

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
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NAME OF PROVIDER OR SUPPLIER CARDINAL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 455 HURFFVILLE-CROSSKEYS ROAD SEWELL, NJ 08080
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A 000	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #: NJ 00174692, NJ 00178167, NJ 00186979</p> <p>Census: 91</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		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00178167</p> <p>Based on interview and record review, it was determined that the Executive Director (ED) failed to develop, implement, and enforce a comprehensive medication management policy and procedure for 1 of 3 residents, Resident # 2. This deficient practice was evidenced by the following:</p> <p>On ^{NJ Exec Order 26} the Department of Health (DOH) received a Facility Reportable Event (FRE) (a document utilized by health care facilities to report events to the DOH) that was investigated on 6/12/25, regarding a medication administration error, where Resident #2 did not receive ordered medication.</p> <p>On 6/12/2025 at 10:04 a.m., the surveyor interviewed the Resident Services Director (RSD) regarding Resident # 2 not receiving his/her medication. The RSD stated that on ^{NJ Exec Order 26}, the physician sent an electronic prescription to the pharmacy, to change the frequency of Resident # 2's ^{NJ Exec Order 26.4b1} (a medication used to treat ^{NJ Exec Order}), since Resident #2's family told the physician that the resident had been ^{NJ Exec Ord}. The RSD further explained that the order was to change the frequency of the medication from 3 times per day to 2 times per day. The RSD also stated that per the pharmacy, there was an additional note on the prescription to discontinue this medication on ^{NJ Exec Order 26.4b}</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>During continued surveyor interview, the RSD stated that Resident # 2 did not receive the [redacted NJ Exec Order 26.4b1] for 7 days.</p> <p>At 10:40 a.m., the surveyor reviewed Resident # 2's closed medical record (MR), which revealed that the resident had an admission date of [redacted NJ Exec Order 26.4b1] with diagnoses of [redacted NJ Exec Order 26.4b1] and [redacted NJ Exec Order 26.4b1]. The MR also indicated there was a discharge date of [redacted NJ Exec Order 26.4b1].</p> <p>Further surveyor review of Resident # 2's MR revealed an electronic prescription from the resident's primary physician, dated [redacted NJ Exec Order 26.4b1] for [redacted NJ Exec Order 26.4b1] milligrams (mg) 3 times per day for [redacted NJ Exec Order 26.4b1]. The MR also indicated that on [redacted NJ Exec Order 26.4b1] the physician sent an electronic prescription for [redacted NJ Exec Order 26.4b1] mg twice daily to the pharmacy. The electronic Medication Administration Record (eMAR) confirmed the prescription, but the prescription also indicated a note to "discontinue this medication".</p> <p>During interview with the RSD, she stated that during the investigation on [redacted NJ Exec Order 26.4b1], it was discovered that the pharmacy never added the ordered prescription to decrease the [redacted NJ Exec Order 26.4b1] [redacted NJ Exec Order 26.4b1] from three times a day to two times a day into the eMAR. The RSD explained that the original order for the [redacted NJ Exec Order 26.4b1] three times a day was discontinued from the eMAR by pharmacy on [redacted NJ Exec Order 26.4b1], as the physician note indicated.</p> <p>Therefore Resident # 2 did not receive the above medication on [redacted NJ Exec Order 26.4b1] [redacted NJ Exec Order 26.4b1] for a total of 16 doses. The medication was ordered and restarted on [redacted NJ Exec Order 26.4b1].</p> <p>The surveyor then inquired of the RSD what the</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>facility procedure was for receiving electronic medication prescriptions. The RSD stated that the pharmacy faxed the electronic prescriptions to the facility and then nursing would review the order for transcription accuracy prior to approving in the eMaR. Further, the RSD stated that she was not sure if she received and reviewed the faxed electronic prescription for Resident # 2's</p> <p><small>NJ Exec Order 28.4b1</small></p> <p>At 12: 00 p.m., the surveyor requested a policy and procedure from the Executive Director (ED) for receipt of electronic physician ordered medication from pharmacy, clarifying medication orders, and transcribing medication orders. The ED and RSD both stated that they did not have a documented policy and procedure.</p> <p>The surveyor reviewed an undated facility policy and procedure titled, "Medication Management General", in which the facility failed to include verification of receiving the order, confirming the order is correct, and transcribing physician or physician designee's orders.</p> <p>Reference: A0935, 8:36-11.4(b)</p>	A 310		
A 745	<p>8:36-7.2(f) Resident Assessments and Care Plans</p> <p>(f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice.</p>	A 745		

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A 745	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00174692</p> <p>Based on interview and record review, it was determined that the facility failed to ensure a comprehensive assessment was completed by a Registered Nurse (RN) upon resident return from the NJ Exec Order 26.4b1 for 1 of 3 residents, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 6/12/25 at 10:40 a.m., the surveyor reviewed the medical record (MR) of Resident #3 which revealed a move in date in NJ Exec Order 26.4b1, with diagnoses of NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1</p> <p>During review of the MR, the surveyor observed that on NJ Exec Order at 1:36 p.m., a Licensed Practical Nurse (LPN) documented that the resident returned to the facility from a NJ Exec Order 26.4b1. In addition, the LPN documented that the resident was noted with NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1</p> <p>Surveyor review of the MR, revealed that on NJ Exec Order at 1:42 p.m., the Resident Care Director (RCD) documented a NJ Exec C assessment and referenced to see a diagram. Continued review of the MR, the surveyor observed a blank "RN Comprehensive Assessment" dated NJ Exec Order 26.4b1, with no RN signature.</p> <p>At 1:25 p.m., the surveyor requested Resident #3's re-admission assesement from the RCD who stated that the former RCD completed a re-admission progress note when Resident #3 returned from the NJ Exec Order 26.4b1. However, the RCD stated that she was not able to locate the assessment.</p>	A 745		

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A 745	Continued From page 5 The surveyor reviewed the facility policy and procedure titled, "Assessment and Plan of Care and Services" which revealed "A new Physical Assessment will be completed any time a resident returns to the community after being admitted to the hospital, ...or rehabilitation center."	A 745		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (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. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00174692, NJ 00186979 Based on interview and record review, it was determined that the facility failed to update the General Service Plan (GSP) with intervention(s) for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 for 2 of 3 residents reviewed, Resident #'s 1 and 3. This deficient practice was evidenced by the following: On 6/12/25 the Department of Health (DOH) investigated a facility reportable event (FRE-a document utilized by facilities to report events to the DOH), received NJ Exec Order 26.4b1 , regarding an NJ Exec Ord.	A 749		

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A 749	<p>Continued From page 6</p> <p>NJ Exec Order 26.4b1 that involved Resident #3 on NJ Exec Order 26.4b1. In addition, the surveyor also investigated a FRE received NJ Exec Order 26.4b1 regarding Resident #1 NJ Exec Order 26.4b1 in his/her apartment.</p> <p>1. On 6/12/25 at 10:40 a.m., the surveyor reviewed the medical record (MR) of Resident #3 which revealed a move in date in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1.</p> <p>During review of the MR, the surveyor noted that on NJ Exec Order 26.4b1 at 4:05 p.m., that a Registered Nurse (RN) documented a "RN NJ Exec Order 26.4b1 Note," which revealed that the resident was NJ Exec Order 26.4b1 and complained of NJ Exec Order 26.4b1. Resident #3 was sent to the hospital and NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1, which required NJ Exec Order 26.4b1.</p> <p>Additional surveyor review of the MR revealed that on NJ Exec Order 26.4b1 at 1:36 p.m., a Licensed Practical Nurse (LPN) documented that the resident returned to the facility from a NJ Exec Order 26.4b1. In addition, the surveyor reviewed Resident #3's GSP dated NJ Exec Order 26.4b1 which revealed that the resident NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. However, the surveyor did not identify intervention(s) that addressed the residents NJ Exec Order 26.4b1 upon return to the facility on NJ Exec Order 26.4b1.</p> <p>At 12:45 p.m., the surveyor interviewed the Resident Care Director (RCD) regarding the residents fall on NJ Exec Order 26.4b1. The RCD stated that she was not employed at the facility on NJ Exec Order 26.4b1. In addition, the RCD stated that Resident #3 returned to the facility from NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 in a wheelchair and was no longer at NJ Exec Order 26.4b1.</p>	A 749		
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A 749	<p>Continued From page 7</p> <p>Continued surveyor review of the MR revealed that on 6/4/25 a Nurse Practitioner documented that the resident [redacted] on [redacted].</p> <p>The surveyor interviewed the RCD, who stated that Resident #3 was [redacted] and was [redacted]. During the interview, the RCD acknowledged that she addressed the resident's [redacted] on the GSP but did not include the intervention(s).</p> <p>2. On 6/12/25 at 11:20 a.m., the surveyor reviewed the MR of Resident #1 which revealed a move in date in [redacted] with a diagnosis of [redacted]. In addition, the surveyor reviewed the initial GSP dated [redacted], and signed by the resident on [redacted], which revealed that the resident was placed on [redacted] and only received [redacted] from the nursing staff or reception staff.</p> <p>During surveyor review of the progress notes, the surveyor observed a note dated [redacted] written by a LPN which revealed that the resident was allegedly [redacted] in his/her apartment and the RCD was notified. The surveyor also identified a progress note dated [redacted], written by the RCD, which revealed that on [redacted], the resident had a [redacted] in his/her apartment.</p> <p>In addition, the RCD documented that on [redacted] that the resident was placed on [redacted] in the apartment and provided the surveyor with the [redacted] record. However, surveyor review of the GSP did not reveal documented evidence that the GSP was updated with the resident's [redacted].</p>	A 749		

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A 749	<p>Continued From page 8</p> <p>At 12:45 p.m., the surveyor interviewed the RCD regarding the resident NJ Exec Order 26.4b1 in his/her apartment. The RCD stated that the resident was placed on NJ Exec Order 26.4b1 and that she NJ Exec Order 26.4b1 the resident during NJ Exec Order 26.4b1.</p> <p>At 1:00 p.m., the surveyor interviewed the Executive Director (ED) regarding the resident's NJ Exec Order 26.4b1 in his/her apartment and the ED stated that on NJ Exec Order 26.4b1 the resident was placed on NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed the facility policy and procedure titled, "Assessment and Plan of Care and Services" which revealed "The Resident Service Director or licensed designee completes the Assessment and Plan of Care and Services. ...These will be reviewed and revised: ...When the resident has a change in medical/health condition/or status. ...in order to accurately determine the resident's level of care and services."</p>	A 749		
A 935	<p>8:36-11.4(b) Pharmaceutical Services</p> <p>(b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.</p>	A 935		

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A 935	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00178167</p> <p>Based on observation, interview and record review it was determined that the facility failed to ensure that medication was accurately transcribed, administered, and documented in accordance with prescriber's orders for 1 of 3 residents, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 6/12/25 the Department of Health (DOH) investigated a Facility Reportable Event (FRE-a document used by facilities to report events to the DOH) received [redacted NJ Exec Order 26.4b] regarding medication that was not administered to Resident #2.</p> <p>At 10:05 a.m., the surveyor interviewed the Resident Care Director (RCD) regarding the medication that was not administered to Resident #2. The RCD stated that on [redacted NJ Exec Order 26.4b] the resident's Physician sent an electronic prescription to pharmacy to decrease the resident's [redacted NJ Exec Order 26.4b1] (a prescription medication used to treat [redacted NJ Exec Order 26.4b1] from three times a day to two times a day.</p> <p>In addition, the RCD stated that during the investigation on [redacted NJ Exec Order 26.4b] it was discovered that the pharmacy never added the ordered prescription into the Electronic Medication Administration Record (eMAR). The RCD explained that the original order for the [redacted NJ Exec Order 26.4b1] three times a day was discontinued from the eMAR by pharmacy on [redacted NJ Exec Order 26.4b].</p> <p>At 11:25 a.m., the surveyor reviewed the medical record (MR) of Resident #2 which revealed that the resident moved into the facility in [redacted NJ Exec Order 26.4b] with diagnoses of [redacted NJ Exec Order 26.4b1] and [redacted NJ Exec Order 26.4b1]</p>	A 935		

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A 935	<p>Continued From page 10</p> <p>NJ Exec Order 26.4b1 The resident expired at the facility in NJ Exec Order 26.4b1.</p> <p>Continued MR review revealed that on NJ Exec Order 26.4b1, the resident was ordered NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 milligrams (mg) give 1 tablet TID (3 times a day) for NJ Exec Order 26.4b1. In addition, the surveyor noted an electronic prescription dated NJ Exec Order 26.4b1 which revealed that the resident was ordered NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 mg tablet BID (2 times a day) for NJ Exec Order 26.4b1. The surveyor also identified that the Physician noted on the NJ Exec Order 26.4b1 to "discontinue this NJ Exec Order 26.4b1 medication."</p> <p>At 11:30 a.m., the surveyor reviewed the resident's NJ Exec Order 26.4b1 eMAR which revealed that the resident's last dose of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 mg tablet TID was signed out by staff as administered on NJ Exec Order 26.4b1 at 8:00 p.m., and then was discontinued. The eMAR also revealed that on NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 mg tablet BID was started and signed out by staff as administered at 9:00 a.m. The resident was not administered the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 for 8 days which was a total of 16 doses.</p> <p>At 1:40 p.m., the surveyor interviewed the Licensed Practical Nurse (LPN) who last administered the resident's NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. The LPN stated that he could not recall all the details surrounding the discontinued NJ Exec Order 26.4b1. However, the LPN explained that not administering the medication was related to a pharmacy electronic system error.</p> <p>At 1:45 p.m., the surveyor reviewed the facility investigation summary which revealed that on NJ Exec Order 26.4b1 the pharmacy faxed a prescription to the</p>	A 935		

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A 935	<p>Continued From page 11</p> <p>facility for the resident's <small>NJ Exec Order 28.4b1</small> <small>NJ Exec</small> mg BID with instructions to discontinue this medication. According to the investigation summary, the facility received no further instruction or prescription communication regarding the <small>NJ Exec Order 28.4b1</small> <small>NJ Exec</small> mg TID order. However, it was noted in the pharmacy eMAR system as "Discontinued" and so the LPN acknowledged the discontinuance.</p> <p>Refer to 8:36-3.4(a)(1)</p>	A 935		



POC#2
9/23/25 Rcd
Accepted 9/25/25
[Signature]

Survey Date: 6/12/25

Complaint # NJ 00178167; Regulation 310A (Failure to develop, implement, and enforce a comprehensive medication management policy)

Immediate Corrective Actions:

1. Corrective Actions for Affected Resident(s):

- a. The Executive Director reviewed the incident and determined the process did not include a step to consistently verify escript orders in the community. The Order Approval Process was updated in November 2024 by the Director of Pharmacy Services to include that the pharmacy will email escript orders to the community. All staff are aware of this update, and the emails provide documentation of the process being completed.
- b. Upon discovering the error, the process was updated; all medications were confirmed for accuracy by the pharmacy, and the resident received all medications as ordered. An exact date is not available as the resident's chart is archived. Resident #2 was receiving **NJ Exec Order 26.4b1** and **NJ Exec Order 26.4b1**

Additional Corrective Actions:

2. Identification of Other Potentially Affected Residents:

- a. All residents could possibly be impacted by medication policies and procedures.

3. Systemic Changes:

- a. The Order Approval Process was updated, and all staff who administer medications will be trained on this process by Resident Care Director, with all trainings completed by September 30, 2025. This training will be completed as part of the orientation process for all staff who are hired to administer medications, beginning October 1, 2025, with instruction completed by the Resident Care Director.
- b. Letters reviewing the importance of providing physician visit summaries and medication lists following appointments were sent to families and physicians by the Executive Director and Regional Director of Operations by September 23, 2025.



- c. A family meeting was held on September 16, 2025. The Regional Director of Operations will review the importance of providing physician visit summaries and medication lists following appointments. This meeting was held for residents, families of all current residents, as well as staff.

Ongoing Quality Assurance Actions:

4. Ongoing Monitoring and Compliance:

- a. An audit of a 5% sample of Resident Records will be completed by Resident Care Director each month, beginning September 2025, to ensure matching orders are available for all prescribed medications. Any discrepancies will result in immediate communication with the prescribing physician and the pharmacy to resolve.
- b. Ongoing compliance, patterns, trends, and findings will be reviewed at Quarterly Quality Assurance Meetings, beginning with a review of Q32025 (July, August, and September 2025) in October 2025.

5. Plans submitted have a correction date of:

- a. October 1, 2025
- b. Responsibility – RCD and ED

accepted 9/25/25
NJ Exec Order 26.481



Complaint # NJ 00174692; Regulation A745 (Failure to ensure a comprehensive assessment was completed)

Immediate Corrective Actions:

1. Corrective Actions for Affected Resident(s):

- a. The RN Assessment for Resident #3 was created, completed, and submitted by the Resident Care Director (RN) on **NJ Exec Order 26.4b1**. However, she failed to sign the document prior to submission. The form was signed by the RCD on **NJ Exec Order 26.4b1**.
- b. An additional RN Assessment had also been completed, with signature, on **NJ Exec Order 26.4b1**.

Additional Corrective Actions:

2. Identification of Other Potentially Affected Residents:

- a. As all residents may be impacted by errors in assessment processes, the Regional Director of Operations will audit all Resident Records to review current assessments to ensure they are all dated and signed. This will be completed by September 15, 2025. Any necessary updates or changes will be completed by the Resident Care Director.

3. Systemic Changes:

- a. The Resident Care Director was educated by the Regional Director on assessment documentation, policies, and procedures on September 10, 2025.
- b. The Resident Care Director will review each assessment for completion of dates and signatures prior to submission into the electronic Resident Record, beginning September 1, 2025.

Ongoing Quality Assurance Actions:

4. Ongoing Monitoring and Compliance:

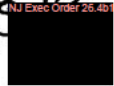
- a. An audit of a 5% sample of Resident Records will be completed by Resident Care Director each month, beginning September 2025, to ensure all assessments are dated and signed.
- b. Ongoing compliance, patterns, trends, and findings will be reviewed at Quarterly Quality Assurance Meetings, beginning with a review of Q32025 (July, August, and September 2025) in October 2025.



5. Plans submitted have a correction date of:

- a. September 15, 2025
- b. Responsibility – RCD

accepted 9/25/25





Complaint #: NJ 00174692, NJ 00186979; Regulation A749 (Failure to update the GSP)

Immediate Corrective Actions:

1. Corrective Actions for Affected Resident(s):

- a. The current GSP for Resident #3 was updated with [NJ Exec Order 26.4b1] information by Resident Care Director on [NJ Exec Order 26.4b1].
- b. The current GSP for Resident #1 was updated by Resident Care Director as of [NJ Exec Order 26.4b1] to include [NJ Exec Order 26.4b1] interventions related to [NJ Exec Order 26.4b1] and this continued until discharge, this resident was [NJ Exec Order 26.4b1]

Additional Corrective Actions:

2. Identification of Other Potentially Affected Residents:

- a. As all residents may be impacted by errors in documentation processes, the Regional Director of Operations will audit all Resident Records to review current GSPs to ensure they are all updated and accurate. This will be completed by September 15, 2025. Any necessary updates or changes will be completed by the Resident Care Director.

3. Systemic Changes:

- a. The Resident Care Director was educated by the Regional Director on GSP completion, including fall interventions and documentation of special needs, on September 10, 2025.
- b. The Resident Care Director will review each GSP for accuracy prior to submission into the electronic Resident Record, beginning September 1, 2025.

Ongoing Quality Assurance Actions:

4. Ongoing Monitoring and Compliance:

- a. An audit of a 5% sample of Resident Records will be completed by Resident Care Director each month, beginning September 2025, to ensure all GSPs are accurate and updated.
- b. Ongoing compliance, patterns, trends, and findings will be reviewed at Quarterly Quality Assurance Meetings, beginning with a review of Q32025 (July, August, and September 2025) in October 2025.

5. Plans submitted have a correction date of:

- a. September 15, 2025
- b. Responsibility – RCD

accepted 9/2 [NJ Exec Order 26.4b1]



Complaint #: NJ 00178167; Regulation A935 (Failure to ensure medication was accurately transcribed, administered, and documented as ordered)

Immediate Corrective Actions:

1. Corrective Actions for Affected Resident(s):

- a. The Executive Director reviewed the incident and determined the process did not include a step to consistently verify escript orders in the community. The Order Approval Process was updated in November 2024 by the Director of Pharmacy Services to include that the pharmacy will email escript orders to the community.
- b. Upon discovering the error, the process was updated; all medications were confirmed for accuracy by the pharmacy, and the resident received all medications as ordered. An exact date is not available as the resident's chart is archived. Resident #2 was receiving NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1
[REDACTED]

Additional Corrective Actions:

2. Identification of Other Potentially Affected Residents:

- a. All residents could possibly be impacted by medication policies and procedures.

3. Systemic Changes:

- a. The Order Approval Process was updated, and all staff who administer medications were trained on this process by Resident Care Director, with all trainings completed by September 30, 2025. This training will be completed as part of the orientation process for all staff who are hired to administer medications, beginning October 1, 2025, with instruction completed by the Resident Care Director.
- b. Letters reviewing the importance of providing physician visit summaries and medication lists following appointments will be sent to families and physicians by the Executive Director and Regional Director of Operations by September 18, 2025.
- c. A family meeting was held on September 16, 2025. The Regional Director of Operations will review the importance of providing physician visit summaries



and medication lists following appointments. This meeting was held for residents, families of all current residents, as well as staff.

Ongoing Quality Assurance Actions:

4. Ongoing Monitoring and Compliance:

- b. An audit of a 5% sample of Resident Records will be completed by Resident Care Director each month, beginning September 2025, to ensure matching orders are available for all prescribed medications. Any discrepancies will result in immediate communication with the prescribing physician and the pharmacy to resolve.
- c. Ongoing compliance, patterns, trends, and findings will be reviewed at Quarterly Quality Assurance Meetings, beginning with a review of Q32025 (July, August, and September 2025) in October 2025.

5. Plans submitted have a correction date of:

- d. October 1, 2025
- e. Responsibility – RCD and ED

accepted 9/25/25

Rec'd
9/23/25



September 23, 2025

35A001- Cardinal Village

RE: Complaint #: **NJ 00188282; Regulations 310A, A753, A1073**

Plan of Correction for Statement of Deficiencies complaint survey visit conducted June 12, 2025. All plans submitted have a correction date of October 1, 2025. Plans of Correction submitted by **NJ Exec Order 26.4b1** CALA, Administrator for Cardinal Village located at 455 Hurffville-Cross Keys Rd Sewell, NJ 08080.

NJ Exec Order 26.4b1

 Signature

CALA _____

9/23/25 _____

Date

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/12/2025
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NAME OF PROVIDER OR SUPPLIER CARDINAL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 455 HURFFVILLE-CROSSKEYS ROAD SEWELL, NJ 08080
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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 #: NJ 00174692, NJ 00178167, NJ 00186979</p> <p>Census: 91</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}		

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

TITLE

(X6) DATE

08/14/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 35A001	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 6/12/2025	Y3
NAME OF FACILITY CARDINAL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 455 HURFFVILLE-CROSSKEYS ROAD SEWELL, NJ 08080		

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 <u>A0310</u>	Correction	ID Prefix <u>A0745</u>	Correction	ID Prefix <u>A0749</u>	Correction
Reg. # <u>8:36-3.4(a)(1)</u>	Completed	Reg. # <u>8:36-7.2(f)</u>	Completed	Reg. # <u>8:36-7.3(a)</u>	Completed
LSC _____	<u>10/01/2025</u>	LSC _____	<u>09/15/2025</u>	LSC _____	<u>09/15/2025</u>
ID Prefix <u>A0935</u>	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # <u>8:36-11.4(b)</u>	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	<u>10/01/2025</u>	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 6/12/2025		<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			