility management, t the facility failed to train cy Preparedness Plan (EPP) ent practice was identified for and was evidenced by the r's staff training records for		alleged that the fa	aredness training	
	the facility's "Annual N Response" training re	Mandatory: 2019 Emergency port revealed that there staff members (21%) that			by alleged practice: staff members that did	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ08004

If continuation sheet Page 4 of 6

PRINTED: 03/03/2021

FORM APPROVED

PRINTED: 03/03/2021 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315506	B. WING				2/06/2020
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICES	-WASHINGTON TOWNSHIP			78 FRIES MILL ROAD EWELL, NJ 08080		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	preparedness training During an interview a Corporate Nurse, sta further information.	r Annual on-line emergency g. t 1 PM, the facility's ted she would provide lowever, the facility did not nee records for the missing urvey conclusion. t1.6(a)		000	not complete the facility's "Annual Mandatory: 2019 Emergency Respon Training". 2. Residents who have the potential to affected by alleged practice: Residents residing in the facility have potential to be affected by alleged practice. 3. Measures to be implemented to en alleged practice does not occur: Human Resources Director and/or designee will educate/reeducate staff are employed by ManorCare Washing Township on "Annual Mandatory: 201 Emergency Response". 4. How will the facility monitor the effectiveness of corrective action: Human Resources Director and/or designee will randomly audit staff at ri (staff who are employed by ManorCare Washington Township) for completion "Annual Mandatory: 2019 Emergency Response" weekly x4 and monthly x2 The findings of these audits will be presented to the Quality Assurance Committee monthly x3 for effectivene and accuracy.	the sure who yton 9 sk re of	
	THIS FACILITY IS IN	COMPLIANCE WITH THE					

If continuation sheet Page 5 of 6

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 COMPLETED A. BUILDING 01 B. WING B. WING OZ/06/2020 NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-WASHINGTON TOWNSHIP (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFICATION NUMBER: A. BUILDING 01 A. BUILDING 01 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 378 FRIES MILL ROAD SEWELL, NJ 08080 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFICATION SHOULD BE COMPLETED							<u>//B NO. 0938-039</u>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANORCARE HEALTH SERVICES-WASHINGTON TOWNSHIP STREET ADDRESS, CITY, STATE, ZIP CODE (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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 Continued From page 5 MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED USING K 000			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANORCARE HEALTH SERVICES-WASHINGTON TOWNSHIP STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (x5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE (COMPLET) TAG Continued From page 5 K 000 K 000 <t< th=""><th></th><th></th><th>315506</th><th>B. WING</th><th></th><th></th><th>02/06/2020</th></t<>			315506	B. WING			02/06/2020
MANORCARE HEALTH SERVICES-WASHINGTON TOWNSHIP 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) COMPLET DATE K 000 Continued From page 5 MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED USING K 000	NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY,	STATE, ZIP CODE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE K 000 Continued From page 5 MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED USING K 000 K 000 <td>MANORCA</td> <td>ARE HEALTH SERVICES</td> <td>S-WASHINGTON TOWNSHIP</td> <td></td> <td></td> <td></td> <td></td>	MANORCA	ARE HEALTH SERVICES	S-WASHINGTON TOWNSHIP				
MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED USING	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORI	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
	K 000	MINIMUM LIFE SAF REQUIREMENTS A	ETY CODE	K			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ08004

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