

New Jersey Department of Health

|   |  |   |  |  |
|---|--|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15A005</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/09/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PREMIER CADBURY OF CHERRY HILL</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2150 ROUTE 38<br/>CHERRY HILL, NJ 08002</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000   | <p>Initial Comments</p> <p>Initial Comments:<br/>Type of Survey: Expansion/Conversion<br/>The facility is requesting eight (8) additional<br/>licensed beds for a total of 96 licensed beds.</p> <p>Capacity: 88 Assisted Living Beds</p> <p>Census: 80</p> <p>The facility is not in substantial compliance with<br/>all of the standards in the New Jersey<br/>Administrative Code 8:36, Standards for<br/>Licensure of Assisted Living Residences,<br/>Comprehensive Personal Care Homes and<br/>Assisted Living Programs. The facility must<br/>submit a Plan of Correction, including a<br/>completion date for each deficiency and ensure<br/>that the plan is implemented. Failure to correct<br/>deficiencies may result in enforcement action in<br/>accordance with provisions of New Jersey<br/>Administrative Code Title 8, Chapter 43E,<br/>Enforcement of Licensure Regulations.</p> | A 000   |  |  |
| A1169   | <p>8:36-16.15(a) Physical Plant</p> <p>(a) Fire extinguishers shall comply with National<br/>Fire Protection Association (NFPA) 10, Standards<br/>For Portable Fire Extinguishers, 2002 edition,<br/>incorporated herein by reference, as amended<br/>and supplemented. National Fire Protection<br/>Association publications are available from:<br/>NFPA, One Batterymarch Park, Quincy, MA,<br/>02269-9101.</p> <p>This REQUIREMENT is not met as evidenced<br/>by:<br/>Based on observations on 08/09/2024 in the</p>  | A1169   |  |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

New Jersey Department of Health

|   |  |   |  |  |
|---|--|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15A005</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/09/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PREMIER CADBURY OF CHERRY HILL</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2150 ROUTE 38<br/>CHERRY HILL, NJ 08002</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A1169   | <p>Continued From page 1</p> <p>presence of facility management, it was determined that the facility failed to:</p> <p>1) Perform a monthly examination for 5 of 5 portable fire extinguishers observed and inspected, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70.</p> <p>References:<br/>NFPA 10 Edition 2010 Standard for portable fire extinguishers reads,<br/>"...4- 3 Inspection Maintenance<br/>4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require ...<br/>4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.<br/>4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers ...<br/>7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification...."</p> <p>The findings include the following,</p> <p>On 08/09/2024, during the survey entrance at approximately 9:17 AM, a request was made to the Administrator and Director of Maintenance</p> | A1169   |  |  |

New Jersey Department of Health

|   |  |   |  |  |
|---|--|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15A005</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/09/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PREMIER CADBURY OF CHERRY HILL</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2150 ROUTE 38<br/>CHERRY HILL, NJ 08002</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A1169   | <p>Continued From page 2</p> <p>(DOM) to provide a copy of the facility lay-out which identifies the eight (8) Resident apartments and Common areas to be inspected for the Conversion survey.</p> <p>Starting at approximately 11:05 AM, in the presence of the DOM, during a tour of the building the surveyor observed five (5) portable fire extinguishers in various locations that were last annually inspected January 2024 with the following issues that were identified:</p> <p>1) At approximately 11:40 AM, one ABC type fire extinguisher on the basement level near stairwell #2 was last annually inspected in January 2024. There was no evidence of a monthly visual inspection being performed and documented on the tag attached to the extinguisher for May, June, and July 2024.</p> <p>2) At approximately 11:45 AM, one ABC type fire extinguisher on the first floor level near stairwell was last annually inspected in January 2024. There was no evidence of a monthly visual inspection being performed and documented on the tag attached to the extinguisher for May, June, and July 2024.</p> <p>3) At approximately 11:51 AM, one ABC type fire extinguisher on the first floor Residents Dining Serving area was last annually inspected in January 2024. There was no evidence of a monthly visual inspection being performed and documented on the tag attached to the extinguisher for May, June, and July 2024.</p> <p>4) At approximately 12:07 PM, one ABC type fire extinguisher in the Main lobby area was last annually inspected in January 2024. There was</p> | A1169   |  |  |

New Jersey Department of Health

|   |   |   |  |  |
|---|---|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15A005</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/09/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PREMIER CADBURY OF CHERRY HILL</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2150 ROUTE 38<br/>CHERRY HILL, NJ 08002</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A1169   | Continued From page 3<br><br>no evidence of a monthly visual inspection being performed and documented on the tag attached to the extinguisher for May, June, and July 2024.<br><br>5) At approximately 12:36 PM, one ABC type fire extinguisher in the Main lobby area next to the Marketing Office was last annually inspected in January 2024.<br>There was no evidence of a monthly visual inspection being performed and documented on the tag attached to the extinguisher for May, June, and July 2024.<br><br>The DOM confirmed the findings at the time of the observations.<br><br>The Administrator was informed of the deficiency during the survey exit on 08/09/2024, at approximately 1:20 PM.<br><br>Refer to:<br>NFPA 10<br>NJAC 8:39 -31.1 (c), 31.2 (e). | A1169   |  |  |
| A1243   | 8:36-17.6(b)<br>Housekeeping-Sanitation-Safety-Maintenance<br><br>(b) The temperature of the hot water used for bathing and handwashing shall be at least 105 degrees and shall not exceed 120 degrees Fahrenheit.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on   | A1243   |  |  |

New Jersey Department of Health

|   |  |   |  |  |
|---|--|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15A005</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/09/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PREMIER CADBURY OF CHERRY HILL</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2150 ROUTE 38<br/>CHERRY HILL, NJ 08002</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A1243   | <p>Continued From page 4</p> <p>08/09/2024 in the presence of the facility's Director of Maintenance (DOM), it was determined that the facility failed to ensure that the Domestic Hot Water (DHW), used by residents for bathing and hand washing was maintained between 105 degrees and 120 degrees Fahrenheit (degree F) for 2 of 8 Resident bathroom sinks.</p> <p>This deficient practice was evidenced by the following:</p> <p>During the entrance conference for the survey at approximately 9:17 AM, a request was made to the Administrator and the DOM to determine if the facility monitored the temperature of the DHW and if they are aware of the temperature range for the hot water. The DOM stated that the facility monitored the temperature and that the DHW runs between 105 degrees F and 120 degrees F. Prior to conducting a facility tour, the surveyor asked the DOM to bring a facility thermometer along to record DHW temperatures with the surveyor.</p> <p>Starting at approximately 11:05 AM, in the presence of the DOM, a tour of the eight (8) apartments that are to be inspected the surveyor observed and recorded the following DHW temperatures in the following locations:</p> <p>1. At approximately 11:17 AM, the surveyor observed and recorded inside Resident apartment [REDACTED] bathroom sink had the following reading:</p> <ul style="list-style-type: none"> <li>- Surveyor digital thermometer 123.3 degrees F.</li> <li>- DOM digital thermometer 124.1 degrees F.</li> </ul> <p>2. At approximately 11:35 AM, the surveyor observed and recorded inside Resident</p> | A1243   |  |  |

New Jersey Department of Health

|   |   |   |  |  |
|---|---|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15A005</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/09/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PREMIER CADBURY OF CHERRY HILL</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2150 ROUTE 38<br/>CHERRY HILL, NJ 08002</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A1243   | <p>Continued From page 5</p> <p>apartment <span style="background-color: black; color: white;">NJ ex order</span> bathroom sink had,</p> <ul style="list-style-type: none"> <li>- Surveyor digital thermometer 121.1 degrees F.</li> <li>- DOM digital thermometer 121 degrees F.</li> </ul> <p>The surveyor made a request to the DOM to lower the temperature of the DHW.<br/>The DOM complied with the request.</p> <p>The Administrator was informed of the deficiency during the survey exit on 08/09/2024 at approximately 1:20 PM.</p> | A1243   |  |  |

New Jersey Department of Health

|   |  |   |  |  |
|---|--|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15A005</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>08/09/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PREMIER CADBURY OF CHERRY HILL</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2150 ROUTE 38</b><br><b>CHERRY HILL, NJ 08002</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| {A 000}   | <p>Initial Comments</p> <p>Initial Comments:<br/>Type of Survey: Expansion/Conversion<br/>The facility is requesting eight (8) additional<br/>licensed beds for a total of 96 licensed beds.</p> <p>Capacity: 88 Assisted Living Beds</p> <p>Census: 80</p> <p>The facility is not in substantial compliance with<br/>all of the standards in the New Jersey<br/>Administrative Code 8:36, Standards for<br/>Licensure of Assisted Living Residences,<br/>Comprehensive Personal Care Homes and<br/>Assisted Living Programs. The facility must<br/>submit a Plan of Correction, including a<br/>completion date for each deficiency and ensure<br/>that the plan is implemented. Failure to correct<br/>deficiencies may result in enforcement action in<br/>accordance with provisions of New Jersey<br/>Administrative Code Title 8, Chapter 43E,<br/>Enforcement of Licensure Regulations.</p> | {A 000}   |  |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/26/24

## STATE FORM: REVISIT REPORT

|  |   |                             |
|--|---|-----------------------------|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>15A005 | MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                 | DATE OF REVISIT<br>8/9/2024 |
| NAME OF FACILITY<br>PREMIER CADBURY OF CHERRY HILL           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2150 ROUTE 38<br>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<br>Y4                                  | DATE<br>Y5                | ITEM<br>Y4  | DATE<br>Y5            | ITEM<br>Y4 | DATE<br>Y5 |
|---|---------------------------|---|-----------------------|------------|------------|
| ID Prefix A1169                             | Correction                | ID Prefix A1243   | Correction            | ID Prefix  | Correction |
| Reg. # 8:36-16.15(a)                        | Completed                 | Reg. # 8:36-17.6(b)   | Completed             | Reg. #     | Completed  |
| LSC   | 08/09/2024                | LSC   | 08/09/2024            | LSC        |            |
| ID Prefix                                   | Correction                | ID Prefix   | Correction            | ID Prefix  | Correction |
| Reg. #                                      | Completed                 | Reg. #  | Completed             | Reg. #     | Completed  |
| LSC   |                           | LSC   |                       | LSC        |            |
| ID Prefix                                   | Correction                | ID Prefix   | Correction            | ID Prefix  | Correction |
| Reg. #                                      | Completed                 | Reg. #  | Completed             | Reg. #     | Completed  |
| LSC   |                           | LSC   |                       | LSC        |            |
| ID Prefix                                   | Correction                | ID Prefix   | Correction            | ID Prefix  | Correction |
| Reg. #                                      | Completed                 | Reg. #  | Completed             | Reg. #     | Completed  |
| LSC   |                           | LSC   |                       | LSC        |            |
| ID Prefix                                   | Correction                | ID Prefix   | Correction            | ID Prefix  | Correction |
| Reg. #                                      | Completed                 | Reg. #  | Completed             | Reg. #     | Completed  |
| LSC   |                           | LSC   |                       | LSC        |            |
| REVIEWED BY<br>STATE AGENCY                 | REVIEWED BY<br>(INITIALS) | DATE  | SIGNATURE OF SURVEYOR | DATE       |            |
| REVIEWED BY<br>CMS RO                       | REVIEWED BY<br>(INITIALS) | DATE  | TITLE                 | DATE       |            |
| FOLLOWUP TO SURVEY COMPLETED ON<br>8/9/2024 |                           | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                       |            |            |