

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ 00125560</p> <p>CENSUS: 71</p> <p>SAMPLE SIZE: 3</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

08/16/19

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00125560</p> <p>Based on observation, interview and record review it was determined that the facility failed to follow the facility policy titled, "Abuse, Neglect, and Exploitation Prohibition and Prevention Program" for [redacted] of [redacted] residents reviewed for abuse, Resident [redacted]. This deficient practice was evidenced by the following:</p> <p>On 7/8/19 at 9:20 a.m., during the entrance conference the surveyor asked the Administrator if there were any incidents or accidents investigated by the facility in past 3 months. The Administrator stated that there were none.</p> <p>At 10:15 a.m., during the tour of the Assisted Living second floor, the surveyor observed Resident [redacted] in a wheel chair in his/her room and the resident [redacted] Executive Order 26, 4.b. Executive Order 26, 4.b. The surveyor asked the resident how he/she was doing and about the care the resident received at the facility. The resident stated that he/she was fine, however, stated that he/she did not care for some staff members. The surveyor asked the resident to explain what he/she meant and Resident [redacted] stated that sometimes staff members were in a "hurry and rough" when assisting him/her during care. Resident [redacted] explained that staff did not always come back when they (staff) said they would come back and would not answer pendant calls on time. The resident explained that it could take up to 45 minutes, "depend on who was</p>	A 310		
-------	---	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	<p>Continued From page 2</p> <p>working." The resident was not able to re-call the staff member(s) that were "rough" with him/her during care.</p> <p>At 11:55 a.m. the surveyor reviewed Resident [redacted] medical record which documented that the resident moved into the facility [redacted] with diagnoses which included [redacted] Executive Order 26, 4.b. The "Resident Review Tool" dated [redacted] documented that the resident was [redacted] Executive Order 26, 4.b.</p> <p>At 2:45 p.m., the surveyor interviewed a Licensed Practical Nurse (LPN) who works on the 3-11 shift and asked her if she there was a staff to resident abuse reported to her. The LPN stated that she re-called an incident in [redacted] when Resident [redacted] family member reported to her that a staff member was "mean" to the resident but she could not re-call the exact date.</p> <p>The LPN continued that she and another staff member went to Resident [redacted] room and spoke with the resident who stated that an Aide was "mean" to him/her. Additionally, the LPN stated that the resident stated that he/she was told by an Aide to, "Get up, hurry up and other mean stuff" and the aide left the room without assisting the resident. Further, the LPN stated that Resident [redacted] was not able to recall the exact date and shift that the staff member was mean to him/her.</p> <p>The surveyor asked the LPN if she reported the above incident to the Administrator when she (LPN) was made aware by the resident and the resident's family member of alleged staff to resident abuse. The LPN confirmed that she did not report the incident to the Administrator and explained that the incident occurred prior to the</p>	A 310		
-------	---	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	<p>Continued From page 3</p> <p>day that the family member notified her (LPN) of the above incident. The surveyor informed the LPN that it was her responsibility to assure that the above incident was reported to the Administrator or designee for further investigation.</p> <p>At 3:15 p.m., the surveyor informed the Administrator of above concern, she stated that she was not aware or notified by the LPN of above incident in order to conduct an investigation of the alleged abuse. She explained that staff members received yearly in-services on the facility's abuse policy.</p> <p>On 7/12/19 at 11:40 a.m., the surveyor interviewed a Certified Medication Aide (CMA), who accompanied the LPN to interview Resident [REDACTED]. According to the CMA, the resident stated that an Aide refused to assist him/her and left the room and did not come back. The CMA stated that the resident was not able to give a description of the Aide or recall the date of the incident. The surveyor asked the CMA if she reported above incident to administration. The CMS stated that she did not since the LPN, whom she reported to, was aware.</p> <p>Surveyor review of the facility policy titled, "Abuse, Neglect, and Exploitation Prohibition and Prevention Program" provided by the Administrator documented, "All employees are informed of their responsibility to immediately report any allegation of abuse, neglect, exploitation, mistreatment and misappropriation of resident property to the the community's administration for investigation, remediation, and reporting to the appropriate state agencies."</p>	A 310		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
A1073 A1073	<p>Continued From page 4</p> <p>8:36-15.6(b) Resident Records</p> <p>(b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint : NJ 00125560</p> <p>Based on interview and record review it was determined that the facility failed to ensure that documentation of services rendered was entered into the medical record for █ of █ residents reviewed, Resident █. This deficient practice was evidenced by the following:</p> <p>On 7/8/19 at 11:55 a.m. the surveyor reviewed Resident █ medical record which documented that the resident moved into the facility with diagnoses which include █. The "Resident Review Tool" dated █ documented that the resident was █.</p> <p>Continued surveyor review of the medical record revealed a note signed as written by the █ dated █, which documented that Resident █ was seen due to concern of █. The █ documented that Executive Order 26, 4.b.</p>	A1073 A1073		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

A1073	<p>Continued From page 5</p> <p>Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.</p> <p>During surveyor interview with Resident [redacted] at 12:10 p.m. regarding the above [redacted] service, the resident stated that he/she had his/her [redacted] because the [redacted] were [redacted]. The surveyor asked the resident if there was an issue during or after the [redacted]. Resident [redacted] stated that his/her [redacted] and he/she may have had a [redacted] but could not recall.</p> <p>At 3:15 p.m., the surveyor interviewed the Administrator and asked if Resident [redacted] had an issue after he/she was seen by a [redacted] on [redacted]. The Administrator stated that she re-called when Resident [redacted] complained of [redacted] and an appointment was made to be seen by a [redacted]. The Administrator stated that she re-called that Resident [redacted] was seated in the lobby and complained that his/her [redacted] were [redacted] after being seen by the [redacted]. The Administrator stated that she took the resident to the Wellness office but could not remember who she (Administrator) handed the resident to for assessment of the [redacted]. The Administrator confirmed that she did not follow-up with the nursing staff and was not able to provide the surveyor with documentation of the assessment of the [redacted].</p> <p>During surveyor review of Resident [redacted] medical record, the surveyor did not observe documented evidence that the resident was assessed by nursing or that the above concern was entered into the resident's medical record.</p> <p>2. Staff Member(s) failed to document in</p>	A1073		
-------	---	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
A1073	Continued From page 6 Resident [REDACTED] medical record the incident that occurred at the facility in [REDACTED] when the resident and a family member notified facility's staff members of alleged staff to resident abuse. Refer to 8:36-3.4(a)(1)	A1073		
A1399	8:36-21.1(b)(3) Quality Improvement (b) Quality improvement activities shall include, but not be limited to, the following: 3. Establishment of objective criteria for evaluation of the resident care provided by each service area; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00125560 Based on interview and record review it was determined that the facility failed to collect and analyze available data in order to determine the timeliness of pendant response times through the facility's quality improvement program. This deficient practice was evidenced by the following: 1. On 7/8/19 at 10:15 a.m., during the tour of the unit, the surveyor observed Resident [REDACTED] seated in a wheel chair in his/her room. The resident appeared Executive Order 26, 4.b. During interview with the resident, he/she informed the surveyor that he/she did not care for some staff members and added that staff do not always come back when they (staff) say they will come back. Resident [REDACTED] explained that the call pendant system could take up to 45 minutes or	A1399		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
A1399	<p>Continued From page 7</p> <p>more to be answered, and stated, "depend on who was working."</p> <p>2. The surveyor interviewed seven (7) additional residents regarding call response times and they also stated that it could take up to 30 minutes or more for the pendant call to be answered and that it depended on the staff on duty at the time of the call. The surveyor interviewed five (5) staff members from nursing and inquired how long it took for the staff to answer a pendant call. The staff responded that it usually takes 15 minutes or less if they are not with other residents.</p> <p>At 12:55 p.m., the surveyor interviewed the Administrator and asked how long it took for the staff to answer a pendant call and the surveyor also requested the facility's pendant call log for review. The Administrator stated that it took 15 minutes for pendant call to be answered.</p> <p>At 1:25 p.m., the surveyor interviewed the Director of Maintenance (DOM) regarding the pendant call and log. The DOM stated that the pendant call system was tied to the fire alarm system and if the pendant was not answered within 20 minutes that the push pendant system would go into trouble mode and display the room number. The DOM added that periodically, the facility would receive telephone calls from the alarm company if the pendant call was not answered and reset after 20 minutes.</p> <p>The surveyor requested the pendant call log for review and he stated that he was not able to print log and would contact the alarm company. The facility did not provide the surveyor with a printed copy of the log of the residents pendant calls.</p> <p>At 3:15 p.m., the surveyor informed the</p>	A1399		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WASHINGTON TOWNSHIP SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
A1399	<p>Continued From page 8</p> <p>Administrator of the above concern and requested the pendant call policy. The Administrator was not able to provide to the surveyor with the same. During interview, the Administrator explained that she was not aware that call log could be printed and that she was informed by the DOM on the survey date, 7/8/19, that the alarm company could provide the information.</p> <p>The facility had the capability to receive a print out of the pendant call response times in order to monitor the timeliness of pendant response times. There was no documented evidence that this information was evaluated as part of the facility's quality improvement program in order to evaluate the effectiveness and implementation of the pendant call system.</p>	A1399		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 35A002	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/9/2019
NAME OF FACILITY WASHINGTON TOWNSHIP SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A0310	Correction	ID Prefix A1073	Correction	ID Prefix A1399	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-15.6(b)	Completed	Reg. # 8:36-21.1(b)(3)	Completed
LSC	07/15/2019	LSC	07/15/2019	LSC	07/15/2019
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 7/8/2019		<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		

Washington Township Senior Living
600 Medical Center Drive
Sewell, NJ 08080
856-582-8700

Plan of Correction (page 1 of 2)
Complaint Visit 7/09/2019

A310 8:36-3.4(a)(1) Administration

Element #1

Resident [REDACTED] was affected by this deficient practice. The Executive Director and Director of Resident Care completed an investigation and met with Resident [REDACTED] to validate his/her concerns and inform him/her that all staff have received training in Reporting Allegations of Abuse and Neglect and Resident Rights.

Element #2

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

Element #3

The Abuse and Neglect policy was reviewed with all nursing staff on 7/10/2019 and 7/11/2019. Training of the same policy was conducted with all team members at the monthly "All Staff" meeting on 7/31/2019 and will be a permanent agenda item at all future "All Staff" meetings. The previously mentioned policies will be a permanent agenda item at the monthly Resident Council meeting. The policies are also reviewed with new residents and their families at move in. The Executive Director will visit Resident [REDACTED] on a regular basis to insure community staff members are meeting his/her needs in a professional, timely and respectful manner. The Executive Director and Director of Resident Care informed Resident [REDACTED] that the community has an open door policy and he/she can speak to us at any time.

Element #4

The community monitors the effectiveness of the corrective actions through formal Resident Surveys. On a monthly basis, the Executive Director and Director of Resident Care will meet with residents at the Resident Council meeting and conduct discussions with residents regarding their care and responsiveness of staff.

Completed: 7/31/2019

A1073 8:36-15.6(b) Resident Records

Element #1

Resident [REDACTED] was affected by this deficient practice. The Director of Resident Care reviewed documentation standards and policies with the Nursing staff.

Washington Township Senior Living
600 Medical Center Drive
Sewell, NJ 08080
856-582-8700

Plan of Correction (page 2 of 2)
Complaint Visit 7/09/2019

Element #2

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

Element #3

Routine audits of resident records will verify that documentation was entered into the resident's medical record when they have had an appointment with a consultant/physician in accordance with policy and procedure. Training will be conducted at monthly nursing meetings to ensure compliance and understanding of documentation policies and procedures.

Element #4

The Director of Resident Care will monitor the continued effectiveness of the audit process on a monthly basis.

Completed: 7/31/2019

A1399 8:36-21.1(b)(3) Quality Improvement

Element #1

Resident [REDACTED] was affected by this deficient practice. An investigation was completed by the Executive Director and Maintenance Director. The investigation showed that the Alarm Company notifies the community via telephone when the call bell response time exceeds 20 minutes. The Alarm Company also notifies the Maintenance Director via letter documenting the date and time when call bell response time exceeded 20 minutes. The Executive Director discussed the results of the investigation with Resident [REDACTED].

Element #2

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

Element #3

The Concierge will notify the Manager on Duty when a call has been received from the alarm company that the call bell was not answered within 20 minutes. The alarm company follows up their phone call with a letter to the Maintenance Director documenting the date and time when the response time exceeded 20 minutes. The Maintenance Director will forward the letter to the Director of Resident Care for follow up with the staff and resident to ensure that the resident's needs were met and the staff member receives additional training/coaching as appropriate.

Element #4

The Executive Director and Director of Resident Care will review call bell response time on a quarterly basis at the Quality Assurance meeting to ensure compliance.

Completed: 7/15/2019

Revised 10/01/2019