STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 CHERRY HILL, NJ 08002**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: 147257 CENSUS: 106 SAMPLE SIZE: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		8/25/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 CHERRY HILL, NJ 08002**

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint#: NJ147257 Based on interviews, review of medical records, and review of other pertinent documentation on 8/5/2021 and 8/6/2021, it was determined that the facility failed to notify the resident's responsible party of a room change before the change occurred. The facility also failed to follow its policy titled "In-House Transfers/Room Changes." This deficient practice was evidenced by the following:	F 580	F 580 Notify of Changes (Injury/ Decline/Room, etc.)CFR(s): 483.10(g)(14)(i)-(iv)(15) 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Responsible party of Resident #2 was notified on [redacted] of room change by DON	

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F 580	Continued From page 2 A review of the Electronic Medical Record (EMR) was as follows: According to the Admission Record (AR), Resident #2 was admitted to the facility on [NJAC 8:43E-2.1 and Exec] and readmitted on [NJAC 8:43E-2.1 and Exec] with diagnoses which included, but were not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] According to the Minimum Data Set (MDS), dated 7/20/2021, Resident #2 had a Brief Interview for Mental Status (BIMS) score of [NJAC 8:43E-] which indicated the resident had [NJAC 8:43E-2.1 and Exec Order 26, 4. b] [NJAC 8:43E-2.1 and Exec Or]. The MDS also showed Resident #2 needed extensive assistance with Activities of Daily Living (ADLs). A review of the Progress Notes (PNs) dated [NJAC 8:43E-2.1 and Exec] revealed that Resident #2 was transferred to another room. During an interview on 8/5/2021 at 9:09 a.m., the Director of Nursing (DON) stated she should have called Resident #2's family sooner than the next day to notify them of the room change. During a second interview on 8/5/2021 at 2:03 p.m., the DON stated she usually called the residents' family members at night before the room change occurred, but she did not call the family this time. During an interview on 8/6/2021 at 11:34 a.m., the Social Worker stated if a room change occurred on the weekend, the nurse was responsible for notifying the family, and the call	F 580	2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be at risk. Facility will audit residents that had room changes in prior 30 days to identify any other residents who may have been affected. If there are residents noted to have had room change where responsible party was not notified of changes; responsible party will immediately be notified and staff will be immediately reeducated. To be completed by 8/25/21 3. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not reoccur? a) A review of room changes was done by the DON for the last 14 days to ensure appropriate notification of the responsible party was done. b) Licensed staff to be educated by the educator on responsible party notification when a room change occurs. To be completed by 8/25/2021 4. How will the corrective actions be monitored to ensure the deficient practice will not reoccur? a) Director of Nursing or Designee will audit all room changes twice weekly x 4 weeks, to ensure the responsible party has been notified in compliance with CMS, NJDOH and facility policies	

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F 580	Continued From page 3 should be done before the room change occurred. A review of the policy titled, "In House Transfers/Room Changes" with a last date revised 07/2017, revealed Under "Policy" included: Clinical Guidelines: Transfers-In-House Room Changes and Change in Roommate Notification." Under "Procedure" included: " ...The following information will be obtained before the move is considered: ...Responsible party notified (provide for the immediate safety of the resident/patient, upon identification of suspect abuse, neglect, mistreatment, and/or misappropriation of property) ... Date for transfer, Additional information as needed." N.J.A.C.: 8.39-13.1 (c)	F 580	b) Findings will be presented to QAPI committee x 1 month 5. The date of correction and the title of who is responsible for each deficiency to be corrected Administrator will be responsible to have the corrective actions complete and the facility is in compliance as of 8/25/2021	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315183 Y1	A. Building B. Wing Y2	8/26/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 08/25/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 8/6/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			