STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 STANDARD SURVEY: 04/29/22 CENSUS: 110 SAMPLE SIZE: 26 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure floor mats were in place for 1 of 2 residents (Resident #81) reviewed for [redacted]. This deficient practice was evidenced by the following: On 04/19/2022 at 11:09 AM, Surveyor #1 observed Resident #81 lying in bed. There was a floor mat folded up against the wall, and there were no floor mats in place on either side of the resident's bed.	F 689	F 689 Element One □ Corrective Actions The floor mats were immediately properly placed on either side of the bed for Resident #81 when in bed and are stored under the bed when Resident #81 is out of bed. The nursing staff that did not properly place the floor mats on the floor on either side of the bed were immediately counseled and re-educated about proper placement when Resident #81 was in and when out of bed. Element Two □ Identification of at Risk	6/11/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/16/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 On 04/21/2022 at 1:33 PM, Surveyor #2 observed Resident #81 lying in bed. There was a floor mat folded up against the wall, and there were no floor mats in place on either side of the resident's bed. On 04/28/2022 at 9:38 AM, Surveyor #1 observed Resident #81 lying in bed. There was a floor mat in place on the right side of the bed. The floor mat on the left side of the bed was folded on the floor, so that it only covered the top portion of the bed and did not extend the full length of bed. According to the Admission Record, Resident #81 was admitted with diagnoses that included, but were not limited to EX Order 26 § 4b1 [redacted] Review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included the resident had a Brief Interview for Mental Status of "[redacted]" indicating the resident's EX Order 26 § 4b1 [redacted]. Further review of the MDS included the resident required extensive assistance of one person with bed mobility and transfers. Review of the resident's Care Plan included a focus of "I am at risk for falls related to my [redacted]," dated 11/11/2020, with an intervention of, EX Order 26 § 4b1 [redacted] Review of a Progress Note, dated 01/15/2022 at 7:50 AM, included that the resident was found on the floor by the bed. Review of the Incident Report, dated 01/15/2022	F 689	Residents All Residents that are at risk for falls have the potential to be affected by this practice. All residents with orders for floor mats were reviewed to assure proper use per physician orders. No deficiencies noted upon review Element Three □ Systemic Change The facility [redacted] prevention policy was reviewed which addresses appropriate measures for prevention of injury such as use of floor mats. Nursing staff were re-educated regarding the policy. Nursing staff were re-educated about the proper placement of floor mats when residents are in and when out of bed including noting this on the care plan and care [redacted] used by the CNAs. Element Four □ Quality Assurance The Unit Managers will conduct daily rounds and audit the proper placement of floor mats for Residents with orders for one week and then weekly for two months to assure proper placement of floor mats. Results will be provided to the DON who will review the findings and provide direction as appropriate. The DON will report the findings in aggregate at the monthly QAPI meeting for further action as required. Director of Nursing will be responsible for maintaining education for staff on Floor mats and correction of deficiency	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 at 7:27 AM, included that the resident was found [redacted] and that the resident, "had no [redacted]." On 04/28/2022 at 9:42 AM, Surveyor #1 observed the Certified Nursing Assistant (CNA) enter Resident #81's room to deliver a cup of water. The CNA did not unfold the floor mat to the left side of the resident's bed, so that it would extend the length of the bed. During an interview with Surveyor #1 on 04/28/2022 at 9:47 AM, the CNA stated that Resident #81 requires complete care for Activities of Daily Living (ADLs) and was unsure if the resident had a history of [redacted] The CNA further stated that she believed the resident was at risk for [redacted] because the resident cannot stand on his/her own. The CNA added that the resident had floor mats in place to both sides of his/her bed, but that she removed one side while the resident eats. The CNA also stated that the purpose of floor mats were to prevent injury if a resident [redacted] During an interview with Surveyor #1 on 04/28/2022 at 10:01 AM, Licensed Practical Nurse #2 (LPN) stated Resident #81 was alert with [redacted] LPN #2 further stated that the resident had a history of [redacted] and had [redacted] in place whenever he/she was in bed. LPN #2 added that during meals, staff will put the overbed table on the floor mat. LPN #2 also stated that the purpose of floor mats were to prevent injury if a fall occurred. During an interview with Surveyor #1 on 04/28/2022 at 10:08 AM, LPN/Unit Manager #2	F 689	The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 6-11-2022 to ensure the deficient F689 SS=D practices will not reoccur.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

(LPN/UM) stated that Resident #81 was alert with [redacted] and required assistance of one person for ADLs. LPN/UM #2 further stated that the resident had a history of [redacted] and had floor mats in place at all times when the resident was in bed. LPN/UM #2 added that during meals, staff placed the overbed table on the floor mat and that the floor mat should extend the length of the bed when in place. LPN/UM #2 also stated that the purpose of floor mats were to protect the resident from injury in the event of a [redacted].

During an interview with Surveyor #1 on 04/28/2022 at 10:17 AM, the Director of Nursing (DON) stated that residents with floor mats should have them in place at all times when in bed. The DON further stated that overbed tables should be placed over the floor mat during meals in case the resident [redacted] while sitting up in bed. When asked about Resident #81, the DON stated that the resident had a history of [redacted] and that interventions included [redacted] floor mats when in bed. The DON further stated that for Resident #81, the staff should place the overbed table on the floor mat and that the floor mat should extend the entire length of the bed. The DON stated that the purpose of floor mats were to decrease the impact in the event the resident [redacted]

Review of the facility's Falls Management policy, revised 01/2020 included, "Assess the resident and immediately implement appropriate measures to prevent injury," and to "Implement goals and interventions with resident/patient/family for inclusion in the interdisciplinary Plan of Care (IPOC) based on individual needs."

The facility was unable to provide a policy that

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 addressed the use of floor mats. NJAC 8:39-27.1 (a)	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		6/11/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 5 by: Based on interview, record review and review of facility documentation, it was determined that the facility failed to a.) consistently follow medication hold parameters according to the physician's order for 1 of 5 residents (Resident #84) reviewed for unnecessary mediations and b.) ensure accurate completion of a Drug Enforcement Agency (DEA) Form-222 (a federal narcotic requisition form), to enable accurate reconciliation of controlled-dangerous substances (medications, that due to their high potential for abuse, are tracked with detail) for 1 of 1 form reviewed . This deficient practice was evidenced by the following: According to the Admission Record, Resident #84 had diagnoses including, but not limited to, [redacted] EX Order 26 § 4b1 1. Review of the Order Summary Report for Active Orders As Of 12/10/2021 reflected an order dated [redacted] for EX Order 26 § 4b1 [redacted] or before meals for DM. Review of the 12/01/21 - 12/31/21 Medication Administration Record for Resident #84 reflected that on Tuesday, 12/21/22 at 7:30 AM, the nurse recorded a [redacted] of [redacted] for Resident #84. The nurse documented the reason the	F 755	F755 Element One □ Corrective Actions The nurse who failed to properly administer [redacted] to Resident #84 on [redacted] was identified and was counseled and re-educated. There was no negative outcome for Resident #84. The DEA Form 222 identified as incomplete by the surveyor was properly completed by the DON after cross checking the date on the corresponding pharmacy delivery slip to include the number of items ordered and the date received. Nursing management that receives controlled medications were re-educated regarding proper completion of the DEA Form 222 in compliance with regulations. Element Two □ Identification of at Risk Residents All Residents with sliding scale insulin orders have the potential to be affected by this practice. An audit of the prior and current months DEA Form 222 was completed to identify any that might have missed information. None were found. Element Three □ Systemic Change The Director of Nursing is the only employee who orders controlled substances using the DEA222 form. Director of Nursing was re-educated by the Regional Nurse on proper procedure	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 6 [redacted] was not administered was [redacted] EX Order 26 § 4b1 [redacted]" During an interview with the surveyor on 04/27/22 at 11:03 AM, the Licensed Practical Nurse #1 (LPN) stated that she would take the resident's [redacted] and then administer the [redacted] EX Order 26 § based on the [redacted] in the physician's order. During an interview with the surveyor on 04/28/22 at 12:57 AM, LPN/Unit Manager #1 (LPN/UM) stated that if a physician's order contained a [redacted] indicating when to administer [redacted] EX Order 26 §, the nurse needed to follow the parameters. During an interview with the surveyor on 04/28/22 at 1:05 AM, the Director of Nursing stated that she expected the nurses to follow the physician orders. Review of the facility's Medication Administration policy, with a review date of 01/2022, reflected that "Medication shall be administered in a safe and timely manner, and as prescribed" and, "Medication must be administered in accordance with the orders, including any required time frame." 2. On 04/22/22 at 12:18 PM, a review of the facility's DEA Form-222 revealed the facility did not complete "last line completed" in Part 1 or the "date the medication was received" in Part 5, as instructed on the face of DEA Form-222, within each section. The inaccuracies were as follows: Order Form Number: 212893367 did not include the last line completed (bottom, left corner) or indicate the date received for Items 1, 2, 3, 4, 5 or	F 755	for completing DEA222 form. An audit of MARs of Residents with sliding scale insulin orders were reviewed for May 8-15th 2022 to assure residents properly received insulin when needed based on blood sugar levels as ordered by the physician. Any deficiency noted nurse will be reeducated, disciplined and medication error completed if needed. Nursing staff received re-education regarding following physician orders for administration of insulin based on resident blood sugar levels. The facility policy and procedure titled Controlled substances in Back Up was reviewed referring to completion of the DEA 222 form on receipt of medications from the pharmacy. Nursing staff that receives control substances re-education about the proper completion of the DEA Form 222. Element Four □ Quality Assurance Monthly the pharmacy provider/pharmacy consultant will review the DEA Form 222 to assure all required items are properly completed in compliance with regulations for three months. Findings are discussed monthly with the DON and action taken as appropriate. The Nursing Home Administrator will audit the DEA 222 forms for proper completion weekly for the next month and monthly for two months and discuss findings with the DON who will act on the findings. The DON will report findings of the audits at	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 7 6. During an interview with the surveyor and survey team on 04/22/22 at 12:22 PM, the Director of Nursing (DON) stated that the copy of the form furnished to the survey team was complete and the number of packages received corresponded to the number of packages ordered. The surveyor asked the DON to reconfirm that the form, as provided, was complete and that there was no omitted documentation due to the faded copy. The DON confirmed that there was nothing omitted, and the copy of the form was complete, despite being faded towards the bottom. During an interview with the surveyor and survey team on 04/28/22 at 2:33 PM, the surveyor referred the DON and facility staff to the instructions on the back of the DEA-222 Form, indicating a need to fill in a number for the last line completed and the date the items were received. During an interview with the surveyor and survey team on 04/29/22 at 9:50 AM, the DON acknowledged that the DEA Form-222 was incomplete, specifically as related to the last line completed (corresponding to the number of items ordered) and the date on which the medication packages ordered were received. The DON further stated, along with the Regional Nurse, that they reviewed the directions on the back of the DEA-222 Form and understand the need to complete the form in its entirety in the future. Review of the policy for ordering medication, "Controlled Drug Substances in Back Up," revealed an effective November 2010 and no revision date. The policy indicated that controlled	F 755	the monthly QA meeting for three months and action will be taken as appropriate based on the findings. Director of Nursing will be responsible for maintaining education for staff on DEA Form 222, Insulin and correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 6-11-2022 to ensure the deficient F555 SS=D practices will not reoccur.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 8 drug substances will be stored and replaced in accordance with all DEA, Federal, and State regulations. The policy further indicated a need for the DEA-222 Form to be completed correctly, including directions that the "Last Line Completed" must always be filled in accordingly. It did not address the need to complete the date that such items were received. NJAC 8:39 - 29.3; 29.7	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) ensure that a resident received [redacted] medication in accordance with the physician's order (Resident #33) and b.) consistently follow medication hold parameters according to the physician's order (Resident #2). The deficient practice was identified for 2 of 7 residents (Residents #2 and #33) reviewed for unnecessary medications and was evidenced by the following: According to the Admission Record, Resident #33 was admitted with diagnoses that included, but were not limited to, EX Order 26 § 4b1 [redacted] Review of the Progress Notes (PN) revealed that Resident #33 had a [redacted]	F 760	F 760 Element One □ Corrective Actions The orders for Resident #33 were immediately reviewed and all current orders reconfirmed with the physician. All current orders were correct. The nurse that failed to properly discontinue the old order when entering the new order for EX Order 26 § 4b1 [redacted] was identified. Nurse no longer works at facility. The nurses who failed to properly administer the [redacted] according to the parameters ordered by the physician for Resident #2 were counseled and re-educated. Element Two □ Identification of at Risk Residents All Residents have the potential to be	6/11/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 9 [redacted] with the Advanced Practice Nurse (APN) for "follow up/medication management." The [redacted] included a recommendation to [redacted] of EX Order 26 § 4b1 [redacted] Further review of the PN revealed a 12/21/21 Nurses Note (NN) that indicated the resident was seen by the [redacted] APN and the [redacted] of EX Order 26 § 4b1 [redacted] The NN further indicated that the family was informed, and the resident's APN agreed with the changes. Review of the "Order Summary Report" (OSR) for active orders as of 01/26/22 revealed a [redacted] physician order (order) for EX Order 26 § 4b1 [redacted] Review of the December 2021 and January 2022 Medication Administration Records (MAR) revealed the aforementioned orders both had a scheduled administration time of 9:00 AM. Further review of the MARs revealed that Resident #33 received both EX Order 26 § 4b1 [redacted] on the following dates during the [redacted] medication administration: [redacted] and [redacted]	F 760	affected by these practices. Element Three □ Systemic Change All nursing staff were re-educated on discontinuing existing orders prior to transcribing new orders. Nursing staff received re-education to re-enforce administration of medications per physician orders and to properly follow physician order that have specific parameters for medication administration. The pharmacy consultant reviews MARs as part of the chart audits completed monthly and monitors compliance with physician orders to assure revised orders are properly discontinued and orders with parameters are properly followed. Findings are provided to the DON monthly for action as appropriate. Element Four □ Quality Assurance The Unit Managers will audit 20 resident MARs weekly for the next four weeks and monthly for two months for those residents with medication parameters. Findings will be provided to the DON on completion of weekly then monthly audits. Staff will receive re-education as appropriate based on results. The DON will report findings in aggregate at the monthly QAPI meeting for action as appropriate. The ADON/Nurse Supervisor will audit 20 residents weekly for one month than monthly for two months to assure physician orders are properly transcribed, discontinued and followed as ordered by	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 10 During an interview with the surveyor on 04/28/22 at 12:54 PM, the Licensed Practical Nurse #2 (LPN) stated that any change in a medication dose would require the nurse to discontinue the old order prior to entering the new order. LPN #2 further stated that if she was not sure of the correct medication dosage, she would hold the medication and verify the order with the physician. During an interview with the surveyor on 04/28/22 at 12:57 PM, LPN #3 stated the nurse should discontinue the old order prior to entering the new order into the Electronic Medical Record (EMR). LPN #3 further stated she that if she was not sure of the correct medication dosage, she would hold medication and call the physician to clarify the medication dosage. LPN #3 added that she would then discontinue the inaccurate order and document the clarification in the progress notes. During an interview with the surveyor on 04/28/22 at 1:08 PM, the LPN/Unit Manager #2 (LPN/UM) stated that she expected the nurse to inform the resident's family, educate the resident about the medication change, discontinue the old order, and input the new order into the EMR. LPN/UM #2 further stated that she expected the nurse to clarify any unclear order with the physician before administering the medication. During an interview with the surveyor on 04/28/22 at 2:37 PM, the Director of Nursing (DON) stated that she expected staff to inform the family and educate the resident about a medication change. The DON further stated that she expected the nurse to discontinue the previous order prior to entering the new order into the EMR. The DON	F 760	[redacted]. Results will be reported monthly to the DON who will act upon findings. Findings will be reported to the QA committee monthly by the DON in aggregate for further direction. Director of Nursing will be responsible for maintaining education for staff on medication parameters, transcription of orders and correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 6-11-2022 to ensure the deficient F760 SS=E practices will not reoccur.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 11	F 760		

added that she expected the nurses to call the physician and clarify any unclear order.

During an interview with the surveyor on 04/29/22 at 9:57 AM, the Regional Nurse confirmed the surveyor's findings and stated that the nurse should have discontinued the previous order prior to entering the new order.

Review of the facility's Physician Orders policy, revised on 02/22/22, reflected to discontinue the current order prior to initiating a new order.

According to the Admission Record, Resident #2 was admitted with diagnoses that included, but were not limited, EX Order 26 § 4b1 [redacted]

Review of the OSR for active orders As of 01/01/2022 reflected an ongoing order dated [redacted] for EX Order 26 § 4b1 [redacted]

The January 2022 MAR reflected the nurses administered the medication out of parameters on the following dates:
01/06/22 at 1700 (5:00 PM) with a [redacted] of EX Order
01/15/22 at 0800 (8:00 AM) with a [redacted] of EX Order
01/21/22 at 0800 with a [redacted] of EX Order

The February 2022 MAR reflected the nurses administered the medication out of parameters on the following dates:
02/09/22 at 1700 with a [redacted] of EX Order
02/20/22 at 0800 with a [redacted] of EX Order
02/28/22 at 1700 with a [redacted] of EX Order

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 12 The March 2022 MAR reflected the nurses administered the medication out of parameters on the following days: 03/06/22 at 1700 with a [redacted] of [redacted] 03/07/22 at 1700 with a [redacted] of [redacted] During an interview with the surveyor on 04/27/22 at 11:03 AM, LPN #1 stated that she would take the resident's [redacted] and then administer the [redacted] based on the [redacted] in the physician's order. During an interview with the surveyor on 04/28/22 at 12:57 AM, LPN/UM #1 stated that if a physician's order contained a sliding scale indicating when to administer insulin, the nurse needed to follow the parameters. During an interview with the surveyor on 04/28/22 at 1:05 AM, the DON stated that she expected the nurses to follow physician orders. Review of the facility's Medication Administration policy, with a review date of 01/2022, reflected that medication shall be administered in a safe and timely manner, and as prescribed and that medication must be administered in accordance with the orders, including any required time frame. NJAC 8:39-27.1(a), 29.2(d)	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		6/11/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 13 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner designed to prevent foodborne illness. This deficient practice was evidenced by the following: On 04/19/22 at 10:57 AM, in the presence of the Dining Regional Manager (DRM), the surveyor observed the following during the kitchen tour: 1. A food service worker (FSW) was observed walking past the dish machine area. The FSW had a beard and was not wearing a beard guard. 2. The can opener blade and holder were soiled and noted with debris of an unknown substance, stuck to the blade. When interviewed, the DRM confirmed the surveyor's finding and was observed attempting to scratch off the unknown	F 812	F 812 Element One □ Corrective Actions The FSW was immediately corrected and counseled and re-educated about the requirement to wear a beard guard when working in the kitchen in compliance with sanitation codes and facility policy. The can opener and holder were immediately cleaned and kitchen staff re-educated about proper cleaning of kitchen equipment. The scoop was immediately removed from the thickener bin and properly stored in the designated holder. Kitchen staff received immediate re-education regarding proper storage of scoops outside bins in compliance with sanitation codes and facility policy.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 14 substance. The DRM further stated that the blade had been cleansed and sanitized via the dish machine that morning. 3. A bin containing thickener was stored near the prep area. The surveyor observed a scooper stored inside of the bin and submerged in the thickener. 4. A bin containing breadcrumbs was stored near the prep area. The surveyor observed a scooper stored inside of the bin and submerged in the breadcrumbs. When interviewed, the DRM stated the scooper should not have been stored inside the bins. 5. In the produce box, the surveyor observed a tray stored on a multitiered cart. The tray contained 27 undated/unlabeled vanilla health shakes. When interviewed, the DRM confirmed the surveyor's findings and stated the health shakes had a 14-day shelf-life after being pulled from freezer. The DRM further stated the staff should have labeled health shakes once they were removed from the freezer. On 04/28/22 at 1:41 PM, in the presence of the DRM, the surveyor observed the following during the second kitchen tour: 6. In the dry storage room, a dented #10 can of whole potatoes was stored on a shelf alongside undented cans. 7. In the dry storage room, a dented #10 can of white/cut potatoes was stored on a shelf alongside undented cans. When interviewed, the surveyor observed the DRM remove the two #10 cans from the rack and place them on the shelf	F 812	The scoop was immediately removed from the bread crumb bin and properly stored in the designed holder. Kitchen staff received immediate re-education regarding proper storage of scoops outside bins in compliance with sanitation codes and facility policy. The health shakes were immediately discarded. Dietary staff received immediate re=education about proper labeling and dating of all health shakes for use within 14 days of pulling from the freezer. The dented can of potatoes was immediately removed and placed in the dented can storage area until picked up by the vendor. Dented cans are removed as stored in separate area labelled dented can shelf. Dietary staff received immediate re-education regarding proper monitoring and removal of dented cans for return to the vendor. Element Two □ Identification of at Risk Residents All Residents have the potential to be affected by these practices. Element Three □ Systemic Change Dietary staff received re-education regarding kitchen sanitation, use of beard guards, proper cleaning of equipment and the procedure for labeling and dating of items when pulled from the freezer and proper storage of scoops in designated holders outside food bins.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 15 designated as the dented can area. Review of the facility's undated "Uniform Policy" revealed that facial hair coverings would be worn to cover facial hair. Review of the facility's "Can Opener Usage/Cleaning Policy, Rev 6.2021," indicated it was the responsibility of the associate using the can opener to clean and sanitize it after each use. Review of the facility's "Food Product Scoop Storage Policy, Rev 4.2021," revealed that scoops to dish out the product must be stored outside the bin and in a container. Review of the facility's "Dented Can Policy, Rev 8.2021," indicated to identify an acceptable/unacceptable dented can. The policy revealed that an unacceptable dented can included any dented, crease, bulge, swelling or rust. The policy further instructed to place dented cans in the designated "Dented Can" area upon discovery. Review of the facility's "Health Shake Storage Policy, Rev 8.2021" indicated that health shakes would be immediately labeled with a 14-day usage sticker upon removal from the freezer. NJAC 8:38-17.2 (g)	F 812	The dietary supervisor daily checklist was revised to include specifically monitoring all areas cited in this tag. Kitchen supervisors were re-educated about the revised checklist. Element Four □ Quality Assurance The FSD will review all daily audit checklist items weekly for four weekly and then monthly for two months to assure compliance with sanitation codes. Results are reported to Administration and the QA committee monthly by the FSD. Actions will be taken as appropriate based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident for 1 of 14 day shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse,	S 560	S 560 Element One □ Corrective Actions A staffing analysis was completed to identify by shift the minimum amount of direct care staff and licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on the daily census. The staffing schedule was reviewed by the DON with the staffing coordinator to identify by shift the required numbers of staff. Immediately when facility noted that staffing requirements where not met for 1 of the 14 days the facility reached out to agencies to fill vacant direct care certified nurse aide and licensed nurse positions. Facility nursing staff were offered bonuses	6/11/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 04/03/2022 through 04/09/2022 and 04/10/2022 through 04/16/2022, the staffing-to-resident ratio that did not meet the minimum requirement of one CNA to eight residents for the day shift is documented below: -04/16/22 had 12 CNAs for 109 residents on the day shift, required 14 CNAs. During an interview with the surveyor on 04/28/2022 at 10:51 AM, the Staffing Coordinator stated that the required staffing ratios were as follows: one CNA to eight residents for dayshift, one CNA to 10 residents on evening shift, and one CNA to 14 residents on night shift. The staffing coordinator further stated that she	S 560	for picking up extra shifts. Agencies are contacted to fill vacant direct care certified nurse aide and licensed nurse positions while the facility advertised for new staff. Facility nursing staff are offered bonuses for picking up extra shifts when needed. The Facility continues to run Online Ads, offers sign on bonus and generous referral bonuses to attract new staff. Interviews are being conducted daily as applicants apply both scheduled or walk-ins. The staffing coordinator reviews the daily, weekly, and monthly staff schedules with the DON to assure staffing levels meet regulatory requirements and to offer extra shifts to cover vacation and days off in advance. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three □ Systemic Change DON/ADON review staffing daily and weekly to ensure all resources have been used to staff the facility as per state mandates on an ongoing basis. Agencies are sent all staffing needs in advance and additional staff requested to cover in the event of callouts. The Facility continues to work with a recruiter and use digital and social media to staff the facility in compliance with regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 ensures the facility is staffed appropriately by calling staffing agencies to replace call outs and offering bonuses for facility staff to pick up extra shifts. During an interview with the surveyor on 04/28/2022 at 11:09 AM, the Administrator stated that the required staffing ratios were as follows: one CNA to eight residents for dayshift, one CNA to 10 residents on evening shift, but she was unsure of the ratio for night shift. The Administrator further stated that she ensures the facility is staffed appropriately by running ads for new hires, offering bonuses, and utilizing agency staff. Review of the facility document titled, "New Hire Process," undated, included placing new job openings at the time clock for facility staff, posting job openings on job recruitment websites, yearly job fairs, and sign on and referral bonuses. NJAC 8:39-5.1(a)	S 560	Administration has formed a staffing committee and has conducted salary analyses and implemented creative strategies for attracting new employees to minimize the use of agency personnel. The staffing committee includes frontline staff and managers to identify ways the facility can improve the work environment to retain and attract new employees. The committee recommendations are shared with regional and corporate staff for review and implementation. Bonuses and incentive programs have been implemented to attract and to retain current staff. The facility is utilizing all types of digital media as well as headhunters to identify and hire new staff. Element Four Quality Assurance Daily staffing levels are reported to administrator and if there are any shortages additional incentives are provided to employees to work an extra shift. The success of bonuses and incentives is being analyzed by the facility Administrator and DON who make recommendations to the ownership regarding what incentives or bonuses are working. Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions. HR and staffing coordinator/designee will track	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 04/29/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3	S 560	efforts and success of initiatives above and report findings to the administrator weekly for four months or until minimum staffing levels have been met on a consistent basis. The administrator will communicate findings to corporate staff for assistance and further direction as appropriate. Days and shifts where facility did not meet staffing requirement along with incentives used to attract staff for the days and shifts will be brought to QAPI on a monthly basis by DON x3 months. Also, recruitment efforts for the month x3 months will be submitted to the Administrator to evaluate progress of recruitment and retention efforts. Findings will be reported to the QAPI committee monthly and recommendations will be made based upon outcomes. The HR Director tracks monthly hiring and retention efforts which are reviewed at the monthly QAPI meeting and shared with Executive Director.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060409 Y1	A. Building B. Wing Y2	6/13/2022 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 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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/11/2022	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
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	ID Prefix Reg. # LSC	Correction Completed
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	
4/29/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	C **04/29/2022**

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/25/22 and 04/26/22 and Premier Cadbury of Cherry Hill was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Premier Cadbury of Cherry Hill is a single story, Type II Un-Protected building that was built in June 1981. The facility is divided into 4 smoke zones.	K 000		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		6/11/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/16/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	C **04/29/2022**

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 1 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations on 04/25/2022, in the presence of facility management, it was determined that the facility failed to maintain the integrity of the smoke barrier wall for 1 of 4 smoke barrier walls observed as evidenced by the following: On 04/25/2022, starting at 9:30 AM, a tour of [redacted] was conducted with the Director of Facilities (DOF) and Assistant Director of Maintenance (ADM). At 9:55 AM, the surveyor observed, above the corridor double smoke doors next to resident room [redacted], an approximately four inch diameter hole with an electrical cable running through the hole. The surveyor further observed an approximately 10 inch by 13 inch section of wall was missing with a copper pipe running through the opening in the smoke barrier wall. These penetrations were observed on both sides through the smoke barrier walls, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The findings were verified and confirmed by DOF and ADM during the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 04/26/2022 at 1:40 PM.	K 372	K372 Element One □ Corrective Actions The holes above the double smoke doors next to room [redacted] on [redacted] were repaired and the section of the wall was replaced to meet life safety codes. Maintenance staff received re-education regarding proper sealing of penetrations and repairing of smoke barrier walls after completion of repairs. Element Two □ Identification of at Risk Residents All Residents have the potential to be affected by this practice. Element Three □ Systemic Change All smoke barrier doors and walls were checked by maintenance to identify and repair any penetrations. No other penetrations were found. The Maintenance Director will check all smoke barrier walls and doors after any repairs to verify any penetrations are properly sealed whenever repair work is required. Element Four □ Quality Assurance The Maintenance Director conducts daily walking rounds to identify any areas in need of repair including smoke barrier penetrations. Weekly for four weeks the Administrator will conduct walking rounds	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	C **04/29/2022**

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 2 NJAC 8:39-31.2(e)	K 372	with the Maintenance Director to monitor compliance with life safety requirements including proper repairs of any penetrations in smoke barrier walls. Findings will be reported at the monthly QA committee meeting by the maintenance director for action as appropriate.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation, and interview conducted on 04/25/2022, in the presence of facility management, it was determined that the facility failed to ensure that the ventilation systems were being properly maintained for 3 of 7 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During the tour starting at 9:30 AM, in the presence of facility's Director of Facilities (DOF) and Assistant Director of Maintenance (ADM), an inspection of 7 Resident rooms was performed.	K 521	K 521 Element One □ Corrective Actions The motor controlling exhaust fans in the bathrooms in rooms [redacted] and [redacted] that was ordered has been received and replaced by the Maintenance Director. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three □ Systemic Change The maintenance director and staff immediately checked all bathroom	6/11/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	C **04/29/2022**

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 3 This inspection identified, when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 3 of 7 resident bathrooms in the following locations: 1. At 10:08 AM, inside resident room [redacted] bathroom, the exhaust system did not function properly when tested. At that time, the surveyor informed the DOF and ADM that the exhaust system did not function properly. 2. At 10:11 AM, inside resident room [redacted] bathroom, the exhaust system did not function properly when tested. At that time the surveyor asked the DOS, "Does the exhaust work?" The DOF said, "No." 3. At 10:14 AM, inside resident room [redacted] bathroom, the exhaust system did not function properly when tested. All of the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The DOF and ADM confirmed the findings at the time of the observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 04/26/2022 at 1:40 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	exhaust fans to assure they functioned properly. All other exhaust fans were functioning properly. Exhaust fans in all closed rooms with no ventilation are checked weekly for proper function as part of the weekly rounds conducted by the maintenance director. Element Four □ Quality Assurance The Maintenance Director conducts daily walking rounds to identify any areas in need of repair including exhaust fan functioning. Weekly for four weeks the Administrator will conduct walking rounds with the Maintenance Director to monitor compliance with life safety requirements including proper repairs of any nonfunctioning exhaust fans. Findings will be reported at the monthly QA committee meeting by the maintenance director for action as appropriate.	

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 01 - MAIN BUILDING 01 B. Wing Y2	6/13/2022 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 Reg. # NFPA 101 LSC K0372	Correction Completed 06/11/2022	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 06/11/2022	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	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
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 4/29/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			