

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2024
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NAME OF PROVIDER OR SUPPLIER HARMONY VILLAGE AT CAREONE CHERRY HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1240 BRACE ROAD 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</p> <p>COMPLAINT #: NJ00159798</p> <p>CENSUS: 53</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		
A1051	<p>8:36-15.2 Resident Records</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00159798</p> <p>Based on interview, and record review it was determined that the facility failed to ensure requested medical records were available for</p>	A1051		

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

TITLE

(X6) DATE

05/17/24

New Jersey Department of Health

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A1051	<p>Continued From page 1</p> <p>review by the Surveyor from the New Jersey Department of Health for 3 of 3 residents reviewed for medication administration Resident #'s: 1, 2, and 3. The deficient practice was evidenced by the following:</p> <p>On 4/29/2024 at 9:12 a.m., during the survey entrance conference, the surveyor informed the facility's Executive Director (ED) and Director of Nursing (DON) that documents from the year [redacted] were needed during the survey. At that time, the facility's ED and DON stated that the facility may not have all the requested documents from [redacted] due to the facility changing owners, and their Electronic Medical Records System (EMRs).</p> <p>At 10:48 a.m., the surveyor requested multiple documents for Resident #'s: 1, 2 and 3. The requested documents included the residents' Medication Administration Records (MARs), and Physician Order Sheets (POS) for the months of [redacted] and [redacted] for Residents #'s 1 and 3 and the MARs and POS for the months of [redacted] and [redacted] for Resident #2.</p> <p>The surveyor reviewed Resident #1's medical record (MR) and observed a document titled, "Admission Record" which indicated an Admission Date of [redacted], and diagnoses which included [redacted] and [redacted]. The surveyor observed that the MR was incomplete and that the MARs and POS for the month of [redacted] were not provided to the surveyor.</p> <p>The surveyor reviewed Resident #2's medical record (MR) and observed a document titled, "Admission Record" which indicated an Admission Date of [redacted], and diagnoses</p>	A1051		

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A1051	<p>Continued From page 2</p> <p>which included NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). Review of the facility's Admit - Discharge Registrar revealed Resident #2 had a move out date of NJ Ex Order 26.4(b)(1). Continued review of Resident #2's MR revealed that the surveyor was not provided with Resident #2's MARs and POS for the month of NJ Ex Order 26.4(b)(1).</p> <p>The surveyor reviewed Resident #3's medical record (MR) and observed a document titled, "Admission Record" which indicated an Admission Date of NJ Ex Order 26.4(b)(1) a diagnosis of NJ Ex Order 26.4(b)(1). Continued review of Resident #3's MR revealed that the surveyor was not provided with Resident #3's MARs and POS for the month of NJ Ex Order 26.4(b)(1).</p> <p>At 11:40 a.m., during surveyor interview, the facility's DON stated that the above mentioned documents were not available due to the facility's transition to a new EMR system in NJ Ex Order 26.4(b)(1). The DON also stated that the facility did not have access to the previous EMR system.</p> <p>At 12:00 p.m., during surveyor interview the facility's ED stated that the facility was still attempting to get requested documents from NJ Ex Order 26.4(b)(1).</p>	A1051		
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04A024	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/22/2024
NAME OF FACILITY HARMONY VILLAGE AT CAREONE CHERRY HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A1051	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:36-15.2	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	06/14/2024	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 _____	
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 4/29/2024	<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
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