STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A024	A. BUILDING: _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE CHERRY H	1240 BRACE ROAD 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: Standard Census: 62 Sample Size: 7 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 310	8:36-3.4(a)(1) Administrator's Responsibilities (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;	A 310		

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

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Based on interview, and record review, it was determined that the Administrator failed to follow its policy and procedures titled, "Employee Infection and Vaccination Status," "General Orientation" and "Documentation of Employee Education and Training," for 7 of 7 employee files reviewed, Employee #'s 1, 2, 3, 4, 5, 6, and 7. This deficient practice was evidenced by the following:

On 10/8/25 at 9:28 a.m., the surveyor reviewed seven (7) personnel employees files, which revealed the following:

1. Employee #1, a Housekeeper was NJ Ex Order 26. 4B1 [redacted], and there was no documented evidence in the employee file to indicate that Employee #1 attended the General Orientation program upon employment. Additionally, the file did not contain documented evidence that the employee had an initial two step *NJ Ex Order 26. 4B1* [redacted], upon employment and annually.

2. Employee #2, a dietary staff was NJ Ex Order 26. 4B1 [redacted], and the employee file did not contain documented evidence that Employee #2 attended the General Orientation program. Additionally, there was no documented evidence to show that Employee #2 had an initial NJ Exec Order 26.4B NJ Ex Order [redacted] upon employment.

3. Employee #3, a Licensed Practical Nurse was *NJ Ex Order 26. 4B1*, and the employee file did not

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A 310	Continued From page 2	A 310		

contain documented evidence that Employee #3 attended the General Orientation program upon employment.

4. Employee #4, a Certified Home Health Aide was NJ Ex Order 26. 4B1, and the file did not contain documented evidence that the employee attended the General Orientation program upon employment.

5. Employee #5, a Certified Medication Aide was NJ Ex Order 26. 4B1, and the employee file did not contain documented evidence that the employee attended the General Orientation program. Additionally, the file did not contain documented evidence that Employee #5 had an initial NJ Exec Order 26.4B NJ Ex Order upon hire.

6. Employee #6, the Executive Director was NJ Ex Order and the employee file did not contain documented evidence that the employee attended the General Orientation program.

5. Employee #7, a Director of Wellness was NJ Ex Order , and the employee file did not contain documented evidence that the employee attended the General Orientation program.

At 2:30 p.m., the surveyor interviewed the Regional Employment Coordinator (REC) and inquired about the General Orientation program. The REC stated that the General orientation was conducted, and documentation was placed in the employee's file. Additionally, the REC stated that the hiring department manager was responsible to conduct their orientation.

The surveyor reviewed the facility policy and procedure titled "General Orientation" dated 5/14/2014, which revealed, "... Policy: Initial

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A 310	Continued From page 3 education and training will be provided to all newly hired employees on topics identified by state, local, or corporate requirements ... Employees should not begin the job specific orientation prior to attending the General Orientation program ..." In addition, the surveyor reviewed the facility policy and procedure and titled, "Documentation of Employee Education and Training" dated 5/14/2014, which revealed, "... documentation of an education program in the individuals education file may include ... and other 'evidence of learning' ..." The surveyor also reviewed the facility policy and procedure titled, "Employee Infection and Vaccination Status" which revealed, " ... Prior to or upon an employee's duty assignment, the facility will assess ... screening for tuberculosis ... 1. Employees will be current with mandated vaccinations prior to performing direct resident care ... "	A 310		
A 935	8:36-11.4(b) Administration of medications (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.	A 935		

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A 935	Continued From page 4 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) administered medications according to prescriber's orders for 1 of 7 residents, Resident #1. This deficient practice was evidenced by the following: On 10/7/25 at 10:41 a.m., the surveyor observed a medication administration with a CMA who was in the process of preparing medications to be administered to Resident #1. The surveyor observed that the CMA administered the medications to the resident and then returned to the medication storage cart without signing off in the electronic medication record (eMAR) that the medication had been administered. The surveyor then inquired of the CMA if she signed out the medications that were administered to the resident in the eMAR. The CMA stated that she documented that the medications were given to Resident #1 prior to administration. During the medication administration observation, the surveyor reviewed the resident's eMAR, which revealed that the resident was scheduled to receive the following medications at 9:00 a.m., that were signed by the CMA prior to administering the medications. 1. *NJ Ex Order 26. 4B1* tablet one time a day at 9:00 a.m., for *NJ Ex Order 26. 4B1*. 2. *NJ Ex Order 26. 4B1* by mouth one	A 935		

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A 935	Continued From page 5 time a day at 9:00 a.m., for NJ Ex Order 26. 4B1. 3. NJ Ex Order 26. 4B1 give 1 tablet one time a day at 9:00 a.m., for NJ Ex Order 26. 4B1 . 4. NJ Ex Order 26. 4B1 tablet give 1 tablet one time a day 9:00 a.m., for NJ Ex Order 26. 4B1. 5. NJ Ex Order 26. 4B1 tablet give 1 tablet one time a day at 9:00 a.m., for NJ Ex Order 26. 4B1. 6. NJ Ex Order 26. 4B1 give 1 NJ Ex Order 26. 4B1 times a day for NJ Ex Order 26. 4B1 at 9:00 a.m. The surveyor reviewed Resident #1's medical record which revealed that the resident moved into the facility NJ Ex Order 26. 4B1 . At 12:30 p.m., the surveyor interviewed the Director of Wellness (DOW) regarding the CMA signing out medication prior to administration. The DOW confirmed that medications should only be signed out after they have been administered. The surveyor reviewed the facilty policy and procedure titled, "Administration of Medication" dated 3/5/10, that revealed "...The Certified Medication Aides will assure the following are strictly adhered to : ...Administer the medication as prescribed ... documentation will be made on the residents MAR after each administration of medication."	A 935		
A 941	8:36-11.5(b)(3)(i-v) Certified Medication Aide Program 3. The certified medication aide shall not:	A 941		

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A 941	Continued From page 6 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. 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) administered medications according to standards of practice for 2 of 7 residents reviewed, Resident #2 and Resident #3. This deficient practice was evidenced by the following: On 10/7/25 at 10:36 a.m., the surveyor observed a medication administration with a Certified Medication Aide (CMA). During the medication observation, the surveyor observed the CMA prepare medication for two residents, Resident #2 and Resident #3, to be administered at the same	A 941		

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A 941	Continued From page 7 time. The surveyor observed the CMA prepare Resident #2's ordered NJ Ex Order 26. 4B1 [redacted]) give 1 tablet by mouth at 9:00 a.m. and NJ Ex Order 26. 4B1 [redacted]) give 1 tablet by mouth at 9:00 a.m. Additionally, the surveyor observed the CMA prepare NJ Ex Order 26. 4B1 [redacted] for Resident #3 to be administered by mouth at 9:00 a.m. The surveyor stopped the CMA from administering the medications to Resident #2 and Resident #3 at the same time in their apartment. The surveyor then interviewed the CMA regarding preparing medications at the same time for the two above residents. The CMA stated that Resident #2 and Resident #3 resided in the same apartment, and that she administered their medications together. During the interview, the CMA confirmed that she was trained to administer medication to one resident at a time. At 1:25 p.m., the surveyor reviewed the Medical Record (MR) of Resident #2 which revealed that Resident #2 was NJ Ex Order 26. 4B1 [redacted]. The surveyor reviewed the physician order sheet (POS) dated [redacted], which revealed that Resident #2 was ordered NJ Ex Order 26. 4B1 tablet by mouth twice a day at 11:00 a.m. and 5:00 p.m. Additionally, on [redacted], Resdient #2 was ordered NJ Ex Order 26. 4B1 [redacted] daily 11:00 a.m. At 2:00 p.m., the surveyor reviewed the MR of	A 941		

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A 941	Continued From page 8 Resdient #3 which revealed that Resident #3 was [redacted]. The surveyor reviewed the POS dated [redacted], which revealed that Resident #3 was ordered [redacted] capsule by mouth at 11:00 a.m. At 12:30 p.m., the surveyor interviewed the Director of Wellness (DOW) regarding the CMA administering medications to Resident #2 and Resident #3 at the same time. The DOW stated that she conducted training and medication observations with the CMAs monthly and quarterly. In addition, the DOW stated that medication staff were not allowed to administer medications to more than one resident at the same time. The surveyor reviewed the CMA medication training records, which revealed that the DOW conducted a medication observation and training with the CMA on [redacted]. In addition, the surveyor observed that during the [redacted] medication observation the CMA was checked of for not pre-pouring medication. At 1:00 p.m., the surveyor interviewed the Executive Director (ED) regarding the CMA administering medication to both residents at the same time. The ED stated that the CMA was removed from medication administration for additional training. The surveyor reviewed the undated CMA job description titled, "Drug administration Functions" which revealed, the CMA must "Accurately and safely prepare ... medications ... that may be ordered for resident use by the attending physician or Medical Director."	A 941		

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A1041	Continued From page 9	A1041		
A1041	8:36-14.3(a) Drills and Tests (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to request of the local fire department at least one joint fire drill be conducted annually. Upon scheduling a joint fire drill, the facility shall notify first aid and civil defense agencies of this drill and shall participate in community-wide disaster drills in accordance with N.J.A.C. 8:36-14.3(b). This deficient practice was evidenced by the following: On 10/7/25 at 10 a.m., the surveyor reviewed documentation provided by the Executive Director	A1041		

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A1041	Continued From page 10 (ED) and Maintenance Director (MD), which revealed that the facility had no documentation of having conducted a community-wide disaster drill in 2024. At 10:30 a.m., during interview, the MD confirmed that the facility had not held a community-wide disaster drill. The MD also stated that the facility had not held a Disaster Drill since his employment at the facility. The surveyor asked the MD how long the MD had held his position at the facility and the MD stated [redacted]. On 10/8/25 at 10:45 a.m., the surveyor interviewed the ED regarding the above disaster drill and the ED confirmed that the facility had not conduct a community-wide disaster drill in 2024.	A1041		
A1095	8:36-16.5(b) Automatic Fire Detection System (b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101.. This REQUIREMENT is not met as evidenced	A1095		

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A1095	Continued From page 11 by: Based on interview and record review, it was determined that the facility failed to inspect and maintain the building Fire Alarm and Detection system as required by the New Jersey Administrative Code 5:70 and National Fire Protection Association (NFPA) 72. This deficient practice was evidenced by the following: On 10/07/25 at 9:12 a.m., during the survey enterance, the surveyor made a request to the facility's Director of Nursing and DEVS to fill out the "Affidavit of Compliance" from 01/01/24 through 10/06/25 and then provide a filled out copy of the "Affidavit of Compliance" along with all Physical Environment Mandatory Inspections from 01/01/24 through 10/06/25 for review. The surveyor also requested a copy of the last smoke detectors sensitivity testing. At 11:10 a.m., the surveyor reviewed the following semi-annual Fire Alarm and Detection system inspections for 03/21/24 and 06/09/25. At 12:10 p.m., the surveyor made a request to the Executive Director (ED) to place a call to the Fire Alarm Inspection Vendor and ask for a copy of the last smoke detector sensitivity testing and provide the report on 10/08/25. On 10/08/25, the surveyor reviewed the Affidavit of Compliance provided by the ED which revealed that the facility conducted fire alarm and detection system inspections on 03/21/2024 and 06/09/25. However, the facility could not provide any additional semi-annual inspections and a smoke detector sensitivity testing. The facility went for 19 months without	A1095		

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A1095	Continued From page 12 conducting a semi-annual (every six months) fire alarm and detection system inspection. On 10/10/25 at 1:24 p.m., during the exit conference, the surveyor informed the ED of the above fire alarm and detection system concerns. Fire Safety hazard.	A1095		
A1097	8:36-16.6 Fire Suppression Systems All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on observations and record review, it was determined that the facility failed to conduct the Semi-Annual (every six months) Kitchen Fire Suppression System inspections and quarterly (every three months) Fire Sprinkler Inspections, in accordance with the New Jersey Uniform Fire Code 5:70 and New Jersey Uniform Construction Code 5:23. This deficient practice was evidenced by the following:	A1097		

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A1097	Continued From page 13 On 10/07/25 at 9:12 a.m., during the survey enterance, the surveyor made a request to the facility's Director of Nursing and DEVS to fill out the "Affidavit of Compliance" from 01/01/24 through 10/06/25 and then provide a filled out copy of the "Affidavit of Compliance" along with all Physical Environment Mandatory Inspections from 01/01/24 through 10/06/25 for review. At 9:20 a.m., in the presence of the DEVS, a tour of the building was conducted. At 9:34 a.m., during an inspection of the main kitchen, the surveyor observed that the inspection tag attached to the Kitchen stoves "Wet Chemical" fire suppression system was last inspected in October 2024. The surveyor also observed that the suppression nozzle over the 6 burner stove was not aimed correctly to cover the six burners on the stove. Additionally, the surveyor reviewed the following facility provided Mandatory Inspections which revealed the following: 1. Semi-Annual (every six months) Kitchen fire suppression system inspections for 10/06/24. 2. Quarterly (every three months) Fire Sprinkler system inspections for 05/09/24, 10/16/24, 01/21/25, 04/17/25 and 08/11/25. The facility conducted only one (1) semi-annual inspection for the kitchen fire suppression system in nineteen (19) month window from 01/01/24 through 10/06/25. The facility also conducted fire (5) quarterly sprinkler system inspections in the nineteen (19) month window from 01/01/24 through 10/06/25. At 11:45 a.m., a request was made to the Executive Director (ED) and DEVS and asked if	A1097		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE CHERRY H	1240 BRACE ROAD 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
A1097	Continued From page 14 the facility could provide any additional mandatory inspections for the Kitchen semi-annual fire suppression system inspections and Quarterly fire sprinkler system inspections along with a copy of the filled out Affidavit of Compliance for review. However, the ED could not provide any additional mandatory inspections for the kitchen semi-annual suppression system and quarterly fire sprinkler system. A review of the facility provided "Affidavit of Compliance" reads in part, Semi-annual Kitchen Suppression System Inspections, 10/16/24. Quarterly Sprinkler System System Tests and maintenance, 8/11/25, 19/16/24 and 01/21/25. On 10/10/25 at 1:24 p.m., during the exit conference, the surveyor informed the ED of the Kitchen Fire Suppression System inspections and Fire Sprinkler Inspections concerns. Fire Safety Hazard.	A1097		
A1249	8:36-17.7 Building and Grounds Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A024	A. BUILDING: _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE CHERRY HI	1240 BRACE ROAD 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
A1249	Continued From page 15	A1249		

This REQUIREMENT is not met as evidenced by:
Based on observation and record review, it was determined that the facility failed to maintain a safe and fire hazard environment for the 62 Residents who reside in the facility. This deficient practice had the potential to affect all residents and was evidenced by the following:

On 10/07/25 at 9:12 a.m., during the survey enterance at approximately 9:12 a.m., the surveyor made a request to the facility's Director of Nursing and DEVS to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.

On 10/7 and 10/8/25 at 9:20 a.m., in the presence of the facility DEV, an inspection tour of the facility was conducted and the surveyor observed the following fire and safety hazards:

1. On 10/7/25 at 10:12 a.m., during a closure test of the corridor double smoke doors between Residents apartment [redacted] and [redacted], the doors were released from the magnetic hold open devices and allowed to self-close. One door did not close into its frame.

The surveyor observed, measured and recorded a three (3) inch gap between the meeting edges and the closure test was repeated two additional times with the same results. This would allow fire, smoke and poisonous gasses to pass from one smoke compartment to another smoke

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A024	A. BUILDING: _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE CHERRY H	1240 BRACE ROAD 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
A1249	Continued From page 16 compartment in the event of a fire. 2. At 10:35 a.m., the surveyor observed inside the Blue Berry Hill outside enclosed center courtyard the "RED" plastic inserts for the two (2) illuminated exit signs were in disrepair and not RED. This disrepair left openings to the bulbs and live electric. The Fire Code requires illuminated exit signs to be Red or Green. 3. At 10:40 a.m., an inspection inside of Sampled Resident #6 apartment was conducted. Additionally, the surveyor observed, measured and recorded in the bathroom under the sink a 4" by 28" section of wallboard and a 4" by 14" section of wallboard to the right of the sink with a black mold like substance adhere to the wallboard. The surveyor also observed to the right of the Kitchenette sink an 11" by 12" section of wallboard with a black mold like substance adhere to the wallboard. 4. On 10/08/25 at 11:15 a.m., during a closure test of the corridor double smoke doors between Resident apartment NJ Ex Order 26. 4B1 the doors were released from the magnetic hold open devices and allowed to self-close into its frame. The surveyor observed, measured and recorded a 5/8 of an inch gap between the meeting edges. This closure test was repeated two additional times with the same results. This would allow fire, smoke and poisonous gasses to pass from one smoke compartment to another smoke compartment in the event of a fire. 5. At 11:31 a.m., during a closure test of the corridor double smoke doors in the service corridor, the doors were released from the magnetic hold open devices and allowed to self-close into its frame. One door moved	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A024	A. BUILDING: _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE CHERRY H	1240 BRACE ROAD CHERRY HILL, NJ 08034

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A1249	Continued From page 17 approximately 6 inches and stopped. The door rubbed on the floor and stopped. The surveyor observed, measured and recorded a 33" opening between the two corridor doors. This closure test was repeated two additional times with the same results. This would also allow fire, smoke and poisonous gasses to pass from one smoke compartment to another smoke compartment in the event of a fire. 6. At 11:35 a.m., the surveyor observed inside the service corridor a designated exit access (Illuminated exit sign above the doors) door that had a combination lock on the door. On 10/10/25 at 1:24 p.m., during the exit conference, the surveyor informed the Executive Director of the above concerns. Fire and Safety hazards.	A1249		

Rcd 12/16/25 POC #4 accepted 12/18/25

Harmony Village at Care One Cherry Hill

1240 Brace Road, Cherry Hill NJ, 08043

CARE ONE
TRUST IN OUR CARE

Plan of Correction Harmony Village at CareOne Cherry Hill #04A024 Survey Date: Oct. 7th & 8th 2025

A310

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   On 10/8/25, The Director of Clinical Services provided in-service education to the Administrator on the facility policies including: "Employee Infection and Vaccination Status," "General Orientation," and "Documentation of Employee Education and Training." The Administrator acknowledged understanding of the policies.

   Employee #1 was provided education on General Orientation on 11/10/25 by the Director of Wellness (DOW). Employee #1 verbalized understanding of this education.

   Employee #1 was administered a NJ Ex Order 26. 4B1 by the DOW on 11/10/25. The NJ Ex Order was assessed as being negative (0mm of induration).

   Employee #2 was provided education on General Orientation on 11/10/25 by the DOW. Employee #2 verbalized understanding of this education.

   Employee #2 was administered a NJ Ex Order 26. 4B1 by the DOW on 11/10/25. The NJ Ex Order was assessed as being negative (0mm of induration).

   Employee #3 was provided education on General Orientation on 11/10/25 by the DOW. Employee #3 verbalized understanding of this education.

   Employee #4 was provided education on General Orientation on 11/10/25 by the DOW. Employee #4 verbalized understanding of this education.

   Employee #5 was provided education on General Orientation on 11/10/25 by the DOW. Employee #5 verbalized understanding of this education.

   Employee #5 had a NJ Ex Order 26. 4B1 in the employee file dated 11/30/2020, prior to date of hire.

   Employee #6 was provided education on General Orientation on 11/10/25 by the DOW. Employee #6 verbalized understanding of this education.

   Employee #7 was provided education on General Orientation on 11/10/25 by the ED. Employee #7 verbalized understanding of this education.

No residents were negatively affected by this practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice.**

   All Residents have the potential to be affected by this practice.

3. **What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.**

   On 10/9/25 The Administrator created a General Orientation Checklist to ensure completion and compliance with the facility's General Orientation Policy.

   On 10/9/25 The Administrator provided in-service education to the facility's department heads. Education included the implementation of the General Orientation Checklist as well as on the policies titled, "Employee Infection and Vaccination Status," "General Orientation," and "Documentation of Employee Education and Training." The department heads acknowledged understanding of these policies and the implementation of the General Orientation Checklist.

   On 10/13/25 through 10/15/25 the Administrator and the Regional Employment Coordinator (REC) conducted an audit of all facility employee files to ensure staff received General Orientation at time of hire and had been screened for NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 prior to date of hire. Any missing items are being addressed.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.**

   The Director of Wellness or designee will conduct an audit of all newly hired staff to ensure screening of NJ Ex Order 26. 4B1 prior to hire as well as General Orientation upon date of hire.

   Audits will be conducted weekly x 4 weeks, then monthly x 3 months with results provided to the Administrator as well as to the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee meets on a monthly basis and will review the audits and provide recommendation for further audits as needed.

5. **Completion Date:** 11/15/25

Harmony Village at Care One Cherry Hill

1240 Brace Road, Cherry Hill NJ, 08043

A 941

Plan of Correction-

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   On 10/7/25, the Director of Wellness (DOW) immediately removed the CMA removed from passing medications and provided in-service re-education to the CMA on the CMA job description titled, "Drug Administration Functions." The CMA acknowledged understanding of this important job function.

   On 10/9/25, the Consultant Pharmacist provided observation of the CMA for medication administration. The CMA correctly prepared and administered medications for one resident at-a-time.

   On 10/7/25, The Director of Wellness (DOW) reviewed the medication orders for Resident #2. There were no untoward findings.

   Resident #2 had no negative effects related to this practice.

   On 10/7/25, The DOW reviewed the medication orders for Resident #3. There were no untoward findings.

   Resident #3 had no negative effects related to this practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

   All Residents have the potential to be affected by this practice.

3. **What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.**

   On 10/7/25 and 10/23/25, the Director of Wellness (DOW) provided in-service education to the Certified Medication Aides (CMAs), Licensed Practical Nurses

(LPNs) and Registered Nurses (RNs) working the 7-3pm, 3-11pm, and 11-7am shifts. Education included the facility's policy titled, "Administering Medications." Staff acknowledged understanding of the policy.

On 10/7/25 and 10/23/25, the DOW provided in-service education to the CMAs working the 7-3pm, 3-11pm and 11-7am shifts. Education included the CMA job description titled, "Drug Administration Functions." Staff acknowledged understanding of the education.

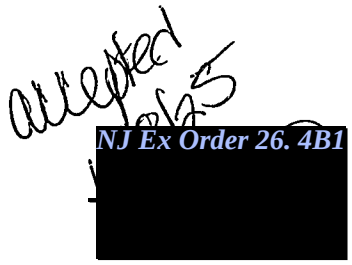
On 10/7/25, 10/9/25, 10/15/25, 10/16/25,10/26/25, 10/30/25 the DOW conducted an observation of 3 CMAs provided medication administration to ensure medications were being prepared and administered in accordance with the facility's policy titled, "Administering Medications." There were no untoward findings.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change**

The Director of Wellness or designee will conduct random audits of 2 Certified Medication Aides (CMAs) to ensure they are passing medications in accordance with their job description and the facility's policy titled, "Administering Medications."

Audits will be conducted weekly x 3 weeks, then monthly x 3 months with results presented to the Administrator and the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI committee meets on a monthly basis and will review the audits and provide feedback for further audits as needed.

5. Completion Date: 10/23/2025



Harmony Village at Care One Cherry Hill

1240 Brace Road, Cherry Hill NJ, 08043

A1041

Plan of Correction-

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   On 10/8/25, the Regional Environmental Director provided inservice education to the Enviromental Services Director on the requirement to invite civil defense agencies (the local fire department) annually to conduct a joint drill at the facility. The Environmental Services Director acknowledged understanding of this requirement.

   Facility Disaster Drill was conducted on 10/22/25 with the local Police and Fire Department in attendance.

   No residents were negatively affected by this practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice.**

   All Residents have the potential to be affected by this practice.

3. **What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.**

   Facility Disaster Drill conducted 10/22/25 with Cherry Hill Police and Fire Department in attendance.

   The Environmental Services Director has added to the facility calendar, an annual invite of local civil defense agencies to perform joint disaster drill training.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.**

The Environmental Services Director or designee will audit the calendar to ensure invitations are extended to local civil defense agencies to annual disaster drill training. Audits will be conducted every six months x 1 year. Results of the audits will be provided to the Administrator and the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee meets on a monthly basis and will review the audits and provide feedback for further audits as needed.

5. **Completion Date:** 10/22/2025

Rcd 12/16/25 [redacted]
DOC#4

POC ACCEPTED 12/18/2025

[redacted]

Harmony Village at Care One Cherry Hill

1240 Brace Road, Cherry Hill NJ, 08043

CARE ONE
TRUST IN OUR CARE

A1095

Plan of Correction-

1. **How the corrective action will be accomplished for those residents found to have been affected by this deficient practice.**

   On 10/8/25 the Regional Director of Environmental Services provided in-service education to the Director of Environmental Services. Education included the requirement in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition to include semi-annual fire alarm and detection system inspection. The Environmental Services Director acknowledged understanding of the regulation.

   On 10/9/25 the Environmental Services Director contacted the vendor to conduct an inspection of the fire alarm and smoke detector sensitivity detection system. Completed on 12/8/25 .

   No residents were negatively affected by this practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

   All Residents have the potential to be affected by this practice.

3. **What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.**

   The Environmental Services Director has added to the facility calendar, a semi-annual inspection of the fire alarm and detection system.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change**

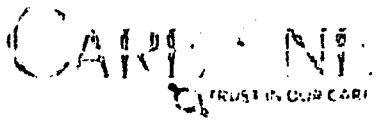
The Environmental Services Director or designee will audit the calendar to ensure semi-annual inspections are scheduled and completed in accordance with the regulation. Audits will be conducted every six months x 1 year.

Results of the audits will be provided to the Administrator and the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee meets on a monthly basis and will review the audits and provide feedback for further audits as needed.

5. **Completion Date:** 12/8/2025

Harmony Village at Care One Cherry Hill

1240 Brace Road, Cherry Hill NJ, 08043



A1097

Plan of Correction-

1. **How the corrective action will be accomplished for those residents found to have been affected by this deficient practice.**

   On 10/8/25, the Regional Environmental Services Director provided in-service education to the Environmental Services Director on the required mandatory inspections that include: 1) semi-annual (every six months) fire Sprinkler Inspections and 2) Quarterly (every three month) Fire Sprinkler Inspections in accordance with the New Jersey Uniform Fire code 5:70 and New Jersey Uniform Construction Code 5:23. The Environmental Services Director acknowledged understanding of this education.

   On 10/8/25, the Maintenance Director immediately reconfigured the kitchen equipment to ensure the suppression nozzle lined up appropriately.

   On 10/8/25 the Fire Suppression Inspection completed by the vendor.

   No residents were adversely affected by this practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

   All Residents have the potential to be affected by this practice.

3. **What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.**

   On 10/9/25, the Environmental Services Director conducted an inspection of the suppression nozzles over the 6 burner stove to ensure alignment to correctly cover the six burners on the stove.

   The Environmental Services Director has added to the facility calendar, a semi-annual inspection of the Kitchen Fire suppression system.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change**

   The Environmental Services Director or designee will audit the calendar to ensure semi-annual inspections of the Kitchen fire suppression system are scheduled and completed in accordance with the regulation. Audits will be conducted every six months x 1 year.

   Results of the audits will be provided to the Administrator and the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee meets on a monthly basis and will review the audits and provide feedback for further audits as needed.

5. **Completion Date:** 10/9/2025

Harmony Village at Care One Cherry Hill

1240 Brace Road, Cherry Hill NJ, 08043

A1249

Plan of Correction-

1. **How the corrective action will be accomplished for those residents found to have been affected by this deficient practice:**

   On 11/20/25, the Regional Environmental Services Director provided in-service education to the Environmental Services Director with regards to the requirement for building and grounds maintenance. The Environmental Services Director verbalized understanding of this education.

   On 10/13/25, the Environmental Services Director replaced the red plastic inserts for the (2) Illuminated EXIT signs outside the NJ Ex Order 26. 4B1 enclosed courtyard.

   On 12/4/2025, the Environmental Services Director adjusted the corridor double doors between Resident NJ Ex Order and Resident NJ Ex Ord apartments.. The doors when released from the magnetic hold, were able to close completely onto its frame leaving no gap for fire, smoke and poisonous gases to pass from one smoke compartment to another smoke compartment in the event of a fire.

   Resident #43 had NJ Exec Order 26.4b1 related to this practice.

   Resident #45 had NJ Exec Order 26.4b1 related to this practice.

   On 10/13/25, the Environmental Services Director removed, assessed and replaced the 4"x28" section of wallboard (with the NJ Ex Order 26. 4B1 substance) under the bathroom sink in Resident #6's bathroom; as well as removed, assessed and replaced the 11"x12" section of wallboard (with the NJ Ex Order 26. 4B1 substance) to the right of the kitchenette sink in Resident #6's bathroom.

   Resident #6 had no untoward effects related to this practice.

   On 10/9/2025 the Environmental Services Director adjusted the corridor double doors between Resident NJ Ex Order and Resident NJ Ex Order 26. apartments. The doors, when released from the magnetic hold, were able to close completedly onto its frame leaving leaving no gap for fire, smoke and poisonous gases to pass from one smoke compartment to another smoke compartment in the event of a fire.

Resident #14 had NJ Exec Order 26.4b1 related to this practice.

Resident #16 had NJ Exec Order 26.4b1 related to this practice.

On 10/9//25 the Environmental Services Director adjusted and planed the corridor double smoke doors in the service corridor. The doors, when released from the magnetic hold, were able to close completedly onto its frame leaving leaving no gap for fire, smoke and poisonous gases to pass from one smoke compartment to another smoke compartment in the event of a fire.

On 10/8/25 the Environmental Services Director immediately removed the combination lock on the service corridor door.

On 10/8/25 the Regional Enviromental Services Director provided in-service education to the Environmental Services Director and the environmental services department on the importance of not placing (combination) locks on designated exit access doors. Staff acknowledged understanding of this education.

No residents were adversely affected by this practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

   All Residents have the potential to be affected by this practice.

3. **What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.**

   On 10/9/25, the Regional Environmental Services Director along with the Environmental Services Director conducted an inspection of all resident rooms to assess for wallboards in bathrooms and around sinks, with black unkown substances. There were no other findings.

   On 10/9/25, the Environmental Services Director immediately conducted rounds on the units to ensure all illuminated exit signs were in red. There were no other findings.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change:**

   The Director of Environmental Services or designee will conduct inspections of all corridor double smoke doors to ensure complete closure without gaps. Inspections will be conducted monthly x 3 months, then quarterly x 3 quarters.

The Director of Environmental Services or designee will conduct regular audits of the illuminated exit signs to ensure all exit signs are lit in red color. Audits will be conducted weekly x 4 weeks, then monthly x 3 months then quarterly x 3 quarters.

The Director of Environmental Services or designee will conduct inspections of all resident bathrooms to ensure no presence of black unknown substance on wallboards or around sinks in resident's rooms/apartments. Inspections will be conducted on 10 resident rooms weekly x 3 weeks, then monthly x 3 months, then quarterly x 3 quarters.

Results of the audits will be presented to the Administrator as well as to the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee meets monthly and will review the audits and provide recommendation for further audits as needed.

5. **Completion Date:** 12/4/25

Respectfully Submitted:

NJ Ex Order 26. 4B1

NJ Exec Order 26.4b1

Executive Director

Harmony Village at CareOne Cherry Hill

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A024	A. BUILDING: _____ B. WING _____	R 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE CHERRY H	1240 BRACE ROAD 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: Standard Census: 62 Sample Size: 7 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}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/21/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
04A024 Y1	A. Building B. Wing Y2	10/8/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE CHERRY HILL	1240 BRACE ROAD 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 A0310	Correction	ID Prefix A0935	Correction	ID Prefix A0941	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-11.4(b)	Completed	Reg. # 8:36-11.5(b)(3)(i-v)	Completed
LSC	11/15/2025	LSC	10/23/2025	LSC	10/23/2025
ID Prefix A1041	Correction	ID Prefix A1095	Correction	ID Prefix A1097	Correction
Reg. # 8:36-14.3(a)	Completed	Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-16.6	Completed
LSC	10/22/2025	LSC	12/08/2025	LSC	10/09/2025
ID Prefix A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/04/2025	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	
10/8/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO