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 02/24/2020

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 COMPLAINTS: NJ#: 111147, 117984, 118007 118017, 123919, 125413 125824, 126078, 128224 130609, 133004 Census: 115 Sample: 11	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		3/22/20

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

Electronically Signed | 03/11/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: C#: NJ: 126078, 133004 Based on interviews, and record review, as well as review of pertinent facility documents on 2/14/20, 2/18/20, 2/19/20, 2/20/20, 2/21/20, and 2/24/20 it was determined that the facility failed to ensure the Resident was treated with dignity during Resident's care for 1 of 2 Residents (Resident #10), observed for [redacted] care. This deficient practice is evidenced by the following: 1. According to the "Admission Record (AR)" form, Resident #10 was admitted to the facility with diagnosis that included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool, dated [redacted] Resident #10 had [redacted] cognition and required extensive assistance from staff with Activities of Daily Living (ADLs). The "Care Plan Type: Unspecified (CPTU)"	F 550	1. CNA # 3 was immediately re-educated on proper washing protocol in regards to respecting the dignity of all residents and their rights. 2. All incontinent residents have the potential to be affected by a failure to follow proper washing procedures during incontinence care. 3. Certified nursing assistants will be in-serviced on the proper washing procedures by the facility in house RN staff educator. This in-servicing was initiated 2/20/20. Nursing staff will be in-serviced on resident rights by facility RN staff educator this in-servicing was initiated 3/2/20. 4. Audits of [redacted] care will be conducted by RN staff educator monthly X 3 months. The audits will be reported to the QA committee monthly. The QA committee will make recommendations based on its findings.	

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F 550	Continued From page 2 initiated on [redacted] showed that the Resident had frequent [redacted] related to [redacted] and [redacted]. Interventions included but were not limited to: provide [redacted] with each [redacted] episodes and assist of one staff with [redacted] care. On 2/21/20 at 9:36 am, the surveyor observed the following during [redacted] care for Resident #10: Resident #10 was in bed, in the presence of Resident's Representative (RR) in the room, Certified Nursing Assistance (CNA #3) gathered her incontinence supplies, including the basin filled with clean water and placed them on the overbed table. Resident #10 was observed with feces on the buttocks. CNA #3, using a wet washcloth wiped the feces from Resident #10's [redacted] and dropped the dirty washcloth which was stained with [redacted] into the basin. CNA #3 removed her dirty gloves, donned clean gloves, took a clean towel and dipped the towel into the same basin where she dropped the dirty washcloth stained with [redacted] and continued to clean Resident # 10's [redacted] Then, CNA #3 applied an [redacted] brief to Resident #10 to complete her [redacted] care. The surveyor conducted an interview with Resident #10 on 2/24/20 at 10:16 am. The Resident stated he/she felt less respected and disgusted when the CNA would use the dirty water to clean him/her. The surveyor conducted a telephone interview with the RR for Resident #10 on 2/24/20 at 10:31 am. The RR stated she observed what CNA #3	F 550		

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F 550	Continued From page 3 did during the aforementioned [redacted] observation on 2/21/20 at 9:36 am. The RR stated that what CNA #3 did was unsanitary considering that Resident #10 had [redacted] The surveyor conducted an interview with CNA #3 on 2/24/20 at 10:59 am. CNA #3 stated that the water was considered dirty when she dropped the wash cloth stained with feces into the basin and used the same water to clean the Resident's [redacted] She stated she forgot to change the water and it was wrong. She stated she should keep her residents clean at all times. The facility's policy titled "RESIDENT RIGHTS", created on 1/2017 and last revised on 1/2019 showed "POLICY All residents will be treated with kindness, respect, and dignity based on established Resident Rights...PROCEDURE...3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity..." The undated facility's policy titled "Nursing Home Residents' Rights" showed "...DIGNITY AND RESPECT The resident has the right to: be treated with dignity, respect and consideration at all times;..."	F 550		
F 609 SS=D	NJAC 8:39-4.1(12) Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		3/20/20

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F 609	Continued From page 4 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C#: NJ: 118017, 130609, 123919 Based on interviews, and record review, as well as review of pertinent facility documents on 2/14/20, 2/18/20, 2/19/20, 2/20/20, 2/21/20 and 2/24/20, it was determined that the facility failed to immediately investigate and report to the New Jersey Department of Health (NJDOH) an injury (bruise) of unknown origin and follow the facility policy for 1 of 4 residents (Resident #1) reviewed for incidents and accidents. This deficient practice is evidenced by the following:	F 609	1. The facility immediately reported to the DOH the injury of unknown origin of resident #1's [redacted] 2. Resident's that are unable to make their needs known have the potential of being affected by the failure to report injuries of unknown origin. 3. Nursing staff including RN's, LPN's and CNA's and management will be in-serviced by the facility RN staff educator on reporting injuries to their superiors and completing the required incident reports in a timely manner	

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F 609	Continued From page 5 1. According to the "Admission Record" form, Resident #1 was initially admitted to the facility with diagnoses that included but were not limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool, dated [redacted] Resident #1 had [redacted] impairment and was dependent on staff with Activities of Daily Living (ADLs). The "INTERDISCIPLINARY CARE PLAN (ICP)" dated [redacted] showed that the Resident was at risk for impaired skin integrity. Intervention included but was not limited to: report changes in skin integrity to supervisor immediately. The "Incident Audit Report (IAR)" dated [redacted] indicated that the Resident Representative (RR) for Resident #1 showed the Unit Manager (UM #1) that the Resident had a [redacted] on the [redacted] of the [redacted] It further showed under "Note" that the Certified Nursing Assistant (CNA #1, Resident #1's primary CNA on [redacted]) first noticed the [redacted] on [redacted]. It further showed that the [redacted] was possibly caused by the Resident leaning on [redacted] in bed. There was no investigation initiated when the [redacted] on the Resident's [redacted] was first identified on [redacted] not until [redacted] The "EMPLOYEE INCIDENT (NON-FALL) STATEMENT (EINFS)" dated [redacted] and documented by CNA #1 showed that the CNA first saw the [redacted] on Resident #1's [redacted] on [redacted] and notified the Registered Nurse (RN #1, primary nurse assigned to Resident #1 on [redacted]. However, RN #1 failed to initiate an	F 609	in-servicing initiated 2/25/20. All administrative staff will be in-serviced on reporting within the required time frame by the administrator in-servicing initiated 3/20/20. 4. Audits will be completed by the administrator monthly X3. Findings of the audit will be presented to the QA committee monthly. The QA committee will make recommendations based on the findings.	

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F 609	Continued From page 6 incident report and failed to notify the Administration of the aforementioned [redacted] on [redacted]. The "Progress Notes (PN)" dated [redacted] at 3:15 pm, documented by UM #1, showed that the Resident had a [redacted] area on the [redacted] of his/her [redacted]. The PN dated [redacted] at 5:23 pm, documented by Resident #1's Primary Physician (PP) showed that the Resident had a [redacted] on the [redacted] of his/her [redacted] PP further documented "Patient is poor historian due to [redacted]". The "Employee Counseling" dated [redacted] documented by Assistant Director of Nursing (ADON #1) showed that RN #1 was reminded that a [redacted] of unknown origin had to be reported so that it could be investigated. The surveyor conducted an interview with CNA #1 on 2/20/20 at 12:14 pm. The CNA revealed that she initially noticed a [redacted] on Resident #1's [redacted] and reported it to the Resident's primary nurse. The surveyor conducted an interview with Registered Nurse (RN #1, primary nurse for Resident #1 on [redacted] at 11:44 am. The RN revealed that she remembered the discoloration on Resident #1's face on [redacted]. She stated that for any falls (witnessed or unwitnessed) as well as an injury of unknown origin, an incident report had to be completed. She further revealed that she did not remember why she did not report Resident #1's [redacted] to the Administration on [redacted] or start an	F 609		

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F 609	Continued From page 7 investigation. The surveyor conducted an interview with Director of Nursing (DON) on 2/21/20 at 9:32 am. The DON revealed that an incident report should have been completed at the time the [redacted] was first identified on [redacted]. She further revealed RN #1 was counseled on reporting [redacted] of unknown origin. However, the DON was aware that the [redacted] on the [redacted] of Resident #1's [redacted] was identified on [redacted] and was not reported to the NJDOH. The surveyor conducted an interview with Assistant Director of Nursing (ADON #2, former UM #1 at the time of the incident on [redacted]) on [redacted] at 10:34 am. She revealed that she initially made aware of the aforementioned [redacted] not until [redacted] when the RR brought it to her attention and that was when the investigation was initiated. She stated that the Resident's [redacted] was of unknown origin and should have been reported to the NJDOH. The surveyor conducted an interview with the Administrator on 2/24/20 at 11:28 am. The Administrator revealed that injuries of unknown origin that could not be immediately ruled out as abuse, should be reported to the NJDOH within 24 hours. The undated facility's job description "JOB TITLE: Registered Nurse" showed that: "ESSENTIAL DUTIES & RESPONSIBILITIES 4. Communicates to the Unit Manager any unusual observations, emergency care, family concerns or any changes that affect the quality of resident care..."	F 609		

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F 609	Continued From page 8 The facility policy titled "INCIDENT REPORTS" created on 1/2017 and revised on 3/2017 showed that: "POLICY: It is the policy of The Facility to monitor and evaluate any adverse occurrence which is not consistent with the routine operation of the facility or care of a particular resident...PROCEDURE...a. An Incident Report is to be completed for any happening which is not consistent with the every day operation of the facility or care of residents, i.e.: resident injury/fall, skin alteration, medication error, resident to resident altercation etc. 4. The Licensed Nurse at the time of the incident must complete and sign the incident report. The Licensed Nurse must ensure that investigation is initiated and must indicate what immediate steps will be taken to prevent recurrence..."	F 609		
F 658 SS=D	NJAC 8:39-27.1 (a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: C#: NJ#: 123919, 126078 Based on interviews, and record review, as well as review of pertinent facility documents on 2/14/20, 2/18/20, 2/19/20, 2/20/20, 2/21/20, and 2/24/20 it was determined that the facility failed to document to indicate that Activities of Daily	F 658	1. Certified nursing assistants were reminded by DON and Unit Managers of need to document ADL's daily. 2. All residents have the potential for their ADL's not being documented daily. 3. Certified nursing assistants will be in-serviced by the facility in house RN staff educator on ADL protocols and the	3/20/20

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F 658	Continued From page 9 Living (ADLs) were performed for 3 of 7 Residents (Resident #1, #3 and #6) reviewed for ADLs. This deficient practice is evidenced by the following: 1. According to the "Admission Record (AR)" form, Resident #1 was initially admitted to the facility with diagnosis that included but was not limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool, dated [redacted], Resident #1 had [redacted] with Activities of Daily Living (ADLs). The "Care Plan Type: Unspecified (CPTU)" initiated [redacted] showed that the Resident had a self-care deficit related to [redacted]. Intervention included but was not limited to: assistance of one (1) staff with bed mobility, showering, bathing, dressing, toileting, [redacted] care and oral care. The form "NURSING ASSISTANT MONTHLY FLOW SHEET (NAMFS)" for [redacted] showed that it was not documented on the form to indicate that Resident #1 was assisted with ADLs such as bed mobility, transfers, eating/drinking, toilet use, locomotion, dressing, personal hygiene and bathing on 2/7/20, 2/11/20, 2/12/20 and 2/13/20 during the night shift, and on 2/9/20, 2/12/20 and 2/13/20 during the evening shift. Resident #1's "Progress Notes (PN)" for [redacted] showed that there was no documentation to	F 658	importance of filling them out daily in-servicing initiated 2/20/20. 4. Random audits will be conducted by the DON monthly X3. The findings of the audits will be presented to the QA committee monthly. The QA committee will make recommendations based on the findings.	

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F 658	Continued From page 10 indicate that the Resident was assisted with ADLs on the aforementioned dates and times. 2. According to the AR, Resident #3 was admitted to the facility with diagnosis that included but was not limited to: [redacted] According to the MDS, dated [redacted], Resident #3 was [redacted] and dependent on staff with ADLs. The CPTU initiated on [redacted] showed that the Resident had a self-care deficit related to [redacted]. Intervention included but was not limited to: assistance of one (1) staff with bed mobility, showering, bathing, dressing, toileting, [redacted] care and oral care. The form NAMFS for [redacted] showed that it was not documented on the form to indicate that Resident #3 was assisted with ADLs on 2/1/20, 2/2/20, and 2/7/20 during the day shift, on 2/4/20, 2/8/20, 2/9/20, and 2/11/20 during the evening shift and on 2/2/20, 2/3/20, 2/7/20, 2/11/20, 2/12/20, and 2/13/20 during the night shift. Resident #3's PN for [redacted] showed that there was no documentation to indicate that the Resident was assisted with ADLs on the aforementioned dates and times. 3. According to the AR, Resident #6 was admitted to the facility with diagnoses that included but were not limited to: [redacted] According to the MDS, dated [redacted], Resident	F 658		

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F 658	Continued From page 11	F 658		

#6 was [redacted] and required limited to extensive assistance from staff with ADLs.

The CPTU initiated on [redacted] showed that the Resident had the self-care deficit related to [redacted] and occasional [redacted] Intervention included but was not limited to: Resident required assistance of one (1) staff with [redacted] care.

The CPTU initiated on [redacted] showed that the Resident was occasionally incontinent [redacted]. Intervention included but were not limited to: require assist of one staff with [redacted] care, check at every 2 hours, and provide [redacted] care as needed.

The form NAMFS for [redacted] showed that it was not documented on the form to indicate that Resident #6 was assisted with eating on 7/9/19 and 7/29/19 during the day shift, and on 7/2/19, 7/3/19, 7/6/19, 7/8/19, 7/13/19, 7/14/19, 7/20/19, 7/21/19, 7/24/19, 7/28/19, and 7/31/19 during the evening shift.

Resident #6's PN for [redacted] showed that there was no documentation to indicate that the Resident was assisted with eating on the aforementioned dates and times.

The form NAMFS for [redacted] showed that it was not documented on the form to indicate that Resident #6 was assisted with toileting on 7/1/19 to 7/31/19 during the night shift, on 7/9/19 and 7/29/19 during the day shift, and on 7/2/19, 7/3/19, 7/6/19, 7/8/19, 7/13/19, 7/14/19, 7/20/19, 7/21/19, 7/24/19, 7/28/19, and 7/31/19 during the evening shift.

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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 658	Continued From page 12	F 658		

Resident #6's PN for [redacted] showed that there was no documentation to indicate that the Resident was assisted with toileting on the aforementioned dates and times

The surveyor conducted an interview with the Unit Manager (UM #2) on 2/19/2020 at 10:24 am. UM #2 stated that it was the CNAs responsibility to document the ADLs for all their residents every shift. She further stated that UMs check the ADLs sheets once a week for missing signatures. She revealed that if ADLs were not documented it meant they were not done.

The surveyor conducted an interview with Certified Nurse Assistant (CNA #3) on 2/19/20 at 11:50 am. The CNA stated that if ADLs were provided, they should document to show that the care was provided to the residents. She went on to state that staff sometimes forgot to document.

The surveyor conducted an interview with CNA #2 (the primary CNA for Resident #1 during the night shift) on 2/24/20 at 11:47 am. The CNA stated that she always performed care for the residents but sometimes did not document it on the NAMFS form due to lack of time or due to her not being able to locate the book where ADLs were should be documented.

The undated facility's Job Description titled "CNA" showed: "POSITION SUMMARY...The CNA is responsible for providing direct care to [Facility] residents, within the physical and psychosocial reals and in accordance with the Interdisciplinary Plan of Care...ESSENTIAL DUTIES & RESPONSIBILITIES...13. Monitors and documents other aspects of resident care as assigned..."

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 02/24/2020

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F 658	Continued From page 13 The facility's policy titled "NURSING DOCUMENTATION" created on 1/2017 showed that: "POLICY Pertinent information should be documented in the individual's record in an accurate, timely, and legible manner ...PROCEDURE 1. Documentation in the individual's record facilitates communication among professionals from different disciplines and on different shifts. It provides information so that health care providers can deliver care in a coordinated manner..." NJAC 8:39-27.1(a)	F 658		