

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/16/2022
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NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT CHERRY HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1979 ROUTE 70 EAST CHERRY HILL, NJ 08003
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint and COVID-19 Focused Infection Control</p> <p>COMPLAINT #: NJ145110 and #NJ152505</p> <p>CENSUS: 72</p> <p>SAMPLE SIZE: 14</p> <p>SURVEY DATE: 03/15/2022 and 03/16/2022</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, based on this Complaint Survey.</p> <p>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> <p>The facility was found to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19, based on this COVID-19 Focused Infection Control Survey.</p>	A 000		

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

TITLE

(X6) DATE

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A 367 A 367	<p>Continued From page 1</p> <p>8:36-4.1(a)(7) Resident Rights</p> <p>(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:</p> <p>7. The right to have or not to have families' and friends' participation in resident service planning and implementation;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ 152505 and C# NJ145110</p> <p>Based on interviews and record review, it was determined the facility failed to ensure residents' power of attorneys (POAs)/responsible parties (RP) were notified when there were changes in medications for three of four residents, Resident #1, Resident #13, and Resident #14 and when NJ Ex Order 26.4b1 occurred for two of four residents, Resident #12 and Resident #14), reviewed for notifications of POAs and RPs.</p> <p>Findings included:</p> <p>1. The surveyor's review of Resident #1's medical record revealed that the resident was admitted to the facility with diagnoses which included NJ Ex Order 26.4b1. A review of the medical record's face sheet indicated Resident #1's family member was the resident's POA and RP.</p>	A 367 A 367		

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A 367	<p>Continued From page 2</p> <p>A surveyor's review of the medication orders for Resident #1 indicated the resident had been prescribed [redacted] NJ Ex Order 26.4b1 and was then discontinued on [redacted] NJ Ex Order 26.4b1. There was no documentation in the clinical record that the facility notified the Resident #1's POA of the new medication, [redacted] NJ Ex Order 26.4b1, and when the medication was started.</p> <p>Review of Licensed Practical Nurse (LPN) #2's progress note, written and dated [redacted] NJ Ex Order 26.4b1, read, "... family requesting resident [be] taken off [redacted] NJ Ex Order 26.4b1. Faxed request to ... APN [advanced practice nurse] and received an order to discontinue [redacted] NJ Ex Order 26.4b1</p> <p>On 03/15/2022 at 10:53 AM, the Resident Care Director stated there was no written policy for the facility to notify the POA of a medication being started or stopped. She stated it would be the responsibility of the doctor making the order to inform the family of the change.</p> <p>On 03/16/2022 at 9:45 AM, LPN #1, the wellness nurse, stated that it was the responsibility of the nurses to notify the family and POA of changes in medications. She then stated that it would be documented in the progress notes when the family was notified. She was asked about the [redacted] NJ Ex Order 26.4b1 being started and asked when they notified Resident #1's family. LPN #1 looked through the clinical record and stated that there was nothing to indicate that the resident's family had been notified.</p> <p>On 03/16/2022 at 10:35 AM, the surveyor interviewed LPN #2 and was asked about the medication changes for Resident #1. She stated that the family never knew the resident was on</p>	A 367		

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A 367	<p>Continued From page 3</p> <p>that medication and once they found out, the family member requested the medication be discontinued. She then stated that it was the responsibility of the floor nurse to notify the family of the medications being changed.</p> <p>On 03/16/2022 at 10:53 AM, the surveyor interviewed the Resident Care Director and was asked as to when the POA was notified of the [redacted] medication being started. She looked through the clinical record for the notification and once completed, she stated that there was no documentation that the family was notified that Resident #1 was started on [redacted]. She then stated that medications were not a change in condition and the physician should be the one notifying of the change.</p> <p>On 03/16/2022 at 11:37 AM, the surveyor interviewed the Executive Director (ED) and was asked when the family was notified of the [redacted] being added to Resident #1's routine medications. The ED stated that the physician nor the nurses notify the resident's family. The ED then stated that the family found out when they requested the medication list. The ED then added that the facility did not have a system in place for notifying family of medication changes.</p> <p>2. Surveyor's review of Resident #13's medical record revealed that Resident #13 had diagnoses which included [redacted]. A review of the medical record's face sheet indicated that a family member was the resident's power of attorney (POA) and responsible party (RP).</p> <p>A review of the history of medication orders</p>	A 367		

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A 367	<p>Continued From page 4</p> <p>indicated (NJ Ex Order 26.4b1) was discontinued on (NJ Ex Order 26.4b1) and that the resident was started on (NJ Ex Order 26.4b1)</p> <p>Further review of Resident #13's medical record revealed that there was no documentation that the resident's POA/RP had been notified of the medication changes that occurred in (NJ Ex Order 26.4b1) and (NJ Ex Order 26.4b1).</p> <p>On 03/16/2022 at 9:58 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reviewed the clinical record for documentation of notification of the medication changes, including when medications were started and discontinued. After the review, she stated there was nothing to indicate that the POA/RP had been notified of the medication changes.</p> <p>On 03/16/2022 at 11:00 AM, the Resident Care Director was asked about the changes in the medication and if the facility had notified the POA/RP of the medication changes. She stated the POA/RP had not been notified of the medication stopping and the new one starting. She then stated there was nothing in the record of the medication changes.</p> <p>On 03/16/2022 at 11:40 AM, the surveyor interviewed the Executive Director (ED) and was asked about the notification of Resident #13's POA/RP of the resident's medication changes. The ED stated that she had no information, and that it was the facility's understanding that the physician would notify the POA/RP. The surveyor asked the ED regarding how the facility ensured that physicians notified the POAs/RPs of the changes. She stated the facility did not have a process in place to ensure the notification was</p>	A 367		
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A 367	<p>Continued From page 5 provided.</p> <p>3. Surveyor's review of Resident #14's medical record revealed that the resident had diagnoses which included NJ Ex Order 26.4b1 [REDACTED]. A review of the medical record's face sheet indicated that Resident #14's family member was the resident's power of attorney (POA) and responsible party (RP). Surveyor's review of Resident #14's history of medication orders revealed that the medication, NJ Ex Order 26.4b1 [REDACTED], was discontinued on NJ Ex Order 26.4b1 [REDACTED].</p> <p>A review of facility incident reports from NJ Ex Order 26.4b1 [REDACTED], for Resident #14, indicated that the resident had NJ Ex Order 26.4b1 [REDACTED] no documentation to indicate the POA/RP had been notified of NJ Ex Order 26.4b1 [REDACTED]. There was no documentation on the incident reports or the electronic record that the POA/RP had been notified of NJ Ex Order 26.4b1 [REDACTED] and/or the medications being stopped.</p> <p>On 03/16/2022 at 10:15 AM, during surveyor's interview with Licensed Practical Nurse (LPN) #1, she looked through the resident's medical record for documentation of the resident's POA/RP being notified of NJ Ex Order 26.4b1 [REDACTED] and the medication changes. She looked through the electronic chart and reviewed all documentation. She stated that the POA/RP was not notified of the changes and there was nothing indicating the POA/RP had been notified of NJ Ex Order 26.4b1 [REDACTED].</p> <p>On 03/16/2022 at 11:06 AM, the surveyor interviewed the Resident Care Director and asked when the resident's POA/RP was notified of the</p>	A 367		

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A 367	<p>Continued From page 6</p> <p>medication changes and [redacted]. The DON then stated that the POA/RP had not been notified of NJ Ex Order 26.4b1 [redacted] being stopped.</p> <p>4. Surveyor reviewed Resident #12's medical record which revealed resident's diagnoses which included NJ Ex Order 26.4b1 [redacted].</p> <p>[redacted] A review of the incident reports for Resident #12 from NJ Ex Order 26.4b1 [redacted], indicated that the resident had [redacted].</p> <p>[redacted] There was no documented evidence that the resident's power of attorney (POA)/responsible party (RP) was notified of [redacted].</p> <p>On 03/16/2022 at 11:00 AM, the surveyor interviewed the Resident Care Director and asked about the resident's [redacted] documented on NJ Ex Order 26.4b1 [redacted]. The surveyor asked as to who was notified of the resident's [redacted] stated that there were no notes documented in the medical record in reference to the NJ Ex Order 26.4b1 [redacted] and that the incident report was blank. The DON then stated that the POA/RP needed to be notified of [redacted] and that it did not occur.</p> <p>On 03/16/2022 at 11:44 AM, the surveyor interviewed the Executive Director (ED) and asked as to when the POA/RP was notified of [redacted]. The ED stated there was nothing documented regarding [redacted] and that a notification occurred. The ED then stated that they had no further information to provide.</p>	A 367		