

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Standard and Complaints</p> <p>COMPLAINT #: NJ00159272, NJ00159570, NJ168647, NJ169504, NJ00173454</p> <p>CENSUS: 48</p> <p>SAMPLE: 11</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 517	<p>8:36-5.6(b)(1-7) General Requirements</p> <p>(b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following:</p> <p>1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment;</p>	A 517		

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

TITLE

(X6) DATE

08/14/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	<p>Continued From page 1</p> <ol style="list-style-type: none"> 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19. <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide documented evidence that 10 of 10 employees received the required in-service training in Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain</p>	A 517		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	<p>Continued From page 2</p> <p>Management. These in-services were to be provided upon hire and annually thereafter. This deficient practice was evidenced by the following:</p> <p>On 6/5/2024 at 9:30 a.m., the surveyor reviewed the employee personnel files and observed there was no documented evidence in the following employee files that the employees received the required in-services listed:</p> <ol style="list-style-type: none"> Employee #1 was hired on NJ ex order 26.4b1 as a Caregiver, there was no completed required annual in-service training on: Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain Management. Employee #2 was hired on NJ ex order 26.4b1 as a Caregiver, there was no completed required annual in-service training on: Assisted Living Concepts, Resident Rights, Abuse and Neglect, Dementia Training, Emergency Training, and Pain Management. Employee #3 was hired on NJ ex order 26.4b1 as a Caregiver, there was no completed required annual in-service training on: Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain Management. Employee #4 was hired on NJ ex order 26.4b1 as a Caregiver, there was no completed required annual in-service training on: Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain Management. Employee #5 was hired on NJ ex order 26.4b1 as a Caregiver, there was no completed required 	A 517		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	<p>Continued From page 3</p> <p>annual in-service training on: Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain Management.</p> <p>6. Employee #6 was hired on [redacted] as a Caregiver, there was no completed required annual in-service training on: Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain Management.</p> <p>7. Employee #7 was hired on [redacted] as the Resident Services Coordinator, there was no completed required in-service training upon hire for Assisted Living Concepts, Dementia Training, Emergency Training, and Pain Management.</p> <p>8. Employee #8 was hired on [redacted] as the Building Services Coordinator, there was no completed required annual in-service training on: Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain Management.</p> <p>9. Employee #9 was a Licensed Practical Nurse (LPN) [redacted] there was no completed required annual in-service training on: Assisted Living Concepts, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain Management.</p> <p>10. Employee #10 was a LPN [redacted], there was no completed required annual in-service training on: Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, Emergency Training, and Pain</p>	A 517		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 517	Continued From page 4 Management. On 6/5/2024 at 9:14 a.m., the surveyor interviewed the Administer who stated that the online system used for employee in-services was switched as of January 2024. Additionally, it was noted that the facility no longer had access to the prior system, nor was there a record that all employees completed their annual training for 2023. The surveyor observed a facility policy titled, "Personnel Records" revised on 12/24/2023, which revealed: "The department leadership should maintain departmental personnel records that may contain the following:... 6. Education and in-service documentation ..."	A 517		
A 547	8:36-5.7(a)(6) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 6. Policies and procedures for the maintenance of personnel records for each employee, including at least his or her name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, records of orientation and inservice	A 547		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

A 547	<p>Continued From page 5</p> <p>education, and evaluation of job performance;</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of facility employee files, it was determined that the facility failed to ensure that personnel records for each employee were completed and maintained for 4 of 10 employees reviewed, Employees #7, #8, #9, # 10. This deficient practice was evidenced by the following:</p> <p>On 6/5/2023 at 9:30 a.m., the surveyor reviewed the personnel files for Employee #'s 7, 8, 9, 10 and observed that they failed to contain the following:</p> <ol style="list-style-type: none"> 1. Employee #7 was hired on [redacted] as the Resident Service Coordinator. There was no documented evidence in the personnel file of a [redacted]. 2. Employee #8 was hired on [redacted] as the Building Service Director. There was no documented evidence in the personnel file of a [redacted]. Additionally, there was no documented evidence of orientation. 3. Employee #9, the [redacted], is a Licensed Practical Nurse (LPN) from a contracted agency. There was no evidence of a [redacted] job description, and no evidence of work history or an application. 4. Employee #10, the [redacted] is a LPN from a contracted agency. There was no evidence a [redacted], job description, or a background 	A 547		
-------	--	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 547	<p>Continued From page 6</p> <p>check.</p> <p>At 11:00 a.m., the surveyor interviewed the Administer who confirmed that Employees #7 and #8 did not have a [REDACTED] in their personnel files. Additionally, Employee #8 did not have evidence of orientation in his file.</p> <p>At 12:35 p.m., the surveyor interviewed the Administrator, who confirmed that Employees # 9 and #10 did not receive orientation from the facility, nor was there a [REDACTED] or [REDACTED] check conducted by the facility.</p> <p>The surveyor reviewed a facility policy titled, "Personnel Records" with a revised date of 12/24/2023, which revealed: under "Departmental Employee Records [,] The department leadership should maintain departmental personnel records that may contain the following:</p> <ul style="list-style-type: none"> ...6. Education and in-service documentation 7. Licensure, certification, registration. 8. Copy of current job description. 9. Departmental orientation ..." 	A 547		
A 749	<p>8:36-7.3(a) Resident Assessments and Care Plans</p> <p>(a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p>	A 749		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

A 749	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00173454</p> <p>Based on interview and record review, it was determined that the facility failed to revise the General Service Plan (GSP) after NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) for 2 of 11 residents reviewed, Resident #1 and #2. This deficient practice was evidenced by the following:</p> <p>On 4/29/2024, 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 "date of event NJ Ex Order 26.4(b)(1)" and a "time of event 1:30 p.m." The report revealed that Resident #2 was NJ Ex Order 26.4(b)(1) Resident #1 NJ ex order 26.4b1. Resident #2 told the caregiver NJ ex order 26.4b1 The incident was unwitnessed but corroborated by Resident #1. Both residents were NJ Ex Order 26.4(b)(1), evaluated and NJ ex order 26.4b1.</p> <p>1. On 5/28/2024 at 10:15 a.m., the surveyor reviewed Resident #2's medical record (MR), Resident #2 had a move-in date of NJ Ex Order 26.4(b)(1) with diagnoses that included NJ Ex Order 26.4(b)(1)</p> <p>Surveyor review of Progress Notes (PNs) written by Licensed Practice Nurse (LPN #2) on NJ ex order 26.4b1 at 1:20 p.m. revealed that Resident #1's LPN (LPN #1), notified her of the incident when Resident #1 NJ ex order 26.4b1 The Caregiver of Resident #2 observed him/her NJ Exec Order 26.4b1 Resident #1 in the hallway. Resident #2 stated NJ ex order 26.4b1 The event was unwitnessed, however, the caregiver heard Resident #1 NJ Ex and went to observe, all parties were made aware: physician,</p>	A 749		
-------	--	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

A 749	<p>Continued From page 8</p> <p>family, Executive Director (ED), Director of Nursing (DON), the [redacted] and [redacted] Resident #2 was [redacted] and [redacted] through the unit. Family was notified that Resident #2 was placed on a [redacted]. Resident #2 [redacted] NJ ex order 26.4b1</p> <p>Surveyor review of PNs, written by the ED, dated [redacted] at 1:48 p.m. revealed Resident #2 [redacted] another resident which resulted in the other resident [redacted] NJ Ex Order 26.4(b)(1) for [redacted]. Family was notified and ED talked to the Nurse Practitioner (NP). Surveyor review of Resident #2's GSP revealed no updated interventions in place after this incident with Resident #1.</p> <p>2. On 5/28/2024 at 10:46 a.m., the surveyor reviewed Resident #1's MR, and observed Resident #1 had a move-in date of [redacted] with diagnoses which [redacted] NJ ex order 26.4b1</p> <p>Surveyor review of Resident #1's PNs written by LPN #1 on [redacted] at 1:20 p.m. revealed Resident #1 was in the hallway talking to Resident #2. Resident #2 [redacted] Resident #1, he/she [redacted] against the [redacted] NJ Exec Order 26.4b1. Resident #1 [redacted] his/her [redacted] NJ Exec Order 26.4b1 [redacted], and [redacted] was noted to the [redacted] of his/her [redacted] NJ Exec Order 26.4b1. Vital signs were done and the following were notified: the family, the physician, the ED, the DON and [redacted] Resident #1 [redacted] NJ ex order 26.4b1</p> <p>Review of 2nd PNs written by the ED on [redacted] at 1:28 p.m. revealed per LPN #1 Resident #1 was involved in a [redacted] NJ Exec Order 26.4b1 [redacted] and [redacted] NJ ex order 26.4b1</p>	A 749		
-------	---	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 749	<p>Continued From page 9</p> <p>Surveyor review of Resident #1's GSP revealed no updated interventions after the incident with Resident #2.</p> <p>On 5/28/2024 at 1:07 p.m., during surveyor interview with the Director of Nursing/Resident Services Coordinator (DON/RSC), when asked when the GSP gets updated, she replied, the service plan would only be updated for Resident #2 because he/she NJ ex order 26.4b1, and not for Resident #1. When the surveyor showed the DON/RSC the GSP for Resident #2, she replied, "normally after an incident yes, the GSP would be updated, I don't see anything (updates)."</p> <p>During a telephone interview on 5/31/2024 at 9:57 a.m. the surveyor interviewed the Certified Nursing Assistant (CNA #1) involved in the incident, she stated that she was in the hallway with the Nurse and another CNA talking in the hallway between the houses and in the corner of her eye she could see Resident #1 was already in the hallway and Resident #2 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Resident #1, NJ ex order 26.4b1. The NJ ex order 26.4b1. She NJ ex order 26.4b1 Resident #1's NJ ex order 26.4b1 and Resident #2 walked away with a CNA by his/her side.</p> <p>During a telephone interview on 5/31/2024 at 10:40 a.m., the surveyor interviewed the agency LPN #2, Nurse assigned to the house near to where the incident occurred. She was informed by Resident #1's Nurse (LPN #1) that Resident #2 NJ Ex Order 26.4(b)(1) Resident #1 and he/she NJ ex order 26.4b1, the residents were NJ Ex Order 26.4(b)(1) and she was sending Resident #1 NJ ex order 26.4b1. LPN#1 evaluated Resident #2 and gave him/her NJ Exec Order 26.4b1, called the family, the physician and the ED, the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) LPN #1</p>	A 749		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 749	<p>Continued From page 10</p> <p>sent Resident #2 to the [REDACTED] Resident #2 told her that he/she [REDACTED] Resident #1 and she documented the incident on an incident report and a progress note. In the same interview when the surveyor asked her who updates the GSP, she replied the DON updated the GSP.</p> <p>On 6/4/2024 at 10:27 a.m., the surveyor asked the DON, in the presence of the Assistant Director of Nursing (ADON), how will she ensure Resident #1 [REDACTED] Resident #2 and how will the staff know to ensure [REDACTED] The DON replied there was a 24 hour report and staff were aware of any behaviors. The DON continued to say for any type of incident, the GSP was updated, but if it was a behavior without an injury, the GSP was not updated. The difference between an incident and a behavior is an injury.</p> <p>On 6/5/2024 at 9:39 a.m., the surveyor asked the Administrator what is the difference between an incident and a behavior, she replied an incident and a behavior is a fine line based on clinical discretion. She continued to say, an incident has an injury and if there is no injury and not a new behavior, it is a behavior..."</p> <p>At the time of the survey, the other staff involved in the FRE were not available for interview.</p> <p>Review of facility policy titled, "Alert Charting" dated 6/2021 revealed the following: Under "Guideline: The Alert Charting Log is a tracking and communication system to alert licensed nurses to change in a resident's condition that warrants continued observation ...Documentation in the electronic clinical record may include, but is not limited to: ...Revision of a service plan including the resident's problem or focus, goal and interventions planned to manage the</p>	A 749		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 749	Continued From page 11 resident's condition ... RSC (Resident Services Coordinator) reviews as part of Daily Clinical Review ..."	A 749		
A 963	<p>8:36-11.5(f) Pharmaceutical Services</p> <p>(f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00173454</p> <p>Based on observation, interview and review of medical records, it was determined that the facility failed to ensure medications were documented as administered to residents in accordance with prescriber's orders for 2 of 11 residents reviewed for medication administration, Residents #1 and Resident #2. Additionally, it was determined that the facility failed to ensure that controlled substances were accounted for, reconciled, and consistently documented as counted between shifts. The deficient practices were evidenced by the following:</p> <p>1. On 5/28/2024 at 10:15 a.m., the surveyor reviewed Resident #2's medical record (MR) and observed a move-in date of [redacted] with diagnoses that [redacted].</p> <p>[redacted] Surveyor review of Resident #2's Physician's Order Sheet (POS) dated [redacted] [redacted] revealed the</p>	A 963		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 963	<p>Continued From page 12</p> <p>resident had current orders as follows:</p> <p>NJ Exec Order 26.4b1 milligram (mg) Tablet for NJ Exec Order 26.4b1 Give NJ tablet by mouth every morning at 7A (7 am)</p> <p>NJ Exec Order 26.4b1 mg Tablet for NJ Exec Order 26.4b1 Give NJ tablets (NJ mg) by mouth at bedtime at and 7 P (7 pm)</p> <p>NJ Exec Order 26.4b1 mg Tablet NJ Tab (Tablet) by mouth every 12 hours at 7 am and 7 pm</p> <p>NJ Exec Order 26.4b1</p> <p>NJ twice daily at 7 am</p> <p>NJ Exec Order 26.4b1 mg Tablet for NJ Exec Order 26.4b1 Take NJ Tablet (NJ mg total) by mouth daily at 7 am</p> <p>NJ Exec Order 26.4b1 mcg Tablet for NJ Exec Order 26.4b1 mcg Take NJ tablet by mouth every day at 7 am</p> <p>NJ Exec Order 26.4b1 Capsule for NJ Exec Order 26.4b1 Give NJ Cap by mouth twice daily at 7 am and 3 pm</p> <p>NJ Exec Order 26.4b1 mg Tablet for NJ Exec Order 26.4b1 Give NJ tablet by mouth twice daily (in the morning and in the evening) Hold if NJ Exec Order 26.4b1 at 7 am and 7 pm</p> <p>The surveyor then reviewed Resident #2's April Medication Administration Record (MAR) and observed that the following medications were not documented as administered according to prescriber's orders as follows:</p> <p>NJ Exec Order 26.4b1 mg NJ tablet in the morning at 7 am</p> <p>NJ Exec Order 26.4b1 mg NJ tablets at 7 pm on NJ Exec Order 26.4b1.</p> <p>NJ Exec Order 26.4b1 Surveyor noted a box on the space for NJ Exec Order 26.4b1 with no initials</p> <p>NJ Exec Order 26.4b1 tablet at 7 am on NJ Exec Order 26.4b1</p> <p>at 7 am on NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 tablet at 7 am on NJ Exec Order 26.4b1</p>	A 963		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

A 963	<p>Continued From page 13</p> <p>NJ Exec Order 26.4b1 tablet at 7 am on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 capsule at 7 am on NJ ex order 26.4b1 NJ Exec Order 26.4b1 tablet at 7 am on NJ ex order 26.4b1</p> <p>Additionally, the surveyor reviewed Resident #2's POS dated NJ ex order 26.4b1 which revealed the following orders: NJ ex order 26.4b1 by mouth in the morning and at bedtime. Surveyor review of Resident #2's May MAR revealed the above medication was not administered as prescribed at 7 pm on NJ ex order 26.4b1. Surveyor noted a box on the space for NJ ex order 26.4b1 with no initials. The surveyor also reviewed Resident #2's PNs section of the medical record, however, there was no documented evidence to address the blank spaces or boxes noted on the MARs.</p> <p>During surveyor interview with the Director of Nursing/Resident Services Coordinator (DON/RSC) on 5/28/2024 at 1:07 p.m., the DON/RSC the surveyor inquired about the NJ ex order 26.4b1 MAR for Resident #2's NJ ex order 26.4b1 for the dates of NJ ex order 26.4b1 and asked what does a box written on the MAR mean with a blank space, and a blank space? The DON/RSC stated "I don't know what the box means, but a blank space means the Nurse forgot to sign it [the medication] out and didn't give it [the medication]."</p> <p>During a telephone interview on 5/31/2024 at 10:28 a.m. with the Licensed Practice Nurse (LPN #3) assigned to Resident #2 on NJ ex order 26.4b1, when asked what a blank space means on the MAR, she replied "[a] blank space means someone [a Nurse] did not sign out the medication and it [the medication] was not given</p>	A 963		
-------	--	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 963	<p>Continued From page 14</p> <p>per my nursing knowledge."</p> <p>2. On 5/28/2024 at 10:46 a.m., the surveyor reviewed Resident #1's MR and observed a move-in date of [redacted] with diagnoses which [redacted].</p> <p>During surveyor review of Resident #1 POS dated [redacted] revealed current medication orders for the following:</p> <p>[redacted]</p> <p>[redacted] for 12 hours at 6 am on and off at 6 pm [redacted] mg tablet for [redacted] tablet by mouth every day at 6 am [redacted] mg tablet for [redacted] tab by mouth at bedtime at 6 pm [redacted] 24 HR (hour) [redacted]</p> <p>6 am on and off 6 pm [redacted] mg tablet for [redacted] tablet by mouth every day at 6 am [redacted] at 11-7, 7-3, 3-11</p> <p>Surveyor review of Resident #1's [redacted] MAR revealed the above medications were not administered as prescribed on the following dates:</p> <p>[redacted]</p> <p>[redacted] tablet at 6 A on [redacted] at 6 pm on [redacted] and [redacted] at 6</p>	A 963		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

A 963	<p>Continued From page 15</p> <p>pm on NJ ex order 26.4b1</p> <p>NJ ex order 26.4b1</p> <p>NJ ex order 26.4b1 at 6 am on NJ ex order 26.4b1</p> <p>NJ ex order 26.4b1 at 11-7 on NJ ex order 26.4b1 through NJ ex order 26.4b1; at 7-3 on NJ ex order 26.4b1 and at 3-11 on NJ ex order 26.4b1</p> <p>NJ ex order 26.4b1</p> <p>NJ ex order 26.4b1</p> <p>Complaint # NJ00168647</p> <p>3. On 6/5/2024 at 9:55 a.m., the surveyor conducted an interview with the facility Resident Care Director, (RCD) who stated that on her first day of employment with the facility, which was NJ ex order 26.4b1, the Corporate Nurse (CN) noted that there were discrepancies with the narcotic count shift to shift, and that the narcotic count sheets were largely blank on almost every cart. The RCD further stated that there was no consistent process being followed, but a process was put in place by the beginning of April. The RDC stated that the CN conducted a review of all carts, interviewed and in-serviced all Nurses and that three Nurses received disciplinary action that included suspension.</p> <p>The RCD stated that the new protocol included having two Nurses sign when they received a controlled substance from the pharmacy, or needed to destroy narcotics that were discontinued; and, that there had been much improvement in the consistency of counting the narcotics between shifts.</p> <p>During continued surveyor interview when asked if a policy was put in place, the RCD stated that</p>	A 963		
-------	--	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 963	<p>Continued From page 16</p> <p>she did not think so and that it was more of a protocol, but she would check.</p> <p>On 6/5/24 at 12:30 p.m., the surveyor reviewed the facility document titled, "Narcotic and Controlled Substance Shift-To-Shift Count Sheet", that included the instructions that "All resident supply AND emergency supply controlled substances must be counted at every shift change."</p> <p>The surveyor observed missing signatures on The Narcotic and Controlled Substance Shift-To-Shift Count Sheet on the following dates and shifts:</p> <p>For the month of September 2023: Boathouse Cove House: off-going first shift: 9/1, 9/2, 9/3, 9/8, 9/9, 9/14, 9/23, 9/24, 9/26, 9/28, 9/30 on-coming first shift: 9/1, 9/5, 9/13, 9/24 off-going second shift: 9/1, 9/11, 9/13, 9/23, 9/24, 9/25 on-coming second shift: 9/1, 9/13, 9/18, 9/19, 9/23, 9/25, 9/26, 9/28, 9/30 off-going third shift: 9/1, 9/2, 9/25, 9/26, 9/30 on-coming third shift: 9/1, 9/2, 9/6, 9/8, 9/22, 9/23, 9/25, 9/27, 9/29, 9/30</p> <p>Country Lane: off-going first shift: 9/1, 9/2, 9/3, 9/8, 9/9, 9/11, 9/14, 9/23, 9/24, 9/26, 9/28 on-coming first shift: 9/1, 9/5, 9/12, 9/13, 9/24, 9/30 off-going second shift: 9/1, 9/5, 9/11, 9/12, 9/13, 9/23, 9/24, 9/25, 9/30 on-coming second shift: 9/1, 9/18, 9/25, 9/26, 9/27 off-going third shift: 9/1, 9/2, 9/17, 9/25, 9/26, 9/27</p>	A 963		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 963	<p>Continued From page 17</p> <p>on-coming third shift: 9/1, 9/2, 9/6, 9/7, 9/8, 9/10, 9/13, 9/22, 9/23, 9/25, 9/27</p> <p>Cottage: off-going first shift: 9/1-9/3, 9/7, 9/8, 9/23, 9/24, 9/26, 9/28 on-coming first shift: 9/1-9/7, 9/12, 9/13, 9/20, 9/24 off-going second shift: 9/1-9/7, 9/11-9/13, 9/20, 9/21, 9/23-9/25, 9/28 on-coming second shift: 9/1, 9/2, 9/6, 9/7, 9/14, 9/21, 9/25 off-going third shift: 9/1, 9/2, 9/7, 9/8, 9/14, 9/21 on-coming third shift: 9/1, 9/2, 9/6-9/8, 9/13, 9/14, 9/22, 9/23, 9/25, 9/27</p> <p>Garden Path off-going first shift: 9/1-3, 9/8, 9/9, 9/23, 9/24, 9/26, 9/28 on-coming first shift: 9/1-9/7, 9/24, 9/26 off-going second shift: 9/1-9/7, 9/11, 9/23-9/26, 9/28 on-coming second shift: 9/1, 9/2, 9/15, 9/21, 9/23, 9/25-9/27, 9/30 off-going third shift: 9/1, 9/2, 9/6, 9/7, 9/23, 9/25-9/27 on-coming third shift: 9/1, 9/2, 9/6-9/8, 9/23, 9/25, 9/27, 9/30</p> <p>The surveyor reviewed the Narcotic and Controlled Substance Shift-To-Shift Count Sheets for the months of September 2023 through March of 2024 which revealed that there was a consistent pattern of multiple missing signatures for each month. The surveyor did not however observe Narcotic and Controlled Substance Shift-To Shift Count Sheets for the month of October 2023.</p> <p>The surveyor interviewed the facility ED about the</p>	A 963		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 963	<p>Continued From page 18</p> <p>missing Narcotic Count Sheets for the month of October 2023 and she stated that she provided all of the sheets that she could find, but would take another look. The ED was unable to provide documentation of Narcotic Count Sheets, or that narcotics had been counted, for the month of October 2023.</p> <p>Review of facility policy titled, "Medication Administration: Medication Pass," dated 6/2021 revealed the following under "Purpose: To safely and accurately prepare and administer medication according to physician order and resident needs [.]". Under "...8. Administer medication...Document initials on MAR for each medication administered..."</p>	A 963		
A 999	<p>8:36-11.7(e) Pharmaceutical Services</p> <p>(e) Discontinued or expired medications shall be destroyed within 30 days in the facility, or, if unopened and properly labeled, returned to the pharmacy for credit, if allowable, and in conformance with N.J.A.C. 13:39 and other State and Federal laws, codes, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00159272</p> <p>Based on observation, interview, and review of resident records and pertinent facility documents, it was determined that the facility failed to destroy expired medications. This deficient practice was evidenced by the following:</p> <p>On 6/4/24 at 10:09 a.m., the surveyor asked the Licensed Practical Nurse (LPN) to open the</p>	A 999		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 999	<p>Continued From page 19</p> <p>medication cart located in the Cottage Unit. The surveyor observed medications that were stored in the cart and dispensed in a Bingo card (a medication delivery system designed to deliver unit of use doses of a medication in a compartment or bubble). The surveyor observed the following medications with past due expiration dates:</p> <p>Carbidopa and Levodopa ER Tablet 25mg-100mg with an expiration date of 2/29/2024 Amlodipine Besylate 2.5mg tablet with an expiration date of 5/31/2024 Acetaminophen 650mg Tablet ER with an expiration date of 2/29/2024 Meloxicam 15mg tablet with an expiration date of 5/24/24 Donepezil Hydrochloride 10mg Tablet with an expiration date of 5/31/24 Amlodipine Besylate 5mg tablet with an expiration date of 4/30/2024 Acetaminophen 650mg Tablet ER with an expiration date of 5/31/2024</p> <p>At 10:20 a.m., the surveyor asked another LPN to open the medication cart located in Country. The surveyor observed medication that was stored in the cart and dispensed in a Bingo card. The surveyor observed the following medications with past due expiration dates:</p> <p>Oxybutynin Chloride 5mg Tablet with an expiration date of 3/31/2024 Acetaminophen 650mg Tablet ER with an expiration date of 5/31/2024 Sertraline HCL F/C 100mg Tablet with an expiration date of 3/31/2024 Quetiapine Fumarate 50mg Tablet with an expiration date of 3/31/2024 Quetiapine Fumarate 50mg Tablet with an expiration date of 5/31/2024 Quetiapine Fumarate 50mg Tablet with an</p>	A 999		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 999	<p>Continued From page 20</p> <p>expiration date of 2/29/2024 Escitalopram Tablet 10mg Tablet with expiration date of 04/30/2024 Famotidine Tablet 20mg Tablet with an expiration date of 3/31/2024 Mucinex 500mg Tablet with an expiration date of 4/12/2024 Memantine Hydrochloride 10mg Tablet with an expiration of 05/31/2024 Quetiapine Fumarate 25mg Tablet with an expiration date of 5/31/2024 Benzonatate 100mg Capsule with an expiration date of 4/30/2024 Atorvastatin Calcium 40mg Tablet with an expiration date of 5/31/2024 Escitalopram Tablet 10mg Tablet with expiration date of 03/31/2024</p> <p>At 12:51 p.m., during surveyor interview with the Resident Services Coordinator (RSC), she stated that she is responsible for checking and cleaning the medication carts. The RSC continued to state that she checked all the medications in three (3) out of four (4) of the community/unit medication carts "about four or five weeks ago" but that she could not remember the exact medication carts.</p> <p>The RSC further confirmed that the expired medications should have been removed from the medication cart.</p> <p>The surveyor reviewed the facility's procedure titled, "Medication Cart Audit" which documented, "... Complete medication cart audit on a weekly basis ... Expired or discontinued medication removed and reordered if needed"</p> <p>The facility failed to remove and destroy expired medications mm from the active inventory of medications in accordance with the regulations</p>	A 999		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 999	Continued From page 21 and per facility "Medication Cart Audit" procedure.	A 999		
A1225	<p>8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance</p> <p>(b) The following safety conditions shall be met:</p> <p>8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition;</p> <p>i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and</p> <p>ii. The written statement shall be available for review by the Department during survey.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an electrician conducted an annual inspection of the facility's electrical system and provided a statement that the system was satisfactory and in safe condition. This deficient practice had the potential to affect all</p>	A1225		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1225	Continued From page 22 residents who currently resided in the facility. Findings included: Review of the facility's life safety code system maintenance reports revealed no documentation to indicate an electrician inspected the facility's electrical system in the past year. During an interview on 06/04/2024 at 9:45 AM, the Building Service Coordinator stated there were no written policies in the facility to conduct the required annual electrician review.	A1225		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-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. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, and interview, the facility failed to ensure the building and grounds were kept free from fire hazards and other hazards to residents' health and safety. Specifically, the facility failed to ensure their remote annunciator panel for their	A1249		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1249	<p>Continued From page 23</p> <p>emergency generator was located in a constantly attended location, failed to clean their kitchen exhaust hood system semiannually, failed to inspect their fire alarm system semi-annually, and failed to conduct fire drills on each shift quarterly. These deficiencies had the potential to affect all residents who currently resided in the facility.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 06/04/2024 beginning at 11:40 AM, the surveyor noted the remote annunciator panel for the emergency standby generator was not located in a constantly attended location as required by the applicable life safety code standard. The panel was in the laundry room in the Cottage Wing. The Building Services Coordinator (BSC) stated he was unaware that the current location of the panel was not in compliance with the applicable life safety code standard. 2. A review of the facility's life safety code system inspection and maintenance documentation revealed no documentation to indicate the facility's main kitchen exhaust hood system semi-annual cleaning in accordance with in National Fire Protection Association (NFPA) 96, Standard for Ventilation Control and Fire Protection of Commercial Kitchen Operations. <p>During an interview on 06/04/2024 at 11:40 AM, the BSC stated he was unaware of the semi-annual cleaning requirements. The BSC stated the facility did not have a policy regarding environmental surveillance rounds.</p> <ol style="list-style-type: none"> 3. A review of the facility's life safety code system inspection and maintenance documentation 	A1249		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1249	<p>Continued From page 24</p> <p>revealed the last documented fire alarm system testing and inspection was conducted on 08/10/2023.</p> <p>During an interview on 06/04/2024 at 11:40 AM, the BSC stated he was unaware of the semi-annual requirements.</p> <p>4. A review of the facility's life safety code system inspection and maintenance documentation revealed no documentation to indicate a fire drill was conducted during the second shift of the second quarter of 2023, the second shift and the third shift during the third or fourth quarter of 2023, or during the third shift in the first quarter of 2024.</p> <p>During an interview on 06/04/2024 at 11:40 AM, the BSC stated he was unaware that the frequency of the completed fire drills were out of compliance. The BSC stated the facility did not have a written policy on the frequency of conducting fire drills.</p>	A1249		
A1275	<p>8:36-18.2(a)(1) Infection Prevention and Control Services</p> <p>(a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications and OSHA standards, incorporated herein by reference, as amended and supplemented:</p> <p>1. Guidelines for Hand Hygiene in Health Care Settings, MMWR/51 (RR-16), October 25, 2002;</p>	A1275		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1275	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility staff failed to perform proper hand hygiene techniques in accordance with the Centers for Disease Control (CDC) and the facility's policy for 2 of 10 staff members observed for handwashing, Employee #'s 1 and 2. This deficient practice was evidenced by the following:</p> <p>On 6/4/2024 during a tour of the facility for a standard survey with complaints, the surveyor observed the following staff members for hand hygiene:</p> <p>1. At 10:35 a.m., the surveyor observed Employee #1 wash her hands at the kitchenette sink. Employee #1 applied soap scrubbed her hands for 20 seconds and then rinsed under running water. Employee #1 dried her hands with a paper towel and retrieved a new paper towel that was used to turn off the sink. The employee failed to first wet her hands before applying soap. Upon post-observation interview, Employee #1 stated that she was educated on handwashing.</p> <p>2. On 6/4/2024 at 10:48 a.m., the surveyor observed Employee #2 wash her hands at the kitchenette sink. Employee #2 applied soap scrubbed her hands for 20 seconds and then rinsed under running water. Employee #1 dried her hands with a paper towel and retrieved a new paper towel that was used to turn off the sink. The employee failed to first wet her hands before</p>	A1275		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1275	<p>Continued From page 26</p> <p>applying soap. Upon post-observation interview, Employee #2 stated that she was educated on handwashing.</p> <p>On 6/5/2024 at 12:30 p.m., the surveyor reviewed an in-service form dated ^{NJ Ex Order 26.4b1} [REDACTED] which reviewed handwashing. Employee #1 and Employee #2's signatures were noted on the sign-in form, which indicated that they both received handwashing education.</p> <p>The surveyor reviewed a facility policy titled, "Hand Hygiene/ Artificial Nails", revised in April 2024, which stated: "Handwashing</p> <ol style="list-style-type: none"> I. Wet hands with water ... II. Apply soap ... III. Lather hands and scrub for a minimum of 15 seconds ... IV. Rinse thoroughly under running water. V. Dry hands with a paper towel. VI. Turn off the faucet with a paper towel." <p>The facility staff failed to ensure that all employees followed the "Handwashing/Artificial Nails" policy.</p> 	A1275		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 15A001 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/16/2024 Y3
NAME OF FACILITY ARDEN COURTS (CHERRY HILL)	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 CHAPEL AVENUE CHERRY HILL, NJ 08002	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0517	Correction	ID Prefix A0547	Correction	ID Prefix A0999	Correction
Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-11.7(e)	Completed
LSC	08/14/2024	LSC	08/14/2024	LSC	08/14/2024
ID Prefix A1225	Correction	ID Prefix A1249	Correction	ID Prefix A1275	Correction
Reg. # 8:36-17.3(b)(8)(i-ii)	Completed	Reg. # 8:36-17.7	Completed	Reg. # 8:36-18.2(a)(1)	Completed
LSC	08/14/2024	LSC	08/14/2024	LSC	08/14/2024
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 6/5/2024		<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 		