STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A005	A. BUILDING: _____ B. WING _____	C 05/31/2019

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
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00117990, NJ00112784, NJ00100050, NJ00100051 CENSUS: 65 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.	A 935		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/12/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 935	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint#: NJ00100050, NJ00100051 Based on observation, interview and record review, it was determined that the facility failed to ensure that medications were administered in accordance with prescriber orders for 2 of 4 residents reviewed, Resident #1 and Resident #2. This deficient practice was evidenced by the following: On 5/31/2019 the surveyor reviewed the medical records of Resident #1 and Resident #2 and observed the following: 1. Resident #1 moved into the facility in February 2017 with diagnoses which included high blood pressure and neuropathy. The surveyor observed a Physician's Order dated 3/3/2017, which documented to discontinue Lisinopril from the list of allergies. Surveyor review of the Medication Administration Record (MAR) revealed that on 3/3/2017, Lisinopril 10 milligrams one tablet by mouth daily for high blood pressure was discontinued. The surveyor observed the MAR for April 2017 and observed that Resident #1 did not receive the Lisinopril as prescribed. The surveyor reviewed the MAR for May 2017 and observed that Lisinopril had been resumed on 5/4/2017. The surveyor interviewed the Director of Nursing on 5/31/2019 at 12:15 p.m., who stated that the Licensed Practical Nurse discontinued Resident #1's, Lisinopril instead of removing the Lisinopril from the list of allergies. The DON also stated that it was the Consultant Pharmacist that caught the error during a quarterly review in May 2017.	A 935		

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A 935	Continued From page 2 The DON further stated that the Lisinopril was resumed on 5/4/2017. 2. Resident #2 moved into the facility in June 2013 with diagnoses which included high blood pressure and glaucoma. The surveyor observed a Physician Order Sheet dated April 2017 and signed by the Medical Doctor (MD) on 4/7/2017, for the following medications: Combigan solution 0.2/0.5%, one drop to be instilled in the left eye twice daily and Lotemax 0.5% ophthalmic gel; one drop left eye twice daily. The surveyor observed the MAR for May 2017, which documented that Resident #2 received the Combigan eye drops once per day at 9:00 a.m., on May 1, 2 and 3, 2017 and Lotemax eye drop once per day at 5:00 p.m., on May 1 and 2, 2017 not as prescribed. The DON stated that Resident #2 received the eye drops, however, the LPN did not sign the MAR after the eye drops were administered. The DON stated that during monthly recaps, the Nurse failed to transcribe the correct times for the eye drop to be administered. The DON confirmed that the MAR documented that the eye drops were signed out once per day and were not signed out twice per day, according to the prescriber orders. The facility failed to ensure that Resident #1 and Resident #2 received medications in accordance with prescriber orders and failed to ensure that medications were always transcribed onto the MARs accurately to alert staff to administer all medications per the prescriber orders.	A 935		