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 ______	10/18/2022

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 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
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		
F 000	INITIAL COMMENTS Survey Date: 10/18/22 CENSUS: 104 SAMPLE SIZE: 23 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 658 SS=D	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: Based on observation, interview, and record review, it was determined that the facility failed to consistently document in the Medication Administration Record (MAR) and Treatment Administration Record (TAR). This deficient practice was identified for 1 of 5 residents (Resident #61) reviewed for unnecessary medications and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title	F 658	F658 Element one Nurses failed to consistently document in the Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) for Resident #61 . Nurses were immediately re-educated on Medication and Treatment Administration in regards to proper documentation.	11/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/02/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." According to the Admission Record, Resident #61 was admitted with a medical diagnosis that included but was not limited to NJ ex order 26.4b1 A review of the Order Summary Report dated NJ ex order 26.4b1 and NJ ex order 26.4b1, NJ ex order 26.4b1 and NJ ex order 26.4b1 MARs and TARs for Resident #61 revealed that there was no documentation to indicate that the medications	F 658	Element two All residents have the potential to be affected by this deficient practice. Medication administration and treatment record was reviewed on 10-20-22. Residents who were affected by this practice were identified, nurses were reeducated, disciplined, and medication error form completed if needed. Element three Nurse will be re-educated in regards to administration of medication/treatment to record signature in the resident□s individual electronic Medication administration Record (EMAR)/electronic treatment administration record (ETAR) once medication /treatments have been administered. Any refusals will be documented on the Electronic Medication administration Record (EMAR)/ electronic treatment administration record (ETAR) and the physician notifies as per facility policy Element Four Medication Administration Audit will be completed daily by Director of Nursing /designee weekly x 4 weeks then monthly x 3 months. Staff with omissions will be re-educated and medication error documented as necessary and corrective discipline provided. Results to be reported in monthly Quality Assurance (QA) x3 months and appropriate action will be taken based on the findings. Director of Nursing responsible for maintaining findings	

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F 658	Continued From page 2 and treatments were administered as ordered on the following dates and times: NJ ex order 26.4b1 Ordered NJ ex order 26.4b1 06:00 AM-NJ ex order 26.4b1 02:00 PM-NJ ex order 26.4b1 10:00 PM NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 subcutaneously every eight hours. Ordered NJ ex order 26.4b1 06:00 AM-NJ ex order 26.4b1 02:00 PM-NJ ex order 26.4b1 10:00 PM-NJ ex order 26.4b1 Vital signs Q (every) shift every shift. Ordered NJ ex order 26.4b1. Evening - 1NJ ex order 26.4b1 Weekly skin checks on shower days in the afternoon every Monday and Thursday. Ordered NJ ex order 26.4b1. 02:00 PM - NJ ex order 26.4b1 NJ ex order 26.4b1 and as needed every shift. Ordered NJ ex order 26.4b1 Day -NJ ex order 26.4b1 Night - NJ ex order 26.4b1 NJ Ex.Order 26.4(b)(1) (when in bed) using pillows and wedges every shift. Ordered NJ ex order 26.4b1 Day - NJ ex order 26.4b1 Night - NJ ex order 26.4b1	F 658	Facility will be in compliance by November 25, 2022.	

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F 658	Continued From page 3 NJ ex order 26.4b1 (right/left/bilateral at all times every shift. Ordered NJ ex order 26.4b1. Day - NJ ex order 26.4b1 Night - NJ ex order 26.4b1 Low bed in lowest position at all times, except during care. Check for bed position every shift. Ordered NJ ex order 26.4b1 Night - NJ ex order 26.4b1 During an interview with the surveyor on 10/14/22 at 1:15 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that the nurse was to administer a medication or treatment and then signed that the medication or treatment was administered in the MAR, and TAR. The LPN/UM added that if the medication or treatment was not signed, it was not given. During an interview with the surveyor on 10/17/22 at 1:50 PM, the Director of Nursing (DON) stated if the MAR or TAR had blanks (no initials indicating the medication or treatment was administered), that meant the medication or treatment was not administered or the nurse forgot to sign the medication or treatment. The DON further stated that she expected the nurse to sign the MAR and TAR once an order was administered, or the nurse would write a note in the progress notes about why the medication or treatment was not administered. A review of Resident #61's progress notes for NJ ex order 26.4b1 did not reveal any documentation of the medications or treatments not being administered on the above dates. A review of the facility's policy titled "Medication	F 658		

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F 658	Continued From page 4 Administration," reviewed 01/2022, revealed the individual administering the medication will record in the resident's medical record the signature and title of the person administering the drug. A review of the facility's policy titled "Medication Administration Guidelines-Treatments," reviewed in October 2017, reflected that the nurse will document the treatment was done by initialing on the EMAR (Electronic Medical Administration Record). NJAC 8:39-29.2(d)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow an active physician's orders to apply NJ Ex.Order 26.4(b)(1). This deficient practice was identified for Resident #61, 1 of 2 residents	F 686	F686 Element one Nursing staff failed to follow an active physician's order to apply NJ ex order 26.4b1 NJ ex order for Resident #61.	11/25/22

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F 686

Continued From page 5

reviewed for position and mobility, and was evidenced by the following:

During the initial tour on 10/05/22 at 11:49 AM, the surveyor observed Resident #61 lying in bed, awake and alert. The surveyor observed two light NJ Ex.Order 26.4(b)(1) lying directly on the bedside nightstand.

On 10/06/22 at 12:03 PM, the surveyor observed Resident#61 lying in bed with bed covers over his/her feet, unable to observe heels. The surveyor observed two NJ Ex.Order 26.4(b)(1) lying directly on the bedside nightstand.

On 10/07/22 at 12:55 PM, the surveyor observed Resident #61 lying in bed with the bed covers over his/her feet. The surveyor observed two light NJ Ex.Order 26.4(b)(1) lying directly on the bedside nightstand. The surveyor interviewed Resident #61, who stated they did not have anything on their feet. Resident #61 said they had not been wearing the NJ Ex.Order 26.4(b)(1) and added, "I want it."

According to the Admission Record, Resident #61 was admitted with a medical diagnosis that included but was not limited to NJ ex order 26.4b1

A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the Resident #61 NJ ex order 26.4b1 , NJ ex order 26.4b1 . The MDS

F 686

Nursing staff were immediately reeducated on placing heel booties on residents and if refused to document refusal and inform Medical Director for further actions if needed.

Element Two
All residents have the potential to be affected by this deficient practice.
All residents where reviewed who had orders for heel booties no other resident was noted to be affected by this practice.

Element three
Nurses were reeducated on following orders to place heel booties for residents with orders to prevent skin breakdown. Consistent pattern of refusal should be referred to physician for any changes in orders. Care plan will be reviewed and updated as needed.
Nurses were re-educated on placing heel booties on residents and if refused to document refusal and inform Medical Director for further actions if needed.

Element Four
Audits will be performed for all residents with orders for heel boots to be in place as per order. Audits will be performed twice daily x1 week, then daily x3 weeks then monthly x 3 months by Assistant Director of Nursing/designee
Results will be reported in Quality Assurance (QA) monthly for 3 months to ensure deficient practice will not reoccur and appropriate action will be taken based on the findings.
Director of Nursing will be responsible for

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F 686	Continued From page 6 reflected that the resident did not have a NJ Ex.Order 26.4(b) at the time of the MDS assessment. According to the NJ ex order 26.4b1 Braden Scale, an assessment tool used to predict the risk for pressure sore development, the facility identified Resident #61 as a NJ ex ord and NJ ex order 26.4b1 A review of Resident #61's NJ ex order 26.4b1 Physician Order Sheet (POS) reflected an NJ ex order 26.4b1 physician's order for NJ ex order 26.4b1 (right/left/bilateral) every shift. A review of the NJ ex order 26.4b1 Treatment Administration Record (TAR) revealed the corresponding NJ ex order 26.4b1 physician's order for NJ ex orde (right/left/bilateral) at all times. The NJ ex order 26.4b1 further revealed that the nurses had initialed that the NJ Ex.Order 26.4(b)(1) were applied as ordered for the day shift on NJ ex order 26.4b1 and NJ ex order 26.4b1. The NJ ex order 26.4b1 TAR did not show documentation that the NJ Ex.Order 26.4(b)(1) were applied on the NJ ex order 26.4b1 day shift. During an interview with the surveyor on 10/11/22 at 11:52 AM, the Certified Nurse Assistant (CNA) assigned to Resident #61 stated that the resident was NJ ex order 26.4b1 but had refused them today. The CNA said she would inform the nurse if the resident refused the NJ Ex.Order 26.4(b)(1) but had not informed the nurse yet. The CNA added that the nursing assistants usually applied the NJ Ex.Order 26.4(b)(1). The CNA further stated that it was important for the resident to wear NJ Ex.Order 26.4(b)(1) to prevent skin breakdown. During an interview with the surveyor on 10/11/22 at 12:07 PM, the Licensed Practical Nurse (LPN	F 686	maintaining findings Facility will be in compliance by November 25, 2022.	

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F 686	Continued From page 7 #1) stated that he had been Resident #61's nurse for the last two days on the day shifts. LPN #1 indicated that Resident # 61 NJ ex order 26.4b1 and had not gotten out of bed in the last two days. LPN#1 further stated that he was unaware of any devices or splint interventions in place to prevent skin breakdown for Resident # 61. LPN#1 added that if a resident refused treatment, he would document the refusal in the TAR and inform the doctor and the family. LPN #1 further stated that Resident #61 had not declined any medications or interventions while under his care for the last two days. During an interview with the surveyor on 10/13/22 at 10:05 AM, the LPN Unit Manager (LPN/UM) stated that the CNA or nurse would apply the NJ Ex.Ord as ordered. If a resident refused a treatment, the nurse would document the refusal on the TAR and write a progress note. If the resident continued to refuse treatment, then the nurses would inform the doctor and family. The LPN/UM further stated that Resident # 61 had a tendency to refuse the NJ ex order 26.4b1 as ordered. A review of Resident #61's October TAR, in the presence of the LPN/UM, confirmed that the nurse had documented on the TAR on the day shift for 1 NJ ex order 26. and 1 NJ ex order 26. indicating the NJ ex ord During an interview with the surveyor on 10/14/22 at 9:48 AM, the Director of Nursing (DON) stated that the NJ Ex.Order 26.4(b)(1) could be applied by either the CNA or the nurse, but it was the nurse who would document in the TAR that the NJ Ex.Order 26.4(b)(1) were applied. The DON further stated that if a resident refused a treatment, the nurse would document the refusal in the TAR, notify the doctor and write a progress note. The DON stated that it was	F 686		

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F 686	Continued From page 8 important to apply the NJ Ex.Order 26.4(b)(1) as ordered to prevent skin breakdown. A review of Resident #61's progress notes for NJ ex order 26.4b1 did not reveal any documentation that the resident had NJ ex order 26.4b1 as ordered until after the surveyor inquiry on NJ ex order 26.4b1 A review of Resident #61's Care Plan did not reveal that the resident NJ ex order 26.4b1 until after the surveyor's inquiry on NJ ex order 26.4b1 . A review of the facility's policy titled "Risk Assessment and Prevention- Wound," reviewed 4/2022, indicated that interventions to manage pressure included but were not limited to: off-load heel pressure. The policy did not specify the interventions of heel boots. A review of the facility's policy titled "Medication Administration Guidelines-Treatments," reviewed in October 2017, reflected that the nurse would document that the treatment was done by initialing on the EMAR (Electronic Medical Administration Record). NJAC 8:39-27.1(a)	F 686		
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	F 755		11/25/22

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F 755	Continued From page 9 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 by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to properly dispose medications for 1 of 5 residents (Resident #29) during medication administration. This deficient practice was identified for 1 of 3 nurses observed during medication administration on 1 of 2 units (Nelson 6) and was evidenced by the following: On 10/11/22 at 8:59 AM, the surveyor observed	F 755	F755 Element one The nurse failed to properly dispose of medications that were crushed and placed in applesauce by a nurse after being offered and refused by Resident #29. Nurse discarded medication in trash bin. Nurses were immediately re-educated to place refused medications in Drug Buster for proper disposal of medication immediately. Medications that were crushed and placed in applesauce and	

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F 755	Continued From page 10 Licensed Practical Nurse #1 (LPN #1) during the medication administration for Resident #29. LPN #1 dispensed the following medications for Resident # 29 as ordered: 1 NJ ex order 26.4b1 2. NJ ex order 26.4b1 3. NJ ex order 26.4b1 The surveyor observed LPN #1 attempt to administer the above medications that were crushed in applesauce to Resident #29 three times and Resident #29 refused all the medications three times. LPN #1 stated that he would discard the medications and try again later. The surveyor observed LPN #1 discard the dispensed crushed medications into the trashcan located on the medication cart. At that time, the surveyor interviewed LPN #1 who stated, "if the medications were not crushed, I would use a [medication disposal system] but since the medications were crushed in applesauce, I can just throw them out in the trash." During an interview with the surveyor on 10/13/22 at 10:48 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that nurses should discard refused medications in the [medication disposal system] and that medications were not to be discarded in the trash. During an interview with the surveyor on 10/14/22 at 09:48 AM, the Director of Nursing(DON), in the	F 755	discarded in trash bin were removed by management and placed into Drug Buster for proper disposal. Element two All residents have the potential to be affected by this deficient practice. No other nurses were noted at that time to have wasted medication that was refused inappropriately. Element three Nurses will be re-educated to place refused medications in Drug Buster for proper disposal of medication, including those already crushed and mixed with applesauce or other food items. Element Four Medication Destruction Competency to be completed by Director of Nurses /Designee weekly x4 then monthly x 3 months with 5 nurses. Failure to use the Drug Buster will result in re-education and repeat competency and appropriate disciplinary action. Results to be reported in monthly Quality Assurance (QA) for 3 months to ensure deficient practice will not occur and action will be taken as appropriate based on the findings. Director of Nursing responsible for maintaining findings Facility will be in compliance by November 25, 2022.	

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F 755	Continued From page 11 presence of the survey team, stated that if a resident refused medications, the dispensed medications were to be discarded in the [medication disposal system] located in the medication storage room. The DON further stated that it was important to dispose medications correctly because the medications could get into the waste and soil and contaminate everyone. Review of the facility's policy titled "Medication Administration," reviewed 1/2022, revealed that if medication was dispensed and the resident refuses, medications would be destroyed using the [medication disposal system]. NJAC 8:39-29.4(i)	F 755		

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	060409	A. BUILDING: ___ B. WING ___	10/18/2022

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 interviews, and review of pertinent facility documentation, it was determined that the facility failed to train the two (2) appointed designated staff members and the facility staff within the required time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program. This deficient practice was evidenced by the following: Findings include: Reference: New Jersey Department of Health	S 560	Element One Three designees of staff will be trained by LGBT Senior Housing and Care. At least one of these representatives will be line staff. This training for the designees is in compliance with NJ S2545 and meets those requirements for designee training. In addition a one-hour training has been secured for all staff and will be completed by 11-25-2022. This training is also provided by the LGBT Senior Housing and Care and meets the requirements for all staff training for NJ S 2545. Element Two All Residents have the potential to be affected by this practice.	11/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/02/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: ____ B. WING ____	10/18/2022

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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S 560	Continued From page 1 (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room;	S 560	Element Three The Education Director, Director of Nursing and Administrator have been in-serviced on meeting the requirements of NJ S 2545. LGBT training has been integrated into the orientation program and provided annually as required by NJ S 2545. Element Four The Education Director will audit all new hires to ensure the one hour training is complete as part of orientation. This audit will be completed for three months. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: ___ B. WING ___	10/18/2022

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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S 560	Continued From page 2	S 560		

3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5);

4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity;

5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice;

6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices;

7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations;

8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and

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	060409	A. BUILDING: ______ B. WING ______	10/18/2022

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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S 560	Continued From page 3 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: ______ B. WING ______	10/18/2022

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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S 560	Continued From page 4	S 560		

consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility.

Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling.

Violations
A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action.

Training
Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey.

The required training shall address:
1. Caring for LGBTQI+ seniors and seniors living with HIV;

2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status;

3. The definition of terms commonly associated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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**

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S 560	Continued From page 5 with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. During an interview with the surveyor on 10/14/22 at 8:55 AM, the Administrator stated the facility designated two (2) staff members and that their training was "in progress," meaning they were registered to take the class. The Administrator added that the two (2) designated staff members should have been trained by 09/30/22. The surveyor inquired about the process to train the other staff members. The Administrator stated that once the two [staff members] got trained, they would then train the rest of the staff, "train	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 6 the trainer." The surveyor inquired if the Administrator was familiar with the LGBTQI+ Law and the Administrator stated that she was familiar with the law and that "it just got by us." During a follow up interview with the surveyor on 10/14/22 at 9:35 AM, the Administrator provided a confirmation for the "LGBTQ+/HIV+ Training for Department Directors, Legal, Designates" with a handwritten date of 10/13/22. The surveyor inquired about the 10/13/22 date and the Administrator confirmed that the training was ordered yesterday. NJAC 8:39-5.1(a)	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315183	A. Building B. Wing	1/13/2023

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 11/25/2022	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 11/25/2022	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 11/25/2022
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
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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	
10/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060409		1/13/2023

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 11/25/2022	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
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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	
10/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING ______	**10/18/2022**

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 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
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 10/17/22 and 10/18/22 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 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of facility management, it was determined that the facility failed to provide horizontal exits with two hour fire-rated construction to resist the passage of smoke, flame, or gases during a fire in accordance with NFPA 101, 2012 Edition, Section 19.2.2.5, 7.2.4,	K 226	K226 Element One The 2-1/2 inch penetration with one (1) BX electrical cable and two (2) black wires running through the two hour fire-rated located above the doors leading to Nelson 5 from the Solarium room were repaired	11/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/03/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING ______	**10/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 226	Continued From page 1 7.2.4.3, 7.2.4.3.1, 7.2.4.3.6, 8.3, 8.3.3, 8.3.3.1, 8.3.4, 8.3.4.1, 8.3.4. The deficient practice was evidenced by the following: On 10/17/22, during the survey entrance at 8:34 AM, a request was made to the facility's Administrator and Director of Facilities (DOF) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility-provided layout identified two buildings (Nelson 5 and Nelson 6) connected by a horizontal exit called the Solarium room. A tour of both buildings was conducted at approximately 8:43 AM in the presence of the facility's Vice President of Buildings and Grounds (VPBG) and the DOF. Along the tour at 10:58 AM, the surveyor observed in Nelson 5 building, above the ceiling tile, a 2-1/2 inch penetration with one (1) BX electrical cable and two (2) black wires running through the two hour fire-rated wall leading into the horizontal exit. This would allow fire, smoke, and poisonous gases to pass into the horizontal exit in the event of a fire. The facility VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NJAC 8:39 -31.1 (c).	K 226	us 3M UL approved WL-2002 penetration stop system. All fire rated doors were checked to be sure there were no other penetrations requiring repair and none were found. Element Two All Residents have the potential to be affected by this practice. Element Three The maintenance department staff were in-serviced on the importance of not having penetrations in a 2-hour fire rated wall and checking after any repairs are made in house or by contractors. Contractors are notified of the need to properly seal all penetrations in smoke barrier locations whenever doing work in the facility. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to monitor all smoke barrier doors to ensure compliance with sealing of penetrations. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	
K 281 SS=E	Illumination of Means of Egress	K 281		11/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING 01 B. WING ______	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 281	Continued From page 2 CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/17/22, in the presence of the facility management, it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 2 of 6 exit access areas observed and was evidenced by the following: During the building tour with the facility Vice President of Buildings and Grounds (VPBG) and Director of Facilities (DOF), the surveyor observed the following areas that failed to provide emergency illumination. 1. At approximately 9:36 AM, the facility's main lobby was observed to have two (2) electrical wall switches. The surveyor noted that the about 20' x 20' room had no lighting when the two switches were shut off. 2. At approximately 10:40 AM, the facility Solarium was observed to have two (2) electrical wall switches. The surveyor noted that the about 20' x 35' room had no lighting when the two switches were shut off.	K 281	K281 Element One The facility's main lobby is being provided with automatic emergency illumination along the route of egress. The facility Solarium is being provided with automatic emergency illumination along the route of egress. All areas used in the event of the need for emergency egress were checked for the presence of emergency illumination. Element Two All Residents have the potential to be affected by this practice. Element Three The maintenance department was re-educated about the importance of having automatic emergency illumination in all areas used for emergency egress. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to monitor all areas	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING ______	**10/18/2022**

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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K 281	Continued From page 3 The facility VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	used for emergency egress to ensure there is emergency illumination as required for safe egress. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		11/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING 01 B. WING	10/18/2022

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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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/18/22, in the presence of facility management, it was determined that the facility failed to provide a separation (grease splash guard) between a deep-fat fryer and an open flame cooking stove to protect against the extension of fire, in accordance with NFPA 96. This deficient practice was evidenced by the following: On 10/18/22, a tour of the building was performed in the presence of the facility's Vice President of Buildings and Grounds (VPBG) and Director of Facilities (DOF). At approximately 10:06 AM, an inspection inside the main kitchen was performed. The surveyor observed that a deep-fat fryer was located approximately nine (9) inches next to a stove with an open flame. There was no evidence of a splash guard in between the two appliances. There was evidence of grease spots, residue, and greasy food remnants on the sides and open shelf directly beneath the open flames for the cooking and heating equipment. The facility VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NJAC 8:39-31.2(e) 19.3.2.5.3*(5)(a)	K 324	K324 Element One A splash guard is being added to the deep-fat fryer in between the two appliances. Element Two All Residents have the potential to be affected by this practice. Element Three Maintenance and Dietary staff received re-education about having a splash guard in place in between two appliances with open flames to prevent fires. Element Four The Maintenance Director and Dietary Director will check will conduct walking rounds monthly for the next three months to monitor the use of a splash guard in between appliances with an open flame. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	

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	315183	A. BUILDING **01** B. WING ______	**10/18/2022**

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K 324	Continued From page 5 NFPA 96	K 324		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/17/22, in the presence of facility management, it was determined that the facility failed to install supervised smoke detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. The deficient practice was evidenced by the following: On 10/17/22, during the survey entrance at 8:34 AM, a request was made to the facility's Administrator and Director of Facilities (DOF) to	K 341	K341 Element One On the Nelson 6 building's resident activity/sitting area, between resident rooms #630 and #615 (skylight) a supervised smoke detector is being installed as required. On Nelson 5 building's resident activity/sitting area, between resident rooms #510 and #526 (skylight) a supervised smoke detector is being installed as required.	11/25/22

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K 341	Continued From page 6 provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility-provided layout identified two buildings (Nelson 5 and Nelson 6) connected by a Solarium room. A tour of both buildings was conducted at approximately 8:43 AM in the presence of the facility's Vice President of Buildings and Grounds (VPBG) and DOF. Along the tour, the surveyor observed that the facility failed to provide supervised smoke detection in the following locations: 1. At 9:41 AM, an inspection in the Nelson 6 building's resident activity/sitting area, between resident rooms #630 and #615, was performed. The surveyor observed no evidence of a supervised smoke detection up inside the four (4) feet by four (4) feet by four (4) feet high raised high ceiling (skylight) area. 2. At 11:01 AM, an inspection in the Nelson 5 building's resident activity/sitting area, between resident rooms #510 and #526, was performed. The surveyor observed no evidence of a supervised smoke detection up inside the eight (8) feet by ten (10) feet by four (4) feet high raised high ceiling (skylight) area. The facility VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22.	K 341	Facility wide rounds were made to assure all locations requiring supervised smoke detectors are in place and functioning. Element Two All Residents have the potential to be affected by this practice. Element Three Maintenance staff received re-education about the requirements for the location of smoke detectors per regulations and regular inspection and monitoring of function. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to monitor supervised smoke detectors for compliance with regulations. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	

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K 341	Continued From page 7 NJAC 8:39-31.1(c), 31.2(e) NFPA 72.	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation on 10/17/22, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The deficient practice was evidenced by the following: On 10/17/22, during the survey entrance at 8:34 AM, a request was made to the facility's	K 351	K351 Element One Supervised sprinkler protection is being installed on the Nelson 6 building's administrative area corridor adjacent to the main lobby. Proper supervised sprinkler protection is being installed on the Nelson 6 building's resident activity/sitting area between resident rooms #630 and #615 by the raised ceiling (skylight) area.	11/25/22

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K 351	Continued From page 8 Administrator and Director of Facilities (DOF) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility-provided layout identified two buildings (Nelson 5 and Nelson 6) connected by a Solarium room. A tour of both buildings was conducted at approximately 8:43 AM in the presence of the facility's Vice President of Buildings and Grounds (VPBG) and DOF. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1. At 9:31 AM, an inspection of the Nelson 6 building's administrative area corridor (three offices and the Administrator's office) adjacent to the main lobby was performed. The surveyor observed no evidence of fire sprinkler protection in the 17 feet six (6) inch long by five (5) feet wide corridor. The surveyor asked the DOF, do you see a fire sprinkler in the corridor? The DOF said, "No." A review of the facility-provided layout identified only two (2) offices and a large open lobby/waiting area. The facility had four (4) offices in the area. 2. At 9:41 AM, an inspection was performed in the Nelson 6 building's resident activity/sitting area between resident rooms #630 and #615. The surveyor observed no evidence of fire sprinkler protection up inside the four (4) feet by four (4) feet by four (4) feet high raised ceiling (skylight) area. 3. At 11:01 AM, an inspection in the Nelson 5 building's resident activity/sitting area, between resident rooms #510 and #526, was performed.	K 351	Proper Supervised sprinkler protection is being installed on the Nelson 6 building's resident activity/sitting area between resident rooms #510 and #526 and in the raised ceiling (skylight) area. Element Two All Residents have the potential to be affected by this practice. Element Three Maintenance received re-education about checking all areas to assure there is proper sprinkler coverage per regulations and monitoring to assure proper functioning. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to monitor the ceiling areas to assure compliance with sprinkler heads per regulations. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	

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K 351	Continued From page 9 The surveyor observed no evidence of fire sprinkler protection up inside the eight (8) feet by ten (10) feet by four (4) feet high raised ceiling (skylight) area. The facility VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ____________________ b) Who provided system test ___________________________ c) Water system supply source _________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		11/25/22

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K 353	Continued From page 10 by: Based on observation and interview on 10/17/22, in the presence of facility management, it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was smoke-resistant and fire-rated for 4 of 12 storage/utility rooms in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. This deficient practice was evidenced by the following: On 10/17/22, during the survey entrance at 8:34 AM, a request was made to the facility's Administrator and Director of Facilities (DOF) to provide a copy of the facility layout which identified the various rooms and smoke compartments in the facility. A review of the facility-provided layout identified two buildings (Nelson 5 and Nelson 6) connected by a Solarium room. Later during the building tour with the facility Vice President of Buildings and Grounds (VPBG) and DOF, the surveyor observed the following: 1) At 10:17 AM, the Nelson 6 building's trash room had two (2), two(2) feet by two (2) feet plastic open grills around the room's fire sprinkler head. This would allow for the passage of heat and smoke into the space above, which would delay the activation of the fire sprinkler system. 2) At 10:32 AM, the Nelson 6 building's storage room (near the lounge) had one (1), two (2) feet by two (2) feet plastic open grill around the room's	K 353	K353 Element One On the Nelson 6 building's trash room (near the lounge) the plastic open grills around the room's fire sprinkler head are being removed and solid ceiling tile installed so not to allow the passage of heat and smoke into the space above. On the Nelson 5 building's trash room the plastic open grills around the room's fire sprinkler head are being removed and solid ceiling tile installed so not to allow the passage of heat and smoke into the space above. Element Three Maintenance staff were re-educated to assure the facility smoke detectors were maintained without any openings to prevent smoke to ensure the ceiling was smoke resistant and met the fire rating requirements and to prevent any delay in the activation of fire suppression system. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to monitor the ceiling areas around sprinkler heads for compliance with regulations. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	

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K 353	Continued From page 11 fire sprinkler head. This would allow for the passage of heat and smoke into the space above, which would delay the activation of the fire sprinkler system. 3) At 11:46 AM, the Nelson 5 building's trash room had one (1), two (2) feet by two (2) feet plastic open grill around the room's fire sprinkler head. This would allow for the passage of heat and smoke into the space above, which would delay the activation of the fire sprinkler system. 4) At 11:50 AM, the Nelson 5 building's housekeeping room had two (2), two (2) feet by two (2) feet plastic open grills around the room's fire sprinkler head. This would allow for the passage of heat and smoke into the space above, which would delay the activation of the fire sprinkler system. The VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355		11/25/22

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K 355	Continued From page 12 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain 1 of 14 portable fire extinguishers in proper condition in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1, and NFPA 10, 2010 Edition. The deficient practice was evidenced by the following: During the building tour on 10/18/22, with the facility Vice President of Buildings and Grounds (VPBG) and Director of Facilities (DOF) at approximately 10:06 AM, an inspection inside the Main Kitchen was performed. The surveyor observed that the Class "K-Type" portable fire extinguisher had evidence of cylinder damage. The facility VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NFPA 10 NJAC 8:39 -31.1 (c), -31.2 (e).	K 355	K355 Element One The damaged Class "K-Type" portable fire extinguisher was replaced in the main kitchen. Element Two All residents have the potential to be affected by this practice. Element Three Maintenance staff were re-educated to assure during monthly fire extinguisher inspections all extinguishers are also checked for damage and replaced immediately if damage is noticed including the fire extinguishers in the main kitchen. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to monitor fire extinguishers, including those in the main kitchen, for and damage and for full compliance with regulations. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K 363		11/25/22

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K 363	Continued From page 13 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/17/22,	K 363	K363	

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PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38** **CHERRY HILL, NJ 08002**

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K 363	Continued From page 14 in the presence of facility management, it was determined that the facility failed to ensure that 1 of 18 corridor doors was able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The deficient practice was evidenced by the following: During the building tour with the Vice President of Building and Grounds (VPBG) and the Director of Facilities (DOF) at 11:37 AM, an inspection inside the Nelson 5 building's medical records room was performed. The surveyor observed that the door knob hardware had been removed, and a hasp with a lock had been installed. The door did not close and latch into its frame, leaving a one-quarter (1/4) inch gap along the door and frame. In the event of a fire, this would allow fire, smoke, and poisonous gases to pass into the exit access corridor. The VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	Element One The Nelson 5 building's medical records room doorknob hardware was replaced and the hasp with a lock had been removed. The door was repaired to fit and properly close and latch into its frame. Element Two All residents have the potential to be affected by this practice. Element Three Maintenance staff were re-educated to assure the facility doors are properly maintained and the importance of all doors closing and latching into the frame as required. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to monitor the doors to assure they close and latch correctly not their frame and the doorknob hardware is in good condition. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate,	K 912		11/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING 01 B. WING ______	10/18/2022

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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K 912	Continued From page 15 highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/17/2021, in the presence of facility management, it was determined that the facility failed to ensure that 4 of 10 electrical outlets located within wet locations (next to a water source) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: During the building tour, in the presence of the facility's Vice President of Buildings and Grounds (VPBG) and the Director of Facilities (DOF), an inspection of the Nelson 5 and Nelson 6 buildings, which included nine (9) resident bathrooms and common areas, was performed. The surveyor observed duplex electrical outlets in wet locations inside each bathroom and common area. At the time of the observations, the surveyor asked the DOF, are the duplex outlets connected to GFCI outlets or a GFCI breaker. The DOF said, "Yes." When the surveyor used a GFCI tester to de-energize the outlets, four (4) outlets did not de-energize, as required by code in the following	K 912	K912 Element One The Ground-Fault Circuit Interrupter (GFCI) protection outlets are being placed in the following areas: " Resident room #632's bathroom. " Resident room #612's bathroom. " Inside Nelson 5's dining/serving area under the steam table. " Resident room #519's bathroom. Element Two All residents have the potential to be affected by this practice. Element Three The maintenance department was re-educated about the importance of having areas within 4 feet of a water source with working Ground-Fault Circuit Interrupter (GFCI) protection. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to ensure all areas within 4 feet of a water source have working Ground-Fault Circuit Interrupter	

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	315183	A. BUILDING **01** B. WING	**10/18/2022**

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PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38** **CHERRY HILL, NJ 08002**

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K 912	Continued From page 16 locations, 1) At 9:38 AM, inside resident room #632's bathroom. 2) At 10:10 AM, inside resident room #612's bathroom. 3) At 11:26 AM, inside Nelson 5's dining/serving area under the steam table. 4) At 11:33 AM, inside resident room #519's bathroom. The facility VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NJAC 8:39 -31.2 (e) NFPA 99	K 912	(GFCI) protection. Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends, and compliance. QA committee will determine need for continuance of audits.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		11/25/22

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	315183	A. BUILDING 01 B. WING ______	10/18/2022

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PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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K 918	Continued From page 17 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/17/22 and 10/18/22, in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: On 10/17/22, during the survey entrance at 08:34 AM, a request was made to the Director of Facilities (DOF) if the facility had an emergency	K 918	K918 Element One An emergency shut off button is being installed distant to the generator as required. Element Two All residents have the potential to be affected by this practice. Element Three Maintenance staff were re-educated about the placement and location of an	

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	315183	A. BUILDING 01 B. WING	10/18/2022

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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K 918	Continued From page 18 generator. The DOF replied, "Yes, we have one." During the building tour on 10/18/22 with the facility Vice President of Buildings and Grounds (VPBG) and DOF at approximately 9:45 AM, an inspection outside, where the diesel emergency generator is located, was performed. At that time, the surveyor asked the VPBG where is the remote emergency shut-off for the generator. The VPBG told the surveyor, "There is no remote emergency shut off." The surveyor observed that the emergency shut-off was located on the generator's control panel. The VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	emergency shut off button for the generator distant to the generator. Element Four The Maintenance Director/designee will conduct walking rounds monthly for the next three months to ensure the emergency shutoff generator button is in place and working when tested. Results will be provided monthly to the Administrator and quarterly to the QA committee determine trends and compliance. QA committee will determine need for continuance of audits.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing	K 923		11/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING ______	**10/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 19 gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/17/22, in the presence of facility management, it was determined that the facility failed to segregate empty and full oxygen cylinders in a manner to avoid confusion in accordance with NFPA 99. This deficient practice was identified for 14 of 31 full E-Type portable oxygen cylinders and was evidenced by the following: On 10/17/22 at approximately 11:30 AM, during the building tour with the facility's Vice President	K 923	K923 Element One The E-Type oxygen cylinders were stored in the area labeled "Empty" were empty only E-Type oxygen cylinders. The E-Type oxygen cylinder in a rolling cart was removed to avoid confusion. The vendor was contacted to schedule removal of empty tanks more frequently.	

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	315183	A. BUILDING **01** B. WING ____	**10/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 20 of Buildings and Grounds (VPBG) and Director of Facilities (DOF), an inspection inside the Nelson 5 building's oxygen storage room was performed. The surveyor observed thirty-one (31) E-Type oxygen cylinders were stored inside the room. The surveyor also observed that fourteen (14) E-Type oxygen cylinders were stored in the area labeled "Empty" cylinder side of the storage area. The surveyor observed on the pressure indicating needles of the 14 cylinders that they were "full." The surveyor also observed one (1) E-Type oxygen cylinder in a rolling cart. Further inspection identified that the oxygen tank in the cart read "empty" on the pressure-indicating needle. This cylinder was not marked to avoid confusion. The VPBG and DOF confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 10/18/22. NJAC 8:39-31.2(e) NFPA 99	K 923	Element Two All residents have the potential to be affected by this practice. Element Three The nursing staff were re-educated about the importance of properly separating full E-type oxygen cylinders from empty cylinders. Re-education also addressed having no E-type rolling carts stored in the oxygen storage room with an E-type tank in it. The oxygen storage rack was properly marked designating full and empty locations. Element Four Radom weekly audits will be performed by Maintenance Director/designee for one month then monthly for two months to ensure no full E-type oxygen tanks are located on the empty side of the storage room and no E-type rolling carts are stored in the room with an E-type tank in it. Results of the audits will be reviewed/reported to QA committee to determine trends, compliance. QA committee will determine need for continuance of audits.Results will be provided monthly to the Administrator and quarterly to the QA committee to determine trends.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315183	A. Building 01 - MAIN BUILDING 01 B. Wing	1/13/2023

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 K0226	Correction Completed 11/25/2022	ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 11/25/2022	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 11/25/2022
ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 11/25/2022	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 11/25/2022	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 11/25/2022
ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 11/25/2022	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 11/25/2022	ID Prefix Reg. # NFPA 101 LSC K0912	Correction Completed 11/25/2022
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 11/25/2022	ID Prefix Reg. # NFPA 101 LSC K0923	Correction Completed 11/25/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
10/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO