STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315245	A. BUILDING _____ B. WING _____	C 10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CHERRY HILL	1399 CHAPEL AVE WEST CHERRY HILL, NJ 08002

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F 000	INITIAL COMMENTS Complaints #: NJ158795, NJ158461, NJ158076, NJ157859, NJ156066, NJ153647, NJ152654, NJ151768, and NJ151022. Census: 120 Sample Size: 11 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey date: 10/18/2022 -10/19/2022	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a resident who required extensive assistance with personal hygiene and bathing received assistance with keeping their fingernails clean and trimmed for 1 (Resident #4) of 3 sampled residents reviewed for activities of daily living (ADL). Findings included: Review of an "Admission Record" revealed Resident #4 had diagnoses that included [redacted] Review of a quarterly Minimum Data Set (MDS),	F 677	F677 Resident #4 was noted with [redacted] debris under [redacted]. Nails were assessed and cleaned of any dirt or debris. All residents could be affected. DON provided in-servicing on proper [redacted] care to all staff. Unit manager or designee will perform conduct weekly audit for [redacted] care of residents requiring extensive assistance with ADLs. Findings will be reported to QAPI X 3 months after which continuation of audit will be determined.	11/30/22

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

Electronically Signed | 11/22/2022

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 677	Continued From page 1	F 677		

dated EX. Order 26.(4) B1, revealed Resident #4 had EX. Order 26.(4) B1 cognitive skills for daily decision making per a staff assessment for mental status. The MDS indicated the resident required extensive assistance with personal hygiene and bathing.

Review of a "Care Plan," dated EX. Order 26.(4) B1, revealed Resident #4 had an EX. Order 26.(4) B1 to the EX. Order 26.(4) B1 and EX. Order 26.(4) B1 to the EX. Order 2 that were present on admission. The goal for the resident was to maintain or EX. Order 26.(4) B1 and EX. Order 2 skin. The interventions included keeping the resident's EX. Order 26.(4) B1 short.

Observation on 10/18/2022 at 11:02 AM revealed Resident #4 in bed with eyes closed. The resident's EX. Order 26.(4) B1 were EX. Order and had an accumulation of a EX. Order substance underneath the nails.

Observation on 10/18/2022 at 3:10 PM revealed Resident #4 in bed, watching television. The resident nodded their head when spoken to but was EX. Order 26.(4) B1 l. The resident's EX. Order 26.(4) B1 remained EX. Order, with an accumulation of a EX. Order substance under them.

Observation on 10/19/2022 at 10:53 AM revealed the resident's EEX. Order 26.(4) B1 remained EX. Order 2, with an accumulation of a EX. Order 2 substance under them.

During an interview on 10/19/2022 at 10:58 AM, Certified Nursing Assistant (CNA) #2 revealed she completed all ADL care for Resident #4, including EX. Order care. The CNA stated EX. Ord care should have been completed when the resident received a bath. The CNA indicated she had not worked the day before and had not seen the

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F 677	Continued From page 2 resident's EX. Order dirty prior to today. During an interview on 10/19/2022 at 11:00 AM, the Unit Manager revealed she preferred to trim Resident #4's EX. Order 26.(4) B1 because the resident took a EX. Order 26.(4) B1 medication. The UM stated she was sidetracked with the survey and did not trim the resident's EX. Order. According to the UM, the resident's EX. Order were not EX. Order enough to cut into resident's skin. During an interview on 10/19/2022 at 12:35 PM, the Director of Nursing (DON) revealed nursing staff were responsible for trimming residents' EX. Order, and she expected residents' EX. Order to be clean and neat. During an interview on 10/19/2022 at 12:47 PM, the Administrator revealed he expected all residents to be clean and neat while at the facility.	F 677		
F 684 SS=D	New Jersey Administrative Code § 8:39-27.2(g) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure	F 684	F684 During survey, missing documentation	11/30/22

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F 684	Continued From page 3 medication administration was conducted and documented in accordance with accepted standards of practice and physician's orders for 1 (Resident #6) of 3 sampled residents reviewed for nursing services. Findings included: Review of an "Admission Record" revealed Resident #6 had diagnoses which included EX. Order [redacted] EX. Order 26.(4) B1 [redacted], Review of an admission Minimum Data Set (MDS), dated EX. Order 26.(4) B1, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of EX. O, indicating the resident was EX. Order 26.(4) B1 During an interview on 10/19/2022 at 1:55 PM, Resident #6 stated their medications were late or missed at times. The resident indicated the nursing staff did assess their EX. Order and administered pain medication when requested. Resident #6 stated they did not go long periods of time in EX. Order. Review of the September 2022 "Medication Administration Record (MAR)" for Resident #6 revealed no documentation the following ordered medications were administered: - EX. Order 26.(4) B1 tablet EX. milligrams (mg), two tablets at EX. Order 26.(4) B1: There were no nurses' initials documented to indicate the medication was administered as scheduled on 09/07/2022 and 09/08/2022 at 9:00 PM.	F 684	was noted on the MAR. All rendered treatments or medication administered must be appropriately documented by the nurse. All residents could be affected. DON reviewed MARs for accuracy and administration. The resident was assessed and the facility found no negative outcomes due to the missing documentation. DON provided in-servicing on treatment and medication administration accuracy to all nursing staff. Unit Manager or designee with conduct daily audit for missing MAR/TAR documentation X 3 months. Findings will be reported to QAPI for review after	

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F 684	Continued From page 4 - EX. Order 26.(4) B1 tablet (EX. Order 26.(4) B1) one tablet by mouth: There were no nurses' initials documented to indicate the EX. Order 26.(4) B1 with EX. Order 26.(4) B1 was administered as scheduled on 09/09/2022 and 09/20/2022 at 9:00 AM. -EX. Order 26.(4) B1 grams by mouth one time a day for EX. Order 26.(4) B1 : There were no nurses' initials documented to indicate the medication was administered as scheduled on 09/02/2022, 09/09/2022, and 09/20/2022 at 9:00 AM. - EX. Order 26.(4) B1 tablet EX. Order 26.(mg (EX. Order 26.(4) B1 m), one tablet by mouth two times a day for EX. Order 26.(4) B1 : There were no nurses' initials documented to indicate the medication was administered as scheduled on 09/02/2022, 09/09/2022, and 09/20/2022 at 9:00 AM. - EX. Order 26.(4) B1 cream, apply to the EX. Order 26.(4) topically two times a day for EX. Order 26.(4) care: There were no nurses' initials documented to indicate the medication was applied as scheduled on 09/02/2022 at 7:30 AM. - EX. Order 26.(4) B1 tablet (EX. Order 26.(4) B1 mg by mouth two times a day for a supplement: There were no nurses' initials documented to indicate the EX. Order 26.(4) B1 was administered as scheduled on 09/02/2022, 09/09/2022, and 09/20/2022 at 9:00 AM. - EX. Order 26.(4) B1 mg, one tablet by mouth three times a day for EX. Order 26.(4) B1 until 09/11/2022. There were no nurses' initials documented to indicate the medication was administered as scheduled on 09/09/2022 at 9:00 AM and 2:00	F 684		

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F 684	Continued From page 5	F 684		

PM.

- EX. Order 26.(4) B1 mg, EX. Orde capsules by mouth EX. Order 26 times a day for EX. Order 26.(4) B1: There were no nurses' initials documented to indicate the scheduled 9:00 AM doses of the medication was administered on 09/02/2022, 09/09/2022 and 09/20/2022. Additionally, there was no documentation the scheduled 2:00 PM doses of the medication were administered on 09/02/2022, 09/09/2022, 09/11/2022, 09/19/2022, 09/20/2022, and 09/22/2022.

During an interview on 10/18/2022 at 1:44 PM, Licensed Practical Nurse (LPN) #2 revealed she was regularly assigned to provide care for Resident #6 on the 7:00 AM to 3:00 PM shift. LPN #2 stated if a resident's MAR was not signed, it either meant the medication was not given or the medication was given and not documented. The nurse stated she administered all her assigned residents' medications and wound treatments as ordered.

During an interview on 10/19/2022 at 3:07 PM, the Director of Nursing (DON) indicated she expected all medications to be administered according to physicians' orders and facility policy. The DON revealed there had been issues with nursing staff not documenting on the residents' MARs after medications were administered.

During an interview on 10/19/2022 at 3:10 PM, the Administrator indicated he expected all medications to be administered as ordered and for staff to follow the facility's policy for medication administration to ensure all residents received medications as ordered.

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F 684	Continued From page 6 Review of an undated facility policy titled, "Administering Medications," revealed, "3. Medications must be administered in accordance with the orders, including any required time frame." The policy also indicated, "11. The individual administering the medication must document in [facility's electronic medical record software] EMAR [Electronic Medication Administration Record] after giving each medication by clicking on the 'Y.' As required or indicated by a medication, the individual administering the medication will record in the resident's medical record as promoted by [software name]: a. The date and time the medication was administered is time stamped with system. b. The dosage. c. The route of administration. d. The injection site (if applicable). e. Any complaints or symptoms for which the drug was administered. f. Any results achieved and when those results were observed. g. The signature and title of the person administering the drug." New Jersey Administrative Code § 8:39-29.2(d)	F 684		