STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHIN	339 GREENTREE ROAD 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: Type of Survey: Complaint Complaint #: NJ00186217, NJ00183115 Census: 98 Sample Size: 4 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) Administrator's Responsibilities (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 07/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00186217, NJ 00183115 Based on interview and record review, it was determined that the facility Administrator failed to implement the following facility policies and procedures titled, '[redacted] "Incident/Accident Reports", "Building Security", "Assessments", and '[redacted]' for 4 of 4 residents reviewed, Resident #'s 1, 2, 3 and 4. This deficient practice was evidenced by the following: 1. On 2/4/25, the Department of Health (DOH) received a Facility Reportable Event (FRE) (a document used by facilities to report events to the DOH) dated [redacted], with an event date of [redacted] According to the FRE report completed by the former Executive Director (ED), at around 10:15 p.m., a staff member called the writer to the resident's room and Resident #1 was seated on a wheelchair with his/her [redacted] The former ED documented that the resident sat up in chair and took [redacted] was called, and the resident was [redacted] at 10:39 p.m. On 6/2/25 at 10:05 a.m., the surveyor reviewed Resident #1's closed medical record, provided by the Resident Care Director/Registered Nurse (RCD)/(RN), revealed a move [redacted]. According to Resident #1's "Health and	A 310		

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A 310	Continued From page 2 Service Assessment" document, a NJ Ex Order 26. 4B1 assessment, dated NJ Exec Order 26, was completed by a RN. The assessment documented the resident was NJ Exec O and NJ Exec Order 26.4b to NJ Exec Order 26.4b1, and was a *NJ Ex Order 26. 4B1* At 10:50 a.m., the surveyor interviewed the Resident Care Director (RCD) regarding Resident #1's NJ Ex Order status. The RCD confirmed that the resident was a NJ Ex Order. Additionally, the RCD stated that when a resident is made a NJ Ex Order 26. 4B1, a physician's order is obtained, and a NJ Ex Order 26. 4B is completed and is placed in the resident's medical record. *NJ Ex Order 26. 4B1* During continued interview, the surveyor informed the RCD that there was no physician's order for NJ Ex Order, and no completed NJ Ex Order 26. 4B in Resident #1's medical record. The surveyor also informed the RCD that Resident #1 was not included on the NJ Ex Order 26. 4B1 list that was updated on NJ Exec Order 26. The RCD acknowledged that the resident was not included on the list. The RCD later provided the surveyor with Resident #1's physician's order for NJ Ex Order and explained that they were late with their filing. Further, the RCD explained that a NJ Ex Order 26. 4B1 list was kept at the front desk, in the Automated External Defibrillator (AED) box located in the receptionist area, and in a narcotic binder in the medication cart. The RCD stated that the list was updated monthly, on admission and whenever there was a change in status.	A 310		

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A 310	Continued From page 3 Finally, the surveyor inquired from the RCD about the completed Incident/Accident report and investigation for Resident #1 when the resident [NJ Ex Order 26. 4B1]. The RCD later informed the surveyor that there was no incident/accident report completed. 2. On 6/2/25 at 11:35 a.m., the surveyor reviewed Resident #2's medical record which revealed a move[NJ Ex Order 26. 4B1]. According to Resident #2's "Face Sheet" the [NJ Exec Order 26.4b1] was [NJ Ex Order 26. 4B1]. In addition, the surveyor observed a "Progress Note" dated [NJ Exec Order 26.4b1] written by the Resident Care Director/Registered Nurse (RCD/RN) which revealed, "[NJ Ex Order 26. 4B1]. " However, surveyor continued review of Resident #2's medical record did not reveal a written physician's order for [NJ Ex Order 26. 4B1]. At 12:25 p.m., the surveyor requested Resident #2's physician's order for the [NJ Exec Order 26.4b1]. The RCD later provided the surveyor with Resident #2's physician's order for [NJ Ex Order] and stated that she had someone retrieve the physician's order. During interview, the RCD stated that the facility had filing issues. The surveyor observed that the physician's order was written for [NJ Ex Order] only, and not [NJ Ex Order 26. 4B1] indicated on the resident's Face Sheet.	A 310		

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A 310	Continued From page 4 Further surveyor review of Resident #2's medical record did not reveal a written physician's order for [NJ Ex. Order 26. 4B1], or a completed [NJ Ex. Order 26. 4B]. Additionally, Resident #2's name was not on the [NJ Ex. Order 26. 4B1] list that was updated on [NJ Exec Order], it was not until [NJ Exec Order 26], when the [NJ Ex. Order 26. 4B1] list was revised. At 2:55 p.m., the RCD provided the surveyor with Resident #2's physician's order for [NJ Ex. Order], and stated that she had someone retrieve the order, and that the facility had filing issues. Surveyor later review of the physician's order revealed that the order was for [NJ Ex. Order] only. 3. At 12:50 p.m., the surveyor reviewed Resident #4's medical record which revealed a move [redacted] According to Resident #4's "Face Sheet," printed [NJ Exec Order 26.4] the code status was [NJ Ex. Order 26. 4B1]. Resident #4's name was on the [NJ Ex. Order 26. 4B1] list updated on [NJ Exec Order] as a [NJ Ex. Order 26. 4B1]. However, there was no documented evidence of a physician's order for [NJ Ex. Order 26. 4B1] in Resident #4's medical record. The RCD later provided the surveyor with an admission order with [NJ Ex. Order] only dated [NJ Exec Order 26.4b] At 1:15 p.m., the surveyor observed the resident in a [NJ Exec Order 26.4] position in his/her apartment with Licensed Practical Nurse (LPN) #1. The surveyor inspected the back of the resident's door and did not observe a copy of the written order (or form) hung on the back of the door, nor a [NJ Exec Order 26.4b1] or label on the back of the resident's [NJ Exec Order 26.4b1] Also there was no [NJ Exec Order 26.4b1] placed on the outside of the resident's apartment near/next to the resident's name. At 1:40 p.m., the surveyor requested Resident	A 310		

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A 310	Continued From page 5 #4's physician's order for the resident's code status. The RCD later provided the surveyor with an "Admission Order" form dated [redacted], which revealed an order for a [redacted] only, and not the [redacted] indicated on the resident's Face Sheet. At 2:55 p.m., during interview with the RCD, the surveyor inquired about Resident #4's lack of [redacted] documentation as specified in the facility's policy. The RCD stated that she has been working on the residents [redacted] after the [redacted] incident, and was aware that the facility has not been consistent with the [redacted] policy. The surveyor reviewed the policy titled, "DNR (Do Not Resuscitate)," provided by the RCD, with no revision date, which revealed, "This community adheres to the wishes of the residents that have a written "DNR" order from their physician." 3. "The community will maintain a current list of residents that are a DNR status." Additionally, the policy documented under "Lists will be located" revealed, "Within each department, with the AED machine, at the front desk and ..." 4. "The DON/designee will review and update the list with every physician's code status order change and/or at least every 6 months." 5. For each resident with a current DNR order, "A written physician's order must be in the chart." "A copy of the written order (or form) hung on the back of the door to the resident's apartment." "A red sticker or label will be put on the back of the resident's pendant." "A red sticker will be placed on the outside of the resident's apartment by their name (if resident agrees). Additionally, the policy titled, "Incident/Accident Reports" revised 3-20-2019, Page 36, provided by the RCD revealed, 3. "Reports need to be	A 310		

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A 310	Continued From page 6 completed for all of the following: ... Death of a resident in the facility (excluding Hospice). Any unusual occurrence that involves a resident." 4. The charge nurse/Resident Care Director/ or designee will complete both pages of the investigation report. This is the 3rd and 4 th page of the Incident Report." 5. The Executive Director/designee will sign and lock the Incident Report." 4. On [redacted] the DOH received a FRE regarding an [redacted] which occurred on [redacted] when Resident #3 [redacted] from the facility at 5:05 a.m., and was [redacted] around 6:20 a.m. On 6/2/25, the surveyor investigated the above concern and at 10:31 a.m., the Executive Director (ED) provided the surveyor with a document titled, "Location Event Report [Facility Name] [redacted]" dated [redacted]. The report indicated that a [redacted] on [redacted] at 5:05 a.m. and was "responded" to 1 minute later at 5:06 a.m. At 10:45 a.m., the surveyor observed the door from which Resident #3 [redacted], in the presence of the ED. The ED stated that when Resident #3 opened [redacted]. The ED further stated that when the door [redacted] activated, the staff that were working should have responded to the [redacted] which should have included going to the door, [redacted] to ensure a resident had not [redacted], and then completing a [redacted] of all residents. At 10:56 a.m., the surveyor, in the presence of the Environmental Service Director (ESD), reviewed the video footage dated [redacted], and timed at 5:05 a.m., which was only visual and did	A 310		

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A 310	Continued From page 7	A 310		

not contain audio. During video review, the surveyor observed Resident #3, NJ Exec Order 26.4b1 [redacted], NJ Ex Order 26. 4B1 the facility NJ Exec Order 26.4b1 at 5:05 a.m. The ESD stated that the security cameras are motion censored and only record when movement is sensed. The ESD stated that the video did not capture the resident NJ Ex Order 26. 4B1 [redacted], just the resident NJ Ex Order 26. 4B1. Continued review of the video revealed that no staff members went to NJ Exec Order 26.4b1 after the NJ Exec Orde was activated.

At 11:15 a.m., the surveyor reviewed Resident #3's closed medical record (MR) which revealed that Resident #3 was NJ Ex Order 26. 4B1 [redacted]. The surveyor observed a General Service Plan dated NJ Exec Order 26.4, completed by the RCD, which indicated Resident #3 had NJ Ex NJ Ex Order 26. 4B1.

During continued review of Resident #3's MR the surveyor observed a document titled, "NJ Health Assessment and Service Assessment Results", dated NJ Exec Order 26, which indicated, "NJ Ex Order 26. 4B1 [redacted] .." However, the surveyor did not observe a completed NJ Ex Order 26. 4B1 assessment in Resident #3's MR.

At 11:53 a.m., the surveyor interviewed the LPN that was on duty the night Resident #3 NJ Ex Order 26. 4 regarding Resident #3's NJ Ex Order 26. 4B1 via telephone. The LPN confirmed that the facility was unaware of Resident #3's NJ Ex Order 26. 4B1 until the resident was NJ Ex Order 26. 4B1 [redacted]. The surveyor attempted to continue to interview the LPN regarding the facility's

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A 310	Continued From page 8	A 310		

process in responding to a NJ Exec Order 26.4b1, as well as Resident #3. The LPN stated that she wanted to talk to her supervisor before continuing the interview, and she ended the call.

At 12:03 p.m., the surveyor interviewed the Resident Aide (RA) #1 regarding Resident #3's NJ Ex Order 26. 4B1 via telephone. RA #1 stated that when a NJ Exec Order 26.4b1 is activated the NJ Exec Orde populates on the tablet. RA #1 continued to state that when a team member disarms the NJ Exec Order 2 the same team member should go to the NJ Exec O and NJ Exec Order 26.4b1 to ensure a resident has not NJ Ex Order 26. 4, complete a NJ Exec Order 26.4b1 of all residents to ensure a resident has not NJ Ex Order 26. 4, and notify the Nurse. RA #1 stated that she did work the night Resident #3 NJ Ex Order 26. 4 and that she was not the staff member who responded to the NJ Exec Order 2

At 12:15 p.m., the surveyor attempted to interview RA #2 who worked the night of the above incident. The surveyor was unable to reach RA #2 via telephone and could not leave a message with a call back request as RA #2's voicemail box was full.

The surveyor reviewed an interview summary between the ED, Resident Care Director (RCD), and RA #2. The summary revealed " ... [RA #2] stated she did not have NJ Exec Order 26.4b1 on her tablet. She stated that no NJ Exec Order 26.4b1 off on her entire shift ... [RA #2] stated that her and [RA #1] did not know [Resident #3] was NJ Ex Order 26. 4B1 until they NJ Exec Order 26.4b1 with LPN and the NJ Ex Order 26. She stated that at that time her and [RA #1] went to check the NJ Exec Orde to see if they would NJ Exec Orde on their tablets and they did ... when was the NJ Exec Order 26.4b1 [Resident #3] and stated she had not seen [him/her] on her shift, which was odd because [he/she] is NJ Exec Order 26.4b1 at

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A 310	Continued From page 9 [NJ Exec Ord] ..." At 12:20 p.m., the ED and RCD both confirmed that the facility policies needed to be updated. At 1:29 p.m., the surveyor interviewed the RCD regarding Resident #3's [NJ Ex Order 26. 4B1] assessment and the RCD confirmed that there was no documented [NJ Ex Order 26. 4B1] assessment for Resident #3. The facility failed to follow and develop comprehensive policies which resulted in Resident #3 being able to [NJ Ex Order 26. 4B1] on [NJ Exec Order 26] without the staff awareness. The surveyor reviewed the following policies and procedures: "Building Security" which indicated, "Policy: Our community considers resident and staff safety a priority ... 7. Employees are trained upon orientation regarding the building security." "Assessments" with a resided date of June 2020 which indicated, "Policy" Assessments will be completed with residents upon admission, as required by the State, and when a significant change has occurred ..." "Elopement" with a revised date of March 2019 which indicated, "Policy: The community makes the resident's safety and well being a priority and will make reasonable attempts to prevent elopements ... Procedure: ... 2. Elopement risk assessments are completed upon admission, as required by the regulations, and as needed ..."	A 310		

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A 310	Continued From page 10	A 310		
A 363	8:36-4.1(a)(5) Resident Rights (a) Each assisted living provider shall 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: 5. The right to make choices with respect to services and lifestyle; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00183115 Based on interview and record review it was determined that the facility failed to respect and comply with a resident's [redacted] request by performing [redacted]	A 363		

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A 363	Continued From page 11 NJ Ex Order 26. 4B1 for 1 of 4 residents, Resident #1, reviewed for NJ Exec Order 26.4b1. This deficient practice was evidenced by the following: On NJ Exec Order 26.4 the Department of Health (DOH) received a Facility Reportable Event (FRE) a (document used by facilities to report events to the DOH) dated NJ Exec Order 2, with an event date of NJ Exec Order 26. According to the FRE report completed by the former Executive Director (ED), at around 10:15 p.m., a staff member called writer to room and Resident #1 was seated on a wheelchair and with his/her NJ Ex Order 26. 4B1 The former ED documented that the resident sat up in chair and took NJ Ex Order 26. 4B1 was called, and the resident was NJ Ex Order 26. 4B1 at 10:39 p.m. On 6/2/25 at 9:40 a.m., the surveyor interviewed a Licensed Practical Nurse (LPN) #1, who was also on duty on NJ Exec Order 26, the date of the above incident, and inquired about Resident #1 when the resident became NJ Ex Order 26. 4B1 at the facility. LPN #1 stated that he was called from the NJ Exec Order 26.4b1 unit by LPN #3 to assist with a resident who was NJ Ex Order 26. 4B1. LPN #1 stated that on arrival to the unit that Resident #1 was NJ Ex Order 26. 4B1 and started the paperwork for transfer. LPN #1, stated that he was not sure if NJ Ex Order was started after he left the scene, but NJ Ex Order 26. 4B1 when he found and provided them with the resident's NJ Exec Order 26.4b1. During the interview, the surveyor asked LPN #1, how staff identified resident's NJ Ex Order 26. 4B1 status. LPN #1, stated that a NJ Exec NJ Ex Order NJ Exec Order 2 is placed on the outside of the resident's	A 363		

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A 363	Continued From page 12	A 363		

chart and stated that he could not recall if Resident #1 had a [redacted] on the chart. LPN #1 also stated that a *NJ Ex Order 26. 4B1* [redacted] list would have the resident's name. The LPN provided the surveyor with a list titled, '*NJ Ex Order 26. 4B1* [redacted] updated [redacted] located in the narcotic binder on the medication cart and Resident #1's name was not on the [redacted] list.

In addition, LPN #1 stated that the resident would have a [redacted] in the chart, however, Resident #1 did not have a [redacted]. The surveyor then asked LPN #1 how often the list was updated and he stated monthly and when a resident was made a [redacted]. *NJ Ex Order 26. 4B1* [redacted]

At 10:05 a.m., the surveyor reviewed Resident #1's closed medical record provided by the Resident Care Director (RCD) which revealed that the resident's move *NJ Ex Order 26. 4B1* [redacted] The resident had *NJ Ex Order 26. 4B1* [redacted]. According to Resident #1's "Health and Service Assessment" *NJ Ex Order 26. 4B1* dated [redacted], completed by a Registered Nurse (RN), the resident was NJ Exec Order 26.4b1 [redacted]. The assessment form also documented that the resident's NJ Exec Order 26.4b1 " was a [redacted].

Continued surveyor review of the medical record observed a "New Jersey Advance Directive for

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ALL AMERICAN ASSISTED LIVING AT WASHIN	339 GREENTREE ROAD 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 363	Continued From page 13 Health Care" (a document that allows individuals to make healthcare decisions in advance) dated [redacted] which revealed that the resident was a [redacted]. The Progress Note (PN) dated [redacted] at 11:50 p.m., written by LPN #3, which documented, "CNA called writer to room around 10:15 p.m., and resident was sitting in wheelchair and with his/her [redacted]. Resident sat up in chair and took [redacted] initiated by other LPN and [redacted] here and [redacted] called and [redacted] resident [redacted] at 10:39 p.m." At 10:50 a.m., the surveyor interviewed the Resident Care Director (RCD) regarding Resident #1 and the resident's [redacted] status. The RCD confirmed that the resident was a [redacted] and that staff was aware of the resident's [redacted]. The RCD stated that when a resident is made a [redacted], a physician order is obtained and [redacted] completed as well and placed in the resident's medical record. During the interview, the surveyor then informed the RCD that there was no physician order for [redacted] and/or completed [redacted] in the resident's medical record. In addition, the surveyor informed the RCD that Resident #1 was not included on the [redacted] list updated [redacted]. The RCD acknowledge that the resident was not included on the list. The RCD later provided the surveyor with Resident #1's physician order for [redacted] and explained that they were late with their filing and had filing issues. Further, the RCD explained that a [redacted] list was kept at the front desk, in the Automated	A 363		

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A 363	Continued From page 14 External Defibrillator (AED) box located in the receptionist area, and in a narcotic binder in the medication cart. The RCD stated that the list was updated monthly, on admission and whenever there was a NJ Ex Order 26. 4B1. At 10:58 a.m., the surveyor inspected the AED box with the RCD and there was no NJ Ex Order 26. 4B1 list available in the AED box. At 11:05 a.m., the RCD provided the surveyor with a NJ Ex Order 26. 4B1 list updated NJ Exec Order 26. At 11:39 a.m., the surveyor interviewed the Certified Nursing Assistant (CNA) who provided care to the resident at the time the resident became NJ Ex Order 26. 4B1. The CNA stated that after giving the resident a NJ Ex Order 26. 4B1 the resident, the resident started 'NJ Ex Order 26. 4B1 and she immediately called LPN #3 who then called LPN #1 for assistance. The CNA stated that she and LPN #3 placed the resident on the NJ Ex Orde and the resident immediately NJ Ex Order 26. 4B1. The CNA stated that she walked away NJ Ex Order 26 and could not recall anything after that. At 3:25 p.m., the surveyor interviewed LPN #3 who was assigned to Resident #1 on NJ Exec Order 2. The LPN stated that on NJ Exec Order 2 she saw the resident at approximately 5 p.m., and at that time the resident did not have NJ Ex Order 26. 4 applied. LPN #3 stated that the resident's NJ Ex Order 26. 4B1 NJ Exec Order 26.4 , however she still encouraged the resident to apply the NJ Ex Order 26. 4 and the resident stated 'NJ Ex Order 26. 4B1." During continued interview, LPN #3 stated that at 10 p.m., she was informed by the above CNA that the resident was NJ Exec Order 26.4b evening care and she told the CNA to NJ Exec Order 26.4b1 the resident and explain the NJ Exec Order 26.4b1 to the resident.	A 363		

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A 363	Continued From page 15 The LPN stated that a few minutes later, she was called to the resident's room by the CNA. LPN #3 stated that on arrival, she observed Resident #1 sitting in a wheelchair NJ Ex Order 26. 4B1. The LPN stated that the resident did NJ Ex Order 26. 4B1 and then took a NJ Ex Order 26. 4B1. The LPN stated that she lowered Resident #1 to the NJ Ex Orde with the assistance of the CNA. LPN #3 stated that she then paged LPN #1 for assistance to NJ Ex Order 26. 4B1 and stayed with the resident until NJ Ex Order 26. 4B1 arrived. During the interview, LPN #3 stated that NJ Ex Order 26. 4B1 arrived and asked if NJ Ex Orde was started and she said "No." LPN #3 stated that she did not perform NJ Ex Orde because she was aware that the resident as a NJ Ex Order. LPN #3 explained that NJ Ex Order 26. 4B1 and NJ Ex Order 26. 4B1 after staff located and provided the NJ Ex Order 26. 4B1 with proof of NJ Exec Order 26.4b1. On 6/9/25, post survey, the surveyor reviewed the NJ Ex Order 26. 4B1 report dated NJ Exec Order 2 which documented that at 10:28 p.m., the resident was found NJ Ex Order 26. 4B1 in room and was NJ Ex Order 26. 4B1 The report documented that as per staff, resident was just assisted with getting NJ Ex Order 26. 4B1 when the resident became NJ Ex Order 26. 4B1 and went into NJ Ex Order 26. 4B1, " NJ Ex Orde at this time." Additionally, the report documented that at 10:35 p.m., "Facility staff returned to room with valid NJ Ex Order for patient and all NJ Ex Order 26. 4B1 were NJ Ex Order 26. 4B." It took facility staff 7 minutes to provide the resident's NJ Exec Order 26.4b1 to NJ Ex Order 26. 4B1. The surveyor reviewed the policy titled, "DNR (Do Not Resuscitate)" provided by the RCD with no revision date which revealed, "This community	A 363		

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A 363	Continued From page 16 adheres to the wishes of the residents that have a written "DNR" order from their physician." 3. "The community will maintain a current list of residents that are a DNR status." Under Lists will be located revealed, "Within each department, with the AED machine, at the front desk and ..." 4. "The DON/designee will review and update the list with every physician's code status order change and/or at least every 6 months." 5. "A written physician's order must be in the chart."	A 363		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall 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 00186217 Based on observation, interview and record review, it was determined that the facility failed to ensure a safe environment was maintained while providing care and services to residents in the community for 1 of 4 residents reviewed,	A 401		

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A 401	Continued From page 17 Resident #3. This deficient practice is evidenced by the following: On [redacted] the Department of Health (DOH) received a Facility Reportable Events (FRE) regarding an [redacted] which indicated that on [redacted] Resident #3 [redacted] from the facility at 5:05 a.m. and was [redacted] around 6:20 a.m. On 6/2/25, the surveyor investigated the above concern and at 10:31 a.m., the Executive Director (ED) provided the surveyor with a document titled, "Location Event Report [Facility Name] [redacted]" dated [redacted]. The report indicated that a [redacted] on [redacted] at 5:05 a.m. and was "responded" to 1 minute later at 5:06 a.m. At 10:45 a.m., the surveyor observed the door where Resident #3 [redacted] from, in the presence of the ED. The ED stated that when Resident #3 opened [redacted]. The ED continued to state that when the [redacted] was activated the staff working should have responded to the [redacted] which should have included going to the [redacted] to ensure a resident had not [redacted], and then completing a [redacted] of all residents to ensure all residents are [redacted]. At 10:56 a.m., the surveyor, in the presence of the Environmental Service Director (ESD), reviewed video footage dated [redacted] and timed at 5:05 a.m. The video footage was only visual and did not contain audio. During video review, the surveyor observed that Resident #3, [redacted] and [redacted] the facility [redacted] at 5:05 a.m. The ESD stated that the security cameras are motion censored	A 401		

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A 401	Continued From page 18	A 401		

and only record when movement is sensed. The ESD stated that the video did not [NJ Exec Order 26.4b1] [redacted], just the resident [NJ Ex Order 26. 4B1]. Continued viewing of the video revealed that no staff members went to check the [NJ Exec Order 26.4b1] was activated.

At 11:15 a.m., the surveyor reviewed Resident #3's closed medical record (MR) which revealed that Resident #3 was [NJ Ex Order 26. 4B1] [redacted]. The surveyor observed a General Service Plan dated [NJ Exec Order 26.] , completed by the Resident Care Director/Registered Nurse (RCD/RN), which indicated Resident #3 had no [NJ Ex Order 26. 4B1] and was [NJ Ex Order 26. 4B1] from the facility in [NJ Ex Order 26. 4B1].

During continued review of Resident #3's MR the surveyor observed a document titled, "NJ Health Assessment and Service Assessment Results", dated [NJ Exec Order 26.4b] which indicated "Resident has current or [NJ Ex Order 26. 4B1] within the residence of the facility. May [NJ Ex Order 26. 4B] outside; health or safety may be [NJ Ex Order 26. 4B1]..."

At 11:53 a.m., the surveyor interviewed the Licensed Practical Nurse (LPN), on duty the night Resident #3 [NJ Ex Order 26.], regarding Resident #3's [NJ Ex Order 26. 4B1] via telephone. The LPN confirmed that the facility was unaware of Resident #3's [NJ Ex Order 26. 4B1] until the Resident was [NJ Ex Order 26. 4B1] [redacted]. The surveyor attempted to continue to interview the LPN regarding the facility's process in responding to a [NJ Exec Order 26.4b1] as well as Resident #3. The LPN stated that she wanted to talk to her supervisor before continuing the interview, and she ended the call.

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A 401	Continued From page 19 At 12:03 p.m., the surveyor interviewed the Resident Aide (RA) #1 regarding Resident #3's [redacted] via telephone. RA #1 stated when a [redacted] is activated the [redacted] on the tablet. RA #1 continued to state that when a team member [redacted] that the same team member [redacted] to ensure a resident has not [redacted], complete a [redacted] of all residents to ensure a resident has not [redacted], and notify the Nurse. RA #1 stated that she did work the night Resident #3 [redacted] and that she was not the staff member who responded to the [redacted] At 12:15 p.m., the surveyor attempted to interview RA #2 who worked the night Resident #3 [redacted]. The surveyor was unable to reach RA #2 via telephone and could not leave a message with a call back request as RA #2's voicemail box was full. The surveyor reviewed an interview summary between the ED, Resident Care Director (RCD), and RA #2. The summary revealed " ... [RA #2] stated she did not have [redacted] on her tablet. She stated that [redacted] went off on her entire shift ... [RA #2] stated that her and [RA #1] did not know [Resident #3] was [redacted] until they [redacted] with LPN and the [redacted]. She stated that at that time her and [RA #1] went to [redacted] to see if they [redacted] on their tablets and they did ... when was the [redacted] [Resident #3] and stated she had not seen [him/her] on her shift, which was [redacted] because [he/she] is [redacted] The facility failed to ensure Resident #3's right to a safe environment when Resident #3 [redacted] from the community despite being identified as a	A 401		

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A 401	Continued From page 20 NJ Ex Order 26. 4B1. The facility was unaware that Resident #3 NJ Ex Order 26. 1 until the resident was NJ Ex Order 26. 4B1 at approximately NJ Ex Order 26. 4B1 later. The surveyor reviewed the facility policy titled, "Elopement" provided by the ED with a revised date of 3/2019, which revealed, "Policy: The community makes the resident's safety and well being a priority and will make reasonable attempts to prevent elopements..."	A 401		
A 625	8:36-5.18(a)(3) Managed Risk Agreements (a) The choice and independence of action of a resident may need to be limited when a resident's individual choice, preference and/or actions are identified as placing the resident or others at risk, lead to adverse outcome and/or violate the norms of the facility or program or the majority of the residents. When the resident assessment process identified in N.J.A.C. 8:36-7 indicates that there is a high probability that a choice or action of the resident has resulted or will result in any of the preceding, the assisted living residence, comprehensive personal care, home or assisted living program shall: 3. Seek to negotiate a managed risk agreement with the resident (or legal guardian) that will minimize the possible risk and adverse consequences while still respecting the resident's preferences; and	A 625		

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A 625	Continued From page 21 This STANDARD is not met as evidenced by: Complaint #: NJ 00183115 Based on interview and record review it was determined that the facility failed to negotiate a NJ Ex Order 26. 4B1 (NJ Exec Orde for 1 of 4 residents, Resident NJ Ex Or who was NJ Exec Order 26.4b1 with treatments and NJ Ex Order 26. 4B1 NJ Exec Order 26.4b1 prescribed by the physician. This deficient practice was evidenced by the following: On 6/2/25 at 10:05 a.m., the surveyor reviewed Resident #1's closed medical record which indicated a move in date in NJ Exec Order 26.4b1, and that the resident NJ Exec Order 26. at the facility on NJ Exec Order 2. The resident had diagnoses of NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 , and was a NJ Exec Order 26.4b1 only. According to Resident #1's "Health and Service Assessment" a NJ Ex Order 26. 4B1 assessment dated NJ Exec Order 26, was completed by a Registered Nurse (RN), and indicated the resident was NJ Exec Or and NJ Exec Order 26.4b1 . The surveyor reviewed the closed medical record of Resident #1 and observed a "Progress Note" (PN) dated NJ Exec Order 26. at 11:43 a.m., written by a Licensed Practical Nurse (LPN) #2, which documented that the resident stated that he/she NJ Ex Order 26. 4B1 . The PN dated NJ Exec Order 26.4 at 10:00 p.m., written by a LPN #3, documented that the resident complained of NJ Ex Order 26. 4B1 at 5:25 p.m., and NJ Ex Order 26. 4B1 NJ Exec Order 26.4b . The LPN #3 documented that the resident was placed on NJ Ex Order 26. 4B1 as per the	A 625		

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A 625	Continued From page 22 resident's physician. The LPN documented that the NJ Ex Order 26. 4B1 and she NJ Exec Order 26.4b1 the resident to go to NJ Ex Order 26. 4B1, however, Resident #4 NJ Exec Order 26.4 to go to NJ Ex O . The PN dated NJ Exec Order 26.4 at 7:40 a.m., written by LPN #4, documented, "... NJ Ex Order 26. 4B1 ." The PN dated NJ Exec Order 26.4b at 10:58 p.m., written by LPN #4 documented Resident #1 had no NJ Ex Order 26. 4B on when she saw the resident. She documented that the resident's NJ Ex Order 26. 4B1 on NJ Exec Order 26.4b and that she applied NJ Ex Order 26. 4B1 after NJ minutes. Additionally, the LPN documented that the resident NJ Exec Order 26.4 NJ Ex Order 26. 4B1 and stated that he/she NJ Exec Order 26.4b1 the NJ Ex Order 26. 4B1 anymore. The PN dated NJ Exec Order 26 at 10:49 a.m., written by LPN #4, which documented that she received report that Resident #1, 'NJ Exec Order 26.4b1. Resident received in room in wheelchair, clothes appeared to not be NJ Exec Orde Resident's NJ Exec Orde were NJ Exec Order 26.4b1 and NJ Exec Order 26.4 to go to the NJ Exec Order 26.4b1 The PN dated NJ Exec Order 2 at 11:50 p.m., written by LPN #3, documented that she was called to the room around 10:15 p.m., and Resident #1 was sitting in wheelchair with NJ Ex Order 26. 4B1 . The LPN documented that the resident sat up in chair and took NJ Ex Order 26. 4B1 was initiated by another LPN, and the resident was NJ Ex Order 26. 4B1 at 10:39	A 625		

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A 625	Continued From page 23 p.m., at the facility. On survey date 6/2/25 at 2:55 p.m., during interview, the surveyor inquired from the Resident Care Director (RCD), a RN, if she was aware that Resident #1 [redacted] treatments and [redacted] The RCD stated that she was aware. The surveyor then asked the RCD if a [redacted] was initiated with the resident since the resident was [redacted] with treatments and [redacted] The RCD stated "No" and asked the surveyor, "Even with residents that were [redacted] and [redacted] At 3:25 p.m., the surveyor interviewed LPN #3, who was assigned to Resident #1 on [redacted] The LPN stated that on [redacted] she saw the resident at approximately 5 p.m., and at that time the resident did not have [redacted] applied. LPN #3 stated that the resident's *NJ Ex Order 26. 4B1* on [redacted], however she still [redacted] the resident to apply the [redacted] and the resident stated "*NJ Ex Order 26. 4B1*" During continued interview, LPN #3 stated that at 10 p.m., she was informed by a Certified Nursing Assistant (CNA) that the resident was [redacted] evening care and she told the CNA to [redacted] the resident and explain to the resident the [redacted]. The LPN stated that a few minutes later, she was called to the resident's room by the CNA. LPN #3 stated that on arrival, she observed Resident #1 seated on a wheelchair "*NJ Ex Order 26. 4B1*. The LPN stated that the resident *NJ Ex Order 26. 4B1* [redacted]. There was no documented evidence that the resident was educated as to the risk of [redacted] treatments and [redacted] nor was there	A 625		

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A 625	Continued From page 24 evidence that alternatives were presented to the resident in order to respect the resident's preference and still meet the resident's clinical needs. Refer to 8:36-4.1(a)(5)	A 625		
A 735	8:36-7.2(e)(1-5) Health Care Assmnt. and Health Service Plan (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00186217, NJ 00183115	A 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHIN	339 GREENTREE ROAD 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 735	Continued From page 25 Based on interview and record review it was determined that the facility failed to develop a Health Service Plan (HSP) for 4 of 4 residents, Resident #'s 1, 2, 3 and 4, reviewed for NJ Ex Order 26. 4B1 [redacted]. This deficient practice was evidenced by the following: 1. On 6/2/25 at 10:05 a.m., the surveyor reviewed Resident #1's closed medical record which revealed a move NJ Ex Order 26. 4B1 [redacted]. According to the resident's 'NJ Ex Order 26. [redacted] Assessment" a NJ Ex Order 26. 4B1 assessment dated NJ Exec Order 26 [redacted], was completed by a Registered Nurse (RN). The assessment indicated that the resident was NJ Exec O [redacted] and NJ Exec Order 26.4b [redacted]. The assessment form also documented that the resident's 'NJ Exec Order 26.4b1" was a NJ Ex Order 26. 4B1 [redacted] Additionally, the surveyor reviewed Resident #1's medical record and did not observe documented evidence that a HSP was developed with intervention(s) to address the resident's NJ Exec Ord [redacted] preferences in the event that the resident was NJ Exec Order 26.4b1 . 2. At 11:35 a.m., the surveyor reviewed Resident #2's medical record which revealed a move NJ Ex Order 26 [redacted] The medical record revealed that Resident #2 was a NJ Ex Order 26. 4B1 and had physician's order only for NJ Ex Order [redacted] dated NJ Exec Order 26 [redacted], NJ Ex Order 26. 4B1 [redacted]	A 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHIN	339 GREENTREE ROAD 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 735	Continued From page 26 NJ Ex Order 26. 4B1 [redacted] However, surveyor review of the resident's medical record did not reveal documented evidence that a HSP was developed to address the resident's NJ Ex Order 26. 4B1 NJ Exec Order 26.4b1. 3. At 12:50 p.m., the surveyor reviewed Resident #4's medical record which revealed a move [redacted]. Surveyor review of the resident's medical record did not reveal documented evidence that a HSP was developed to address the resident's NJ Ex Order NJ Exec Order 26.4b1. At 2:55 p.m., the surveyor interviewed the Resident Care Director (RCD) regarding Resident #'s 1, 2 and #4's HSP not being developed to reflect their NJ Exec Order 26.4b1 preferences. The RCD acknowledged that there was no HSP developed for the above residents' NJ Exec Order 26.4b1. 4. On 6/2/25 at 9:25 a.m. during entrance conference the surveyor requested the HSP list from the Resident Care Director/RN (RCD/RN). The HSP list was provided to the survey team at 9:45 a.m., and Resident #3 was not on the HSP list. At 11:15 a.m., the surveyor reviewed Resident #3's closed medical record (MR) which revealed that Resident #3 was NJ Ex Order 26. 4B1 [redacted].	A 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALL AMERICAN ASSISTED LIVING AT WASHIN	339 GREENTREE ROAD SEWELL, NJ 08080

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A 735	Continued From page 27 During continued review of Resident #3's MR the surveyor observed consultations which indicated that Resident #3 was followed by [redacted] services, with medication management, and was identified as a [redacted]. At 12:20 p.m. the surveyor interviewed the RCD/RN and the Executive Director (ED) regarding Resident #3. The RCD/RN confirmed that a HSP was not created for Resident #3, despite that the resident was known to [redacted], was a [redacted], received [redacted] services with medication management. Surveyor review of the MR revealed no documentation to reflect that a HSP was developed for Resident #3 to include information about the resident's [redacted] services with medication management; or, staff education on interventions related to recommendations and physician orders.	A 735		
A1073	8:36-15.6(b) Resident Records (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.	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHIN	339 GREENTREE ROAD 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 28 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that residents NJ Exec Order 26.4b1 were accurately documented in the residents' medical record for 2 of 4 residents, Resident #2 and Resident #4, reviewed for *NJ Ex Order 26. 4B1* [redacted] This deficient practice was evidenced by the following. 1. On 6/2/25 at 11:35 a.m., the surveyor reviewed Resident #2's medical record which revealed a move *NJ Ex Order 26. 4B1* [redacted] According to Resident #2's "Face Sheet" the NJ Exec Order 26.4b1 was *NJ Ex Order 26. 4B1*. In addition, the surveyor observed a "Progress Note" dated NJ Exec Order 26.4b1, written by the Resident Care Director/Registered Nurse (RCD/RN) which revealed, "*NJ Ex Order 26. 4B1* [redacted] ." However, surveyor continued review of the Resident #2's medical record did not reveal a written physician's order for *NJ Ex Order 26. 4B1*. At 12:25 p.m., the surveyor requested Resident #2's physician's order for the NJ Exec Order 26.4b1. The RCD later provided the surveyor with Resident	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: _____ B. WING _____	C 06/02/2025

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ALL AMERICAN ASSISTED LIVING AT WASHIN	339 GREENTREE ROAD SEWELL, NJ 08080

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A1073	Continued From page 29 #2's physician's order for [NJ Ex Order] and stated that she had someone retrieve the physician's order. During interview, the RCD stated that the facility had filing issues. The surveyor observed that the physician's order was written for [NJ Ex Order] only, and not [NJ Ex Order 26. 4B1] indicated on the resident's Face Sheet. However, further surveyor review of Resident #2's medical record did not reveal a written physician's order for [NJ Ex Order 26. 4B1], or a completed [NJ Ex Order 26. 4B]. Additionally, Resident #2's name was not on the [NJ Ex Order 26. 4B1] list that was updated on [NJ Exec Order 2], it was not until [NJ Exec Order 26.4b] when the [NJ Ex Order 26. 4B1] list was revised. At 2:55 p.m., the RCD provided the surveyor with Resident #2's physician's order for [NJ Ex Order], and stated that she had someone retrieve the order, and that the facility had filing issues. Surveyor later review of the physician's ealed that the order was for [NJ Ex Order] only. 2. At 12:50 p.m., the surveyor reviewed Resident #4's medical record which revealed a move [NJ Ex Order 2] According to Resident #4's "Face Sheet," printed [NJ Exec Order 26.4b], the [NJ Exec Order 26.4b1] was [NJ Ex Order 26. 4B1]. Resident #4's name was on the [NJ Ex Order 26. 4B1] list updated on [NJ Exec Order 2] as a [NJ Ex Order 26. 4B1]. However, there was no documented evidence of a physician's order for [NJ Ex Order 26. 4B1] in Resident #4's medical record. The RCD later provided the surveyor with an admission order with [NJ Ex Order] only dated [NJ Exec Order 26.4b] At 1:15 p.m., the surveyor observed the resident in a reclined position in his/her apartment with Licensed Practical Nurse (LPN) #1. The surveyor inspected the back of the resident's door and did	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHIN	339 GREENTREE ROAD SEWELL, NJ 08080

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A1073	Continued From page 30 not observe a copy of the written order (or form) hung on the back of the door, nor a [NJ Exec Order 26.4b1] or label on the back of the resident's [NJ Exec Order 26.4b1]. Also there was no [NJ Exec Order 26.4b1] placed on the outside of the resident's apartment near/next to the resident's name. At 1:40 p.m., the surveyor requested Resident #4's physician's order for the resident's [NJ Exec Ord]. The RCD later provided the surveyor with an "Admission Order" form dated [NJ Exec Order 26.], which revealed an order for a [NJ Ex Order] only, and not the [NJ Ex Order 26. 4B1] indicated on the resident's Face Sheet. At 2:55 p.m., during interview with the RCD, the surveyor inquired about Resident #4's lack of [NJ Ex Order] documentation as specified in the facility's policy. The RCD stated that she has been working on the residents [NJ Ex Order 26. 4B1] [NJ Exec Order 26.4b1] after the [NJ Exec Order 26.4b1], and was aware that the facility has not been consistent with the [NJ Ex Order 26. 4B1] policy. The surveyor reviewed the policy titled, "DNR (Do Not Resuscitate)," provided by the RCD, with no revision date, which revealed, "This community adheres to the wishes of the residents that have a written "DNR" order from their physician." 3. "The community will maintain a current list of residents that are a DNR status." Additionally, the policy documented under "Lists will be located" revealed, "Within each department, with the AED machine, at the front desk and ..." 4. "The DON/designee will review and update the list with every physician's code status order change and/or at least every 6 months." 5. For each resident with a current DNR order, "A written physician's order must be in the chart." "A copy of the written order (or form) hung on the back of the door to the resident's apartment." "A red	A1073		

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A1073	Continued From page 31 sticker or label will be put on the back of the resident's pendant." "A red sticker will be placed on the outside of the resident's apartment by their name (if resident agrees).	A1073		

All American ASSISTED LIVING

DEFICIENCY TAG#: A 310

(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;

- HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
  - Resident #1 [redacted] NJ Ex Order 26. 4B1
  - Resident #2 moving out [redacted] NJ Exec Order 26.4B1 Order obtained [redacted] NJ Exec Order 26.4B1 and chart updated.
  - Resident #3 moved out on [redacted] NJ Exec Order 26.4B1
  - Resident #4 is still residing in the community. Order obtained [redacted] NJ Exec Order 26.4B1 and chart updated.

- HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
  - All residents have the potential to be affected.

- WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee in-serviced all staff on facility policies and procedures for Do Not Resuscitate (DNR), Incident/Accident reports, Building Security, Assessments, Elopement and Door Alarms. Started June 14, 2025 and will be completed by 8/15/2025.
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee to in-service and assign Licensed Practical Nurses (LPN's) on shift to complete timely filing of all resident documentation. Started June 14, 2025 and will be completed by 8/15/2025.
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee to in-service all staff on responsiveness and cooperation with surveyor(s) investigation. Started June 14, 2025 and will be completed by 8/15/2025.
  - On 6/2/25 all Automated External Defibrillator (AED) boxes were updated with a list of Do Not Resuscitate (DNR) status for all residents residing in the building.
  - Do Not Resuscitate/Do Not Intubate (DNR/DNI) sheets will be updated with each new admission and/or with each code status change in the residents medical chart, on the medication cart, and in the company vehicles.
  - Physician orders for Life-Sustaining Treatment (POLST) will be obtained for all residents and a written order will be placed in the chart with Do Not Resuscitate (DNR) and Do Not Intubate (DNI) status. Started June 14, 2025 and will be completed by 8/15/2025.
  - A red or DNR sticker will placed on the outside spine of their medical chart. Started June 14, 2025 and will be completed by 8/15/2025.
  - A copy of the DNR will be maintained in the medication cart. On June 14, 2025 a copy of DNR list was placed on all medication carts.

Received 7/14/25
Accepted 7/15/25

DEFICIENCY TAG#: A 310 continued

- On June 14, 2025 Elopement assessments started for all potential residents with a history of wandering behavior prior to move in, at the 6-month assessment, or change in condition completed 7/10/25.
- At orientation all new hires to be educated on building security by the Maintenance Director. Started June 14, 2025 and will be completed by 8/15/2025.
- DNR Policy reviewed on June 18, 2025.
- Revised DNR policy on June 27, 2025 and education started June 30, 2025 and will be completed by 8/15/2025.

➢ HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?

- Maintenance Director and/or designee to ensure elopement drills are completed quarterly. Elopement drill completed 5/9/25 for all shifts.
- Regional Nurse, Resident Care Director, and/or designee to complete chart audits, to ensure timely filing; weekly x 4 weeks, then monthly x 2 months, then monitored through quality assurance quarterly.
- Regional Nurse, Resident Care Director (RCD), and/or designee will audit Elopement Assessments, Do Not Resuscitate (DNR)/Do Not Intubate (DNI) sheet updates for compliance quarterly.

➢ COMPLETION DATE: 8/15/2025

All American ASSISTED LIVING

DEFICIENCY TAG#: A 363

(a) Each assisted living provider shall 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: 5. The right to make choices with respect to services and lifestyle;

- HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
  - Resident #1 *NJ Ex Order 26. 4B1*

- HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
  - All residents have the potential to be affected.

- WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
  - Director of Business Administration and/or designee pull NJ Exec Order 26.4b very Monday to audit completion of all in-services.
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee in-serviced all staff on Resident Rights takes place upon hire, annually, and as needed. Started June 14, 2025 and will be completed by 8/15/2025.
  - On July 22, 2025 Resident Rights will be reviewed and re-distributed, at Resident Council, to all residents.
  - All new residents are given a copy of resident rights prior to moving in.
  - Resident rights are reviewed at orientation, annually through Relias training, and as needed.
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee to in-service all staff on facility policies and procedures for Do Not Resuscitate (DNR), Started June 14, 2025 and will be completed by 8/15/2025.
  - On 6/2/25 all Automated External Defibrillator (AED) boxes were updated with a list of Do Not Resuscitate (DNR) status for all residents residing in the building.
  - Do Not Resuscitate/Do Not Intubate (DNR/DNI) sheets will be updated with each new admission and/or with each code status change in the residents medical chart, on the medication cart, AED, and in the company vehicles.
  - Physician orders for Life-Sustaining Treatment (POLST) will be obtained for all residents and a written order will be placed in the chart with Do Not Resuscitate (DNR) and Do Not Intubate (DNI) status. Started June 14, 2025 and will be completed by 8/15/2025.
  - DNR Policy reviewed on June 18, 2025.
  - Revised DNR policy on June 27, 2025 and education started June 30, 2025 and will be completed by 8/15/2025.

DEFICIENCY TAG#: A 363 continued

- HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee to monitor compliance quarterly through quality assurance audits.
  - Regional Nurse, Resident Care Director (RCD), and/or designee will audit Do Not Resuscitate (DNR)/Do Not Intubate (DNI) sheet updates for compliance quarterly.
- COMPLETION DATE: 08/15/2025

All American ASSISTED LIVING

DEFICIENCY TAG#: A 401

(a) Each assisted living provider shall 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;

- HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
  - Resident #3 moved out [NJ Exec Order 28.461]

- HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
  - All residents have the potential to be affected.

- WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
  - Executive Director (ED), Regional Nurse, and/or Resident Care Director (RCD) in-serviced all staff on facility policies and procedures for Elopement, Visual Inspection of area, Head Count and Door Alarms. Started 6/14/25, completed by 8/15/2025.
  - Assistant Resident Care Director (ARCD) started in-servicing on elopement and door alarms June 8, 2025 and in-servicing is expected to be completed by 8/15/2025, which will also include visual inspection of the area and head count.
  - Regional Nurse and Resident Care Director (RCD) to in-service all staff on signs and symptoms of wandering and exit seeking, to be completed by 8/15/25.
  - Prior to admission, assessing Registered Nurse (RN) to complete a Brief Interview of Mental Status (BIMS), and an elopement assessment for all residents that have a history of wandering, and a Health Service Plan for all residents that have a history of wandering behavior. If no history of wandering behavior is present prior to moving in and resident starts to display this behavior Resident Care Director (RCD) to complete a reassessment of the resident to include an updated BIMS and Health Service Plan when applicable.

- HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
  - Executive Director (ED), Regional Nurse, and/or Resident Care Director (RCD) to monitor compliance monthly.
  - Maintenance Director and/or designee to ensure elopement drills are completed quarterly.
  - Maintenance Director completed door checks 5/8/25.
  - On 5/8/25, Maintenance Director called alarm company and verified that all alarms are working properly.
  - On 5/9/2025 Assistant Resident Care Director completed Elopement Drill x 3 shifts.

DEFICIENCY TAG#: A 401 continued

- On 5/9/2025 NJ Exec Order 26.4b1 [redacted] ompleted an elopement drill.
- Regional Nurse, Resident Care Director and/or designee to complete chart audits weekly x 4 weeks, then monthly x 2 months, then through quality assurance quarterly. Started 6/26/25 and will be completed by 8/15/25.

➢ COMPLETION DATE: 8/15/2025

All American
ASSISTED LIVING

DEFICIENCY TAG#: A 625

(a) The choice and independence of action of a resident may need to be limited when a resident's individual choice, preference and/or actions are identified as placing the resident or others at risk, lead to adverse outcome and/or violate the norms of the facility or program or the majority of the residents. When the resident assessment process identified in N.J.A.C. 8:36-7 indicates that there is a high probability that a choice or action of the resident has resulted or will result in any of the preceding, the assisted living residence, comprehensive personal care, home or assisted living program shall: 3. Seek to negotiate a managed risk agreement with the resident (or legal guardian) that will minimize the possible risk and adverse consequences while still respecting the resident's preferences;

- HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
  - Resident #1 *NJ Ex Order 26. 4B1*

- HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
  - All residents have the potential to be affected.

- WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
  - Executive Director (ED) and/or designee in-serviced covering Resident Care Director (RCD) and upon hire of new Resident Care Director (RCD) on situations that require a managed risk assessment/agreement. Started June 14, 2025 and will be completed 8/15/25.
  - Executive Director (ED), Regional Nurse and/or designee to audit compliance and initiate a managed risk agreement for all residents who are non-compliant with treatment and facility policy and procedures. Started 6/26/25 and will be completed by 8/15/25.

- HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee to monitor compliance monthly by auditing 10 charts per week until resolved. Once caught up, we will audit 5 charts per month, then through quality assurance audits quarterly. Started 6/26/25 and will be completed by 8/15/25.
- COMPLETION DATE: 8/15/2025

All American
ASSISTED LIVING

DEFICIENCY TAG#: A 735

(e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment.

- HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
  - Resident #1 NJ Ex Order 26. 4B1
  - Resident #2 moved out NJ Exec Order 26.4
  - Resident #3 moved out on NJ Exec Order 26.4b.
  - Resident #4 is still residing in the community. On NJ Exec Order 26.4b1 the chart was reviewed and we ensured that the General Service Plan was complete and up to date. NJ Exec Order 26.4b1 updated NJ Exec Order 26.4b1 Documents were not in the resident's chart at the time of the audit on NJ Exec Order 26.4b1 The documentation was found in the Resident Care Directors (RCD) Office and placed in the correct binder.

- HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
  - All residents have the potential to be affected.

- WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
  - Regional Nurse to educated Resident Care Director (RCD) 2/12/25 when a written health service plan should be developed, with interventions, to address resident needs.
  - Regional Nurse, Resident Care Director (RCD), and/or designee will add Do Not Resuscitate (DNR)/Do Not Intubate (DNI) status list to Health Service Plan (HSP) binder. Completed 7/1/25.
  - Resident Care Director (RCD), and/or designee will update every ninety days, or more frequently if required, on all residents on Health Service Plans (HSP). Started June 14, 2025 and will continue as needed.
  - Regional Nurse and/or designee audited all the care plans and updated for Do Not Resuscitate (DNR)/Do Not Intubate (DNI). Started June 14, 2025 and will be completed 8/15/25.

- HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?
  - Regional Nurse, Resident Care Director (RCD), and/or designee to complete 10% chart audit of Health Service Plan (HSP); weekly x 4 weeks, then monthly. Started June 26, 2025, and will be completed 8/15/25.

- COMPLETION DATE: 8/15/2025

All American ASSISTED LIVING

DEFICIENCY TAG#: A 1073

(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.

- HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?
  - Resident #2 [redacted]
  - Resident #4 is still residing within the community. Documentation of [redacted] status updated on [redacted] Resident is not a [redacted]

- HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?
  - All residents have the potential to be affected.

- WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee in-serviced all staff on facility policies and procedures for Do Not Resuscitate (DNR)/Do Not Intubate (DNI). Started June 14, 2025 and will be completed by 8/15/2025.
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee to in-service and assign Licensed Practical Nurses (LPN's) on shift to complete timely filing of all resident documentation. Started June 14, 2025 and will be completed by 8/15/2025.
  - Executive Director (ED), Regional Nurse, Resident Care Director (RCD), and/or designee to in-service and assign Licensed Practical Nurses (LPN's) on shift to complete timely filing of all resident documentation. Started June 14, 2025 and will be completed by 8/15/2025.
  - On 6/2/25 all Automated External Defibrillator (AED) boxes were updated with a list of Do Not Resuscitate (DNR) status for all residents residing in the building.
  - Physician orders for Life-Sustaining Treatment (POLST) will be obtained for all residents with Do Not Resuscitate (DNR) and Do Not Intubate (DNI) status. Started June 14, 2025 and will be completed by 8/15/2025.
  - DNR Policy reviewed on June 18, 2025.
  - Revised DNR policy on June 27, 2025 and education started June 30, 2025 and will be completed by 8/15/2025.

- HOW THE FACILITY WILL MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?

DEFICIENCY TAG#: A 1073

- Regional Nurse, Resident Care Director, and/or designee to audit documentation and accuracy (code status, new orders); weekly x 4 weeks, then monthly x 2 months, then through quality assurance quarterly.
- Regional Nurse, Resident Care Director (RCD), and/or designee will audit Do Not Resuscitate (DNR)/Do Not Intubate (DNI) sheet updates for compliance quarterly.

➢ COMPLETION DATE: 08/15/2025

Accepted
7/10/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08A012 Y1	A. Building B. Wing Y2	7/18/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHINGTON TOWNSHI	339 GREENTREE ROAD 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 A0363	Correction	ID Prefix A0401	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(5)	Completed	Reg. # 8:36-4.1(a)(22)	Completed
LSC	08/15/2025	LSC	08/15/2025	LSC	08/15/2025
ID Prefix A0625	Correction	ID Prefix A0735	Correction	ID Prefix A1073	Correction
Reg. # 8:36-5.18(a)(3)	Completed	Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. # 8:36-15.6(b)	Completed
LSC	08/15/2025	LSC	08/15/2025	LSC	08/15/2025
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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/2/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08A012 Y1	A. Building B. Wing Y2	7/18/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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