STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A006	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS CHERRY HILL	1450 MARLTON PIKE CHERRY HILL, NJ 08034

(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 #: NJ00164798 CENSUS: 117 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 235	8:36-2.4(d) Licensure Procedures (d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and resident records and conferences with residents. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00164798 Based on interview, and record review it was	A 235		

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

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 235	Continued From page 1 determined the facility failed to provide the surveyor full access to the electronic medical record (EMR) for review for 3 of 3 residents reviewed Resident #'s: 1, 2, and 3. This deficient practice was evidenced by the following: On 4/8/2024 at 9:26 a.m., during the entrance conference, the surveyor requested full access to the facility's EMR. At that time, the facility's Executive Director (ED) stated that he would be able to provide the surveyor with access to the EMR. At 9:57 a.m., the surveyor received EMR login information from the ED. At 10:05 a.m., the surveyor was unable to login to the EMR. At 10:25 a.m., the surveyor was granted partial access to the EMR. At 2:00 p.m., the surveyor tried to access Resident #2's Tasks tab and Medication Administration Record (MAR), but the tabs were not viewed on the computer. In the presence of the Director of Nursing (DON), the surveyor asked her, do you see the tasks tab or the "report" tab for the MAR on the computer screen for Resident #2, she replied "no". The surveyor interviewed the DON and made her aware that full access to the EMR was not given as requested. The DON responded and stated that she "wasn't sure since [the] corporate [office] sets it [EMR access] up." The surveyor was not granted full access to the EMRs for Resident #'s: 1, 2, and 3 but was provided paper copies of the requested documents from the EMRs.	A 235		

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A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Complaint#: NJ00164798 Based on interview, and record review it was determined that the Executive Director (ED) failed to ensure the implementation and enforcement of the facility's policy and procedures, titled "Incidents/Accidents Reports-Risk Management" to include a thorough investigation with witness statements and documentation, when a resident NJ Ex Order 26 from the facility on NJ Ex Order 26.4(b), for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: Surveyor review of a Facility's Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents, dated NJ Ex Order 26.4(b) with "date of event" of NJ Ex Order 26.4(b), and a "time of event"	A 310		

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A 310	Continued From page 3	A 310		

of 10:05 p.m., revealed the following:

"On [redacted] at approximately 10:05 p.m., Resident #2 was found in the [redacted], immediately [redacted] and assessed by the Licensed Practice Nurse (LPN), noted to have [redacted] on his/her [redacted]. Resident #2 stated he/she [redacted], while [redacted], noted on [redacted]. completed and [redacted] ordered, Resident was [redacted] around with his/her [redacted] and insisted he/she's at his/her [redacted]. Registered Nurse (RN) and ED notified. RN called [redacted] The FRE also stated Resident #2 was placed on [redacted] throughout the night and [redacted] Resident #2 was recently hospitalized from [redacted] with a [redacted]. Resident #2 was last seen on camera at 9:17 p.m [redacted] and at 10:05 p.m. was seen [redacted] through the [redacted]."

A review of an "Investigation Report" provided on-site with the FRE dated [redacted], written by the LPN revealed "Resident #2 was found in the [redacted] by caregiver (Caregiver #1). Resident #2 was found with [redacted] and [redacted] saying he/she was trying to [redacted]. Per camera view, Resident #2 [redacted], [redacted] and [redacted] to [redacted]." Under Witnesses or Individual with knowledge of alleged event: "Caregiver #3 found the Resident [redacted] and another caregiver (Caregiver #2) also saw him/her. Caregiver #1 last saw Resident #2 approximately [redacted] prior when he/she [redacted] him/her back to his/her apt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A006	A. BUILDING: _____ B. WING _____	C 04/08/2024

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A 310	Continued From page 4	A 310		

[apartment]."

On 4/8/2024 at 10:35 a.m. during surveyor review of Resident #2's Medical Record (MR), revealed a move in date of NJ Ex Order 26.4(b)(1) with diagnoses which included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(or NJ Ex Order 26.4(b)(1). Resident resided on the NJ Ex Order 26.4(b)(1) unit on NJ Ex Order 26.4(b .

A review of Resident #2's "Progress Notes *New* (PNNs)" with an effective date NJ Ex Order 26.4(b at 12:57 p.m., written by the Wellness Nurse (WN), revealed Resident#2 had a NJ Ex Order 26.4(b)(1) done which showed NJ Ex Order 26.4(b)(1 or NJ Ex Order 26.4(only a NJ Ex Order 26.4(b(to [the] NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 .

A continued review of PNNs dated NJ Ex Order 26.4(b , at a time of 00:45, written by the WN, revealed "[the] Resident NJ Ex Order 26.4(b)(1) in a NJ Ex Order 26.4(b)(, when returned he/she stated he/she had NJ Ex Order 26.4(b)(1), when assessed nurse noticed NJ Ex Order 26.4(b on NJ Ex Order 26.4(b resident NJ Ex Order 26.4(b)(1), resident is saying he/she is trying to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) currently in place for safety [.] Director of Resident Care (DRC) aware and Physician notified ...."

On entrance at 9:26 a.m with the ED, the surveyor requested the FRE with all the names of the staff involved, to include phone numbers, if not working at the facility.

At 10:31 a.m., the surveyor requested the FRE information a second time, to include witness statements from the staff involved.

During an interview on 4/8/2024 at 11:08 a.m.,

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 310	Continued From page 5	A 310		

when the surveyor asked if an investigation was done, the ED replied, "yes." The ED stated that he interviewed everyone and got [witness] statements all in an investigation report, but that he couldn't find the statements, but that he will look for them. He continued to say at the time of the incident, the receptionist [area] closed at 10 p.m., but currently it is open 24 hours now and that the camera footage was only saved for the past 2 weeks and that there was none for and at the incident.

During an interview at 2:00 p.m., when the surveyor asked if she was involved with the investigation, the Director of Nursing (DON) stated, she was not in the building at that time, but that she was involved and was talking to the nurses aides [caregivers] and the nurse involved. She stated that she thought she documented their [witness] statements, but that she can't find it [them].

During continued survey interview at 2:44 p.m., when the surveyor asked about the camera footage, the ED stated the following: "...at approximately 9:30 p.m., Resident #2 was seen NJ Ex Order 26.4(b)(1) [redacted], 2 caregivers were NJ Ex Order 26.4(b)(1) [redacted] him/her back to his/her apartment, about 5-10 minutes later, the Resident was seen NJ Ex Order [redacted] and the next time Resident #2 was seen was on the NJ Ex Order [redacted] camera, slightly after 10:00 p.m., NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and a few minutes later, another caregiver saw the Resident and NJ Ex Order 26.4(b) [redacted] him/her to the Wellness Office."

In the same interview, when the surveyor asked about the witness statements, the ED replied, "I did not have staff write any [witness] statements. I

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A 310	Continued From page 6 just took notes. Normally, when an incident occurs, "yes, the staff write statements, I don't know what happened, if I accidentally disposed of them." Surveyor review of the facility's policy titled, "Section: Resident Care" and "Incident/Accident Reports-Risk Management" with a revised date of October 2023, revealed the following: "...Policy: To document the events of any accident/incident involving a resident, employee, visitor, or other person." ...Standard: ...4. If the first emergency contact cannot be reached, call the second contact, until contact is made. Document all attempts. 5. Complete all sections of the Incident/Accident designated in PCC [Point Click Care] which include the following: a. Details -of incident ...d. Factors-which may have contributed to incident[,] e. Witness-if staff or other present[,] f. Actions-call physician, family, DRC (Director of Resident Care) [,] g. Notes-documentation implementation & follow up ...9. Types of incidents/accidents to be reported; but not limited to ...Elopement/Missing Resident...."	A 310		
A1051	8:36-15.2 Resident Records The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00164798 Based on interview, and record review it was	A1051		

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A1051	Continued From page 7	A1051		

determined that the facility failed to ensure requested electronic medical records (EMRs) were available for review to the surveyor for 3 of 3 residents sampled, Resident #'s: 1, 2 & 3 and other facility documentation requested for an incident that occurred when a resident NJ Ex Order 26 from the facility were available for review, Resident #2. This deficient practice was evidenced by the following:

Surveyor review of a Facility's Reportable Event (FRE), (a New Jersey Department of Health document used by the healthcare facilities to report incidents) (NJDOH) dated NJ Ex Order 26.4(b, "date of event" of NJ Ex Order 26.4(b and a "time of event" of 10:05 p.m., revealed the following:

"On NJ Ex Order 26.4(b at approximately 10:05 p.m., Resident #2 was found in the NJ Ex Order 26.4(b)(1) , immediately NJ Ex Order 26.4(b)(1 and assessed by the Licensed Practice Nurse, noted to have NJ Ex Order 26.4(b)(1) on his/her NJ Ex Order 26.4(b)(1). Resident #2 stated he/she NJ Ex Order 26.4(b)(1) while NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) noted on NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(completed and treatment ordered, Resident was NJ Ex Order 26.4(b) walking around with NJ Ex Order 26.4(b)(1) and insisted he/she's NJ Ex Order 26.4(b)(1). Registered Nurse (RN) and ED notified. RN called NJ Exec O The FRE also stated Resident #2 was placed on NJ Ex Order 26.4(b)(1) throughout the night and NJ Ex Order 26.4(b)(1). Resident #2 was recently hospitalized from NJ Ex Order 26.4(b)(- NJ Ex Order 26.4(b with a NJ Ex Order 26.4(b)(1) . Resident #2 was last seen on camera at 9:17 p.m. NJ Ex Order 26.4(b)(1) and at 10:05 p.m. was seen NJ Ex Order 26.4(b)(1) through the NJ Ex Order 26.4(b)(."

A review of an "Investigation Report" provided

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A1051	Continued From page 8	A1051		

with the FRE onsite, dated [NJ Ex Order 2] written by the Licensed Practice Nurse (LPN) revealed, "Resident #2 was found in the [NJ Ex Order 26.4(b)(1)] by caregiver (Caregiver #1). Resident #2 was found with [NJ Ex Order 26.4(b)(1)] and [NJ Ex Orde] saying he/she was [NJ Ex Order 26.4(b)(1)] Per camera view, Resident #2 [NJ Ex Order 2], walked [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] ...Witnesses or Individual with knowledge of alleged event: ...Caregiver #3 found the Resident [NJ Ex Order 26.4(b)(1)] and another caregiver (Caregiver #2) also saw him/her. Cargiver #1 last saw Resident #2 approximately 30 minutes prior when he/she [NJ Ex Order 26.4(b)(1)] him/her back to his/her apt [apartment]."

On 4/8/2024 at 9:26 a.m., during the entrance conference, the surveyor requested full access to the facility's EMR and the Facility Reportable Event (FRE). At that time, the facility's Executive Director (ED) stated that he would be able to provide the surveyor with access to the EMR and provide a copy of the FRE.

At 9:57 a.m., the surveyor received EMR login information from the ED.

At 10:31 a.m., the surveyor requested the FRE information a second time, to include witness statements from the staff involved.

At 10:05 a.m., the surveyor was unable to login to the EMR.

At 10:25 a.m., the surveyor was granted partial access to the EMR.

During an interview on 4/8/2024 at 11:08 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A006	A. BUILDING: _____ B. WING _____	C 04/08/2024

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A1051	Continued From page 9	A1051		

when the surveyor asked if an investigation was done, the ED replied, "yes." He indicated that he interviewed everyone and got [witness] statements all in an investigation report, but he couldn't find the statements, but that he will look for them. He continued to say that at the time of the incident, the receptionist [area] closed at 10 p.m., "but currently it is open 24 hours now and the camera footage was only saved for the past 2 weeks, there was none for the incident."

During an interview at 12:31 p.m., Caregiver #1 assigned to Resident #2 stated that she did not recall being involved in this incident.

At 2:00 p.m., the surveyor tried to access Resident #2's Tasks tab and Medication Administration Record (MAR), but the tabs were not viewed on the computer. In the presence of the Director of Nursing (DON), the surveyor asked her, do you see the tasks tab or the "report" tab for the MAR on the computer screen for Resident #2, she replied "no." The surveyor then made the DON aware that full access to the EMR was not given as requested. The DON replied, "...wasn't sure since [the] corporate [office] sets it [EMR access] up." In continued surveyor interview, when the surveyor asked if she was involved with the investigation, the DON stated that she was not in the building at the time, but that she was involved by interviewing and talking to the nurses aides [caregivers] and the nurse involved and she thought she documented their [witness] statements, but she can't find it [them].

During continued survey interview at 2:44 p.m., when the surveyor asked about the camera footage, the ED stated the following: "...at approximately 9:30 p.m., Resident #2 was seen

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A1051	Continued From page 10 in NJ Ex Order 26.4(b)(1), two caregivers were NJ Ex Order 26.4(b)(1) him/her back to his/her apartment, about 5-10 minutes later, the Resident was seen NJ Ex Order and the next time Resident #2 was seen was on the NJ Ex Order camera, slightly after 10:00 p.m., NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and a few minutes later, another caregiver saw the resident and NJ Ex Order 26.4(b) him/her to the NJ Exec Order 26.4(b) Office." During a telephone interview on 4/9/2024 at 1:15 p.m., Caregiver #2 stated that she remembered seeing Resident #2 and NJ Ex Order 26.4(b)(1) him/her, but that it was a long time ago and that she did not recall the details. At the time of the survey, the other staff member involved with the incident were unavailabe for interview. The surveyor was not granted full access to the EMRs for Resident #'s: 1, 2, and 3 but was provided paper copies of the requested documents from the EMRs. The surveyor was not provided a Summary and Conclusion for the FRE to include witness statements. The facility's investigative report was not available to confirm facility conducted a complete comprehensive investigation of the incident. Resident #'s 1, 2, and 3 records were not readilly available and accessible to the representative of the Department.	A1051		
A1179	8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance (a) The facility shall provide and maintain a	A1179		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1179	Continued From page 11 sanitary and safe environment for residents. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00164798 Based on interview and record review, it was determined that the facility failed to ensure that the doors were upgraded and facility staff were educated on door safety, after a resident [redacted] through an [redacted] as noted in the Facility Reportable Event (FRE) for 1 of 3 residents sampled, Resident #2. This deficient practice was evidenced by the following: Surveyor review of a Facility's Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents, dated [redacted], "date of event" of [redacted] and a "time of event" of 10:05 p.m., revealed the following: "On [redacted] at approximately 10:05 p.m., Resident #2 was found in the [redacted], immediately [redacted] and assessed by the Licensed Practice Nurse, noted to have [redacted] on his/her [redacted] Resident #2 stated he/she [redacted] while [redacted] noted on [redacted] completed and treatment ordered, Resident was [redacted] and insisted he/she's at his/her [redacted]. Registered Nurse (RN) and ED notified. RN called [redacted] The FRE also stated, "Resident #2 was placed on	A1179		

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
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A1179	Continued From page 12	A1179		

NJ Ex Order 26.4(b)(1) throughout the night and NJ Exec Order 26.4b NJ Exec Order 26.4b1 Resident #2 was recently hospitalized from NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b) with a NJ Ex Order 26.4(b)(1)). Resident #2 was last seen on camera at 9:17 p.m. entering NJ Ex Order 26.4(b)(1) and at 10:05 p.m. was seen NJ Ex Order 26.4(... per the Director of Nursing (DON), at the time of the incident, the NJ Ex Order 26.4(b)(1) only NJ Ex Order 26 one computer, but the facility plan was to NJ Ex Order 26.4(b)(1) ...Per the Administrator, the NJ Ex Order were going to NJ Ex Order 26.4(b)(1) , NJ Ex Orde and the NJ Ex Order 26.4(b)(1) that was NJ Ex Order 26.4 with a chime on the Wellness Office computer. This update would take 60 days and NJ Ex Order 26.4(b)(1) were increased to twice a day. The chime would NJ Exec O the staff to an NJ Ex Order 26.4(b)(1) and the resident's NJ Ex Order 26.4(b)

A review of an "Investigation Report" provided with the FRE on-site, dated NJ Ex Order 2, written by the Licensed Practice Nurse (LPN) revealed, "Resident #2 was found in the NJ Ex Order 26.4(b)(1) by caregiver (Caregiver #1). Resident #2 was found with NJ Ex Order 26.4(b)(1) and NJ Ex Orde saying he/she was trying to NJ Ex Order 26.4(b)(1) . Per camera view, Resident #2 NJ Ex Order 2 , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) ... Witnesses or Individual with knowledge of alleged event: ...Caregiver #3 found the Resident NJ Ex Order 26. and another caregiver (Caregiver #2) also saw him/her. Caregiver #1 last saw Resident #2 approximately 30 minutes prior when he/she NJ Ex Order 26.4(b)(1) him/her back to his/her apt [apartment]."

A review of education titled "Inservice Training", included "In-Service Topic" as "Door Alarm

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	04A006	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS CHERRY HILL	1450 MARLTON PIKE CHERRY HILL, NJ 08034

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A1179	Continued From page 13	A1179		

Inservice" dated [NJ Ex Order 2]; however, there was no information provided on what type of education was provided regarding the door.

On 4/8/2024 at 9:38 a.m., the surveyor interviewed the Receptionist. She stated that her cell phone [NJ Exec Ord] her when a resident [NJ Ex Order 26.4(b] and [NJ Ex Order 2] by giving the room number and resident name, but she didn't mention the [NJ Ex Order 2] She continued to say that the Maintenance Supervisor educated her on [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26] all the (front desk) [NJ Ex Order 2] but that she was unable to give a staff name or date of the education. She stated, "all staff get [NJ Ex Order 26.4(b)(1)] [education] [,] [the] same tour at orientation."

On 4/8/2024 at 10:35 a.m., surveyor's review of Resident #2's Medical Record (MR) revealed a move in date of [NJ Ex Order 26.4(b)(1)], with diagnoses which included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Resident resided on the NJ Exec Order 26.4b1 unit on [NJ Ex Order 26.4(b].

During an interview at 11:08 a.m., when the surveyor asked about the [NJ Ex Order 26.4(b)(1)] on the computer, the ED stated,"The device on the [NJ Ex Ord] did not [NJ Ex Order 2] The [NJ Ex Ord] device (when the [NJ Ex Ord] opened) went to the computer, but didn't [NJ Exec O] the nurse, the [NJ Exec O] that NJ Ex Order 26.4(b)(1) popped up [on the computer screen] with no sound." He continued to say, "when the [NJ Ex Order 26.4(b)(1)], [an] [NJ Exec O] pops up on the [computer] screen now and makes [a] sound, only in [the] Wellness office.

At 11:37 a.m., while on tour on the NJ Exec Order 26.4b1 Unit, the surveyor observed that the [NJ Exec Order 26] Care [NJ Ex Orde] was [NJ Ex Order 26.4] and a beeping sound was heard.

At 11:50 a.m., in the presence of the Maintenance

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A1179	Continued From page 14	A1179		

Director (MD), the surveyor toured the [NJ Exec Order 26.4] (Resident #2's previous apartment) and exited down [NJ Exec Order 26.4b1] at the bottom of the stairs on the 1st floor, there was a door, labelled as "Floor 1 Tower [redacted] [,] Emergency Exit Do Not Block push bar to open alarm will sound." At that time, with a push bar across the center of the door to open, the bar was pushed and the door opened. When the surveyor asked the MD about an alarm sound, he stated it is a silent alarm and alarm will sound to the nurse's station, [the] Wellness office. This door exits to the back of the building, the left side of the building and the parking lot goes all the way around the building. The main entrance is located on the side of the building.

During an interview at 12:17 p.m., when the surveyor asked about the process with the computer and the doors, the Wellness Nurse stated, "if a resident goes [NJ Ex Order 26.4(b)(1)], the computer [NJ Exec Or] the nurse, comes up [pops up] on screen, but [computer] doesn't [NJ Ex Orde] and [the] front desk, caregivers, Certified Medication Aides (CMAs) or Certified Home Health Aides (CHHAs) have a cell phone [NJ Exec O] if a [NJ Ex Order 26.4(b)(1)]

In the same interview, when asked if educated on door safety, the WD stated it was part of her orientation [NJ Exec Order 2] ago.

During an interview at 12:31 p.m., Caregiver #1 assigned to Resident #2 on [NJ Ex Order 26.4(b] stated, she did not recall being involved in this incident. When the surveyor asked her if she was aware when a [NJ Ex Order 26.4(b)(1)], she replied, "I don't know when a [NJ Ex Order 26.4(b)(1)] in the building, I only know when it [NJ Ex Order 26.4(b)(1)] in the [NJ Exec Order 26] care [unit] because the door beeps." She continued to say, "the cell phone and walkie talkie notifies me of

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A1179	Continued From page 15	A1179		

the call bell/pendant." In the same interview, Caregiver #1 said she was not educated on the door.

During an interview at 12:49 p.m., when the surveyor asked if in- services were done on the door, the Administrator replied he did in-services on Emergency Preparedness and the NJ Ex Orde but he did not have any documentation of what was presented on the NJ Ex Orde The Administrator continued to say that he only educated the nurses and the caregivers on the NJ Ex Orde

At 1:30 p.m., the surveyor asked the MD to open a door while the surveyor observed the computer screen in the Wellness Office. When the MD opened NJ Ex Order 26.4(b)(1), the surveyor observed the following NJ Exec O appear on the computer screen, it was titled "NJ Ex Order 26.4(b)(1)" included: "Create Time": NJ Ex Order 26.4(b), 1:31:44 sec [seconds] "NJ Ex Order Text" "NJ Ex Order 26.4(b)(1)." There was no sound [chime as mentioned in the FRE] heard on the computer screen. Once the NJ Ex Orc was closed, the NJ Exec O disappeared from the screen.

During an interview at 1:48 p.m., when the surveyor asked about the NJ Ex Orc process, the DON stated, "the NJ Ex Orc NJ Exec Orc the computer system on the screen that a NJ Ex Orc is opened." She continued to say, all the aides in Assisted Living (AL) have a cell phone that NJ Exec Orc them when a NJ Ex Orc opens, it is the same system as [the] call pendant.

During an interview at 2:08 p.m., the Administrator stated if a NJ Ex Orc opens, nursing and the front desk know because it is on their cell phone and only nursing was educated on [the] door safety, but he was unable to provide documentation of the education provided for the

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A1179	Continued From page 16 NJ Exec Order 26.4b1. During an interview at 2:30 p.m., when the surveyor asked about the NJ Ex Ord opening NJ Exec O the Certified Home Health Aide (CHHA)/Caregiver, working in AL stated, she is not NJ Exec Order 2 on her cell phone if a NJ Ex Order 26.4(b)(1), her cell phone only NJ Exec Ord her for the NJ Exec Order 26.4b1. She continued to say. "if a resident NJ Ex Order 26 at front desk, front desk notifies her [but] if a resident goes out a NJ Ex Orde no one knows." In the same interview, when the surveyor asked CHHA/Caregiver if she was educated on the NJ Ex Orde she replied, she was not educated on NJ Ex Ord or NJ Ex Order 26.4(b)(1). During the exit at 4:48 p.m., the surveyor asked about the NJ Ex Order 26.4(b)(1) mentioned in the FRE, the Administrator stated, "the door was supposed to be upgraded but [I] hit roadblocks with the company." He continued to say that he would send me copies of the emails. At the time of the survey, the other staff involved with the incident were unavailabe for interview. At the time of the survey, there was no evidence to show the NJ Ex Order 26.4(b)(1) was in progress or education was provided on door safety. During a post survey telephone interview on 4/9/2024 at 1:15 p.m., Caregiver #2 who cared for Resident #2 on NJ Ex Order 26.4(b)(stated that she remembered redirecting Resident #2 back to his/her room, but that the incident was a long time ago. She continued to say, when NJ Ex Order 26.4(b)(1), it shows on the computer, but that she didn't know the details and did not remember receiving any education on NJ Ex Order 26.4(b)(1)	A1179		

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
04A006 Y1	A. Building B. Wing Y2	5/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS CHERRY HILL	1450 MARLTON PIKE CHERRY HILL, NJ 08034

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 A0235	Correction	ID Prefix A0310	Correction	ID Prefix A1051	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-15.2	Completed
LSC	05/17/2024	LSC	05/17/2024	LSC	05/17/2024
ID Prefix A1179	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/01/2024	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 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	
4/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO