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 11/30/2023

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 Complaint #: NJ00163880, NJ00164147, NJ00164488 Census: 118 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		1/5/24

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

Electronically Signed | 12/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 690	Continued From page 1 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Complaint #:NJ00164488 Based on observation, interview, record review, and review of other facility documentation on 11/28/23 and 11/30/23, it was determined that the facility failed to provide care for a resident with a *Ex Order 26. 4B1* [redacted] in accordance with physician's orders. The deficient practice was identified for Resident #1, 1 of 3 residents reviewed for *Ex Order 26. 4B1* care and was evidenced by the following: On 11/28/23 at 10:32 AM the surveyor observed Resident #1 lying in bed with a *Ex Order 26. 4B1* hanging off their bed with a small amount of *Ex Order 26. 4B1* inside the bag. When interviewed, Resident #1 stated that it depended on which staff members were working if their *Ex Order 26. 4B1* was emptied or their *Ex Order 26. 4B1* was flushed. According to the Admission Record, Resident #1 was admitted on *Ex Order 26. 4B1*, with medical diagnoses that included but were not limited to	F 690	1. Resident's drainage bag was changed and *Ex Order 26. 4B1* care was provided. 2. All residents with suprapubic catheter have the potential to be affected by this deficient practice. An audit was completed on all residents and patients with suprapubic catheter; no concerns noted. 3. Education was completed for nursing staff on the importance of suprapubic catheter care and changing & emptying foley bag. Nursing staff was also educated on following doctor's orders and documenting appropriately. 4. The Director of Nursing, or designee, will conduct random audits weekly for 4 weeks then monthly for 2 months on residents with suprapubic catheter to ensure orders are being followed and care is being provided appropriately & according to the order. The results of the audits will be reported	

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F 690	Continued From page 2 Ex Order 26. 4B1 [redacted] The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, revealed the resident had a Ex Order 26. 4B1 score of [redacted], which indicated the resident had Ex Order 26. 4B1. The MDS also indicated that Resident #1 had an Ex Order 26. 4B1 [redacted]. Review of Resident #1's care plan revealed a "Focus," that the resident had a Ex Order 26. 4B1 [redacted]. Review of Resident #1's Order Summary Report (OSR), revealed a physician's order (PO) dated Ex Order 26. 4B1 to, "Change Ex Order 26. 4B1 [redacted] weekly on Fridays to prevent infections every night shift every Fri [Friday]." Review of Resident #1's Ex Order 26. 4B1 Treatment Administration Record (TAR) revealed the aforementioned Ex Order 26. 4B1 order, with the administration time of night shift. The TAR reflected no documentation that the Ex Order 26. 4B1 [redacted] was changed on the following dates: Night shift: 05/05/23, 05/12/23, and 05/19/23. Further review of Resident #1's OSR, revealed a PO, dated Ex Order 26. 4B1 to, "Empty Ex Order 26. 4B1 every 4	F 690	at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations.	

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F 690	Continued From page 3 hours." Review of Resident #1's [redacted] TARs revealed the aforementioned [redacted] order, with the administration times of 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. The TARs reflected no documentation that the [redacted] was emptied on the following dates and times: 12:00 AM: 05/13/23. 4:00 AM: 05/02/23, 05/06/23, 05/08/23, 05/13/23, 10/01/23, 10/13/23, 10/23/23, 10/27/23, 10/28/23, and 11/03/23. 8:00 AM: 10/12/23, 10/14/23, 10/15/23, 10/20/23, 10/22/23, 10/26/23, 11/04/23, and 11/26/23. 12:00 PM: 05/01/23, 10/12/23, 10/14/23, 10/15/23, 10/20/23, 10/22/23, 10/26/23, 11/04/23, and 11/26/23. 8:00 PM: 10/07/23. Further review of Resident #1's OSR, revealed a PO dated [redacted] to, "Flush [redacted] with [redacted] every 8 hours." Review of Resident #1's [redacted] TARs revealed the aforementioned [redacted] order, with the administration times of 12:00 AM, 8:00 AM, and 4:00 PM. The TARs reflected no documentation that the [redacted] was flushed on the following dates and times: 8:00 AM: 10/12/23, 10/14/23, 10/15/23, 10/20/23,	F 690		

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F 690	Continued From page 4 10/22/23, 10/26/23, 11/04/23, and 11/26/23. Review of Resident #1's Progress Notes failed to reveal any documentation that the Ex Order 26. 4B1 was emptied or that the Ex Order 26. 4B1 was flushed on the aforementioned dates. During an interview with the surveyor on 11/28/23 at 12:18 PM, Certified Nursing Assistant (CNA) #1 stated she was expected to empty Resident #1's Ex Order 26. 4B1 and tell the nurse the amount of output recorded. During an interview with the surveyor on 11/28/23 at 1:21 PM, Licensed Practical Nurse (LPN) #1 stated that she provided care for Resident #1's Ex Order 26. 4B1 and that it included cleansing, flushing, and monitoring it for any abnormal signs. LPN #1 continued that she flushed Resident #1's Ex Order 26. 4B1 once a shift. LPN #1 stated that once you signed that the flushes were completed that it would be reflected on the TAR. LPN #1 added that it was important to sign off that the care tasks for the Ex Order 26. 4B1 were completed because it verified that the tasks were done. During an interview with the surveyor on 11/28/23 at 2:58 PM, the Director of Nursing (DON) stated she expected residents with Ex Order 26. 4B1 to have their Ex Order 26. 4B1 flushed and emptied. The DON continued that nursing staff should monitor residents with Ex Order 26. 4B1 for sediment, odors, and the color of the Ex Order 26. 4B1 in the tube. The DON continued that these POs were put into place to prevent the tube from becoming clogged and to prevent infection. The DON added that all the interventions should be documented in the TAR as frequently as they were ordered.	F 690		

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F 690	Continued From page 5 Review of the undated facility policy, "Catheter Care, Urinary" did not address the care which was supposed to be provided for residents with suprapubic catheters. NJAC 8:39-27.1(a); 19.4(a)(5).	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		1/5/24

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F 755	Continued From page 6 §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: Complaint #: NJ00163880, NJ00164147 Based on observation, interview, record review, and review of other facility documentation on 11/28/23 and 11/30/23, it was determined that the facility failed to follow up with a medical provider when a routinely scheduled medication was unavailable. The deficient practice was identified for Resident #2, 1 of 3 residents reviewed for medication administration, and was evidenced by the following: On 11/28/23 at 11:02 AM, the surveyor observed Resident #2 in their bed. The resident did not respond to the surveyor's questions. According to the Admission Record, Resident #2 was admitted on Ex Order 26. 4B1, with medical diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted]. The annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, revealed that the resident had short-term and long-term Ex Order 26. 4B1. The MDS also indicated that Resident #2 had a Ex Order 26. 4B1 as a resident. Review of Resident #2's care plan revealed a "Focus," that the resident had a Ex Order 26. 4B1. The care plan included an intervention to, "Give	F 755	1. Resident is currently in the facility. An audit was completed to ensure all of resident's medications were in house and available for the resident; no current concerns. 2. All residents receiving medication at the facility have the potential to be affected by this deficient practice. An audit was completed to ensure all medications were available for the residents in-house; no current concerns. 3. Education was completed for nurses on pharmacy services procedures including follow up with a medical provider when a routinely scheduled medication is unavailable. 4. The Director of Nursing, or designee, will conduct 5 random audits weekly for 4 weeks then monthly for 2 months on residents receiving medications at the facility to ensure all residents have their medications available and if they do not, medical provider is notified. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations.	

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F 755	Continued From page 7 Ex Order 26. 4B1 as ordered by doctor. Monitor/document side effects and effectiveness." Review of Resident #2's Order Recap Report for the dates of Ex Order 26. 4B1 revealed a Ex Order 26. 4B1 active Physician's Order (PO) for Ex Order 26. 4B1 . The PO specified to give 1 tablet every 12 hours for Ex Order 26. 4B1 . Review of Resident #2's Ex Order 26. 4B1 Medication Administration Record (MAR) revealed the aforementioned Ex Order 26. 4B1 order, with the administration times of 9:00 AM and 9:00 PM. The MAR reflected the following documentation: 04/09/23 09:00 AM: blank. 04/10/23 09:00 AM: "Other/See Progress Notes" 04/10/23 09:00 PM: "Other/See Progress Notes" Review of the Ex Order 26. 4B1 Progress Notes (PN) did not reveal any documentation that the Ex Order 26. 4B1 was administered. Review of the PN revealed an, "Order Note," dated Ex Order 26. 4B1 and timed 11:30 AM, that the nurse called the pharmacy to check on the reorder status of the Ex Order 26. 4B1 . The PN continued that the nurse was told by the pharmacy that the resident's Ex Order 26. 4B1 was on order and that it would be delivered later that day. Review of the PN revealed an "Orders-Administration Note," dated Ex Order 26. 4B1 and timed 11:40 AM, that the Ex Order 26. 4B1 was on order.	F 755		

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F 755	Continued From page 8 Review of the PN revealed an "Orders-Administration Note," dated Ex Order 26. 4B1 and timed 10:01 PM, that Ex Order 26. 4B1 was, "awaiting delivery." Review of the PN revealed a "Health Status Note," dated Ex Order 26. 4B1 and timed 11:48 PM, that the resident missed his/her 9 PM Ex Order 26. 4B1 . The PN continued that the nurse called the pharmacy around 10 PM to find out when the medication would be delivered and was told around 12 AM. The Resident had two Ex Order 26. 4B1, one from 10:10 PM- 10:16 PM and the second from 11:11 PM-11:17 PM. The PN continued that the Nurse Practitioner was notified and said that the resident should be sent to the Ex Order 26. 4B1. At 11:20 PM, Ex Order 26. 4 was called and the resident was transferred to the Ex Order 26. 4B1. Further review of the PN did not reveal any documentation that the resident's physician was made aware that Resident #2 did not receive Ex Order 26. 4B1 on Ex Order 26. 4B1 at 9:00 AM, Ex Order 26. 4B1 at 9 AM, and Ex Order 26. 4B1 at 9:00 PM. Review of the "LTC Reportable Event Survey" regarding the Ex Order 26. 4B1 "medication error" revealed under the "Summary and Investigation" (Summary) section that a dose of Ex Order 26. 4B1 was missed on Sunday Ex Order 26. 4B1 and that according to the nurse the Ex Order 26. 4B1 was not available. "However, the nurse failed to call the physician to make them aware." The Summary further revealed that the medication was not delivered by the pharmacy which led to Resident #2 missing two more doses of Ex Order 26. 4B1 on Monday Ex Order 26. 4B1. Resident #2 had two witnessed Ex Order 26. 4B1 on Ex Order 26. 4B1 at 10 PM and 11 PM and was sent to the Ex Order 26. 4B1.	F 755		

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F 755	Continued From page 9 During an interview with the surveyor on 11/28/23 at 1:21 PM, Licensed Practical Nurse (LPN) #1 stated medication should be administered between an hour before and an hour after the time for which they were ordered. LPN #1 continued that nurses were responsible to reorder medications from the pharmacy. LPN #1 added that she reordered medication when there were between 8 and 10 doses of medication left. LPN #1 stated if there were no doses of a medication left that she would call the physician or health care provider. During an interview with the surveyor on 11/30/23 at 12:02 PM, LPN #2 stated that he worked as Resident #2's nurse on Ex Order 26. 4B1 on the 3PM-11PM shift. LPN #2 stated that he administered Resident #2's last dose of Ex Order 26. 4B1 on Ex Order 26. 4B1. LPN #2 continued the medication was already ordered and was to be delivered on Monday Ex Order 26. 4B1, but it was not delivered. During an interview with the surveyor on 11/30/23 at 12:18 PM, LPN #3 stated that on Ex Order 26. 4B1 at 9:00 AM Resident #2's Ex Order 26. 4B1 was not available. LPN #3 stated that she called the pharmacy to see an estimated time of arrival when it would be delivered to the facility. LPN #3 continued that she was not aware that she was supposed to call the physician when a medication was not available and stated that she received education, "after the incident" where Resident #3 had a Ex Order 26. 4B1 and was sent to the Ex Order 26. 4B1. During an interview with the surveyor on 11/30/23 at 1:47 PM, the Medical Doctor (MD) stated the nurse should first call the pharmacy if a	F 755		

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F 755	Continued From page 10	F 755		

medication was not available. The MD continued that if the pharmacy could not give the medication, the nurse would contact the resident's physician to discuss other options. The MD continued that Ex Order 26. 4B1 was an, "important medication" to help control Resident #2's Ex Order 26. 4B1.

During an interview with the surveyor on 11/30/23 at 1:59 PM, and in the presence of the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) stated that Resident #2 missed a dose of Ex Order 26. 4B1 on Sunday Ex Order 26. 4B1 and two doses on Monday Ex Order 26. 4B1. The LNHA continued that LPN #4 did not sign the MAR on Ex Order 26. 4B1 at 09:00 AM and that a dose was not recorded in the medical record. The DON stated she expected for medications to be administered between an hour before and an hour after the designated administration time. The DON continued that when a dose of medication is missed, she expected to see a progress note explaining why the medication was not given. The DON continued that she expected the nurses to called the pharmacy regarding the missing medication and then call the physician. The DON further stated the importance of administering Ex Order 26. 4B1 was to prevent Ex Order 26. 4B1.

During an interview with the surveyor on 11/30/23 at 2:40 PM, the LPN #4 stated she did not administer Resident #2's Ex Order 26. 4B1 on Ex Order 26. 4B1 at 09:00 AM because at first, she could not find it. LPN #4 stated that she did not reach out to the health care provider about the missed dose of medication because she was, "adamant about finding" the medication. LPN #4 continued that she located the medication at change of shift

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F 755	Continued From page 11 with the oncoming nurse, LPN #2, and that he administered the medication to Resident #2 after she left. LPN #4 stated that if she could not locate a medication that she would call the pharmacy and call the doctor. Review of the facilty's undated "Administering Medications" policy, revealed under the "Policy Interpretation and Implementation" section that, "Medications must be administered in accordance with the orders, including any required time frame." The facility policy also indicated, "If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall click "N" on the EMAR [electronic medication administration record] and then document as prompted by [electronic medical record]." NJAC 8:39-29.2(d),(e)(5).	F 755		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		1/5/24

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ARISTACARE AT CHERRY HILL	**1399 CHAPEL AVE WEST 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
F 842	Continued From page 12 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 13 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00164488 Based on observation, interviews, medical record review, and review of other pertinent facility documents on 11/28/23 and 11/30/23, it was determined that the facility staff failed to consistently document on the "Documentation Survey Report" the [redacted] status and care provided to the resident. The deficient practice was identified for Resident #1, 1 of 3 residents reviewed for documentation and was evidenced by the following: On 11/28/23 at 10:32 AM, the surveyor observed Resident #1 lying in bed and interviewed him/her at this time. Resident #1 stated it depended which staff member was assigned as their CNA if they received timely [redacted] care. According to the Admission Record, Resident #1 was admitted on [redacted], with medical diagnoses that included but were not limited to [redacted]	F 842	1. [redacted] records were reviewed for compliance on 12/21/23; no concern noted. Daily review of [redacted] records will be completed. 2. All residents needing ADL documentation has the potential to be affected by this deficient practice. 3. Education was completed for nursing staff on the importance of providing ADL care and documenting the information. 4. The Director of Nursing, or designee, will conduct 5 random audits weekly for 4 weeks then monthly for 2 months on ADL documentation to ensure all ADL care is being documented appropriately. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations.	

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F 842	Continued From page 14 [redacted].	F 842		

The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had a [redacted] score of [redacted], which indicated the resident had [redacted]. The MDS also indicated that Resident #1 had an [redacted] and that they required between substantial/maximal assistance and [redacted] with [redacted] care.

Review of Resident #1's care plan revealed a "Focus," that the resident had a decline in [redacted].

Review of Resident #1's "Documentation Survey Report v2" form (DSR) (a form that documents the [redacted] care provided by the Certified Nursing Assistants (CNAs)) for [redacted] revealed blank spaces indicating the tasks were not completed as follows:

Bed Mobility, Locomotion off Unit, Locomotion on Unit, Personal Hygiene, Toilet Use, Transferring, Walk in Corridor, Bladder Elimination, Bowel Elimination, Monitor Behavior Symptoms, and Skin Observation on [redacted] on the night shift.

Dressing, Walk in in Room, and Change in Patient Status on [redacted],

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F 842	Continued From page 15	F 842		

Ex Order 26. 4B1 [redacted] on the evening shift.

Snacks on *Ex Order 26. 4B1* [redacted] on the evening shift.

Eating on *Ex Order 26. 4B1* [redacted] and *Ex Order 26. 4B1* for the 5 PM meal.

Amount Eaten on *Ex Order 26. 4B1*, and *Ex Order 26. 4B1* for the 8:00 AM meal, *Ex Order 26. 4B1* [redacted] for the 12 PM meal, *Ex Order 26. 4B1* [redacted] for the 5 PM meal.

Review of Resident #1's DSR for *Ex Order 26. 4B1* revealed blank spaces indicating the tasks were not completed as follows:

Dressing, Change in Patient Status, Lower Body Dressing, Oral Hygiene, Putting On/ Taking off Footwear, Upper Body Dressing, Walk 10 Feet, Walk 150 Feet, Walk 50 Feet with Two Turns, Wheel 150 Feet, Wheel 50 Feet with Two Turns, and Wheelchair/Scooter Use on *Ex Order 26. 4B1* [redacted] on the evening shift.

Toilet Use, Transferring, Bladder Elimination,

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F 842	Continued From page 16 Bowel Elimination, 1 Step, 12 Steps, 4 Steps, Chair/ Bed-to-Chair Transfer, Lying to Sitting on Side of Bed, Personal Hygiene, Picking up Object, Roll Left and Right, Shower/ Bathe Self, Sit to Lying, Sit to Stand, Toilet Transfer, Toilet Hygiene, Tub/ Shower Transfer, Monitor Behavior Symptoms, and Skin Observation on Ex Order 26. 4B1 [redacted] on the day shift, Ex Order 26. 4B1 [redacted] on the evening shift, Ex Order 26. 4B1 [redacted] on the night shift. Snacks on Ex Order 26. 4B1 [redacted] on the evening shift. Amount Eaten on Ex Order 26. 4B1 [redacted] for the 8:00 AM meal, Ex Order 26. 4B1 [redacted] for the 12 PM meal, Ex Order 26. 4B1 [redacted] for the 5 PM meal. During an interview with the surveyor on 11/28/23 at 12:18 PM, CNA #1 stated she took care of Resident #1. CNA #1 stated that she provided high quality Ex Order 26 [redacted] care to the residents assigned to her including checking them for Ex Order 26. 4B1 [redacted] every 2 hours and whenever they rang the call bell. CNA #1 added that Ex Order 26 [redacted] care should be documented on the DSR for every resident every shift. During an interview with the surveyor on 11/28/23 at 1:21 PM, Licensed Practical Nurse (LPN) #1 stated that staff were able to provide high quality Ex Order 26 [redacted] care for all the residents including checking residents for Ex Order 26. 4B1 [redacted] every 2 hours. LPN #1	F 842		

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F 842	Continued From page 17 stated that CNAs were expected to document the [redacted] care they provided to residents every shift in order to verify that the task was completed. During an interview with the surveyor on 11/30/23 at 02:58 PM, the Director of Nursing (DON) stated [redacted] care should be documented in the DSR. The DON continued that the nurses, unit managers, and nursing administration were responsible to make sure that there was "100% completion" of the [redacted] sheets. The DON added the purpose of the [redacted] documentation was to verify that the care was provided. NJAC 8:39-35.2 (d)(6).	F 842		

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	060417	A. BUILDING: _____ B. WING _____	C 11/30/2023

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S 000	Initial Comments Complaint #: NJ00163880, NJ00164147, NJ00164488 Census: 118 Sample Size: 3 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 review of other facility documentation on 11/28/23 and 11/30/23 was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratio for the day shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 13 of 21 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts. This deficient practice had the potential to affect all residents.	S 560	1. Staffing schedule and ratio will be reviewed daily. 2. All residents residing in the facility have the potential to be affected by this deficient practice. 3. Education was completed for Staffing Coordinator by the Administrator on the importance on meeting state staffing ratio	1/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/29/23

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S 560	Continued From page 1 Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. As per the "Nurse Staffing Report" completed by the facility for the week of 05/21/2023 to 05/27/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -05/21/23 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/22/23 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs. -05/23/23 had 10 CNAs for 102 residents on the	S 560	daily and for each shift. 4. The Administrator, or designee, will review schedule and staffing ratio daily for 4 weeks then monthly for 2 months on staffing ratio to ensure state requirement is being met. The results of the audits will be reported at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations.	

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S 560	Continued From page 2 day shift, required at least 13 CNAs. -05/27/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. 2. As per the "Nurse Staffing Report" completed by the facility for the weeks of 11/12/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -11/12/23 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -11/13/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -11/14/23 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs. -11/15/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -11/17/23 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -11/19/23 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. -11/20/23 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -11/20/23 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. -11/24/23 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -11/25/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs.	S 560		
S 885	8:39-9.4(e)(4) Mandatory Administration (e) The facility shall notify the Department immediately by telephone (609-633-8981, or 1-800-792-9770 after office hours), followed within 72 hours by written confirmation, of any of the following:	S 885		1/5/24

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S 885	Continued From page 3 4. All fires, disasters, deaths, and imminent dangers to a resident's life or health resulting from accidents or incidents in the facility. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00163880, NJ00164147 Based on observation, interview, review of medical records, and review of other pertinent facility documentation on 11/28/23, and 11/30/23, it was determined that the facility failed to notify the New Jersey Department of Health (DOH) immediately by telephone and failed to provide written confirmation to the DOH within 72 hours of an imminent danger to a resident's life or health resulting from an accident or incident in the facility. The deficient practice was identified for Resident #2, 1 of 4 residents reviewed for accidents and incidents and was evidenced by the following: According to the Admission Record, Resident #2 was admitted on [redacted], with medical diagnoses that included but were not limited to [redacted]. The annual Minimum Data Set (MDS), an	S 885	1. Reportable event was reported and investigated. 2. All residents residing in the facility have the potential to be affected by this deficient practice. 3. Education was completed for Administrator by Chief Clinical Officer on the importance on reporting significant events within 72 hours of an imminent danger to a resident's life or health resulting from an accident or incident in the facility. 4. The Chief Clinical Officer, or designee, will review reportable events weekly for 4 weeks then monthly for 2 months to ensure reporting requirements are being met. The results of the audits will be reviewed at the monthly QAPI meeting for 3 months and as needed thereafter for any additional recommendations.	

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S 885	Continued From page 4	S 885		

assessment tool used to facilitate the management of care, dated [redacted], revealed that the resident had short-term and long-term [redacted]. The MDS also indicated that Resident #2 had a [redacted] as a resident.

Review of Resident #2's care plan revealed a "Focus," that the resident had a [redacted]. The care plan included an intervention to, "Give [redacted] as ordered by doctor. Monitor/document side effects and effectiveness."

Review of Resident #2's Order Recap Report for the dates of [redacted] revealed a [redacted] active Physician's Order (PO) for [redacted]. The PO specified to give 1 tablet by mouth every 12 hours for [redacted].

Review of Resident #2's [redacted] Medication Administration Record (MAR) revealed the aforementioned [redacted] order, with the administration times of 9:00 AM and 9:00 PM. The MAR reflected the following documentation:

04/09/23 09:00 AM: blank.

04/10/23 09:00 AM: "Other/See Progress Notes"

04/10/23 09:00 PM: "Other/See Progress Notes"

Review of the 04/09/23 Progress Notes (PN) did not reveal any documentation that the [redacted] was not administered.

Review of the PN revealed an, "Order Note," dated [redacted] and timed 11:30 AM, that the nurse called the pharmacy to check on the reorder status of the [redacted]. The

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S 885	Continued From page 5 PN continued that the nurse was told by the pharmacy that the resident's Ex Order 26. 4B1 was on order and that it would be delivered later that day. Review of the PN revealed an "Orders-Administration Note," dated Ex Order 26. 4B1 and timed 11:40 AM, that the Ex Order 26. 4B1 were on order. Review of the PN revealed an "Orders-Administration Note," dated Ex Order 26. 4B1 and timed 10:01 PM, that the Ex Order 26. 4B1 was, "awaiting delivery." Review of the PN revealed a "Health Status Note," dated Ex Order 26. 4B1 and timed 11:48 PM, that the resident missed his/her 9 PM Ex Order 26. 4B1 medication Ex Order 26. 4B1. The PN continued that the nurse called the pharmacy around 10 PM to find out when the medication would be delivered and was told around 12 AM. The Resident had two Ex Order 26. 4B1, one from 10:10 PM- 10:16 PM and the second from 11:11 PM-11:17 PM. The PN continued that the Nurse Practitioner was notified and said that the resident should be sent to the Ex Order 26. 4B1. At 11:20 PM, 9-1-1 was called and the resident was transferred to the Ex Order 26. 4B1. Further review of the PN did not reveal any other documentation that a health care provider was made aware that Resident #2 did not receive Ex Order 26. 4B1 on Ex Order 26. 4B1 at 9:00 AM, Ex Order 26. 4B1 at 9 AM, or Ex Order 26. 4B1 at 9:00 PM. Review of the "LTC Reportable Event Survey" regarding the Ex Order 26. 4B1, "medication error" revealed that a significant event was not called in and that the event was reported in writing on Ex Order 26. 4B1. Further review of the "LTC Reportable Event Survey" revealed under the "Summary and	S 885		

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S 885	Continued From page 6 Investigation" (Summary) section that a dose of Ex Order 26. 4B1 was missed on Sunday Ex Order 26. 4B1 and that according to the nurse the Ex Order 26. 4B1 was not available, "however, the nurse failed to call the physician to make them aware." The Summary section continued that the medication was not delivered by the pharmacy which led Resident #2 to miss two more doses of Ex Order 26. 4B1 on Monday, Ex Order 26. 4B1. Resident #2 had two witnessed Ex Order 26. 4B1 on Ex Order 26. 4B1 at 10 PM and 11 PM and was sent to the Ex Order 26. 4B1. During an interview with the surveyor on 11/30/23 at 02:28 PM, the Licensed Nursing Home Administrator (LNHA) stated the facility reported the incident after representatives from the New Jersey Office of the Long Term Care Ombudsman (NJLTCO) investigated the occurrence. The LNHA stated she did not know the incident was a reportable event until the person from the NJLTCO told her that she needed to report the incident as a medication error.	S 885		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315245		1/22/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CHERRY HILL	1399 CHAPEL AVE WEST 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 F0690 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 01/05/2024	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 01/05/2024	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 01/05/2024
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 11/30/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060417 Y1	A. Building B. Wing Y2	1/22/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CHERRY HILL	1399 CHAPEL AVE WEST 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 01/05/2024	ID Prefix S0885 Reg. # 8:39-9.4(e)(4) LSC	Correction Completed 01/05/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO