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
	35A002	A. BUILDING: ______ B. WING ______	09/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON TOWNSHIP SENIOR LIVING	**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	Initial Comments Initial Comments: Census: 72 Sample Size: 6 TYPE OF SURVEY: Standard Survey of 94 residential units 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 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures;	A 517		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE 03/28/22

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A 517	Continued From page 1 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19. This REQUIREMENT is not met as evidenced by: Based on interview and employee file and policy review, it was determined that the facility failed to ensure staff received orientation and annual in-service education for 1 of 5 employees whose file was reviewed, Licensed Practical Nurse [LPN] #6. Findings included:	A 517		

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A 517	Continued From page 2 1. LPN #6 was hired on 06/29/2018. A review of the employee file revealed no documented evidence of orientation conducted or record of in-service education having been provided annually. During an interview on 09/19/2021 at 10:22 AM, the Business Office Manager confirmed there was no evidence of orientation or annual in-servicing in the employee file for LPN #6. A review of the facility's policy, titled, "Personnel Files," dated 11/15/2010, revealed, in part, "The following documents will be required for all personnel ... Documentation of Orientation ...Documentation of attendance at in-services and continuing educational offerings ... Proof of in-service education."	A 517		
A 547	8:36-5.7(a)(6) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 6. Policies and procedures for the maintenance of personnel records for each employee, including at least his or her name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description,	A 547		

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A 547	Continued From page 3 records of orientation and inservice education, and evaluation of job performance; This REQUIREMENT is not met as evidenced by: Based on interview, employee file and policy review, it was determined that the facility failed to ensure employee files included records of physical examinations for 4 of 5 employees Licensed Practical Nurse [LPN] #6, Certified Medication Aide [CMA] #5, Activity Director [AD], and CMA #4 whose employee files were reviewed. Findings included: 1. The surveyor reviewed the employee file for LPN #6 who was hired on 06/28/2019. There was no documented evidence that the LPN received a physical examination. 2. The surveyor reviewed the employee file for CMA #5 who was hired on 11/04/2014. There was no documented evidence that CMA #5 received a physical examination. 3. The surveyor reviewed the employee file for the AD who was hired on 11/18/2014. There was no documented evidence that the AD received a physical examination. 4. The surveyor reviewed the employee file for CMA #4 was hired on 06/05/2018. There was no documented evidence that CMA #4 received a physical examination. During an interview on 09/19/2021 at 10:27 AM,	A 547		

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A 547	Continued From page 4 the Business Office Manager confirmed the facility did not have records of physical examinations for LPN #6, CMA #5, AD, or CMA #4. A review of the facility's policy titled, "Personnel Files," dated 11/15/2010, revealed, in part, "All associates are required to fill out a pre-employment health screening form prior to beginning their first assignment."	A 547		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Based on interview, record and policy review, it was determined the facility failed to review general service plans semi-annually for four of five residents, Residents #1, #2, #3, and #4 reviewed for general service plans. This had the potential to affect all residents in the facility. Findings included: 1. Resident #1 had a move-in date of NJ Exec. Order 26 4.b.1 . A review of the resident's medical records indicated 01/12/2021 had been the most recent	A 749		

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A 749	Continued From page 5 date the resident's general care plan had been reviewed. An evaluation was due 07/11/2021, 6 months since the initial review. 2. Resident #2 had a move-in date of NJ Exec. Order 26:4.b.1 A review of the resident's medical records indicated 01/10/2021 was the most recent date the resident's general care plan had been reviewed. An reevaluation was due by 07/23/2021. 3. Resident #3 had a move-in date of NJ Exec. Order 26:4.b.1 A review of the resident's medical records indicated 01/11/2021 was the most recent date the resident's general care plan had been reviewed. An evaluation was due by 08/19/2021. 4. Resident #4 had a move-in date of NJ Exec. Order 26 4.b.1. A review of the resident's medical records indicated 01/11/2021 was the most recent date the resident's general care plan had been reviewed. An evaluation was due by 09/05/2021. On 09/19/2021 at 11:00 AM, the Divisional Director of Clinical Services (DDCS) confirmed residents should be assessed every six months and the general care plan reviewed and revised if needed. She stated the facility followed the regulation, but as this was not her facility, she could not find documentation. The Administrator and the Director of Nursing were not in the facility during the survey. A facility policy titled, "Resident Assessment and Re-Assessment Process," dated 04/01/2019, indicated, "All new and existing residents are assessed or re-assessed in accordance with state laws and regulations and/or upon a change in status."	A 749		

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A 751	8:36-7.3(b) Resident Assessments and Care Plans (b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to review health service plans on a quarterly basis for four of four residents receiving hospice care, Residents #2, #3, #4, and #5 reviewed for health service plans. This could affect the nine residents in the facility that were receiving hospice services and had the potential to affect all residents with health service plans. Findings included: 1. Resident #2 had a move-in date of NJ Exec. Order 26 4.b.1 and was receiving Ex Order 26. 4B1 services. A review of the resident's medical record indicated the most recent nursing assessment had been completed on 01/10/2021. The facility failed to provide any further associated health service plan. A quarterly assessment of the resident's health service plan was due 04/23/2021 and 07/23/2021. 2. Resident #3 had a move-in date of NJ Exec. Order 26 4.b.1 and was receiving Ex Order 26. 4B1 services. A review of the resident's medical record indicated the most recent nursing assessment had been completed on 01/11/2021, The facility failed to provide any further associated health service plan. A	A 751		

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A 751	Continued From page 7 quarterly assessment of the resident's health service plan was due 03/25/2021 and 06/25/2021. 3. Resident #4 had a move-in date of NJ Exec. Order 26 4.b.1 and was receiving Ex Order 26. 4B1 services. A review of the resident's medical record indicated the most recent nursing assessment had been completed on 01/11/2021. The facility failed to provide any further associated health service plan. A quarterly assessment of the resident's health service plan was due 03/05/2021 and 06/05/2021. 4. Resident #5 had a move-in date of NJ Exec. Order 26 4.b.1 and was receiving Ex Order 26. 4B1 services. A review of the resident's medical record indicated the most recent nursing assessment had been completed on 01/11/2021, The facility failed to provide any further associated health service plan. A quarterly assessment of the health service plan was due 04/26/2021 and 07/26/2021. On 09/16/2021 at 10:00 AM, the Business Office Manager (BOM), who was the senior staff member in the facility during the survey, told the surveyor that residents who were receiving hospice care were among those residents who should have a nursing health service plan. On 09/19/2021 at 11:00 AM, the Divisional Director of Clinical Services (DDCS) confirmed residents who needed a health service plan should be assessed every quarter and the nursing health service care plan revised if needed. She stated the facility followed the regulation, but as this was not her facility, she could not find documentation. A facility policy titled, "Resident Assessment and Re-Assessment Process," dated 04/01/2019, indicated, "All new and existing residents are	A 751		

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A 751	Continued From page 8 assessed or re-assessed in accordance with state laws and regulations and/or upon a change in status."	A 751		
A 783	8:36-7.5(e) Resident Assessments and Care Plans (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to document annual physical examinations and associated certifications for the appropriateness of the assisted living residence level of care for five of five residents, Residents #1, #2, #3, #4, and #5 reviewed for annual certification. This had the potential to affect 49 residents who had resided in the facility for at least one year. Findings included: 1. Resident #1 had a move-in date of NJ Exec. Order 26 4.b.1 A review of the resident's medical record indicated no documentation of a current yearly physician's certification that the resident's needs could be met at the assisted living facility. 2. Resident #2 had a move-in date of NJ Exec. Order 26:4.b.1	A 783		

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A 783	Continued From page 9 A review of the resident's medical record indicated no documentation of a current yearly physician's certification that the resident's needs could be met at the assisted living facility. 3. Resident #3 had a move-in date of NJ Exec. Order 26:4.b.1 A review of the resident's medical record indicated no documentation of a current yearly physician's certification that the resident's needs could be met at the assisted living facility. 4. Resident #4 had a move-in date of NJ Exec. Order 26:4.b.1 A review of the resident's medical record indicated no documentation of a current yearly physician's certification that the resident's needs could be met at the assisted living facility. 5. Resident #5 had a move-in date of NJ Exec. Order 26:4.b.1 A review of the resident's medical record indicated no documentation of a current yearly physician's certification that the resident's needs could be met at the assisted living facility. On 09/19/2021 at 1:41 PM, the Divisional Director of Clinical Services (DDCS) stated it was a regulation for each resident to have an annual physician's exam for program certification. She stated the facility followed the regulation, but as this was not her facility, she could not find documentation that residents were examined and certified as having needs that could be met in the assisted living facility. The Administrator and the Director of Nursing were not in the facility during the survey. On 09/19/2021 at 1:54 PM, the Business Office Manager (BOM) stated each resident's physician should do an annual "evaluation" for the resident.	A 783		

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A 783	Continued From page 10 A facility policy titled, "Resident Assessment and Re-Assessment Process," dated 04/01/2019, indicated, "All new and existing residents are assessed or re-assessed in accordance with state laws and regulations and/or upon a change in status."	A 783		
A 885	8:36-10.3 Dining Services The facility shall designate a food service coordinator who, if not a dietitian, functions with scheduled consultation from a dietitian. When meals are prepared in the facility, the food service coordinator or designee shall be present in the facility. The food service coordinator shall ensure that dining services are provided as specified in the dining portion of the health care plan. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documents, it was determined the facility failed to ensure the Food Service Coordinator (FSD) worked in consultation with a dietitian. This had the potential to affect all residents. Findings included: 1. During an interview on 09/16/2021 at 2:30 PM, the Business Office Manager (BOM) stated the FSD did not have dietary credentials, and there was no dietitian who worked with the facility on a consultant basis. During an interview on 09/17/2021 at 1:44 PM, the FSD informed the surveyor that he/she had started in the position of FSD on 09/01/2021. The	A 885		

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A 885	Continued From page 11 FSD told the surveyor that he/she had previously been the facility Maintenance Director and was now working in both capacities. The FSD told the surveyor he/she had not received training in the Food Service Department. Post survey, a surveyor reviewed the FSD's file for in service education. There was no documented evidence of education provided on dietary services for this employee who had previously served as Maintenance Director. During an interview on 09/19/2021 at 10:22 AM, the BOM confirmed there was no scheduled consulting with a dietitian.	A 885		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based observation, interview, policy review and the New Jersey Administrative Code (NJAC) 8:24, it was determined the facility failed to prevent contamination from bare-hand contact	A 891		

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A 891	Continued From page 12 with food, failed to ensure proper hand hygiene, and failed to ensure hygienic practices. This had the potential to impact all residents with the hazard of food borne illness. Findings included: Reference: NJAC 8:24-3.3 (a)2 indicates, in part, "Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment, except when washing fruits and vegetables ..." 1. On 09/16/2021 at 9:28 AM, a dishwashing staff member was observed cutting a pancake and holding it with their bare hand. On 09/16/2021 at 11:10 AM, the cook touched plated chicken with their bare hand while serving. During an interview on 09/17/2021 at 1:50 PM, the Food Service Director (FSD) confirmed with the surveyor that staff should not touch food with their bare hands. Reference: NJAC 8:24-6.7(j), indicates, "Each handwashing sink or group of adjacent sinks shall be provided with the following: 1. Individual, disposable towels; 2. A continuous towel system that supplies the user with a clean towel; or 3. A heated-air hand-drying device." 2. On 09/16/2021 at 11:18 AM, the cook was observed washing their hands. There was no paper towels available to dry them. The cook turned off the sink with their hands. On 09/16/2021 at 12:00 PM, the cook was	A 891		

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A 891	Continued From page 13 observed touching a raw hamburger patty while wearing gloves. The cook removed the gloves and replaced them with a new pair without cleaning their hands. On 09/16/2021 at 12:35 PM, the cook was observed picking up a piece of garbage from the floor with a bare hand. The cook rinsed their hand with water and placed a glove on it. On 09/16/2021 at 11:22 AM, the cook was observed turning pages of food temperature logs and licking their finger to turn each page. The cook donned gloves without washing their hands. During an interview on 09/17/2021 at 11:40 AM, the cook confirmed with the surveyor that she should have washed her hands properly between glove changes, should not have touched food with her hands, and should not have licked her fingers to turn pages of the temperature log without washing hands before donning new gloves. During an interview on 09/17/2021 at 1:50 PM, the Food Service Director (FSD) informed the surveyor that staff should wash their hands between glove changes and they are supposed to use paper towels to shut off the sink. During an interview on 09/19/2021 at 10:22 AM, the Business Office Manager stated the facility did not have a policy for food handling with bare hands. 3. On 9/16/2021 at 11:35 AM, the surveyor observed the Dietary Aide (DA) #13 blowing their nose while in the kitchen and then using hand sanitizer to clean their hands.	A 891		

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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 891	Continued From page 14 During an interview on 9/17/2021 at 1:50 PM, the FSD stated staff should not blow their nose in the kitchen. A review of the facility policy titled, "Sanitation," dated 09/01/2018, revealed, in part, "Hand washing is performed ... after coughing sneezing, or blowing the nose ...Hand sanitizers are not used in the kitchen." A review of the facility's policy titled, "Sanitation," dated 09/01/2018, revealed, in part, "Hand washing is performed: c. After contact with soiled or contaminated articles, such as waste removal ... c. After contact with an object or source where there is a concentration of microorganisms, such as mucous membranes ... body fluids ... k. After removal of ... utility gloves" and "employees will observe the following procedures and guidelines ... 4. Handwashing methods ... e. Dry hands with a paper towel; f. Turn water off using a dry paper." Reference: NJAC 8:24-2.4, Hygienic Practices, indicates, "(a) The following requirements shall apply to eating, drinking, or using tobacco: 1. Except as provided under (a)2 below, an employee shall only eat, drink, or use any form of tobacco, in compliance with the New Jersey Smoke-Free Air Act at N.J.S.A. 26:3D-55 through 3D-64 and the rules promulgated thereunder, in designated areas where the contamination of exposed food, clean equipment, utensils, linens, unwrapped single service and single-use articles, or other items needing protection cannot result." 4. On 9/17/2021 at 1:30 PM, a dishwashing staff member and DA #12 were observed eating pizza in the kitchen.	A 891		

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A 891	Continued From page 15 During an interview on 9/17/2021 at 1:50 PM, the FSD informed the surveyor that staff should not eat in the kitchen.	A 891		
A1027	8:36-14.1(c) Emergency Services and Procedures (c) At least one employee trained in cardiopulmonary resuscitation and the Heimlich maneuver shall be available in the facility at all times. This REQUIREMENT is not met as evidenced by: Based on interview, policy and document review, it was determined that the facility failed to ensure at least one employee trained in cardiopulmonary resuscitation (CPR) was always available in the facility for 10 shifts between 08/31/2021 and 09/19/2021. This had the potential to impact all residents. Findings included: 1. The surveyor reviewed the facility staff schedule which revealed that the facility did not have at least one employee trained in CPR available for 10 shifts between 08/31/2021 and 09/19/2021. During an interview on 09/19/2021 at 12:30 PM, the Administrator (Adm) informed the surveyor that the staffing schedule had been reviewed to ensure someone in the building was certified for CPR for each shift. The Adm stated the facility utilized a lot of agency staff and the Adm was not	A1027		

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A1027	Continued From page 16 sure if all the agency staff were CPR certified. During an interview on 09/19/2021 at 1:55 PM, the Business Office Manager (BOM) told the surveyor that the facility did not have proof of CPR certification on file for employees. The BOM further revealed that they had called and asked each person if they were certified and were still awaiting a response from some. A review of the facility's policy titled, "Personnel Files," dated 11/15/2010, revealed, in part, "The following documents will be required for all personnel ... Current CPR certification."	A1027		
A1089	8:36-16.3(b) Physical Plant (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure mechanical ventilation was functioning properly for 2 of 7 bathrooms that did not have windows to the outside.	A1089		

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A1089	Continued From page 17 Findings included: On 09/16/2021 at 1:15 PM, the surveyor tested the ventilation in the men's bathroom on the first floor in the presence of the Business Office Manager (BOM) by holding toilet paper up to the vent grid. There were no windows in the bathroom. The ventilation failed to draw the paper up to the grid indicating it was not functioning properly. On 09/16/2021 at 1:43 PM, the surveyor tested the ventilation in the first-floor spa in the presence of the BOM. There were no windows in the spa. The surveyor tested the ventilation with toilet paper held to the vent. The ventilation failed to draw the paper up to the grid indicating it was not functioning properly. On 09/17/2021 at 2:00 PM, the Maintenance Director confirmed the ventilation was not functioning in the men's bathroom and first-floor spa. On 09/19/2021 at 10:22 AM, the BOM informed the surveyor that the facility did not have a policy related to mechanical ventilation for rooms without windows.	A1089		
A1179	8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance (a) The facility shall provide and maintain a sanitary and safe environment for residents.	A1179		

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A1179	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy review, it was determined the facility failed to ensure a safe environment for one of four residents, Resident #6, who was reviewed for Ex Order [redacted]. This deficient practice had the potential to affect the eleven residents who were at also at Ex Order of Ex Order 26. 4B1. The census was 72. During the standard survey of 09/16/2021, the surveyor identified two exterior doors that did not have a functioning Wanderguard system as the Wanderguard unit sounded but did not activate the doors to automatically lock. As a result, on 09/16/2021 at approximately 3:45 AM, Resident #6 was able to exit the facility and was found approximately 30 minutes later by a staff member walking in a hospital parking lot approximately 0.2 miles away from the facility. The resident traveled in the dark through a medical office building complex and across a street with a stoplight to arrive at the hospital. During the time of the resident's Ex Order 26. 4B1, the resident sustained a Ex Order 26. 4B1 below the Ex Order 26. 4B1 of approximately three by three inches and a smaller Ex Order 26. 4B1 on the Ex Order 26. 4B1. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause serious injury, harm, impairment, or death to residents. On 09/16/2021 at 4:18 PM, the Business Office Manager (BOM), the senior staff member at the facility was informed of the non-compliance and the required development and implementation of a Plan of Removal (POR). The deficient practice was evidenced by the	A1179		

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A1179	Continued From page 19 following: 1. Resident #6 was admitted to the facility on NJ Exec. Order 26 4.b.1 with a history of Ex Order 26. 4B1 . A physician's examination dated 06/01/2021, indicated Resident #6 was Ex Order 26. 4B1 . The Resident's Health Service Plan dated 08/16/2021, indicated Resident #6 had experienced an episode of Ex Order 26. 4B1 . Goals included, "My safety will be maintained," and "I will not leave the community unattended." Interventions included, "I wear a Ex Order 26. 4B1 as ordered by a health care practitioner." On 09/16/2021 at 4:02 PM, the surveyor observed Resident #6 sitting in a recliner with a Ex Order 26. 4B1 on the resident's Ex Order 26 , and a bandage on the Ex Order 26. 4B1 and Ex Order 26. 4B1 . The resident did not appear in distress. The resident appeared pleasant, Ex Order 26. 4B1 and appeared to struggle to express thoughts. The surveyor asked Resident #6 if he/she received NJ Exec. Order 26:4.b.1 , and the resident responded, "No, it is just the stuff that goes on here." On 09/16/2021 at approximately 3:45 AM, despite wearing a Ex Order 26. 4B1 , Resident #6 was able to Ex Order 26. 4 from the facility because the exit doors failed to lock. The resident was found approximately 30 minutes later by a staff member walking in a hospital parking lot approximately 0.2 miles away from the facility. The resident traveled in the dark through a medical office building complex and across a street with a stoplight to arrive at the hospital. During the time of the resident's Ex Order 26. 4B1 , the resident sustained a	A1179		

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A1179	Continued From page 20 Ex Order 26. 4B1 below the Ex Order 26. 4B1 of approximately three by three inches and a smaller Ex Order 26. 4B1 on the Ex Order 26. 4B1. The resident had previously Ex Order 26. 4B1 from the facility during the night/early morning of 08/16/2021 and had taken approximately the same route, and had arrived at the same hospital at 5:58 AM. It was after this first Ex Order 26. 4B1 incident on 08/16/2021, that the resident was assessed as an Ex Order 26. 4B1 and the facility intimated the intervention of the Ex Order 26. 4B1 . During the standard survey of 09/16/2021, the surveyor identified two exterior doors that did not have a functioning Wanderguard system. The Wanderguard unit sounded but failed to activate the doors to automatically lock. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause serious injury, harm, impairment, or death to residents. A medication administration record (MAR) entry dated 09/15/2021 for the 11:00 PM to 7:00 AM shift indicated Resident #6 had a Ex Order 26. 4B1 on the Ex Order 26. 4B1. An untimed nurse's progress note dated 09/16/2021 indicated that at approximately 3:45 AM, Licensed Practical Nurse (LPN) #14 heard the stairwell alarm sounding and discovered Resident #6 was not in the resident's room. The note indicated that after searching the facility building and the parking lot, staff discovered the resident in the hospital parking lot. The note further indicated the resident was returned to the facility, assessed, and Ex Order 26. 4B1 on the Ex Order 26. and	A1179		

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A1179	Continued From page 21 Ex Order 26. 4B were cleaned and dressed. The note identified that the physician, the administrator (ADM), and the family were notified of the Ex Order 26. 4B1. The note further confirmed the resident was NJ Exec. Order 26:4.b.1 A universal transfer form, dated Ex Order 26. 4B1 at 5:30 AM, indicated Resident #6 was transferred from Washington Township Senior Living to Jefferson (hospital). The reason for the transfer was, Ex Order 26. 4B1 The form indicated the resident was at Ex Order for Ex Order 26. 4B1 and the resident had an Ex Order 26. 4B1 to the Ex Order 26 . A physician's order dated 09/17/2021, indicated an Ex Order 26. 4B1 to be applied to Resident #6's Ex Order 26. 4B1 . On 09/17/2021 at 6:00 PM, the surveyor reviewed the log documenting weekly checks for the functioning of the exit doors and the Wanderguard system. The log contained no entries documenting the exit doors had been checked for proper function during September 2021. On 09/16/2021 at 2:47 PM, the BOM confirmed Resident #6 had Ex Order 26. 4B1 from the building during the night at about 4:27 AM. The BOM stated the event was reported at 6:10 AM by telephone to the state health department, and a written report was due that day. The BOM stated the family had refused Ex Order 26. 4B1 as it	A1179		

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A1179	Continued From page 22 might make the resident feel they had done something wrong so staff were checking on the resident every 15 minutes. On 09/17/2021 at 8:44 AM, the BOM confirmed with the surveyor that while the Wanderguard system did make an alarm sound when a Wanderguard unit was within a few feet, it did not activate the doors to lock. The BOM stated that when the Wanderguard alarm went off, it was heard at the front desk and on the pagers carried by the nurses. On 09/18/2021 at 3:49 AM and 4:08 AM, the surveyor attempted to contact Licensed Practical Nurse (LPN) #14, the nurse on duty during the elopement of 09/16/2021. These attempts were unsuccessful. A message was left for a return call, but at the time of this writing attempts to speak with LPN #14 had been unsuccessful. On 09/19/2021 at 9:35 AM, the Maintenance Director stated he had checked the outside doors weekly in September to confirm the Wanderguard locks were working. He told the surveyor however, he failed to document his inspections. A facility policy, titled, "Resident Safety Equipment Policy," dated 04/01/2021, indicated, "By implementing the following policy and procedure, it will help to minimize elopement and wandering, and an overall improvement to resident safety ...On a weekly basis, maintenance will conduct/document the following ...5. Audible Door Alarm and Bracelet/Pendant system ...ensure that doors lock when the transmitter is within the detection range ..." Removal Plan:	A1179		

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A1179	Continued From page 23 "Please find the proposed Removal Plan for the State Survey currently in process. Based on the conversation with the Survey Team, [Names], Washington Township Senior Living is suspected to have had an alleged deficient practice in regulation: 1. One resident identified as negatively impacted by this alleged deficient practice. 2. 11 residents identified as Wander/Elopement Risk have the potential to be affected by alleged deficient practice. 3. Two exit doors where Wanderguard system is currently not functioning appropriately are currently being continuously monitored, as of 7:00 PM on 9/16/2021, by staff until corrections are made to restore system to fully functional." On 09/17/2021 at 11:40 AM, the Plan of Removal was accepted, and the facility began implementing corrective action. The facility had placed the resident on frequent checks after returning to the facility. In addition, the facility hired extra staff to be located by and monitor each of the doors that were not locking with the Wanderguard system and implemented this intervention at approximately 7:00 PM on 09/16/2021. On 09/17/2021 at 9:20 AM, the surveyor observed staff stationed and monitoring both doors. The facility placed calls to the Wanderguard vendor for emergency services. On 09/19/2021 at 9:59 AM, the BOM demonstrated the doors to the outside were functioning properly and locked when approached with a Wanderguard. On 09/17/2021 at 6:35 PM, the locking function of	A1179		

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A1179	Continued From page 24 the Wanderguard system had been restored to both doors. 2. On 09/16/2021 at 1:35 PM, the fire doors next to the elevator on the first floor were checked to ensure proper closure. This surveyor observed an overlap of one of the doors by 1/8th of an inch that caused a gap of approximately one inch between the doors. The Business Office Manager (BOM) was present and verified the doors would not close properly. On 09/16/2021 at 2:00 PM, the fire doors to the left of the elevator on the second floor were checked to ensure proper closure. This surveyor observed one of the doors would not close, as it was caught on the floor, leaving a gap of three inches between the doors. The BOM was present and verified the doors would not close properly. On 09/17/2021 at 9:55 AM, the Divisional Director of Clinical Services (DDCS) demonstrated the fire doors on the first floor could be manually closed with effort. On 09/17/2021 at 9:58 AM, the DDCS attempted to close the fire doors on the second floor. The door was obstructed from closure by a broken hinge with screws sticking out. The DDCS removed the screws and manually closed the door. On 09/17/2021 at 2:19 PM, the DDCS sent an email to "Washington Township ALL staff" that said, "Fire Doors on floor one near the lobby and on floor two near elevators need to be manually closed in the event of a fire." On 09/17/2021, no time indicated, an in-service	A1179		

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A1179	Continued From page 25 was conducted by DDCS to inform staff that, "Fire doors on floor one near front lobby and on floor two near elevators need to be manually closed in the event of a fire. On 09/19/2021 at 9:48 AM, the fire doors on the first and second floors were observed with signs that said, "This door must be manually closed in the event of a fire."	A1179		
A1225	8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition; i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey.	A1225		

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A1225	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to conduct an annual inspection to ensure electrical circuits and wiring were in a safe condition. This had the potential to affect all residents. Findings included: A review of facility records revealed the most recent electrician inspection was conducted on 05/25/2007. During an interview on 09/19/2021 at 12:45 PM, the Business Office Manager informed the surveyor that the facility had not had any other electrical inspections. They stated the corporate office had been contacted and confirmed annual inspections had not been conducted. The BOM identified that the facility did not have a policy related to electrical inspections.	A1225		
A1307	8:36-18.4(a)(1) Infection Prevention and Control Services (a) Each new employee upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux	A1307		

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WASHINGTON TOWNSHIP SENIOR LIVING	**600 MEDICAL CENTER DRIVE SEWELL, NJ 08080**

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A1307	Continued From page 27 tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview, policy review and employee file review, it was determined that the facility failed to ensure each new employee received tuberculin (TB) testing upon hire for 4 of 5 employees, (Licensed Practical Nurse [LPN] #6, Certified Medication Aide [CMA] #5, Activity Director [AD], and CMA #4) reviewed for employee files. Findings included: 1. Record review of an employee file revealed LPN #6 was hired on 06/28/2019. There was no record of tuberculin testing upon hire. 2. Record review of an employee files revealed CMA #5 was hired on 11/04/2014. There was no record of tuberculin testing upon hire. 3. Record review of an employee file revealed the AD was hired on 11/18/2014. There was no record of tuberculin testing upon hire. 4. Record review of an employee file revealed	A1307		

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
	35A002	A. BUILDING: ______ B. WING ______	09/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON TOWNSHIP SENIOR LIVING	**600 MEDICAL CENTER DRIVE SEWELL, NJ 08080**

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A1307	Continued From page 28 CMA #4 was hired on 06/05/2018. There was no record of tuberculin testing upon hire. During an interview on 09/19/2021 at 10:46 AM, the Business Office Manager informed the surveyor that the facility did not conduct tuberculin testing upon hire. A review of the facility policy titled, "Personnel Files," dated 11/15/2010, revealed, in part, "All associates are required to show proof of TB test within last 12 months or obtain a TB test within 6 months of hire and annually thereafter."	A1307		

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Plan of Correction
Survey 9/19/2021

A 517 8:36-5.6(b)(1-7) General Requirements
Element #1
LPN #6 received training is Concepts of Assisted Living, Emergency Plans and Procedures, Infection Prevention and Control, Resident Rights, Abuse and Neglect, Pain Management and the Care of Residents with Alzheimer's and related Dementia conditions.
Completed 10/19/2021

Element #2
All new hires will receive the required mandatory training as part of the orientation process. The deficient practice has the potential to affect all residents

Element #3
There will be an annual Education Fair, presented during the third quarter to educate staff on Concepts of Assisted Living, Emergency Plans and Procedures, Infection Prevention and Control, Resident Rights, Abuse and Neglect, Pain Management and the Care of Residents with Alzheimer's and related Dementia conditions. This training will be mandatory for all employees.
Completed 10/19/2021

Element #4
The Business Office Manager will maintain a record of all employees that will document the annual mandatory training. Audits will be conducted quarterly to identify and employees that may not have received the training during the previous 12 months.

A 547 8:36-5.7(a)(6) General Requirements
Element #1
A physical exam has been scheduled for LPN #6, CMA #5, AD and CMA #4.
Completed 11/3/2021

Element #2
The Business Office Manager will conduct a full audit of current employee files and identified those employees that require a physical examination. The deficient practice has the potential to affect all residents.

Element #3
The community has entered into a contract with a local occupational health provider to complete physical examinations.

Element #4

The Business Office Manager will conduct a monthly audit of new hires to identify any employees that have not received a physical examination.

A 749 8:36-7.3(a) Resident Assessments and Care Plans
Element #1
The General Service Plan for resident's #1, #2, #3 and #4 has been updated.
Completed 10/11/2021

Element #2
The deficient practice has the potential to affect all residents. An audit was conducted by the Executive Director to identify residents with an outdated general service plan.
Completed 10/11/2021

Element #3
General Service Plans for all current residents have been updated and signed by the RN.
Completed 10/11/2021

Element #4
The Executive Director or designee will review the General Service Plan binders on a quarterly basis to insure compliance.

A 751 8:36-7.3(b) Resident Assessments and Care Plans
Element #1
Health Service Plans for Residents #2, #3, #4 and #5 are being reviewed and updated.
In process

Element #2
The deficient practice has the potential to affect all residents. The clinical team at the community will review all residents to determine if additional residents require a Health Service Plan.
In process

Element #3
Health Service Plans will be reviewed quarterly; nursing will identify any residents requiring service plans during the monthly collaborative At Risk meetings.

Element #4
The Executive Director or designee will review the Health Service Plan binder quarterly to insure compliance.

A 783 8:36-7.5(e) Resident Assessments and Care Plans
Element #1

The Primary Care Providers for Residents #1, #2, #3, #4 and #5 have been notified and asked to complete the annual recertification for their residents.

Element #2
The deficient practice has the potential to affect all residents The medical records for all residents have been reviewed and those needing physician recertification were identified.

Element #3
An audit tool will be created by the Executive Director to identify, by month, residents that are due for their annual physician recertification.
In process

Element #4
The Executive Director or designee, will review the audit tool on a monthly basis and add any new residents and verify physician re-certifications are up to date.. Primary Care Physicians will be notified 30 days in advance when their resident is due for re-certification. The charge nurse will follow up with the provider weekly until the form has been completed and returned to the community.

A 885 8:36-10.3 Dining Services
Element #1
The community has reached out to Crandall to contract for a Dietician to provide quarterly consultation.

Element #2
The deficient practice has the potential to affect all residents. The contract is currently under review.

Element #3
Crandall has indicated they need to recruit a dietician for this area. Until that occurs we will have access to our National Director of Dining Services, Ronda Watson, RD, who will be available for consultation with the Food Service Director.
Completed 10/1/2021

Element #4
When a Dietician has been assigned to the community; he/she will be scheduled quarterly for consultation.

A 891 8:36-10.5(a) Dining Services
Element #1
(DA) #12, (DA) #13, the cooks and dishwashing staff member have been trained on Infection Control policies and procedures.
Completed 10/19/2021

Element #2
The deficient practice has the potential to affect all residents

Element #3
All employees have been trained in Infection Control policies and procedures.
Completed 10/19/2021

Element #4
The Food Service Director or designee will review Infection Control policies and procedures at monthly meetings. The Manager on Duty will observe Dietary employees daily to verify Infection Control policies and procedures are being followed.

A 1027 8:36-14.1(c) Emergency Services and Procedures
Element #1
CPR classes have been scheduled for October and November. To date 7 additional staff members have become CPR certified and an additional 9 staff members were able to provide proof they are currently CPR certified.

Element #2
The deficient practice has the potential to affect all residents. All nursing staff will be required to become CPR certified by 12/31/2021

Element #3
CPR certification will be verified at time of employment. The Business Office Manager will create a "tickler" to identify staff requiring recertification. The nursing schedules will be reviewed prior to posting to verify that at least one CPR certified staff member is assigned for each shift.

Element #4
The Director of Resident Care or designee will review schedules monthly to insure compliance.

A 1089 8:36-16.3(b) Physical Plant
Element #1
The motors for the mechanical ventilations found in the 2 bathrooms that were not functioning properly have been replaced.
Completed 9/20/2021

Element #2
The deficient practice has the potential to affect all residents.

Element #3
The mechanical ventilation in all bathrooms will be tested on a quarterly basis and motors repaired/replaced as needed.

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Element #4
The Executive Director or designee will randomly test the mechanical ventilation for 5 bathrooms on a monthly basis.

A 1179 8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance
Element #1
A sign was placed on the fire doors on the first and second floor indicating they need to be manually closed and all staff were educated. Resident #6 was transferred to a secure community with Memory Care on 9/30/2021; he was assigned a 1:1 around the clock until his transfer.

Element #2
The deficient practice has the potential to affect all residents
Note: On 10/9 there was a fire in the elevator mechanical room and both sets of doors closed completely when they were automatically and simultaneously released by the fire alarm system.

Element #3
A sign was placed on the fire doors on the first and second floor indicating they need to be manually closed and all staff have been educated. A quote has been submitted and approved to replace both sets of doors. Update from the vendor the doors will be installed the week of 12/27/2021; they were on backorder.

Both fire doors were installed 1/4/2021

Element #4
Quarterly Inspections of the fire alarm system by the vendor and Fire Marshall will verify that the fire doors remain in good working order.

A 1225 8:36-17.3(b)(8)(i-ii)
Element #1
Electrical inspection was completed by a licensed electrician in accordance with N.J.A.C. 13:31 on 9/28/2021

Element #2
The deficient practice has the potential to affect all residents.

Element #3
The electrical inspection is scheduled with the vendor to be completed annually no later than the 30th of September.

Element #4
The Executive Director or designee will verify that the inspection is scheduled and completed annually.

A 1307 8:36-18.4(a)(1) Infection Prevention and Control Services
Element #1
A weekly PPD clinic is being held at the community every Tuesday.

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Element #2
The deficient practice has the potential to affect all residents. The Business Office Manager has audited the employee files to identify those employees needing a PPD test.

Element #3
Employees have been notified and are being scheduled for their PPD**.** All new hires will receive their initial PPD at Orientation. Administration of the PPD test will be available on all shifts and 7 days per week. Compliance is expected by November 30, 2021.

Element #4
The Executive Director or designee will review the PPD status for all employees on a monthly basis and identify any employees who have fallen out of compliance.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
35A002 Y1	Y2	3/27/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON TOWNSHIP SENIOR LIVING	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 A0517 Reg. # 8:36-5.6(b)(1-7) LSC	Correction Completed 12/31/2021	ID Prefix A0547 Reg. # 8:36-5.7(a)(6) LSC	Correction Completed 12/31/2021	ID Prefix A0749 Reg. # 8:36-7.3(a) LSC	Correction Completed 12/31/2021
ID Prefix A0751 Reg. # 8:36-7.3(b) LSC	Correction Completed 12/31/2021	ID Prefix A0783 Reg. # 8:36-7.5(e) LSC	Correction Completed 12/31/2021	ID Prefix A0885 Reg. # 8:36-10.3 LSC	Correction Completed 12/31/2021
ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 12/31/2021	ID Prefix A1027 Reg. # 8:36-14.1(c) LSC	Correction Completed 12/31/2021	ID Prefix A1089 Reg. # 8:36-16.3(b) LSC	Correction Completed 12/31/2021
ID Prefix A1179 Reg. # 8:36-17.1(a) LSC	Correction Completed 12/31/2021	ID Prefix A1225 Reg. # 8:36-17.3(b)(8)(i-ii) LSC	Correction Completed 12/31/2021	ID Prefix A1307 Reg. # 8:36-18.4(a)(1) LSC	Correction Completed 12/31/2021
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 9/19/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			