STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A002	A. BUILDING: _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT CHERRY HILL	1979 ROUTE 70 EAST CHERRY HILL, NJ 08003

(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: Complaint COMPLAINT #: NJ00162319 CENSUS: 104 SAMPLE SIZE: 3 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 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, any elopements; and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and	A 563		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 563	Continued From page 1 extent of damages;	A 563		

This REQUIREMENT is not met as evidenced by:
NJ00162319

Based on interview and record review, it was determined that the facility failed to immediately report a medication error to the Department of Health (DOH) which resulted in a medication [redacted] and hospitalization for 1 of 3 residents, Resident #2. This deficient practice was evidenced by the following:

On 3/15/23 at 12:35 p.m., the surveyor reviewed Resident #2's Medical Record (MR). According to the "Resident Face Sheet Profile," Resident #2 moved into the facility on [redacted] with diagnoses which included NJ Ex Order 26.4(b)(1) ([redacted]).

During review of the MR, the surveyor identified documentation in the "Progress Notes" dated [redacted] which indicated the Resident Care Director (RCD) documented [Resident #2] with "c/o [complaints of] [redacted] and [redacted].Vital signs [were] taken (clinical measurements) and [Resident #2's [redacted]." Resident #2 on [redacted] was "given NJ Ex Order 26.4(b)(1) ([redacted]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT CHERRY HILL	1979 ROUTE 70 EAST CHERRY HILL, NJ 08003

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A 563	Continued From page 2 NJ Ex Order 26.4(b)(1)) @ [at] 7:30 am [a.m.] despite not having an order stating to do so...it was decided to send [Resident #2] to [the] ER [Emergency Room] as NJ Ex would not stabilize." According to the hospital "After Visit Summary," Resident #2 was initially seen on NJ Ex Order 26.4 and admitted for NJ Ex Order 26.4(b)(1) after being NJ Ex Order 26.4(b)(1) by administration of NJ Ex Order 26.4(b)(1) at facility." Resident #2 was discharged from the hospital on NJ Ex Order 26.4. On 3/15/23 at 2:29 p.m., the surveyor interviewed the RCD regarding the administered NJ Ex Order 26.4(b) of NJ Ex Order 2 given to Resident #2, and the RCD explained that an internal investigation was conducted, training of staff, and a report was sent to the DOH. The RCD provided the surveyor with copies of the report and upon review the report to the DOH was dated NJ Ex Order 26.4 which was NJ Ex O and NJ Ex Order 26.4(b)(1 past date of Resident #2 being given NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(On 3/15/23 at 2:50 p.m., the surveyor interviewed the Executive Director (ED) over the telephone in the presence of the RCD, who both explained that they misinterpreted the DOH reporting guidelines which resulted in a delay in reporting. On 3/15/23 at 3:00 p.m., the surveyor reviewed the facility policy and procedure titled, "Medication Errors" and listed under "Policy... All medication errors should be reported internally, and a state report completed as per your state guidelines. ... Procedure: Wrong dose- any medication given at a dose not ordered by the physician. ..." Reference: 8:36-11.5(f)	A 563		

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A 963	Continued From page 3	A 963		
A 963	8:36-11.5(f) Pharmaceutical Services (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders. This REQUIREMENT is not met as evidenced by: NJ00162319 Based on interview and record review, it was determined that the facility failed to ensure that medication was accurately administered by the Certified Medication Aide (CMA) according to prescribers' orders for 1 of 3 residents, Resident #2. This deficient practice was evidenced by the following: On 3/15/23 at 12:35 p.m., the surveyor reviewed Resident #2's Medical Record (MR) and according to the "Resident Face Sheet Profile" Resident #2 moved into the facility on NJ Ex Order 26.4(with diagnoses which included NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) During review of the MR, the surveyor identified "Progress Notes" (PN) dated NJ Ex Order 26.4, written by the Resident Care Director (RCD) which showed on NJ Ex Order 26.4 Resident #2 had "c/o [complaints of] NJ Ex Order 26.4(b)(1) ." In addition, the RCD documented "Vital signs (clinical measurements) [were] taken and [a NJ Ex Order 26.4(b)(1) ." Also on NJ Ex Order 26.4, according to the PN's documented by the RCD dated NJ Ex Order 26.4, Resident	A 963		

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A 963	Continued From page 4	A 963		

#2 was "given NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) @ [at] 7:30 am [a.m.] despite not having an order stating to do so. Nursing staff proceeded to attempt to [redacted] [Resident #2's NJ Ex Order 26.4(b)(1) [with] NJ Ex Order 26.4(b)(1) ...under the supervision of APN (Advanced Nurse Practitioner) [and] it was decided to send [Resident #2] to ER [Emergency Room] as [redacted] would not stabilize."

The surveyor next reviewed the APN's "Visit Note" dated [redacted], which showed Resident #2 was assessed "because [Resident #2] received NJ Ex Order 26.4(b)(1). Diagnoses NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)): Per nursing patient [Resident #2] received NJ Ex Order 26.4(b)(1) this morning...transferred to the ED [Emergency Department]."

On 3/15/23 at 1:00 p.m., the surveyor reviewed Resident #2's NJ Ex Order 26.4(b)(1) Medication Administration Record (MAR) which showed Resident #2 was to be given NJ Ex Order 26.4(b)(1) [redacted] as directed NJ Ex Order 26.4(b)(1) four times a day before meals and at bedtime. According to the MAR, on [redacted] at 7:30 a.m., the Certified Medication Aide (CMA) documented a [redacted] and the amount of [redacted] documented as given was [redacted] In addition, the surveyor reviewed Resident #2's NJ Ex Order 26.4(b)(1) "Physician Orders" which also indicated according to Resident #2's NJ Ex Order 26.4(b)(1) [redacted] was to be administered to Resident #2 for a [redacted] range of "[redacted] give [redacted]

On 3/15/23 at 2:15 p.m., the surveyor interviewed the CMA who performed medication administration on [redacted] to Resident #2 and

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A 963	Continued From page 5	A 963		

inquired about Resident #2 receiving NJ Ex Order 26.4(b)(1) [redacted]. The CMA explained she, the CMA, on the morning of NJ Ex Order 26.4 checked Resident #2's NJ Ex Order [redacted] and the result did not require NJ Ex Order 2 to be administered according to the NJ Ex Order 26.4(b)(1). However, the CMA explained she, the CMA, misinterpreted the NJ Ex Order 2 order and gave Resident #2 NJ Ex Order 26.4(b)(1), which then caused Resident #2's NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) [redacted]. In addition, care staff alerted the CMA that Resident #2 NJ Ex Order 26.4(b)(1) after breakfast and nursing staff was alerted. The CMA also, explained that the RCD was made aware of the NJ Ex Order 26.4(b)(1) being given to Resident #2 and reviewed the MAR and explained to the CMA that Resident #2 was not to receive NJ Ex Order 2 according to ordered NJ Ex Order 26.4(b)(1).

On 3/15/23 at 2:29 p.m., the surveyor interviewed the RCD regarding Resident #2 being administered NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 by the CMA. The RCD explained on NJ Ex Order 26.4 she, the RCD, was alerted by care staff that Resident #2 was NJ Ex Order 26.4(b)(1), and was NJ Ex Order 26.4(b) with a NJ Ex O [redacted]. In addition, the RCD explained that she, the RCD, accompanied the CMA to the MAR and asked the CMA to show what was administered. According to the RCD, the CMA administered the NJ Ex Order 26.4(b)(1) labeled on the NJ Ex Order 26.4(b)(1) [redacted] (NJ Ex Order 26.4(b)(1)) which was NJ Ex Order 26.4(b)(1), instead of following the NJ Ex Order 26.4(b)(1) that was ordered. The RCD then removed the CMA from medication administration.

On 3/15/23 at 2:35 p.m., the surveyor reviewed Resident #2's Hospital "Summary of Care" which listed next to "Admitting Diagnosis: NJ Ex Order 26. [redacted], Accidental Or Unintentional, Initial Encounter." Surveyor also reviewed Resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 963	Continued From page 6 #2's Hospital "AFTER VISIT SUMMARY" which listed an "initial encounter [of] NJ Ex Order 26.4 - NJ Ex Order 26.4." The "Discharge Information" showed Resident #2 was "admitted for NJ Ex Order 26.4(b)(1) after being NJ Ex Order 26.4(b)(1) administered NJ Ex Order 26.4(b)(1) at facility." Resident #2 "received NJ Ex Order 26.4(b)(1) as inpatient. NJ Ex Order 26.4(b)(1)) levels back to baseline." On 3/15/23 at 3:00 p.m., the surveyor reviewed the facility policy and procedure titled "Medication Errors" and listed under "Policy... A medication error is any preventable event that may cause or lead to inappropriate medication use or resident harm, while the medication is in the control of the health care professional... Procedure: Wrong dose - any medication given at a dose not ordered by the physician. ..." The facility failed to ensure that Resident #2 received the prescribed NJ Ex Order 2 dose as written on the Physician orders and the MAR which caused Resident #2 to be hospitalized from NJ Ex Order 26.4 to NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1).	A 963		

THE RESIDENCE at Cherry Hill

1979 Route 70 East
Cherry Hill, NJ 08003
T 856-424-7227

accepted 6/1/23

8:36-5 10(a)(2) General Requirements

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

Resident #2:

- on notification and conclusion that resident was having a NJ Ex Order 26.4(b)(1) the resident was given NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)
  - This brought NJ Ex Order 26.4(b)(1) up to the NJ Ex Orde NJ Ex Orde and NJ Ex Order
- APN was notified and came down for assessment
- NJ Ex Order 26.4(b were taken every NJ Ex Order 26.4(b)(1) per direction of APN for the next NJ Ex Order 26.4(b)(1)
  - NJ Ex Orde would come down to the NJ Ex Or and NJ Ex Orde in between NJ Ex Order 26.4(b)(1)
- 911 called to take the resident to the ER for evaluation
  - NJ Ex Or and vitals were stable at the time; resident NJ Ex Order 2
- POA called
- EMTs arrived, report given
- Resident transported to ER reported to be NJ Ex Order 26.4(b by ER physician and kept for observation
- ER called with report
- Resident reported to be by ER physician and kept for observation
- Resident returned to the community on NJ Ex Order 26.4(b)(1) with no new orders
  - RN assessment done with NJ Exec Order 26.4b1

How the facility will identify other residents having the potential to be affect by the same deficient practice:

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

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

- Executive Director, RN/RN Designee and all Managers will be in-serviced on State Regulation Reportable Events
  - Completed by: 4/14/23

- All medication errors will continue to be investigated by RN/RN Designee per facility policy. Any findings of major occurrence or incident of unusual nature will be reported to DOH via telephone immediately and followed up with a written report within 72 hrs.
  - Completed by: 4/14/23 and Ongoing

- All med error investigations will be reviewed monthly at facility QA meeting to ensure that there was no oversight regarding investigative conclusions that ***did not yield a decision major occurrence or incident of unusual nature***
  - Completed by: 4/28/23 and monthly ongoing

THE RESIDENCE at Cherry Hill

1979 Route 70 East
Cherry Hill, NJ 08003
T 856-424-7227

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

- RN/RN Designee will notify Executive Director of all Med Errors
- Med error investigation will be reviewed by Executive Director for potential need to report
- Registered /Registered Nurse Designee, Executive Director will bring all med error investigations for review at monthly QA

Completed by 4/28/23 and ongoing

8:36-11.5(f) Pharmaceutical Services

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

Resident #2: Timeline of events regarding the resident:

- Upon notification and conclusion that resident was having a NJ Ex Order 26.4(b)(1) the resident was given NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)
  - This brought NJ Ex Order 26.4(b)(1 up to the NJ Ex Orde NJ Ex Ord and NJ Ex Orde
- APN was notified and came down for assessment
- NJ Ex Order 26.4(b were taken every NJ Ex Order 26.4(b)(1) per direction of APN for the next NJ Ex Order 26.4(b)(1)
  - NJ Ex Ord would come down to the NJ Ex Ord and NJ Ex Orde in between NJ Ex Order 26.4(b)(1)
- 911 called to take the resident to the ER for evaluation
  - NJ Ex Ord and vitals were stable at the time; resident NJ Ex Order 26.4
- POA called
- EMTs arrived, report given
- Resident transported to ER reported to be NJ Ex Order 26.4(b by ER physician and kept for observation
- ER called with report
- Resident reported to be NJ Ex Order 26.4(b by ER physician and kept for observation
- Resident returned to the community on NJ Ex Order 26.4(b)(1) with no new orders
  - RN assessment done with NJ Exec Order 26.4b1

Regarding CMA:

- CMA was removed from the cart and med pass was concluded by an alternate CMA at the time of the event
- Investigation and education started that day

1/13/23 – 1/19/23

- CMA had approximately 15 hours of education via: 1:1 with RNs; Demonstration and educational videos with 1:1 Q&A afterwards with RN, and 1:1 repeat in-services with RNs
- CMA had over 10 hours of shadow time with high performing CMA colleagues

THE RESIDENCE at Cherry Hill

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- CMA had approximately 15 hours of education via: 1:1 with RNs; Demonstration and educational videos with 1:1 Q&A afterwards with RN, and 1:1 repeat in-services with RNs
- CMA had over 10 hours of shadow time with high performing CMA colleagues
- CMA had RN Med pass observation prior to restarting the cart on 1/19/23; several shifts later on 1/24/23 another RN Med pass observation was done and a third-party Pharmacy RN Med pass observation several days after that on 1/26/23

1/24/23

- Weekly Med Pass Observations being conducted for the CMA involved.

How the facility will identify other residents having the potential to be affect by the same deficient practice:

All residents receiving medication administration have the potential to be affected by the deficient practice.

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

Increased frequency of Diabetic Education as well as reading orders for all CMA's/Nurses to include but not limited too:

- Insulin/Sliding Scale
- Hypoglycemia/Hyperglycemia
- Monthly in services to include but not limited to -
  - Diabetic Education (high/low blood sugar s/s; sliding scales, etc..)
  - 6 Rights of Medication Administration
  - Three Checks regarding medication administration/Stop and Halt

Completed by 4/28/23 and monthly ongoing

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

- Weekly monitoring of a random sample of 10% of resident EMAR will be reviewed and audited for the next 4 weeks. 4/21/23, 4/28/23, 5/5/23 and 5/12/23
- Weekly med pass observations for a random sample of 10% of residents next 4 weeks – 4/21/23, 4/28/23, 5/5/23 and 5/12/23
- Continue with quarterly Med Tech Observations - 4/30/23 and quarterly ongoing
- Review findings of the above by Executive Director, Resident Care Director, Resident Services Supervisor at Monthly QA – 4/28/23 and ongoing monthly

accepted 6/1/23

completed 5/12/23 and ongoing as applicable.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
15A002	A. Building B. Wing	3/15/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT CHERRY HILL	1979 ROUTE 70 EAST CHERRY HILL, NJ 08003

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 A0563 Reg. # 8:36-5.10(a)(2) LSC	Correction Completed 05/31/2023	ID Prefix A0963 Reg. # 8:36-11.5(f) LSC	Correction Completed 05/31/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO