

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/13/2025
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NAME OF PROVIDER OR SUPPLIER SPRING HILLS CHERRY HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1450 MARLTON PIKE CHERRY HILL, NJ 08034
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(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	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint # NJ00189227</p> <p>Census: 102</p> <p>Sample Size: 3</p> <p>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.</p>	A 000		
A 935	<p>8:36-11.4(b) Administration of medications</p> <p>(b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.</p>	A 935		

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

TITLE

(X6) DATE

01/23/26

New Jersey Department of Health

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A 935	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00189227</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that prescribed medications were administered by a qualified person for 1 of 3 residents reviewed, Resident #3 when the resident received another resident's morning medications administered by the Certified Medication Aide (CMA #1). This deficient practice was evidenced by the following:</p> <p>On 11/10/25 at 10:13 p.m., the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The report included a document titled, "Incident date: [redacted] which revealed that at 9:45 a.m., Resident #3 received the following incorrect medications administered by CMA: NJ Exec Order 26.4b1 [redacted]. The CMA was removed from the medication cart. Resident #3 only received 2 of his/her prescribed medications: NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p> <p>Further review of the FRE, revealed that Resident #3 received the following Incorrect medications: NJ Exec Order 26.4b1 [redacted].</p> <p>Resident #3 was assessed by the Registered Nurse, vital signs were within NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 was identified to Resident #3.</p> <p>On 11/13/25 at 10:30 a.m., the surveyor</p>	A 935		
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A 935	<p>Continued From page 2</p> <p>interviewed Resident #3 and inquired about the medication error. Resident #3 stated that CMA#1 gave him/her the wrong morning medications. Resident #3 explained that he/she normally received three pills in the morning and noticed that CMA#1 gave him/her more than three pills. Resident #3 stated that he/she questioned CMA #1, and that was when CMA #1 realized that she had administered the wrong medications to the wrong resident. Resident #3 stated that he/she was informed also by the nurse on duty about the medication error incident, an assessment was conducted every hour to monitor for any adverse reactions. Resident #3 also stated that the physician assessed him/her on that same day.</p> <p>At 1:25 p.m., the surveyor reviewed the Medical Record (MR) of Resident #3 which revealed that Resident #3 was admitted to the facility in [redacted] of [redacted] with a diagnoses of [redacted] and [redacted].</p> <p>During record review, the surveyor confirmed that the following medications were administered to Resident #3 in error: [redacted]</p> <p>The facility failed to ensure that Resident #3 received correct medication administration by the CMA on [redacted].</p> <p>Surveyor reviewed a facility policy dated 4/22/2025 titled, " Medication Error Policy" which revealed that ... "A medication error is defined as any discrepancy, irregularity, interruption of dosage of a prescribed medication due to human error. This includes failure to administer a</p>	A 935		

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A 935	Continued From page 3 medication, administration of the wrong medication, administration of the wrong amount of medication, failure to administer medication at the prescribed time, administration to the wrong resident, administration through the wrong route ... 2. The HWD/designee will notify the physician's office. Notification will be documented in the resident's progress notes along with any resulting physician's order ... 3. The HWD/designee will notify the family/personal representative of medication error and actions taken in response. Notification will be documented in the resident's progress notes..."	A 935		
A 941	8:36-11.5(b)(3)(i-v) Certified Medication Aide Program 3. The certified medication aide shall not: i. Administer any injection other than pre-drawn properly packaged and labeled insulin as described in (b)1 above; ii. Calculate a medication dosage; iii. Pre-pour medications for more than one resident at a time; iv. Contact prescribers for changes in medication, to clarify an order, or contact the pharmacist for questions regarding a dispensed medication; or v. Administer bolus doses of enteral feedings, or stop and/or start an existing enteral feeding pump or gravity-fed system.	A 941		

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A 941	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the Certified Medication Aide (CMA #2) administered medications within the scope of practice for 1 of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 11/13/25 at 10:50 a.m., the surveyor conducted a medication observation with CMA #2. Upon entering Resident #1's room, the surveyor observed four white pills in a pill cup, beside Resident #1. The surveyor interviewed Resident #1 about the four pills in the pill cup, on the bed. Resident #1 stated that he/she was not aware that there were pills left on the bed, and did not know who left the pills there.</p> <p>During continued medication observation, the surveyor interviewed CMA #2 and inquired about the four pills beside Resident #1. CMA #2 stated that she was not sure why the four medications were left in the cup beside Resident #1's bed, and she did not know who left the pills there. CMA #2 explained that Resident #1 medications were only administered by the facility staff and she confirmed that medications were not to be left in Resident #1's apartment.</p> <p>At 11:34 a.m., the surveyor interviewed the Director of Wellness (DOW), regarding the four pills observed in a pill cup in Resident #1's room, and inquired about prepouring medications. The DOW stated that the CMAs were not permitted to</p>	A 941		

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A 941	<p>Continued From page 5</p> <p>prepour medications. The suveyor asked the DOW who conducted medication observations with the CMAs. The DOW confirmed that she conducted quarterly medication observation with the CMAs, and that the CMAs were not allowed to leave medications in residents room. The surveyor requested a copy of Resident #1's service plan (SP).</p> <p>At 1:25 p.m., the surveyor reviewed the Medical Record (MR) of Resident #1 which revealed that Resident #1 was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted] NJ Exec Order 26.4b1, and [redacted] NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed the SP dated [redacted] NJ Ex Order 26.4b1 which revealed that Resident #1 required staff assistance with [redacted] NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed the Medication Administration Record (MAR) of Resident #1, and observed that there was no documentation that indicated Resident #1's medication was missed or refused.</p> <p>The surveyor reviewed a copy of printed progress notes (PN) dated [redacted] NJ Exec Order 26.4b1 and observed that there was no documentation that indicated Resident #1's medication was missed or refused.</p> <p>During the exit conference, the surveyor interviewed the Executive Director (ED) regarding the four medications left in a pill cup beside Resident #1's bed. The ED confirmed that the medications should not have been left in Resident #1's room.</p> <p>Surveyor reviewed a facility policy dated 6/30/2023 titled, "Medication Administration Records (MAR)/Medication Observation Record</p>	A 941		

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A 941	Continued From page 6 (MOR) "Policy" revealed that "... If a medication was not given or resident refused medication, staff should document this on the MAR/MOR. The staff member will document a detailed explanation of missed/refused dose on the back of the MAR/MOR or into the EHR system..."	A 941		
A 957	8:36-11.5(c) Certified Medication Aide Program (c) Each resident shall be identified prior to medication administration. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00189227 Based on observation, interview and record review, it was determined that the facility failed to ensure that a Certified Medication Aide (CMA #1) properly identified a resident prior to medication administration for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 11/10/25 at 10:13 p.m., the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The report included a document titled, "Incident date: [redacted] which revealed that at 9:45 a.m., Resident #3 received incorrect medications from a CMA. The CMA was immediately removed from the medication cart. Further review of the FRE, revealed that Resident	A 957		

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A 957	<p>Continued From page 7</p> <p>#3 received the following Incorrect medications: NJ Exec Order 26.4b1 [REDACTED]</p> <p>Resident #3 was assessed by the Registered Nurse (RN), vital signs were within NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 was identified to Resident #3.</p> <p>At 9:30 a.m., during entrance conference with the Executive Director (ED), the surveyor interviewed and inquired about the medication error incident. The ED confirmed that the CMA #1 administered the wrong medications to Resident #3. The ED explained that all measures were followed, and he also met with Resident #3 after the incident. The surveyor requested CMA #1's personnel records, incident reports, statements, summary and conclusion of the medication error incident.</p> <p>On 11/13/25 at 10:30 a.m., the surveyor interviewed Resident #3 and inquired about the medication error. Resident #3 stated that CMA #1 gave him/her the wrong morning medications. Resident #3 explained that he/she normally received three pills in the morning and noticed that CMA#1 gave him/her more than three pills. Resident #3 stated that he/she questioned CMA #1, and that was when CMA #1 realized that she had administered the wrong medications to the wrong resident. Resident #3 stated that he/she was informed also by the RN on duty about the medication error incident, an assessment was conducted every hour to monitor for any adverse reactions. Resident #3 also stated that the physician assessed him/her on that same day.</p> <p>At 1:25 p.m., the surveyor reviewed the Medical Record (MR) of Resident #3 which revealed that</p>	A 957		
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A 957	<p>Continued From page 8</p> <p>Resident #3 was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted] and [redacted].</p> <p>The surveyor reviewed the personnel record for CMA #1, who was hired on [redacted].</p> <p>At 4:06 p.m., the surveyor interviewed CMA #1 and inquired about the medication error with Resident #3 and what process was followed before medications were administered to Resident #3. CMA #1 stated that she had pulled up the intended resident on the Medication Administration Record (MAR) profile to administer the medication. CMA #1 stated that residents looked alike, so she assumed that was the intended resident. CMA #1 further stated that she called out Resident #3 by name, and Resident #3, acknowledged the name. So, she proceeded, and administered the medications to Resident #3. CMA #1 continued to explain that it was after the other staff verified the Resident #3, that was when she realized that she had administered another resident's medications to Resident #3. CMA #1 confirmed that she had not used the proper resident's verification to identify Resident #3, before medication administration.</p> <p>Surveyor reviewed a facility policy dated 6/30/2023 titled, "Medication Administration Records (MAR)/Medication Observation Record (MOR) Policy" revealed ... "The community will maintain a Medication Administration Record (MAR) or Medication Observation Record (MOR) for residents receiving medications. Each MAR/MOR should be accurate and up to date. The MAR/MOR may be on paper or electronic health records (EHR) ...Each MAR/MOR will be maintained for each resident and will include Resident's Name, Medication Name, Medication</p>	A 957		

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A 957	Continued From page 9 Dose, Frequency, Route, Time, Date of Medication, Ancillary direction... . Staff assisting/administering medications must refer to the MAR/MOR to obtain correct medication, time, dosage, and route of administration as ordered by the physician for each individual resident ..."	A 957		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of a thorough investigation to include witness statements and documentation and notes from health care and service providers after a medication error for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 11/10/25 at 10:13 p.m., the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to	A1073		

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A1073	<p>Continued From page 10</p> <p>the NJDOH. The report included a document titled, "Incident date: [redacted]" which revealed that at 9:45 a.m., Resident #3 received incorrect medications by Certified Medication Aide (CMA).</p> <p>On 11/13/25 at 9:30 a.m., during entrance conference with the Executive Director (ED), the surveyor interviewed the ED and inquired about the medication error incident. The ED confirmed that the CMA #1 administered the wrong medications to Resident #3, and explained that all measures were followed, and he also met with Resident #3 after the incident, and notified Resident #3's family. The surveyor requested CMA #1's personnel records, incident reports, statements, summary and conclusion of the incident.</p> <p>At 1:25 p.m., the surveyor reviewed the Medical Record (MR) of Resident #3 which revealed that Resident #3 was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted] and [redacted].</p> <p>The surveyor reviewed progress notes (PN) dated [redacted] and there were no evidence of incident documentation of Resident #3's medication error.</p> <p>Additionally, the surveyor reviewed the MR and that there were no documentation in the PN that showed Resident #3's physician and family were notified about the medication error incident.</p> <p>At 3:45 p.m., during exit conference with the ED, the surveyor informed the ED that there was no documentation in the MR and PN about the medication error incident on [redacted].</p> <p>At 4:06 p.m., during interview with CMA #1, the</p>	A1073		
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A1073	<p>Continued From page 11</p> <p>surveyor asked whether she had completed any statements after the medication error incident. CMA #1 explained that she was <small>NJ Exec Order 26.4b1</small> and <small>NJ Exec Order 26.4b1</small> about the incident. CMA #1 stated that she was removed from the medication cart immediately. She further stated that the pharmacy consultant was at the facility on that same day and conducted medication observation with her. The surveyor asked CMA #1 if she completed any statements of incident reports. CMA #1 stated that she could not remember if she completed statements of the incidents, because she was <small>NJ Exec Order 26.4b1</small> about the medication error.</p> <p>Surveyor reviewed a facility policy dated 4/22/2025 titled, " Medication Error Policy" which revealed that ... "A medication error is defined as any discrepancy, irregularity, interruption of dosage of a prescribed medication due to human error. This includes failure to administer a medication, administration of the wrong medication, administration of the wrong amount of medication, failure to administer medication at the prescribed time, administration to the wrong resident, administration through the wrong route ... 2. The HWD/designee will notify the physician's office. Notification will be documented in the resident's progress notes along with any resulting physician's order ... 3. The HWD/designee will notify the family/personal representative of medication error and actions taken in response. Notification will be documented in the resident's progress notes..."</p>	A1073		

SPRINGHILLS

CHERRY HILL™

Accepted 1/30/26

A 935 — N.J.A.C. 8:36-11.4(b) Administration of Medications

Requirement: All medications must be administered by qualified personnel per prescriber orders, policy, manufacturer requirements, warnings, and law.

Finding: Resident #3 received another resident's morning medications administered by CMA #1 **NJ Exec Order 26.4b1** Only **NJ Exec Order 26.4b1** were the resident's own meds.

1) Corrective Action for the Resident(s) Affected

- On **NJ Exec Order 26.4b1** resident #3 was immediately assessed by DOW, RN; vitals **NJ Exec Order 26.4b1** noted. Confirmed by the ED.
- Attending physician and family/representative notified on 11/7/2025; recommendations implemented. Confirmed by the ED.
- On 11/14/2025 A late-entry nursing note (dated **NJ Exec Order 26.4b1**) was completed by DOW to reflect the above assessments and notifications in accordance with professional standards and facility policy. Confirmed by the ED.
- On 11/7/2025, CMA #1 was removed from med pass by the ED, counseled, and placed on administrative hold pending investigation; returned to duty only after successful re-education and post-test competency validation by the pharmacy consultant same- day on 11/7/2025. Confirmed by the ED.

2) How We Identified Other Residents at Risk & Corrective Action

-All residents have the potential to be affected by deficient practice.

- 11/7–11/8/2025: DOW completed 100% review of the eMAR for the prior 72 hours to identify any variances, with resident condition checks where indicated—no additional errors found. Confirmed by Executive Director on 11/8/2025.
- 11/8/2025: DOW completed Med cart reconciliation and on-shift huddle training conducted to reeducate no pre-pour and one-resident-at-a-time administration. Confirmed by the Executive Director.

3) Systemic Changes to Prevent Recurrence

- On 11/7/2025, wellness staff began updating eMAR photos updated/current (≤ 12 months), with "Name Alert" banners for look-alike/sound-alike residents, and will be completed by 1/25/2026. Confirmed by the Executive Director.
- On 11/7/2025 Med cart organization standardized; "stop and verify" decals at each cart 11/7/2025. Completion confirmed by the Executive Director.

Education & Competency:

On 11/7/2025 the DOW will educate:

- All current Med Techs and Licensed Nurses with duties of med pass will be re-educated on policy, two identifiers, seven rights, look-alike risks, and error reporting. Completion will be confirmed by the Executive Director.
- Return-demonstration competency checklists for identification steps and eMAR documentation by the DOW or designee.

DOW will complete ongoing education and completing will be confirmed by the Executive Director by 1/31/2026.

4) Monitoring/Quality Assurance

Medication Pass Observations:

- On 11/7/2025 DOW or designee will conduct 2 unannounced med pass observations per week for 3 weeks, then 1/week (through 2/28/2026). Completion will be confirmed by the Executive Director.
- On 11/7/2025, Compliance with two identifiers and "seven rights." Any error will result in immediate coaching, by the DOW or designee, re-observation within 48 hours, and corrective action as applicable. Completion confirmed by the Executive Director.

eMAR Audits:

- On 11/7/2025, DOW or designee will conduct daily spot check of 10 resident EMAR per day, for accuracy and real-time documentation $\times 4$ weeks, then 1/week (through 1/31/2026) Completion will be confirmed by the Executive Director.

QAPI Oversight:

- On 11/7/2025 DOW initiated Monthly QAPI review to include any med error occurrence, MAR audit results, 3 months (Jan-Mar/2026), then quarterly thereafter. Completion will be reviewed with and confirmed by the Executive Director.

A 941 — N.J.A.C. 8:36-11.5(b)(3)(i-v) Certified Medication Aide Program

Requirement: CMAs shall not pre-pour for more than one resident, among other scope limits.

Finding: For Resident #1, four pills were left in a cup at bedside; CMA #2 could not account for them; medications are not to be left in room; no MAR/EHR documentation of missed/refused dose.

1) Corrective Action for the Resident(s) Affected

- NJ Exec Order 26.4b1 Resident #1 assessed—NJ Exec Order 26.4b1 Physician and family notified; guidance implemented. Confirmed by the Executive Director.
- NJ Exec Order 26.4b1 A late-entry nursing note documented the incident by the DOW, assessment, notifications, and any orders per professional standards. Completion confirmed by the Executive Director on NJ Exec Order 26.4b1

2) How We Identified Other Residents at Risk & Corrective Action

-All residents have the potential to be affected by deficient practice.

- 11/14 through 11/30/2025: an audit was conducted by the DOW/ designee in current resident apartments to verify no unattended medications. None were found. Confirmed by the Executive Director.
- 11/14/2025: MAR/EHR DOW/ designee completed review for all residents on that shift to confirm documentation of administered/missed/refused doses. Confirmed by ED.

3) Systemic Changes to Prevent Recurrence

On 11/14/2025, Med Tech and LPN's were educated by DOW on the company's Medication Policy to include the following:

- No pre-pouring for more than one resident; staff must remain with resident until medication is swallowed; no medications left at bedside unless there is a documented self-administration assessment and prescriber order.
- Missed/Refused Documentation: If not administered, staff must chart "missed/refused" and a detailed explanation in the MAR/EHR immediately, per policy.

Ongoing education by the DOW. Completion will be confirmed by the ED on 1/31/2026.

Service Plans:

- On 11/14/2025, DOW Reaffirmed Resident #1 is staff-assisted, not self-admin. Self-administration authorization, where applicable, will include assessment + prescriber order and secure storage plan. Audit will be completed for current resident service plans for accurate med assistance level by 1/31/2026. Completion will be confirmed by the Executive Director.

4) Monitoring/Quality Assurance

Room Rounds:

- On 11/8/2025, LPN or DOW to conduct daily random room rounds (5 rooms/day) for 4 weeks to ensure no unattended meds, then (5 rooms/ day) weekly through 2/28/2026. Completion will be confirmed by the Executive Director.

Documentation Audits:

- On 11/7/2025, DOW or designee will conduct daily spot check of 10 EMAR's per day, for accuracy and real-time documentation × 4 weeks, then 1/week (through 1/31/2026) Completion will be confirmed by the Executive Director.

QAPI:

- On 11/7/2025 DOW initiated Monthly QAPI review to include any med error occurrence, MAR audit results, 3 months (Jan-Mar/2026), then quarterly thereafter. Completion will be reviewed with and confirmed by the Executive Director.

A 957 — N.J.A.C. 8:36-11.5(c) Resident Identification Prior to Medication Administration

Requirement: Each resident shall be identified prior to medication administration.

Finding: CMA #1 failed to properly identify Resident #3 and administered another resident's medications; reliance on appearance and name call-out only.

- 1) Corrective Action for the Resident(s) Affected

- On [NJ Exec Order 26.4b1] Resident #3 was immediately assessed by DOW, RN; vitals [NJ Exec Order 26.4b1] noted. Confirmed by ED.
- Attending physician and family/representative notified on [NJ Ex Order 26.4(b)(1)] recommendations implemented. Confirmed by ED.
- A late-entry nursing note (dated [NJ Exec Order 26.4b1]) was completed by DOW to reflect the above assessments and notifications in accordance with professional standards and facility policy on [NJ Exec Order 26.4b1] Confirmed by ED.
- On [NJ Exec Order 26.4b1] CMA #1 was removed from med pass by the ED, counseled, and placed on administrative hold pending investigation; returned to duty only after successful re-education and post-test competency validation by pharmacy consultant same- day on [NJ Exec Order 26.4b1] Confirmed by the ED.

2) How We Identified Other Residents at Risk & Corrective Action

-All residents have the potential to be affected by deficient practice.

- On 11/7/2025 DOW reviewed 72-hour retrospective documentation and outcome review for all residents during the relevant period—no additional misidentification discovered. Confirmed by the Executive Director.

3) Systemic Changes to Prevent Recurrence

- On 11/7/2025, wellness staff began updating eMAR photos updated/current (≤12 months), with “Name Alert” banners for look-alike/sound-alike residents and will be completed by 1/25/2026. Confirmed by the Executive Director.

4) Monitoring/Quality Assurance

- On 11/7/2025 DOW initiated Monthly QAPI review to include any med error occurrence, MAR audit results, 3 months (Jan-Mar/2026), then quarterly thereafter. Completion will be reviewed with and confirmed by the Executive Director.

A 1073 — N.J.A.C. 8:36-15.6(b) Resident Records

Requirement: All assessments and treatments by health care and service providers shall be entered per professional standards; documentation/notes from all providers shall be entered accordingly.

Finding: Incomplete documentation of investigation and clinical notes for the 11/7/2025 medication error (missing witness statements, clinical notes, physician/family notifications in MR/PN).

1) Corrective Action for the Resident(s) Affected

- On ^{NJ Exec Order 26.4b1} [REDACTED] DOW completed late-entry progress notes for Resident #3 (timeline of event, assessments/vitals, physician/family notifications, orders, resident response). Confirmed by ED.
- On 11/7/2025, CMA #1 and involved staff submitted signed statements documenting their account of the event; these will be filed with the incident packet. Confirmed by the ED on 11/7/2025.

2) How We Identified Other Residents at Risk & Corrective Action

-All residents have the potential to be affected by deficient practice.

- On 11/14/2025 DOW will educate Nurses and Med Techs on:
 - RN assessment and monitoring documented per policy
 - Physician/family notifications documented per policy
 - Witness statements present, if applicable
 - Final investigation summary with conclusions and corrective actions
 - Any missing items will be corrected via late entries and documented addenda.

Ongoing education by the DOW. Completion will be confirmed by the ED on 1/31/2026.

3) Systemic Changes to Prevent Recurrence

On 11/7/2025 Education by DOW/ designee:

- Med tech's and Licensed nurses with incident reporting duties and supervisors will be re-educated by the DOW or designee on company documentation standards, and to include late-entry documentation.
- EHR: DOW or designee confirm required fields and alerts for incident notes. Completion will be confirmed by the Executive Director.

Ongoing education by the DOW. Completion will be confirmed by the ED on 1/31/2026.

4) Monitoring/Quality Assurance

- On 11/7/2025 DOW initiated Monthly QAPI review to include any med error occurrence, MAR audit results, 3 months (Jan-Mar/2026), then quarterly thereafter. Completion will be reviewed with and confirmed by the Executive Director.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04A006 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/30/2026 Y3
NAME OF FACILITY SPRING HILLS CHERRY HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 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 A0935	Correction	ID Prefix A0941	Correction	ID Prefix A0957	Correction
Reg. # 8:36-11.4(b)	Completed	Reg. # 8:36-11.5(b)(3)(i-v)	Completed	Reg. # 8:36-11.5(c)	Completed
LSC	01/30/2026	LSC	01/30/2026	LSC	01/30/2026
ID Prefix A1073	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/30/2026	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/13/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

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Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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FOLLOWUP TO SURVEY COMPLETED ON 11/13/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		