STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A024	A. BUILDING: _____ B. WING _____	12/15/2021

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HARMONY VILLAGE AT CAREONE CHERRY HILL	1240 BRACE ROAD CHERRY HILL, NJ 08034

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A 000	Initial Comments Initial Comments: Census: 57 Sample Size: 5 TYPE OF SURVEY: Standard Survey of 50 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

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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 policy review, it was determined that the facility failed to ensure its staff received orientation and annual in-service education for 5 of 5 employees, Cook #9, Medication Aide (MA) #11, Lifestyle and Leisure Specialist (LLS) #12, Certified Nurse Aide (CNA) #13, and Housekeeper #14, whose employee files were reviewed for training and education. This deficient practice was evidenced by the	A 517		

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A 517	Continued From page 2 following: 1. Cook #9 was hired on [redacted]. Surveyor review of the employee file revealed no evidence of in-service education on resident rights, abuse and neglect, or pain management. 2. MA #11 was hired on 1[redacted]. Surveyor review of the employee file revealed no evidence of in-service education on concepts of assisted living. 3. LLS #12 was hired on [redacted]. Surveyor review of the employee file revealed no evidence of in-service education upon orientation. 4. CNA #13 was hired on [redacted]. Surveyor review of the employee file revealed no evidence of in-service education on resident rights, infection control, or pain management. 5. Housekeeper #14 was hired on [redacted]. Surveyor review of the employee file revealed no evidence of in-service education on concepts of assisted living, resident rights, infection control, abuse and neglect, or pain management. On 12/14/2021 at 4:55 PM, the surveyor interviewed the Business Office Manager (BOM) who stated that in-service education was scheduled in a computer program. The BOM indicated it was the BOM's responsibility, along with department heads, to ensure education was completed. The BOM indicated the education and in-servicing, as noted above, for the five employees had not been completed. During surveyor interview on 12/15/2021 at 3:30 PM, the Executive Director stated that there was no facility policy regarding training and in service	A 517		

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A 517	Continued From page 3 education upon orientation to the facility.	A 517		
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 and record review it was determined the facility failed to develop an individualized Health Service Plan (HSP) for 1 of 5 residents reviewed for HSPs, Resident #5. This deficient practice was evidenced by the following: 1. According to review of the medical record, Resident #5 had a move-in date of [redacted] and had diagnoses which included [redacted] Surveyor review of the medical record revealed that Resident #5 had a General Service Plan dated [redacted] there was no HSP. The surveyor reviewed Resident #5's medical record, which indicated that on [redacted], Resident #5 began receiving physical therapy services. The surveyor identified that no HSP had been initiated for the start of physical therapy services. On 12/14/2021 at 3:26 PM, the surveyor interviewed the Administrator (ADM), who confirmed that Resident #5's physical therapy	A 751		

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A 751	Continued From page 4 services ended on [redacted]. The ADM stated that quarterly assessments and individualized HSPs were only completed with a change in resident's change. On 12/15/2021 at 9:56 AM, during surveyor interview, Licensed Practical Nurse (LPN) #3 identified that there was no HSP initiated for rehabilitative services for Resident #5. The facility failed to provide the surveyor with an individualized HSP or documentation of therapy services provided between [redacted] and [redacted] for Resident #5. Facility policy titled, "Assessments," dated February 2020, indicated, "All assessments will be completed per state regulation. All residents will be reassessed upon return from the hospital or other higher level of care such as skilled care services."	A 751		
A 765	8:36-7.4(c)(1) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital;	A 765		

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A 765	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to assess 1 of 5 residents reviewed for General Service Plan (GSP) and Health Service Plan (HSP), upon readmission to the facility from a hospital, Resident #5. This deficient practice was evidenced by the following: 1. Resident #5 had a move-in date of [redacted] with diagnoses which included [redacted]. According to surveyor review of a Nurse's Progress Note, dated [redacted] at 2:30 PM, Resident #5 was found on the floor in [redacted] and limited [redacted] to the [redacted]. The physician and family were notified, and the resident was transferred by ambulance to a local hospital. According to a Nurse's Progress Note, dated [redacted] at 10:06 AM, Resident #5 was admitted to the hospital with a left femur fracture. A Nurse's Progress Note, dated [redacted] at 12:35 PM, indicated that Resident #5 was readmitted to the facility after the hospital stay. Surveyor review of Resident #5's medical records revealed that Resident #5 was reassessed for a GSP on [redacted], [redacted] days after readmission to the facility, and was reassessed for a HSP for falls on [redacted], [redacted] days after readmission to the facility. During surveyor interview on 12/15/2021 at 3:55 PM, the Regional Nurse stated that HSPs should be developed for residents with falls, and should include interventions related to the root cause.	A 765		

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A 765	Continued From page 6 On 12/15/2021 at 4:36 PM, the surveyor interviewed the Administrator (ADM), who acknowledged that Resident #5 was not assessed immediately upon return to the facility from the hospital stay for either a GSP or a HSP. Review of facility policy titled, "Assessments," dated February 2020, revealed documented, "All assessments will be completed per state regulation. All residents will be reassessed upon return from the hospital or other higher level of care such as skilled care services."	A 765		
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 on observations, facility policy review, interview, and New Jersey Administrative Code (N.J.A.C.) 8:24, it was determined the facility failed to prevent contamination from bare hand contact with food and failed to ensure hygienic practices. This had the potential to impact all residents, the findings included:	A 891		

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A 891	Continued From page 7 Reference: N.J.A.C. 8:24-2.2 (f) 1-9 indicates, in part, "Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles, and: 1. After touching bare human body parts other than clean hands and clean, exposed portions of arms; 2. After using the toilet room; 3. After caring for or handling service animals or aquatic animals; 4. After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking, except as specified in N.J.A.C. 8:24-2.4(a)2; 5. After handling soiled equipment or utensils; 6. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; 7. When switching between working with raw food and working with ready-to-eat food; 8. Before donning gloves for working with foods; and 9. After engaging in other activities that contaminate the hands." 1. On 12/14/2021 at 12:30 PM, the surveyor observed Care Partner (CP) #8 clear dirty dishes in the dining room. The CP then proceeded to serve dessert, clear more dirty dishes, and then serve dessert again. CP #8 was wearing gloves and did not change them between working with dirty dishes and serving food. On 12/14/2021 at 12:35 PM, the surveyor observed Certified Medication Aide (CMA) #4 clear tables of dirty dishes and then serve food. The CMA was wearing gloves and did not change them between working with dirty dishes and serving food.	A 891		

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A 891	Continued From page 8 On 12/15/2021 at 8:15 AM, the surveyor observed that Cook #9 was wearing gloves while opening the refrigerator, cabinets, doors, and touching clothing. Cook #9 then prepared toast, and touched the toast with gloved hands. Cook #9 did not change gloves prior to working with the ready-to-eat food. During surveyor interview on 12/15/2021 at 9:07 AM, Cook #9 stated that gloves should be changed after touching each item and before touching anything else. On 12/15/2021 at 9:15 AM, the surveyor observed that Cook #10 was wearing gloves while serving coffee and assisting a resident. While assisting the resident Cook #10 touched the resident's arm, then served fruit and toast, while touching it with their gloved hand. Cook #9 did not change gloves prior to working with the ready-to-eat food. During surveyor interview on 12/15/2021 at 12:00 PM, Cook #10 stated that each time they touch something, they should change their gloves, especially when touching food. Surveyor interview on 12/15/2021 at 12:15 PM, the Executive Director (ED) stated that gloves should not be worn at all times, but they should be worn during serving, and should be changed when moving from dirty to clean. The ED stated that the facility did not have a policy regarding glove use during serving meals. Reference: N.J.A.C. 8:24-4.6(c), indicates, "Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	A 891		

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A 891	Continued From page 9 2. On 12/14/2021 at 12:45 PM, the surveyor observed that the walk-in refrigerator was with dust on the ceiling and fan. On 12/15/2021 at 9:07 AM, the surveyor interviewed Cook #9 who stated that cleaning the walk-in refrigerator was on the kitchen cleaning list. At 12:00 PM on 12/15/2021, Cook #10 stated that cleaning the ceiling of the walk-in refrigerator was missing from the cleaning list. On 12/15/2021 at 3:30 PM, the Executive Director (ED) stated that any items not high touch in the kitchen should be cleaned weekly. Surveyor review of facility cleaning logs revealed that the ceiling and fan in the walk-in refrigerator was not included on the assigned cleaning tasks list. The surveyor requested to review the facility policy regarding kitchen sanitation and cleaning list, however the policy was not received.	A 891		
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 tuberculin skin tests administered to new employees shall be acted upon as follows:	A1307		

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A1307	Continued From page 10 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 document review and interview, it was determined that the facility failed to ensure each new employee received tuberculin testing upon hire for 1 of 5 employees files reviewed, Housekeeper #14. This deficient practice was evidenced by the following: 1. Housekeeper #14 was hired on [redacted]. Surveyor review of the employee file revealed there was no record of tuberculin testing upon hire. In an email received on 12/20/2021, the Executive Director stated that the facility did not have a tuberculin test on file for Housekeeper #14. The surveyor requested facility policy on employee testing for tuberculin, however, no such policy was received.	A1307		