STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

Complaint NJ #'s: 170564, 171126, 172314, 172595, 172932, 173863, 174562, 175642, and 176585

Survey Date: 11/6/24 to 11/20/24

Census: 107

Sample: 22 + 2 closed records

A Recertification/LSC survey was conducted at Premier Cadbury at Cherry Hill from 11/6/24 through 11/20/24, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.

During the survey a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.24(a)(3) F 678 as the facility failed to activate their emergency response by calling emergency services/911. The facility documented on NJ Exec Order 26.4b1 , Certified Nursing Aide (CNA #1) found Resident #103 NJ Exec Order 26.4b1, who was a NJ Exec Order 26.4b status NJ Exec Order 26.4b1), and notified the Licensed Practical Nurse (LPN #1). LPN #1 initiated NJ Exec Order 26.4b1 and at NJ Exec Order 26.4b1 LPN #1 reported to the Registered Nurse (RN #1) that the resident was NJ Exec Order 26.4b1 and RN #1 NJ Exec Order 26.4b1 There was no documented evidence that the facility called emergency services/911 in accordance with Basic Life Support (BLS) for Healthcare Providers.

The US FOIA (b)(6) was informed of the F678 IJ and was provided with the IJ template on

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

Electronically Signed | 12/20/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 000	Continued From page 1 11/13/24 at 4:17 PM. An acceptable Removal Plan (RP) was received on 11/14/24 at 10:34 AM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the facility's Code Blue/CPR policy was updated to reflect for staff to call 911 during an emergency response; LPN #1 and RN #1 will be educated by the NJ Exec Order 26.4b1 [redacted]) on the facility's Code Blue/CPR policy prior to working their next shift; all licensed nurses will be educated on the facility's Code Blue/CPR policy; and the US FOIA (b)(6) [redacted] will ensure at least 50% of all licensed nurses in the building at all times is CPR certified. The survey team verified the RP on-site on 11/14/24, and determined the IJ for F 678 was removed as of 11/14/24 at 12:52 PM.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 550	Continued From page 2 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that residents were served their meals in a manner that promotes respect and dignity during lunch. This deficient practice was identified for 6 out of 10 unsampled residents who were not served their meals at the same time and for 1 of 1 resident (Resident #40) who also experienced a significant delay in meal service delivery in the [redacted] Dining Room. This deficient practice was evidenced by the following:	F 550	Tag 0550 Element One Corrective Actions The [redacted] stated that the food cart arrived however Resident #40 tray was still not available so she immediately got their meal tray. In addition the [redacted] ensured the remaining 6 residents that did not receive their meals at the same time of the other residents were provided trays immediately. Element Two Identification of at Risk	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 550	Continued From page 3 On 11/6/24 at 12:03 PM, the surveyor observed residents who were seated in the [NJ Exec Order 28.4b1] Dining Room who awaited meal service. On 11/6/24 at 12:09 PM, the surveyor observed that the food cart was delivered to the nursing unit and staff had begun to pass out trays to residents in their rooms. On 11/6/24 at 12:18 PM, the surveyor observed that three (3) of ten (10) residents were served lunch and had begun to eat while seven (7) other residents waited for their lunch. On 11/6/24 at 12:29 PM, the food cart was placed in front of the dining room. On 11/6/24 at 12:30 PM, Resident #40 sat at a small table with an unsampled resident who ate their meal in front of the resident. At that time, the staff had begun to move four (4) residents, including Resident #40, away from the tables where other residents were already eating. On 11/6/24 at 12:32 PM, the 4 residents were served beverages while they awaited meal delivery. On 11/6/24 at 12:34 PM, the [U.S. FOIA (b)(6)] stated that the resident's food cart was not there yet and that the other residents were served from the first food cart. The [redacted] stated "you can not put a resident in front of someone eating a meal" and that was why she moved the residents because it was a dignity issue. On 11/6/24 at 12:46 PM, the [U.S. FOIA (b)(6)] stated that	F 550	Residents All Residents were at risk for being served their meals in a manner that does not promote respect and dignity. Immediately rounds were performed to assure no other residents were still waiting to be served their lunch while other resident's were eating around them. No other findings noted. Element Three Systemic Change The facility "Resident Dining-Protocol" policy was reviewed which addresses no resident should be eating their meal until all residents at the specific location have their trays. All staff were re-educated regarding the policy by the Facility Educator. All staff were re-educated that at no residents should be eating their meal until all residents at the specific location have their trays. Element Four Quality Assurance The Nurse or Designee will conduct rounds every meal for one week and then weekly for three months. Results will be provided to the LNHA who will review the findings and provide direction as appropriate to assure 100 percent compliance. If findings are not 100 percent compliant further education and or discipline will be provided. The LNHA will report the findings in aggregate at the monthly QAPI meeting x 3 months. Facility Educator will be responsible for maintaining education for staff on ensuring no residents should be eating their meal until all residents at the specific	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 550	Continued From page 4 the food cart arrived. Resident #40's tray was still not available on the food cart and that she would get the resident's meal tray. The resident was the only resident in the dining room who had not yet received their meal tray and was seated in the presence of three (3) other unsampled residents who were served and ate their meals in his/her presence. On 11/12/24 at 2:56 PM, the surveyor interviewed the[redacted]) who stated he would not expect to see one (1) resident eating in front of another resident for both their dignity and their resident rights. A review of the facility's undated "Resident Dining-Protocol" included: ...No resident should be eating their meal until all residents at the specific location have their trays.	F 550	location have their trays. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0550 will not reoccur.	
F 607 SS=D	NJAC 8:39-4.1(a)12 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the	F 607		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 607	Continued From page 5 QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their new hire policy to ensure reference checks were completed. This deficient practice was identified for 4 of 10 employee files reviewed (Employee #1, #6, #8, and #10) and was evidenced by the following: A review of the employee files for reference check reflected the following: Employee #1, a U.S. FOIA (b)(6) with a date of hire of NJ Exec Order 2, did not have a reference check on file. Employee #6 a U.S. FOIA (b)(6) with a date of hire of U.S. FOIA (b)(6), did not have a reference check on file. Employee #8, a U.S. FOIA (b)(6) with a date of hire of	F 607	Tag 0607 Element One Corrective Actions Human Resources was immediately educated by the nursing home administrator on documenting the request for 3 reference checks for all new employees and ensure they have been reached out to prior to their start date. Facility immediately reached out to the 4 employees references and documented attempts. Facility will continue to attempts and document. Element Two Identification of at Risk Residents All Residents could be at risk for possible abuse and neglect due to the facilities failure to ensure all reference checks were reached out to prior to Employees #1, #6, #8 and #10 start date. Element Three Systemic Change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 607	Continued From page 6 NJ Exec Order 26.4B1 did not have a reference check on file. Employee #10, a U.S. FOIA (b)(6)) with the hire date of NJ Exec Order 26.4, did not have a reference check on file. On 11/12/24 at 1:03 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated two (2) references were done on every employee. The U.S. FOIA (b) stated "we will not hold back an employee if we have not received all the references, but will continue to call the references and hope they respond." The U.S. FOIA (b) then stated if they were unable to contact the references, they asked the employee for additional references. A review of the facility's undated "New Hire Employee References/Physicals - Protocol," included, "1. Upon hire the facility will request for 3 references. 2. The facility will reach out to all references and before their start date." NJAC 8:39-4.1(a)5	F 607	The facility "New Hire Employee References/Physical Protocol" policy was reviewed which addresses that upon hire the facility will request for 3 references and will reach out to all references before the new hires start date. Human Resources and Department Heads were re-educated by the nursing home administrator regarding the policy. Element Four Quality Assurance Human Resources or Designee will conduct monthly audits for 3 months to assure 100 percent compliance on every new hire has provided three references and that all attempts to reach out to the references will be documented and recorded prior to the new hires start date. Results will be provided to the LNHA who will review the findings and provide direction as appropriate. The LNHA will report the findings in aggregate at the monthly QAPI meeting x 3 months. Human Resources will be responsible for maintaining education for the correction of deficiency. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0607 will not reoccur.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 609	Continued From page 7 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ172932 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) a [redacted] for 1 of 4 residents (Resident #310) reviewed for [redacted]. This deficient practice was evidenced by the following:	F 609	Tag 0609 Element One Corrective Actions Facility administrator and Director of Nursing were immediately educated on initiating a reportable event for any and all [redacted] by the companies CEO. Nursing home administrator called in the resident to [redacted] to the department of health.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 609	Continued From page 8 On 11/8/24 at 11:46 AM, the surveyor reviewed Resident #310's closed medical record. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Further review of the MDS revealed the resident had NJ Exec Order 26.4b1 [redacted] A review of the individual comprehensive care plan (ICCP) included a focus area, dated U.S. FOIA (b)(6) that the resident's NJ Exec Order 26.4b1. Further review of the ICCP included a focus area, dated U.S. FOIA (b)(6), that the resident had the potential to be NJ Exec Order 26.4b1 . Interventions included: staff to intervene before NJ Exec Order 26.4b1; NJ Exec Orde resident away from source of NJ Exec Order 26.4b engage NJ Exec Order 2 in conversation; if response is NJ Exec Order 26.4b1 staff to NJ Exec Order 26.4b1, and approach later. A review of the Progress Notes (PN) included a Nurses Note (NN), dated NJ Exec Order 26.4b1	F 609	Element Two Identification of at Risk Residents All Residents that are at risk for possible verbal abuse as the facility failed to initiate a reportable event for resident to resident verbal abuse. Element Three Systemic Change The facility "Abuse Investigation and Reporting" policy was reviewed which addresses all alleged violation involving abuse, neglect, exploitation, or mistreatment will be reported by the facility Administrator or his/her designee. Facility administrator and Director of Nursing were re-educated regarding the policy by the companies CEO. Element Four Quality Assurance The Facility administrator or Designee will conduct audits for any and all verbal abuse that could of occurred within facility weekly for 4 weeks then monthly for 3 months. Results will be provided to the CEO who will review the findings and provide direction as appropriate. The Facility administrator will report the findings in aggregate at the monthly QAPI meeting for 4 months. Facility Educator will be responsible for maintaining education on what constitutes a reportable event. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0609 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 609	Continued From page 9 which revealed Resident #310 was walking down the hallway and NJ Exec Order 26.4b1 at another resident. The NN further revealed Resident #310 NJ Exec Order 26.4b1, but the nurse was able intervene before Resident #310 made NJ Exec Order 26 with the other resident. According to the NN, the nurse had to bring Resident #310 NJ Exec Order 2 [redacted]" and that 911 was called for the resident to be sent NJ Exec Order 26.4b1 [redacted] Further review of the PN included a NJ Exec Order [redacted] Notification note, dated NJ Exec Order 26.4b1 which indicated Resident #310 had a NJ Exec Orde [redacted] A review of the NJ Exec Order 26.4b1 Evaluation NJ Exec Order 26 [redacted] revealed the resident was seen for an initial evaluation. Further review of the NJ Exec Order 26.4b1 included the resident was sent to NJ Exec Order 26.4b1 [redacted], and that the resident admits he/she continued to experience NJ Exec Order 26.4b1 [redacted] The NJ Exec Order 26.4b1 also included recommendations from the NJ Exec Order 26.4b1 to adjust Resident #310's NJ Exec Order 26.4b1 medications. On 11/8/24, the surveyor requested all Facility Reportable Events (FRE) for Resident #310, but the facility was unable to provide a FRE for the NJ Exec Order 26.4b1 [redacted] that took place on NJ Exec Order 26.4b [redacted] On 11/12/24 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 who stated NJ Exec Order 26.4b1 [redacted] were reportable events and that "the state has to be aware of the NJ Exec Order 26.4b1	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 609	Continued From page 10 On 11/12/24 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated NJ Exec Order 26.4b1 were reported to "the state." On 11/12/24 at 12:50 PM, the surveyor interviewed the NJ Exec Order 26.4b1) who stated a NJ Exec Order 26.4b1 could be NJ Exec Order 26.4b1. The NJ Exec Ord further stated U.S. FOIA (b)(6) were reported to the physician and the resident's family. When asked whether Resident #6's NJ Exec Order 26.4b1 on NJ Exec Order 26.4b should have been reported to the NJDOH, the NJ Exec Orde stated she was unsure. A review of the facility's "Abuse Investigation and Reporting" policy, revised January 2023, included, "All alleged violations involving abuse, neglect, exploitation, or mistreatment will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: ... The State licensing/certification agency responsible for surveying/licensing the facility." Further review of the policy included, "The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident."	F 609		
F 610 SS=D	NJAC 8:39-5.1(a) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 11 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ172932; NJ172314 Based on interview, record review, and review of facility documents, it was determined that the facility failed to conduct a thorough investigation for a.) a NJ Exec Order 26.4b1 , and b.) an NJ Exec Order 26.4b1 . This deficient practice was identified for 2 of 4 residents (Resident #6 and #310) reviewed for NJ Exec Order 26 and was evidenced by the following: 1.) On 11/8/24 at 11:46 AM, the surveyor reviewed Resident #310's closed medical record. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1]	F 610	Tag 0610 Element One Corrective Actions The Nursing staff were immediately educated on completing a through investigation to which must include an incident report and statements from the staff by the U.S. FOIA (b)(6) The facility ensured a full investigation was completed for Resident #6 and Resident #310. Element Two Identification of at Risk Residents All Residents are at risk as the facility failed to complete a through incident report. Element Three Systemic Change The facility "Management and Reporting of Resident Incidents" policy was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 12 NJ Exec Order 26.4b1 [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated U.S. FOIA (b)(6) included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1 [redacted] Further review of the MDS revealed the resident had NJ Exec Order 26.4b1 [redacted] A review of the individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4 that the resident's NJ Exec Order 26.4b1. Further review of the ICCP included a focus area, dated NJ Exec Order 26.4, that the resident had the potential to be NJ Exec Order 26.4b1 [redacted]. A review of the Progress Notes (PN) included a Nurses Note (NN), dated NJ Exec Order 26.4b1 which revealed Resident #310 was walking down the hallway and NJ Exec Order 26.4b1 at another resident. The NN further revealed Resident #310 NJ Exec Order 26.4b1 [redacted], but the nurse was able intervene before Resident #310 made contact with the other resident. According to the NN, the nurse had to bring Resident #310 NJ Exec Order 2 [redacted] s," and that NJ Exec O	F 610	reviewed which addresses when an accident or incident occurs to a resident, an investigation is conducted to determine any/all factors contributing to the incident. Facility administrator and Director of Nursing were re-educated regarding the policy that a they must analyze the cause and effect and ensure the staff from the previous 2 shifts who provided care for that resident are interviewed and give statements by the companies CEO. Element Four Quality Assurance The Director of Nursing or Designee will conduct weekly audits for three months for any and all incident reports within the facility to ensure they include a through investigation and witness statements from the staff from the previous 2 shifts. Results will be provided to the facility administrator who will review the findings and provide direction as appropriate. The Facility administrator will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education on completing a through investigation for all incident reports. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0610 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 13 was called for the resident to be sent to [redacted] Further review of the PN included a [redacted] Notification note, dated [redacted] which indicated Resident #310 had a [redacted] A review of the [redacted] Evaluation ([redacted], revealed the resident was seen for an initial evaluation. Further review of the [redacted] eval included the resident was [redacted] on [redacted], and that the resident [redacted] The [redacted] also included recommendations from the [redacted] adjust Resident #310's [redacted] medications. On 11/8/24, the surveyor requested all incident reports for Resident #310, but the facility was unable to provide an incident report or investigation for the [redacted] that took place on [redacted] On 11/12/24 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 who stated when there was a [redacted], the residents were [redacted]. LPN #3 further stated that any staff present on the unit during the [redacted] should complete a written statement. LPN #3 added that it was important to thoroughly investigate [redacted] to document the resident's [redacted] and determine how the facility could better handle the resident's [redacted] On 11/12/24 at 12:03 PM, the surveyor	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 14	F 610		

interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated when there was a NJ Exec Order 26.4b1, the residents were NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1 if needed, and an incident report was completed. LPN/UM #1 further stated that the importance of the incident report was so the investigation could be initiated and so that 'NJ Exec Order 26.4b1." LPN/UM #1 added that NJ Exec Order 26.4b1 had to be thoroughly investigated to prevent further incidents and to maintain the safety of residents and staff.

On 11/12/24 at 12:50 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated a NJ Exec Order 26.4b1 could be NJ Exec Order 26.4b1. The U.S. FOIA (b) further stated for a NJ Exec Order 26.4b1, the nurse should complete an incident report, but for a NJ Exec Order 26.4b1, the nurse would only need to write a NN. When asked if a NJ Exec Order 26.4b1 resulting in a resident being sent to NJ Exec Ord would require an incident report, the U.S. FOIA (b) verified that an incident report should be completed. At that time, the surveyor informed the U.S. FOIA (b) of the missing incident report for Resident #310's NJ Exec Order 26.4b1, and the U.S. FOIA (b) confirmed that an incident report should have been completed. The U.S. FOIA (b) added that it was important to thoroughly NJ Exec Order 26.4b1 to prevent future occurrences.

2.) On 11/6/24 at 9:57 AM, the surveyor observed Resident #6 lying in bed.

On 11/6/24 at 1:22 PM, the surveyor reviewed the medical record for Resident #6.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 15 A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool used, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident's [redacted]. Further review of the MDS revealed the resident had [redacted] A review of the individual comprehensive care plan (ICCP) included a focus area, dated [redacted], that the resident had a [redacted] related to [redacted]. Interventions included: anticipate and meet needs, be sure call light is within reach, and modify environment as needed to meet current needs. A review of the PN included an Alert Note (AN), dated [redacted] which revealed the resident had [redacted] Further review of the AN revealed the resident was [redacted] at baseline, vital signs were normal, and the resident was assessed from head to toe. Further review of the PN revealed documentation that the resident had [redacted] or [redacted] on the following dates: [redacted]	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 16	F 610		

NJ Exec Order 26.4b1

A review of a U.S. FOIA (b)(6) Progress Note, dated NJ Exec Order 26.4b1, revealed the resident had NJ Exec Order 26.4b1 recently but had no recall of the and NJ Exec Order 26.4b1.

Further review of the PN included a NN, dated NJ Exec Order 26.4b1, revealed the resident complained of when moved up or when sitting up in the wheelchair. Further review of the NN revealed an order for of the was obtained.

A review of a NN, dated 3/20/24 at 2:13 PM, revealed the resident's NJ Exec Order 26.4b1 showed a and the resident was sent to the hospital for further evaluation.

A review of a NN, dated NJ Exec Order 26.4b1, included the resident returned from the hospital NJ Exec Order 26.4b1

On 11/8/24, the surveyor requested the complete investigation related to Resident #6's on

On 11/12/24 at 9:00 AM, the facility provided the surveyor with a copy of the Facility Reportable Event (FRE) for Resident #6's NJ Exec Order 26.4b1 which revealed the following:
On , the resident NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1.
Resident was NJ Exec Order 26.4b1, however did NJ Exec Order 26.4b1 .
On , the resident informed staff that he/she was NJ Exec Order 26.4b1 when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 17 being moved and sitting in the wheelchair. An [redacted] was ordered for the [redacted]. On [redacted], the [redacted] for a [redacted] and the resident was [redacted]. The FRE did not include an incident report for the [redacted] and the investigation did not include statements from staff for the shifts leading up to the resident's [redacted] On 11/12/24, the surveyor requested the incident report for the [redacted], however the facility was only able to provide an incident report for the resident's [redacted]. On 11/12/24 at 11:50 AM, the surveyor interviewed LPN #3 who stated any [redacted] of [redacted] were reported immediately to the supervisor and all staff assigned to the resident for the three days prior would have to complete a written statement. LPN #3 further stated that it was important to thoroughly investigate [redacted] "to find out where it came from and to rule out [redacted] On 11/12/24 at 12:03 PM, the surveyor interviewed LPN/UM #1 who stated when there was an [redacted], the facility would launch a full investigation and obtain statements from all staff assigned to the resident in the past 72 hours. LPN/UM #1 further stated that it was important to thoroughly investigate [redacted] to '[redacted]." On 11/12/24 at 12:50 PM, the surveyor interviewed the [redacted] who stated when there was	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 18	F 610		

an NJ Exec Order 26.4b1, an incident report was completed, and statements were obtained from the nurses and certified nursing assistants going back 72 hours. At that time, the surveyor informed the U.S. FOIA (b) of the missing incident report and statements for Resident #6's NJ Exec Order 26.4 on NJ Exec Order 26.4b1 and the U.S. FOIA (b) confirmed that there should have been an investigation into whether something happened to the resident between the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1. The U.S. FOIA (b) further stated that statements should be obtained to rule out NJ Exec Order 26

A review of the facility's "Management and Reporting of Resident Incidents" policy, revised September 2016, included, "When an accident or incident occurs to a resident, an investigation is conducted to determine any/all factors contributing to the incident, analyze the cause and effect, and to identify and implement interventions in an effort to prevent or minimize future occurrences." Further review of the policy included, "If an injury of unknown origin has been identified, the Unit Manager will communicate with shift supervisors to ensure that staff from the previous 2 shifts who provided care for that resident are interviewed and give statements."

A review of the facility's "Abuse Investigation and Reporting" policy, revised January 2023, included, "If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual." Further review of the policy included, "The individual conducting the investigation will, as a minimum: ... Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 610	Continued From page 19	F 610		
F 623 SS=D	NJAC 8:39-4.1(a)(5) Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 623	Continued From page 20 allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 623	Continued From page 21 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to notify the [redacted] of a resident hospitalization. This deficient practice was identified for 1 of 1 resident (Resident #2) reviewed for hospitalization and was evidenced by the following: On 11/6/24 at 10:01 AM, the surveyor observed that Resident #2 was not in their room. On 11/7/24 at 12:00 PM, the surveyor reviewed the medical record for Resident #2. A review of the Admission Record, an admission	F 623	Tag 0623 Element One Corrective Actions Administrative staff were immediately educated on compliance regarding the Ombudsman Notification of Transfer-Protocol by the nursing home administrator. An audit was performed to ensure all recent notifications were sent out to which there were no findings. For the month in question the nursing home administrator sent out Ombudsman Notification via email. Element Two Identification of at Risk Residents All Residents could be at risk for improper	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 623	Continued From page 22 summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 [redacted] A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident's [redacted] A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated [redacted], that the resident had [redacted] A review of the Progress Notes (PN) included a Nurse's Note (NN), dated NJ Exec Order 26.4b1, which included that the resident was admitted to the hospital for [redacted]. Further review of the PN included a Social Services (SS) note dated NJ Exec Order 26.4b1, which indicated that a Bed Hold Notice was placed in the resident's room as the resident was his/her own responsible party and had no Power of Attorney. On 11/8/24 at 8:35 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) who stated that she sent out the Bed Hold Notices and the	F 623	notification of hospitalization to the Office of the State Long-Term Care Ombudsman. Element Three Systemic Change The facility "Ombudsman Notification of Transfer-Protocol" policy was reviewed which addresses that at the beginning of each month the facility will establish a list of all residents that were sent out to the hospital for the previous month by the nursing home administrator. The facility will electronically fax a sheet to the local NJ Ombudsman Office containing all the appropriate information and the sheets will be saved along with the fax confirmation. Administrative staff were re-educated regarding the policy. Element Four Quality Assurance The Social Worker or designee will conduct monthly audits to assure 100 percent compliance on the Ombudsman Notification of Transfer sheets along with supporting fax confirmation monthly for 3 months. Results will be provided to Facility administrator who will review the findings and provide direction as appropriate. The Facility administrator will report the findings in aggregate at the monthly QAPI for 3 months. Facility Educator will be responsible for maintaining education on proper monthly Ombudsman notification of transfer protocol. The facility will be in compliance with regard to this deficiency, and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 623	Continued From page 23 nurses notified the resident's representative of the hospitalization. On 11/8/24 at 12:33 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that he was responsible for the notification of the U.S. FOIA (b)(6) and agreed to furnish the notification. On 11/12/24 at 8:42 AM, the U.S. FOIA (b)(6) stated that a former employee who worked in medical records was responsible to notify the U.S. FOIA (b)(6) and there was no record of facsimile (fax) confirmation to confirm notification. A review of the facility's undated "Ombudsman Notification of Transfer-Protocol" included: At the beginning of each month the facility will establish a list of all residents that were sent out to the hospital for the previous month. The facility will electronically fax a sheet to the local NJ Ombudsman Office containing the following: Resident Name, Date of transfer, Was voluntary or involuntary (facility initiated), What hospital the resident was transferred to, Reason for transfer. These sheets will be saved along with the fax confirmation.	F 623	corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0623 will not reoccur.	
F 657 SS=D	NJAC 8:39-4.1(a)3 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 657	Continued From page 24 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint NJ#: 171267 and 173863 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to revise a resident's individual comprehensive care plan after a resident fall for 2 of 3 residents (Resident #87 and #309) reviewed for [redacted] This deficient practice was evidenced by the following: 1.) On 11/6/24 at 9:51 AM, the surveyor observed staff providing care to Resident #87 in his/her room.	F 657	Tag 0657 Element One Corrective Actions #1. Resident #87 The facility immediately updated Resident #87 Individualized Comprehensive Care Plan (ICCP) to reflect new intervention after the resident's [redacted]. All nursing staff were immediately counseled and re-educated by the director of nursing about the importance of a Resident's Individualized Comprehensive Care Plan (ICCP) to reflect all new interventions after a [redacted] to help possibly avoid future	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 657	Continued From page 25 On 11/6/24 at 12:34 PM, the surveyor reviewed the medical record for Resident #87. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] included the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's [redacted] was [redacted]. Further review of the MDS revealed the resident had [redacted] since the prior assessment. A review of the individualized comprehensive care plan (ICCP) included a focus area, dated [redacted] that the resident had an [redacted] related to [redacted] All interventions for that focus area were dated [redacted] A review of the Progress Notes (PN) included a Nurses Note (NN), dated [redacted], which revealed a nurse witnessed the resident [redacted] while the resident was walking around the nurses' station. Further review of the NN revealed the resident [redacted], was [redacted] his/her [redacted]. The NN further included the [redacted] was notified and an order for a [redacted] was obtained.	F 657	#2 Resident #309 The Facility immediately updated Resident #309 Individualized Comprehensive Care Plan (ICCP) to reflect new interventions after the resident's [redacted]. All nursing staff were immediately counseled and re-educated by the director of nursing about the importance of a Resident's Individualized Comprehensive Care Plan (ICCP) to reflect all new interventions after a [redacted] to help possibly avoid future [redacted]. Element Two Identification of at Risk Residents #1 Resident #87 All Residents that are at [redacted] have the potential to be affected by this practice. All [redacted] residents were reviewed to assure proper interventions were put into place on the Resident's Individualized Comprehensive Care Plan (ICCP). No deficiencies were noted upon review. #2 Resident #309 All Residents that are at [redacted] have the potential to be affected by this practice. [redacted] residents were reviewed to assure proper interventions were put into place on the Resident's Individualized Comprehensive Care Plan (ICCP). No deficiencies were noted upon review. Element Three Systemic Change #1 Resident #87 The facility "Falls Prevention" policy was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 657	Continued From page 26 Further review of the ICCP did not include any new interventions related to the resident's [redacted] A review of the incident report (IR), dated [redacted], revealed Resident #87 was observed [redacted] at the nurses' station and staff attempted to NJ Exec Order 26.4b1 [redacted]. The [redacted] further revealed a nurse witnessed the resident [redacted] on his/her [redacted] and the immediate action taken was the U.S. FOIA (b)(6) was notified and an order for a NJ Exec Order 26.4b1 was obtained. The [redacted] did not indicate whether the resident's ICCP was updated to include new interventions related to the [redacted] A review of the Supervisor [redacted] Incident Investigation, dated [redacted], revealed the section "New Interventions/Recommendations" was not filled out and was left blank. On 11/12/24 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 who stated that if a resident [redacted] the nurse should update the resident's ICCP as soon as possible. LPN #3 further stated it was important to update the ICCP with new interventions to prevent future [redacted] On 11/12/24 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that if a resident [redacted], the interdisciplinary team would meet to update the resident's ICCP. LPN/UM #1 further stated that it was important to update the ICCP with new interventions to prevent further injuries. On 11/12/24 at 12:50 PM, the surveyor	F 657	reviewed which addresses identifying pertinent interventions to try to prevent subsequent [redacted] and documenting them on each Resident's Individualized Comprehensive Care Plan (ICCP). Nursing staff were re-educated regarding the policy by the director of nursing. #2 Resident #309 The facility "Falls Prevention" policy was reviewed which addresses identifying pertinent interventions to try to prevent subsequent [redacted] and documenting them on each Resident's Individualized Comprehensive Care Plan (ICCP). Nursing staff were re-educated regarding the policy by the director of nursing. Element Four Quality Assurance #1 Resident #87 The Unit Managers or Designee will conduct weekly audits for 4 weeks then monthly for 3 months to ensure any resident that had a fall that week has an updated care with new interventions on the Resident's Individualized Comprehensive Care Plan (ICCP). Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI for 4 months. Facility Educator will be responsible for maintaining education for staff on updating the Resident's Comprehensive Care Plan (ICCP) with new interventions in regards to a fall.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 657	Continued From page 27 interviewed the U.S. FOIA (b)(6) who stated that if a resident NJ Exec, the interdisciplinary team or nursing staff would update the resident's ICCP as soon as possible to prevent additional NJ Exec O. At that time, the surveyor informed the U.S. FOIA (b) that Resident #87's ICCP was not updated with new interventions after the resident's NJ Exec on NJ Exec Order 26, and the U.S. FOIA (b) confirmed that the ICCP should have been revised to include new interventions NJ Exec Order 26.4b1 2.) On 11/8/24 at 12:25 PM, the surveyor reviewed the closed electronic medical record (EMR) for Resident #309. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included NJ Exec Order 26.4b1 A review of the admission Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b included the resident had a Brief Interview Mental Status score of U.S. FOIA (b)(6) which indicated the resident's NJ Exec Order 26.4b1 Further review of the MDS revealed the resident has NJ Exec Order 26.4b1 since admission. A review of the individualized comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4b that the resident was a NJ Exec Order 26.4b1 All interventions for that focus area were dated NJ Exec Order 26.4b A review of the Progress Notes (PN) included a Nurses Note (NN), dated NJ Exec Order 26.4b1	F 657	#2 Resident #309 The Unit Managers or Designee will conduct weekly audits for 4 weeks then monthly for 3 months to ensure any resident that had a fall that week has an updated care with new interventions on the Resident's Individualized Comprehensive Care Plan (ICCP). Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for 4 months. Facility Educator will be responsible for maintaining education for staff on updating the Resident's Comprehensive Care Plan (ICCP) with new interventions in regards to a fall. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0657 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 657	Continued From page 28 which revealed the resident was NJ Exec Order 26.4b1 by a NJ Exec Order 26.4b1). Further review of the NN revealed safety measures were put into place. Further review of the ICCP did not include any new interventions related to the resident's NJ Exec Order A review of the incident report (IR), dated NJ Exec Order 26.4 M, revealed Resident #309 had an NJ Exec Order 26.4b1 The U.S. FO did not indicate whether the resident's ICCP was updated to include the new interventions related to the NJ Exec On 11/12/24 at 11:46 AM, the surveyor interviewed LPN #4 who stated that that the care plan was updated by the U.S. FOIA (b)(6) She stated she was unsure if was it was updated after each U.S. FOIA since the U.S. FOIA was responsible for updating the care plans. On 11/12/24 at 11:55 AM, the surveyor interviewed LPN/UM #2 who stated that the previous U.S. FOIA (b)(6) wanted the nurses to update the care plans all at once after the Interdisciplinary Team (IDT) meeting which was every couple of days. She then stated the current NJ Exec Orc wanted the care plan to be updated immediately after each incident. On 11/12/24 at 12:05 PM, the surveyor interviewed the NJ Exec Offe in the presence of the NJ Exec Order 26.4b1 who stated the nurses, MDS, U.S. FOIA, social services and dietary were all responsible for creating the care plan related to the specific issues. She stated that the care plan was updated after the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 657	Continued From page 29 IDT reviewed the incident and updated the interventions accordingly. The [U.S. FOIA (b)] confirmed there should be interventions in place after each [NJ Exec] to prevent [NJ Exec Order 26.4b1] On 11/12/24 at 12:12 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] in the presence of the [U.S. FOIA (b)] who stated they had issues with the previous [U.S. FOIA (b)] and the care plans was one of the issues. The [NJ Exec Order] stated that anything that occurred the care plan should be updated accordingly and specialized to the individual residents. He further stated that the expectation was for the care plan to be updated to include interventions after each fall. On 11/13/24 at 1:57 PM, in the presence of the survey team both the U.S. FOIA (b)(6) acknowledged there were no interventions in place for Resident #309 after the [NJ Exec Order 26.4b1] and that there should have been interventions put into place after [redacted]. A review of the facility's "Falls - Clinical Protocol" policy, revised June 2022, included, "the staff and physician will identify pertinent interventions to try to prevent subsequent falls." A review of the facility's "Care Planning - Interdisciplinary Team" policy, revised December 2023, included, "A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS)."	F 657		
F 678 SS=J	NJAC 8:39-27.1(a) Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)	F 678		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 30 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interviews, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to activate their emergency response system including calling NJ Exec Order 26.4b1 for a resident (Resident #103) who was found and was a NJ Exec Order 26.4b1) in accordance with the NJ Exec Order 26.4b1 for Healthcare Providers. This deficient practice was identified for 1 of 4 residents (Resident #103) reviewed for a NJ Exec Orde in the facility. A review of the Progress Notes (PN) and interviews with the licensed nursing staff revealed that on NJ Exec Order 26.4b1, the Certified Nursing Assistant (CNA #1) found Resident #103 NJ Exec Order 26.4b1 it to the Licensed Practical Nurse (LPN #1) who began NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 LPN #1 stopped NJ Exec Or, did not call 911 and did not notify the Registered Nurse (RN #1) until NJ Exec Order 26.4b1 RN #1 did not perform NJ Exec Orde or call 911, and NJ Exec Order 26.4b1 Resident #103 NJ Exec Order 26.4b1 The facility's failure to ensure their emergency response system was activated including calling	F 678	Element One Corrective Actions Resident #103 is no longer a resident in the facility. The interdisciplinary team met, and the facilities NJ Exec Order 26.4b1 policy was updated to include obvious signs of NJ Exec Order 26.4b1 would not be indicated and emergency response system activation would not be indicated, even in the case where a resident was a NJ Exec Order 26.4b. The facility has been unable to contact Licensed Practical Nurse #1, as she NJ Exec Order 26.4b1. RN#1 was educated by the U.S. FOIA (b)(6) on the facilities policy for NJ Exec Order 26.4b1. LPN #1 and RN#1 will not return to work at the facility until successful completion of a NJ Exec Order 26.4b1 drill/competency assessed by the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) completed an audit of all our licensed nursing inhouse/agency staff ensuring up to date NJ Exec Orde certifications. Element Two Identification of at Risk Residents All Residents have the potential to be affected by this deficient practice. Element Three Systemic Change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 31 NJ Exec Order 26.4b1 [redacted] This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 09/27/24 at 4:30 AM, when Resident #103 was NJ Exec Order 26.4b1, and the facility failed to call 911. The facility Administration was notified of the IJ on 11/13/24 at 4:17 PM. The facility submitted an acceptable Removal Plan (RP) on 11/14/24 at 10:34 AM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 11/14/24. The evidence was as follows: A review of the facility provided "Code/Blue/CPR" policy dated revised February 2022, included it is the policy to activate a Code Blue in response to a cardiac or respiratory arrest. Basic Life Support in this setting will include: 1. initiating CPR, oxygen, and defibrillation (if necessary); 2. Activating the Emergency Response System. In the event of a cardiac and/or respiratory arrest, a "Code Blue" will be announced on the unit. Providers from each unit will respond to the Code Blue. The resident's assigned nurse will be the designated team leader. The procedure is as follows: first person confirms cardiac or respiratory arrest, checks code status; calls for help and begins CPR; second person assigns someone to activate Code Blue and applies [automated external defibrillator] AED (a device used to deliver an electronic shock to restart heart rhythm) pads and sets up suction machine...third person activates a Code Blue and Emergency Response System; completes transfer form and assigns a staff member to wait for paramedics at front door.	F 678	The Director of Nursing/designee began education for all licensed nurses on the facilities policy for Code Blue/CPR. Education for all staff further included activation of the emergency response system indicating for staff to call 911, utilizing our walkie talkie system that are located at each nurses station and to announce out loud on the unit we are experiencing a code blue emergency, except when obvious signs of irreversible death are observed. All nurses were educated regarding this practice by 11/15/2024. Agency will ensure they are providing the facility will CPR certification prior to starting their shift. Element Four Quality Assurance The nurse educator/designee will conduct monthly Code Blue/CPR education, activation of the emergency response system indicating for staff to call 911, for the next six months. This content will be included in the general orientation as well as the annual mandatory in-service. The Director of Nursing/designee will conduct weekly Code Blue/CPR drills weekly for six weeks to ensure drills are completed on weekdays, weekends and all shifts. The drills will audit staff response to a code blue situation and activation of the emergency response system indicating for staff to call 911. The Director of Nursing will report the findings in aggregate at the monthly QAPI meeting x 6 months. Facility Educator will be responsible for maintaining education for staff on our code blue policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 32 On 11/07/24 at 11:25 AM, the surveyor reviewed the closed medical record of Resident #103. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated a NJ Exec Order 26.4b1. A review of Resident #103's Order Summary Report (OSR) revealed a physician's order dated NJ Exec Order 26.4 NJ Exec Order 26.4b, which indicated that the resident was a . A review of the New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) dated NJ Exec Order 2, revealed that the resident wanted full treatment which included but was not limited to; a NJ Exec Order 26.4b1 [redacted]), attempt r NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted] as needed for	F 678	The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 11/21/2024 to ensure the deficient Tag 0678 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 33	F 678		

NJ Exec Order 26.4b1

A review of the individual comprehensive care plan (ICCP) included a focus area dated [redacted], that the resident had an Advance Directive in place related to the completed POLST form on the chart, Power of Attorney, and a living will. Interventions included that the resident requested NJ Exec Order 26.4b1 and that health care wishes were discussed with resident and/or health care representative to assure the resident's wishes were being met.

A review of the PN dated 9/27/24 at 6:57 AM by LPN #1, revealed that upon receiving the resident at the beginning of the 11:00 PM to 7:00 AM (11-7) shift, Resident #103 was NJ Exec Order 26.4b1 [redacted] CNA #1 completed rounds at NJ Exec Order 26.4b1 [redacted] At that time, the resident was [redacted], and the resident reported NJ Exec Order 26.4b1 [redacted] Around [redacted] CNA #1 reported NJ Exec Order 26.4b1 with the resident, and upon LPN #1 assessing the resident, the resident had NJ Exec Order 26.4b1 [redacted] until RN #1 was called to assess (the resident). RN #1 NJ Exec Order 26.4b1 resident NJ Exec Order 26.4b1, and the family and doctor were immediately notified.

During an interview with the surveyor on 11/8/24 at 10:34 AM, CNA #3 stated that she was not familiar with Resident #103. When asked what a CNA's role was in a NJ Exec Order 26.4b1 [redacted]), she stated the aide got the nurse and emergency equipment, and the NJ Exec Order 26.4b1 called 911. CNA #3 further stated that an announcement was made for 911 for the specified room number, a code was called, and all staff reported.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 34 During an interview with the surveyor on 11/8/24 at 10:39 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1) stated that during a [NJ Exec Orde] [redacted] the nurse obtained vital signs ([redacted]), performed an assessment, got the code cart, called 911, and [NJ Exec Order 26.4b1] until 911 services took over. LPN/UM #1 stated that it should be documented that 911 was dispatched in the PN. LPN/UM #1 stated that Resident #103 was administered [NJ Exec Or] and RN #1 should have been assisting LPN #1 with [U.S. FOIA (b)] LPN/UM #1 stated that LPN #1 was out on medical leave and was not able to be interviewed. LPN/UM #1 read the PN aloud that was written by LPN #1 and confirmed it was not documented that LPN #1 called 911. LPN/UM #1 stated that staff were told that they had to document everything. During an interview with the surveyor on 11/8/24 at 11:32 AM, the [NJ Exec Order 26.4b1]) stated that during a [NJ Exec Order 26.4b1], the aide would notify the nurse and the nurse would complete a full assessment. The [U.S. FOIA (b)] stated the nurse checked the resident's [NJ Exec Order 26.4b1], and they went "straight to work" and added that the nurse called an alert, assessed the resident, and if [NJ Exec Order 26.4b1], 911 was called and [U.S. FOIA (b)] was performed until emergency medical services (EMS) came to the facility and took over. The [U.S. FOIA (b)(6)] reviewed Resident #103's PN with the surveyor and confirmed that there was no documentation that was 911 called and 911 should have been called. The [U.S. FOIA (b)] stated that RN #1 was ultimately responsible for ensuring	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 35	F 678		

911 was called and was disciplined and received education for that on [redacted]. The [redacted] confirmed RN #1 was certified in [redacted].

On 11/8/24 at 12:35 PM, the surveyor reviewed an "Employee Counseling Record" dated [redacted] in RN #1's employee file which revealed that RN #1 failed to follow procedure for the incident on [redacted] at 5:50 AM. The document was signed by RN #1, the [redacted], and the [redacted]

On 11/12/24 at 8:33 AM, the facility provided the surveyor with copies of [redacted] Program Certificates that were issued to LPN #1 on [redacted], and RN #1 on [redacted].

During a phone interview with the surveyor on 11/12/24 at 12:41 PM, RN #1 stated that on the morning of [redacted], he was passing out medications on the [redacted] Unit, when LPN #1 called him and stated that "she needed me urgently and I rushed to her." RN #1 stated that Resident #103 was in bed, and the resident [redacted] when he called the resident's name. RN #1 stated, "I tried to sit the resident up and there were [redacted]." RN #1 stated that the resident [redacted] RN #1 stated that he tried [redacted] he put the [redacted]t, and [redacted]. RN #1 stated that he pronounced the [redacted] and notified the physician. RN #1 stated that the [redacted] protocol was when [redacted], you had to [redacted]. RN #1 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 36	F 678		

LPN #1 did not call 911, but he acknowledged that he should have. RN #1 stated when he arrived on the unit, LPN #1 was at the nurse's station, and she reported that she performed NJ Exec Order 26.4b1 [redacted]. RN #1 stated, "[redacted] RN #1 stated when he went to assess Resident #103, the resident NJ Exec Order 26.4b1 [redacted] so I did not call 911."

During an interview with the surveyor on 11/12/24 at 12:54 PM, LPN/UM #1 stated that if the aide informed the nurse that the resident NJ Exec Order 26.4 [redacted], the nurse should have checked the NJ Exec Order [redacted] called a NJ Exec Orde [redacted] called 911, got the NJ Exec Orde [redacted] and NJ Exec Orde [redacted] When the surveyor asked if an NJ Exec Ord [redacted] was used on Resident #103 during NJ Exec Orde [redacted] she stated it was not documented as used. LPN/UM #1 stated, "Unfortunately, there was a breakdown in the protocol, and they (911) should have been called."

During an interview with the surveyor on 11/12/24 at 1:58 PM, the surveyor asked the U.S. FOIA (b) [redacted] if U.S. FOIA [redacted] #1 used the NJ Exec Ord [redacted] during NJ Exec Orde [redacted] for Resident #103, the NJ Exec Ord [redacted] responded it was not documented as used.

During an interview with the surveyor on 11/13/24 at 1:05 PM, the surveyor was unable to reach CNA #1, who was assigned to care for Resident #103 on NJ Exec Order 26.4 [redacted], during the 11-7 shift, by phone and instead interviewed CNA #5 who also worked on the NJ Exec Or [redacted] Unit that shift. CNA #5 stated that if something happened that night, she did not notice. CNA #5 stated that if you were aware of a NJ Exec Orde [redacted] you were supposed to help the nurse. CNA #5 stated that she had never been asked to go and get help or to call 911.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 37 During an interview with the surveyor on 11/13/24 at 1:13 PM, in the presence of the survey team, the U.S. FOIA (b) stated that she did not do an investigation and did not question the time lapse from when CNA #1 found the resident NJ Exec Order 26.4b1 and notified LPN #1, to LPN #1 notifying RN #1 at NJ Exec Order 26.4b1 The U.S. FOIA (b) stated that she did not focus on the time and just asked RN #1 about NJ Exec Order and why 911 was not called. The U.S. FOIA (b)(6) who was present stated, "RN #1 thought that it was an NJ Exec Order 26.4b1 to keep NJ Exec Order 26.4b1". During an interview with the surveyor on 11/13/24 at 2:38 PM, the U.S. FOIA (b)(6) stated that when there was a NJ Exec Order 26.4b1 and someone stopped NJ Exec Order 26.4b1, he expected whoever was in the building to call the nursing supervisor, perform NJ Exec O and call 911. Emergency Medical Services (EMS) would arrive to the facility with NJ Exec Order 26.4b1, to treat NJ Exec Order 26. emergencies such as NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, and/or the use of an NJ Exec Order The U.S. FOIA (b)(6) stated that EMS took over the care of the resident and NJ Exec Order 26.4b1 them if indicated. The U.S. FOIA (b)(6) stated that he "was notified of the scenario and clearly, 911 should have been notified." An acceptable Removal Plan (RP) on 11/14/24 at 10:34 AM, indicated the action the facility will take to prevent NJ Exec Order 26.4b1 from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the facility's NJ Exec Order 26.4b1 policy was updated to reflect staff are to call 911 during emergency response; LPN #1 and RN #1 will be	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 678	Continued From page 38 educated by the [U.S. FOIA (b)] on the facility's [NJ Exec Orde] [redacted] policy prior to working next shift; all licensed nurses will be educated on the facility's [NJ Exec Order 26.4b1] policy; and the [US FOIA (b)(6)] [redacted] will ensure at least 50% of all licensed nurses in the building at all times are [NJ Exec Or] certified. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 11/14/24.	F 678		
F 684 SS=G	NJAC 8:39-4.1 (3), 9.6 (g),14.2(b) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00173863 Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure a treatment that was ordered for a [NJ Exec Order 26.4b1] was implemented without a 23-day delay which resulted in the [NJ Exec Order 26] [NJ Exec Order 26.4b1] with a [NJ Exec Order 26.4b] ([NJ Exec Order 26.4b1] [redacted]) [NJ Exec Order 26] [redacted] that required a [NJ Exec Order 26.4b1] [redacted] This deficient practice was identified	F 684	Tag 0684 Element One Corrective Actions Resident #305 no longer resides in the facility. The Nursing staff were all immediately educated on the importance that once a [NJ Exec Order 26.4b1] [redacted] is identified, nursing will immediately assess the area, obtain measurements, and identify the possible source and or cause, notify MD/Nurse practitioner (NP) and obtain orders, notify resident primary	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 684	Continued From page 39 for 1 of 4 residents (Resident #305) reviewed for NJ Exec Order 26.4b1 and was evidenced by the following: On 11/6/24 at 12:30 PM, the surveyor reviewed the closed medical record for Resident #305. A review of the Admission Record face sheet (an admission summary) revealed that the resident had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4, included the resident's NJ Exec Order 26.4b1 [redacted]; the resident needed NJ Exec Order 26.4b [redacted], NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1; and NJ Exec Order 26.4b1 in all other activities of daily living and mobility. Further review revealed the resident hac NJ Exec Order 26.4b1 [redacted]. A review of the Progress Notes (PN) included a Nurses Note (NN) dated NJ Exec Order 26.4b1 which revealed that the nurse was notified by the resident's NJ Exec Order 26.4b1 that the resident had a new NJ Exec Order 26 on the NJ Exec Order 26.4b1. The resident was assessed for a U.S. FOIA (b)(6) [redacted]), the doctor was notified, a new treatment order was put in the electronic medical record (EMR), and all necessary documentation was completed. A review of the Progress Notes included a Physicians Note (PN) dated NJ Exec Order 26.4 at 5:16 PM, which revealed a late entry for NJ Exec Order 26.4b1 [redacted] The PN included that the resident	F 684	contact, implement risk management in PCC (EMR), implement NJ Exec Order 26.4b1 [redacted] medications as needed, update care plan to reflect new NJ Exec Order 26.4b1 and interventions and notify Director of Nursing. Element Two Identification of at Risk Residents All Residents within the facility have the potential to be affected by this deficient practice. Element Three Systemic Change The facility "Weekly Skin Observation-Licensed Staff" policy was reviewed which addresses weekly wound observations of the resident from head to toe for any visualizations of the skin. The facility "Pressure Ulcer-Clinical Protocol" policy was reviewed which addresses the importance that once a pressure ulcer/open area is identified, nursing will immediately assess the area, obtain measurements, and identify the possible source and or cause, notify MD/Nurse practitioner (NP) and obtain orders, notify resident primary contact, implement risk management in PCC (EMR), implement skin packet and interventions, administer pain medications as needed, update care plan to reflect new skin issue and interventions and notify Director of Nursing. Nursing staff were re-educated regarding both policies. The interdisciplinary team will now be meeting weekly to discuss all new skin injuries from the prior week to ensure Pressure Ulcer policy is being followed and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 684	Continued From page 40 developed a NJ Exec Order 26.4b1 which was now NJ Exec Order 26.4b1 Assessment and plan included that the NJ Exec Order 26.4b1 To NJ Exec Order 26.4b1 . A review of the Order Summary Report (OSR) dated as of NJ Exec Order 26 included the following physician orders (PO): A PO dated NJ Exec Order 26.4, to NJ Exec Order 26.4b1 ; cover with NJ Exec Orde and paper tape one time a day for NJ Exec Order 26.4b1. This order did not address the NJ Exec Order 26.4b1 which was documented on the NJ Exec Order 26.4 Progress Notes. A review of the NJ Exec O and NJ Exec Order 26.4b1 Physician's Order Sheet (POS) and Treatment Administration Record (TAR) did not include any PO for the new NJ Exec Order 26.4b1 , which was 23 days after. A review of the OSR dated as of NJ Exec Order 26 included the following PO: A PO dated NJ Exec Order 26.4, to clean NJ Exec Order 26.4b1	F 684	Care Plan was updated to reflect the new skin issue along with the interventions along with ensuring 100% compliance of the weekly skin observations. Element Four Quality Assurance The Unit Managers or Designee will audit skin injuries on their unit are immediately assessed, obtained measurements, identify the possible source and or cause, notify MD/Nurse practitioner (NP) and obtain orders, notify resident primary contact, implement risk management in PCC (EMR), implement skin packet and interventions, administer pain medications as needed, update care plan to reflect new skin issue and interventions and notify Director of Nursing for one week and then weekly for three months. The Unit Managers or Designee will audit completion of the weekly skin observations weekly for 3 months to assure 100% completion. The Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for 3 months to determine if further action as required. Facility Educator will be responsible for maintaining education for staff on documenting skin injuries and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 684	Continued From page 41 A PO dated [redacted], for [redacted] checks every day shift every Saturday. A review of the resident's individual comprehensive care plan (ICCP) did not include a focus area or interventions for the new [redacted] identified on [redacted]. On 11/8/24 at 12:40 PM, the facility was unable to provide the [redacted] nursing notes but provided the [redacted] care plans that included the following: A hospice care plan dated [redacted], included a [redacted] on the [redacted]. A [redacted] care plan dated as of [redacted], included a [redacted]. A review of the Incident Report (IR) for a [redacted], included that the treatment order was placed in the EMR for [redacted] and that the care plan was updated. The IR did not include any measurements or description of the [redacted]. The IR included the risk management form dated [redacted]. The risk management form did not include any measurements or description of the [redacted]	F 684	corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0684 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 684	Continued From page 42	F 684		

A review of the weekly [redacted] assessment dated [redacted], included that the resident did not have any NJ Exec Order 26.4b1 on the [redacted] but also identified that the resident's NJ Exec Order 26.4b1 [redacted]. The weekly [redacted] assessment did not include the NJ Exec Order 26.4b1 of the [redacted] the [redacted] the [redacted] or if the [redacted] had any [redacted]

There was no documented evidence of [redacted] assessments completed after [redacted], through [redacted]

A review of the weekly [redacted] assessment dated [redacted], included that a NJ Exec Order 26.4b1 had a treatment currently in place. There was no description or measurement of the [redacted]

On 11/12/24 at 10:08 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted], who confirmed that the NJ Exec Order 26.4b1 [redacted] who wrote the Progress Note on [redacted] and the U.S. FOIA (b)(6) [redacted] who signed the PO on [redacted], for the U.S. FOIA (b)(6) [redacted] were not employed at the facility anymore.

On 11/12/24 at 10:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA#2), who stated that she remembered Resident #305 and that the resident was on [redacted] CNA#2 stated the [redacted] came in early to NJ Exec Order 26.4b1 the resident, then then she cared for the resident the rest of the shift. CNA#2 could not recall if the resident had any NJ Exec Order 26.4b1.

On 11/12/24 at 10:37 AM, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 684	Continued From page 43	F 684		

interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM#1), who stated that that if a U.S. FOIA (b)(6) was identified, the nurse completed a risk management form in the EMR; completed an Incident Report; measured the NJ Exec Order 26 contacted the doctor; and obtained treatment orders. The NJ Exec Order 26.4b1 assessments were completed by the medication nurse and included the NJ Exec Order 26.4b1, if there was any NJ Exec Order 26.4b1, how the NJ Exec O around the NJ Exec Order 2 appeared and any treatments that were ordered. LPN/UM#1 further stated that when a resident was on U.S. FOIA (b)(6), the NJ Exec Order 26.4b Nurse assessed the NJ Exec Order 26.4 and gave recommendations for a treatment. The staff nurse obtained a PO for the treatment and completed the NJ Exec Order 26.4b1 as ordered. LPN/UM#1 stated that the ICCP should be updated with interventions when a NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 was identified.

At that time, the surveyor and LPN/UM#1 reviewed the Progress Notes, the PO, the ICCP, and the weekly NJ Exec O assessments in the EMR. LPN/UM #1 confirmed that she had entered the PO on NJ Exec Order 26.4, in the EMR and it should have been for the NJ Exec Order 26.4b1 and not the NJ Exec Order NJ Exec Order 26 LPN/UM#1 stated that weekly NJ Exec O assessments should have been completed weekly and should have included NJ Exec Order 26.4b NJ Exec Order 26.4b1 and any NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 of the NJ Exec Order 26 LPN/UM#1 confirmed that a treatment order for the NJ Exec Order 26.4b1 was not on the POS or the TAR until NJ Exec Order 26.4. LPN/UM#1 further stated that on NJ Exec Order 26.4, when the NJ Exec Order 26.4b1 , a NJ Exec O assessment should have been completed. After reviewing the Progress Notes, LPN/UM#1 could not recall if the NJ Exec Order 26.4b1 had notified her about the NJ Exec O

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 684	Continued From page 44	F 684		

U.S. FOIA (b)(6) between NJ Exec Order 26.4b1. LPN/UM #1 stated that the NJ Exec Order 26.4b1 Nurse usually visited the resident twice a week.

On 11/12/24 at 11:56 PM, the surveyor interviewed Resident #305's U.S. FOIA (b)(6)), who stated that if the nurse identified a NJ Exec Order 26.4b1 , they called the U.S. FOIA (b) and a NJ Exec Order 26 treatment would be ordered as well as a NJ Exec Order 26 consultation (consult) if needed. The U.S. FOIA (b) stated that Resident #305 was on NJ Exec Order 26.4 so a NJ Exec Order 26 consult would not have been ordered. The surveyor and the U.S. FOIA (b) reviewed the Progress Notes and POs for Resident #305. The U.S. FOIA (b) confirmed that the treatment PO on NJ Exec Order 26.4 , had been entered wrong and should have been for the NJ Exec Order 26.4b1 . The U.S. FOIA (b) reviewed the weekly assessments and confirmed that the assessments were not completed weekly and did not include measurements, or identifiable assessments such as NJ Exec Order 26.4b1. The U.S. FOIA (b) stated that it was important to complete NJ Exec Order 26.4b1 as recommended or the NJ Exec Order 26 could get NJ Exec Order 26.4b1. The further stated, "I think that when a resident is on NJ Exec Order 26.4 , the staff relies too much on the NJ Exec Order 26 aides and nurses for the resident's care."

On 11/12/24 at 1:11 PM, the surveyor interviewed the NJ Exec Order 26.4b1 who stated that when a new NJ Exec Order 26.4b1 was identified, the nurse assessed the , completed an Incident Report, called the doctor, obtained new treatment orders, updated the ICCP, and notified the resident's representative. The NJ Exec Orde further stated that weekly assessments were completed by the medication nurse or unit managers and the weekly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 684	Continued From page 45	F 684		

assessments should include the location, [NJ Exec Order 2] measurements, type of [NJ Exec Order 26] and details about the [NJ Exec Order 26] The [U.S. FOIA (b)] stated that it was important to obtain a PO for [NJ Exec Order 26] treatment and complete the [NJ Exec Order 2] treatment as ordered because it could prevent any NJ Exec Order 26.4b1 of the [NJ Exec Order 26] When a resident was on [U.S. FOIA (b)(6)], the [U.S. FOIA (b)(6)] Nurse made [NJ Exec Order 26] care recommendations and the staff nurse obtained a PO from the attending physician.

On 11/13/24 at 1:56 PM, the surveyor interviewed the NJ Exec Order 26.4b1 who stated that he was made aware of Resident #305's NJ Exec Order 26.4b1 by the [NJ Exec Order 26.4b] Nurse and by the U.S. FOIA (b)(6). The [U.S. FOIA (b)(6)] stated he could not remember the exact date, but it was when the resident was still in the facility.

A review of the facility's undated "Pressure Ulcer-Clinical Protocol" policy, included that once a pressure ulcer/open area is identified, nursing will: immediately assess the area, obtain measurements, and identify the possible source and or cause, notify MD/Nurse practitioner (NP) and obtain orders, notify resident primary contact, implement risk management in PCC (EMR), implement skin packet and interventions, administer pain medications as needed, update care plan to reflect new skin issue and interventions and notify wound NP...

A review of the facility' "Hospice" policy, dated revised December 2022, included that generally it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 684	Continued From page 46 appropriately based on the individual resident's needs. A review of the facility's "Physicians Order" policy, dated revised January 2022, included that the purpose of the policy is to ensure all physician orders are complete and accurate. The policy also included that treatment orders will include the following: a description of the treatment, including the treatment site. A review of the facility's "Treatment Administration" policy, dated revised January 2016, included that the nurse will administer all treatments as ordered and document.	F 684		
F 688 SS=E	NJAC 8:39-27.1(a) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 688	Continued From page 47 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to a.) clarify and transcribe a Physician's Order (PO) for [redacted] and b.) follow a physician's order for the application of a NJ Exec Order 26.4b1 to [redacted], and c.) document in the Treatment Administration Record (TAR). This deficient practice was identified for 1 of 1 resident (Resident #91) reviewed for [redacted] and [redacted] and was evidenced by the following: On 11/6/24 at 10:21 AM, during the initial tour, the surveyor observed Resident #91 NJ Exec Order 26.4b1, lying in bed with NJ Exec Order 26.4b1 [redacted]. The surveyor observed NJ Exec Order 26.4b1 [redacted] lying on the overbed table. On 11/7/24 at 9:03 AM, the surveyor observed Resident # 91 NJ Exec Order 26.4b1 lying in bed, with NJ Exec Order 26.4b1 [redacted]. The surveyor observed NJ Exec Order 26.4b1 [redacted] lying on the overbed table. Resident # 91 stated that they used the [redacted] sometimes but just did not want them on at this time. On 11/8/24 at 10:02 AM, the surveyor observed Resident # 91 NJ Exec Order 26.4b1 lying in bed, with NJ Exec Order 26.4b1 [redacted] without	F 688	Tag 0688 Element One Corrective Actions The Nursing staff and Therapy department were all immediately educated on the importance of entering new orders correctly into the system to NJ Exec Order 26.4b1 and maintain [redacted] and how to apply carrot hand [redacted] by the Director of Nursing. All physician orders in question were corrected so that the order is carried over to the TAR. Element Two Identification of at Risk Residents All Residents with new splint orders could be at risk due to the facility incorrectly adding in a new order for carrot hand splints. All Residents with splinting orders were reviewed to ensure all orders were correctly entered into the system. Element Three Systemic Change The facility "Splints" policy was reviewed which addresses that all splints should be in the EMR as an order under the TAR. The facility "Resident Mobility and Range of Motion" policy was reviewed which addresses that residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. Nursing staff were re-educated regarding both policies by the Director of Nursing. The interdisciplinary team will now be meeting weekly to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 688	Continued From page 48 NJ Exec Order 26.4b1 . The surveyor observed NJ Exec Order 26.4b1 lying on the overbed table. On 11/8/24 at 9:08 AM, the surveyor reviewed the medical record for Resident #91. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 A review of the quarterly Minimum Dats Set (MDS), an assessment tool, dated, NJ Exec Order 26.4b, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b . Further review of the MDS revealed the resident NJ Exec Order 26.4b1 in all activities of daily living and NJ Exec Order 26.4b A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4b, that the resident had NJ Exec Order 26.4b1 Interventions included: NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 at all times except for routine care and NJ Exec Order 26.4b1 A review of Resident # 91's NJ Exec Order 26.4b1 Summary, dated NJ Exec Order 26.4b revealed recommendations to donn (apply) NJ Exec Order hands at all times, except during care with NJ Exec Order 26.4b1. A review of the Order Summary Report (OSR) included a physician's order (PO), dated NJ Exec Order 26.4b all times,	F 688	discuss all new splinting orders from the prior week to observe any possible trends. If trends or behaviors are noted the Individualized Comprehensive Care Plan will be updated immediately to reflect this. Element Four Quality Assurance The Therapy Department or Designee will audit splinting checks to assure if any residents have orders for splinting it is being carried out by the nursing staff weekly for 4 weeks and then monthly for 3 months. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for 4 months. Facility Educator will be responsible for maintaining education for staff on importance of properly inputting new orders for splints and how to appropriately apply equipment for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0688 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 688	Continued From page 49 except during care. A review of the NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 Treatment Administration Record (TAR) did not reveal a corresponding PO to donn NJ Exec Order 26.4b1, at all times, except during care. A review of Resident #91's Progress Notes (PN) did not reveal any documentation that the NJ Exec [redacted] at all times, except during care were applied as ordered. The PN did not reveal any documentation of the resident's NJ Exec Order 26.4 [redacted] On 11/9/24 at 10:04 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #4) who stated that Resident # 91 required total care and used NJ Exec Order 26.4b1 the resident in bed. CNA #4 stated "I do not apply the NJ Exec Order 26.4b1 I think NJ Exec Order 26.4 does that. I was not taught how to use the NJ Exec Order 26.4b1 On 11/9/24 at 10:14 AM, the surveyor interviewed the Registered Nurse (RN#2) who stated that Resident # 91 only uses NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 but NJ Exec Order 26.4b1 [redacted] At that time, the surveyor and RN #2 reviewed the active TAR and RN #2 confirmed there was no PO on the TAR for NJ Exec Order 26.4b1 [redacted]. On 11/9/24 at 10:18 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]). The U.S. FOIA (b)(6) stated that Resident #91 was NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 with recommendations to donn NJ Exec Order 26.4b1,	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 688	Continued From page 50 at all times, except for hygiene care. The [redacted] stated that the [redacted] would enter the [redacted] recommendations PO into the electronic medical record (EMR). At that time, the surveyor reviewed the PO for the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1 The [redacted] confirmed that the PO was entered into the EMR incorrectly, without directions and never transferred to the TAR. The [redacted] further stated that the importance of the NJ Exec Order 26.4b1 were for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . On 11/9/24 at 10:18 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #2) who stated that when [redacted] recommended a [redacted] or [redacted], the [redacted] would enter the PO into the EMR. LPN/UM #2 confirmed that the PO for the [redacted] were entered incorrectly and were not transferred to the MAR or TAR. LPN/UM #2 stated that the importance of the NJ Exec Order 26.4b1 [redacted]. On 11/9/24 at 10:18 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the [redacted] entered the PO for [redacted] into the EMR and the nurse would acknowledge the PO. The [redacted] acknowledged that the PO were entered incorrectly in the EMR. The [redacted] further stated that it was important to follow the recommendation for the NJ Exec Order 26.4b1 and document in the TAR to NJ Exec Order 26.4b1 [redacted] On 11/12/24 at 3:12 PM, surveyor reviewed the concern with the NJ Exec Order 26.4b1 [redacted] A review of the undated facility's "Splints- Clinical"	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 688	Continued From page 51 policy, included that splints should be in [the EMR] as order under the TAR. A review of the facility's "Resident Mobility and Range of Motion" policy, revised March 2024, included that residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. A review of the facility's "Physicians Order" policy, revised January 2022, revealed that the purpose of the policy is to ensure all physician orders are complete and accurate. The policy also included that treatment orders will include the following: a description of the treatment, including the treatment site. NJAC 8:39-27.1 (a)	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ172314 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to complete an incident report and thoroughly investigate a	F 689	Tag 0689 Element One Corrective Actions The Nursing staff were all immediately educated that when a resident has a [redacted] an incident report with details of the incident must be completed along with an	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 689	Continued From page 52 resident's [NJ Exec] for 1 of 3 residents (Resident #87) reviewed for accidents. This deficient practice was evidenced by the following: On 11/6/24 at 9:51 AM, the surveyor observed staff providing care to Resident #87 in their room. On 11/6/24 at 12:34 PM, the surveyor reviewed the medical record for Resident #87. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated [NJ Exec Order 26.4b1], included the resident had a Brief Interview for Mental Status score of [NJ Exec Order 26.4b1] which indicated the resident's NJ Exec Order 26.4b1 [redacted]. Further review of the MDS revealed the resident had NJ Exec Order 26.4b1 since the prior assessment. A review of the individual comprehensive care plan (ICCP) included a focus area, dated [NJ Exec Order 26.4b1] that the resident had an [NJ Exec Order 26.4b1] or was at [NJ Exec Order 26.4b1] related to new and [NJ Exec Order 26.4b1] [redacted]. Interventions included to be sure that the call bell and personal items were within reach, encourage a clutter free environment, and bed in the [NJ Exec Order 26.4b1] [redacted] at all times except during care. A review of the Progress Notes (PN) included a	F 689	investigation detailing potential causes of the [NJ Exec] interventions to prevent reoccurrence and evidence that the [NJ Exec] was reviewed by the interdisciplinary team by the Director of Nursing. The facility immediately completed a full investigation after the surveyor inquiry. Element Two Identification of at Risk Residents All Residents that have experienced a fall are possibly at risk due to the facility missing a thorough incident report. All recent residents that have experience a fall within the facility over the last 30 days were reviewed for completion of incident reports and interventions. No negative findings were found. Element Three Systemic Change The facility "Falls" policy was reviewed which addresses that the staff will continue to collect and evaluate information to see if the cause of the fall can be identified. The facility "Management and Reporting of Resident Incidents" policy was reviewed which addresses that the nurse will complete all sections of the incident/accident report and the Interdisciplinary Team will review significant incidents on the first business day in the morning following the incident. Nursing staff were re-educated regarding both policies by the Director of Nursing. The interdisciplinary team will now be meeting daily to discuss all new significant incidents from the prior business day to ensure all documentation is completed in full and a proper investigation is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 689	Continued From page 53 Nurses Note (NN), dated NJ Exec Order 26.4b1 revealed the nurse was notified that Resident #87 NJ Exec in the NJ Exec Order 26.4b1 and was observed NJ Exec Order 26.4b1. Further review of the NN revealed the resident had NJ Exec Order 26.4b1 and was sent to the hospital for further evaluation. On 11/12/24 at 11:30 AM, the U.S. FOIA (b)(6) provided the surveyor with a copy of the NJ Exec packet for Resident #87's NJ Exec Order 26.4b1. The NJ Exec packet consisted of a statement from the nurse, a statement from a U.S. FOIA (b)(6) member, and a copy of the NN, dated NJ Exec Order 26.4b1. The NJ Exec packet did not include an incident report with details of the incident, nor did it include an investigation detailing potential causes of the NJ Exec interventions to prevent reoccurrence, or evidence that the NJ Exec was reviewed by the interdisciplinary team. On 11/12/24 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 who stated that if a resident U.S. FO, there was a NJ Exec packet the nurse would complete which included completing an incident report. On 11/12/24 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that if a resident NJ Exec O, there was a NJ Exec packet the nurse would complete which included an incident report. LPN/UM #1 further stated it was important to complete a thorough investigation of a resident's NJ Exec to develop interventions and maintain the safety of the resident. On 11/12/24 at 12:50 PM, the surveyor	F 689	completed. Element Four Quality Assurance The Unit Managers or Designee will audit all falls weekly for 4 weeks and then for 3 months to ensure all incident reports are completed along with the investigation as to why they fell. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for 4 months. Facility Educator will be responsible for maintaining education for staff on completing incident reports along with investigations and report education to the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0689 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 689	Continued From page 54 interviewed the [redacted]) who stated that if a resident [redacted] the nurse should complete an incident report and investigation. At that time, the surveyor informed the [redacted] of the missing incident report and investigation for Resident #87's [redacted] and the [redacted] confirmed that an incident report and investigation should have been completed at the time of the [redacted] A review of the facility's "Falls - Clinical Protocol" policy, revised June 2022, included, "The staff will evaluate and document falls that occur while the individual is in the facility ..." and, "The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable." A review of the facility's "Management and Reporting of Resident Incidents" policy, revised September 2016, included, "When an accident or incident occurs to a resident, an investigation is conducted to determine any/all factors contributing to the incident ..." and, "The nurse will complete all sections of the incident/accident report including, when possible, the resident's account of the event." Further review of the policy included, "All falls and/or significant incidents will be reviewed by the Interdisciplinary Team after the morning departmental meeting on the first business day following the incident."	F 689		
F 692 SS=D	NJAC 8:39-27.1 (a) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 692	Continued From page 55 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Complaint #NJ176585 Based on interview, record review, and review of facility documents, it was determined that the facility failed to follow standard operational procedures in accordance with the facility policy for a resident with NJ Exec Order 26.4b1 [redacted] for 1 of 5 residents (Resident #304) reviewed for NJ Exec Order 26.4b1 status and was evidenced by the following: A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 [redacted]	F 692	Tag 0692 Element One Corrective Actions US FOIA (b)(6) and Nursing staff were immediately educated on the importance of completing all the residents monthly NJ Exec Order 2 [redacted] in ensure an accurate picture for any NJ Exec Order 26.4b1 by the Director of Nursing. An audit was performed to ensure all scales are currently up and in working order to which there were no findings. Element Two Identification of at Risk Residents All Residents could be at risk for possible undocumented significant weight loss.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 692	Continued From page 56 NJ Exec Order 26.4b1 A review of the resident's annual Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated that the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed the resident was [redacted] inches tall and weighed [redacted] pounds and had not experienced a weight (wt) NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 or [redacted] of NJ Exec Order 26.4b1. Further review of the MDS revealed that the resident was ordered a NJ Exec Order 26.4b1. A review of the resident's individual comprehensive care plan (ICCP) included a focus area of: I have a NJ Exec Order 26.4b1. Interventions included: Monitor/record/report to medical doctor as needed signs/symptoms of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Provide and serve NJ Exec Order 26.4b1 as ordered. A review the Order Summary Report (OSR), included the following physician orders (PO): A PO, dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. A PO dated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) one time a day record % consumed, may substitute with facility equivalent. A PO dated NJ Exec Order 26.4b1 to NJ Exec Order monthly every day	F 692	Element Three Systemic Change The facility "Weight Taking and Recording" policy was reviewed which addresses monthly weights will be taken for each resident and will be recorded in the weight record sheet provided by the dietician. The nursing staff and dietician were re-educated regarding the policy by the Director of Nursing. They were educated that if these monthly weights are not recorded the interdisciplinary team will not have an accurate picture to review individual weight trends over time to help avoid significant weight changes. Element Four Quality Assurance The Dietician or designee will conduct weekly audits for three months to assure proper weight taking documentation was completed then the audits will remain monthly. Results will be provided to Facility administrator who will review the findings and provide direction as appropriate. The Facility administrator will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education on weight taking and recording. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0692 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 692	Continued From page 57 shift every 1 (one) month (s) starting on the 1st for 10 day (s) for [redacted]. Start date [redacted]. A PO dated [redacted] to Obtain resident's [redacted] weekly x 4 (four) post admission every day shift every Wednesday for Baseline for 4 weeks. Obtain resident' [redacted] weekly x 4 post admission beginning 1 week post admission (Start date [redacted], End Date [redacted]). A review of the Progress Notes (PN) included a [redacted] Note dated [redacted] at 12:05 PM, which included ...[redacted]. No current [redacted] to review....continues on [redacted] [redacted] is [redacted] preferences updated frequently. Observed resident [redacted] to not miss his/her [redacted]. [redacted] suggesting a [redacted] to monitor and [redacted], monitor meds, [redacted] and [redacted] Follow quarterly and as needed (PRN). Further review of the PN included a [redacted] Note dated [redacted] at 10:27 AM, which included [redacted] continues to trigger for [redacted]. Currently [redacted] x [redacted]. Discussed with resident, encouraged [redacted]. A review of the [redacted] and Vitals Summary revealed the following: [redacted] (wheelchair) [redacted]. (wheelchair) [redacted]. (wheelchair) [redacted] (wheelchair) [redacted]. (wheelchair). There was no [redacted] to confirm a [redacted]. There was no documented [redacted] for [redacted].	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 692	Continued From page 58	F 692		

NJ Exec Order 26.4b1. (standing)
NJ Exec Order 26.4b1. (wheelchair)
NJ Exec Order 26.4b1. (wheelchair)
NJ Exec Order 26.4b1 (wheelchair)
NJ Exec Order 26.4b1. (wheelchair)
NJ Exec Order 26.4b1. (wheelchair)
NJ Exec Order 26.4b1. (wheelchair)
NJ Exec Order 26.4b1. (wheelchair)
NJ Exec Order 26.4b1 (wheelchair)

On 11/8/24 at 8:49 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the resident was NJ Exec Order 26.4b1 with choosing NJ Exec Order 26 and ordered out. The US FOIA stated that the resident NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 NJ Exec O was never explained. The US FOIA stated that the resident was ordered NJ Exec Order 26.4b1 and NJ Exec NJ Exec Order 2 . The US FOIA stated that in NJ Exec Order 26.4b1 we met and discussed NJ Exec O preferences and the resident only wanted NJ Exec Or and NJ Exec Order 26.4b1 due to an NJ Exec Order 26.4b1. The US FOIA stated that the resident was ordered NJ Exec Order 26.4b1

The US FOIA further stated that in NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 Then in NJ Exec Order 26.4b1 there was a NJ Exec Order 26.4b1, a NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 NJ. The US FOIA stated that the resident was starting to NJ Exec Order 26.4b1. The US FOIA stated that NJ Exec Order 26.4b1 was ordered daily in addition to a selective menu. The US FOIA stated that the residents NJ Exec Order 26.4b1 was not documented unless the resident was ordered a NJ Exec Order 26.4b1. the US FOIA stated that the resident NJ Exec Order 26.4b1. The surveyor asked the US FOIA why in NJ Exec Order 26.4b1 the resident's NJ Exec Order 2 was not recorded under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 692	Continued From page 59	F 692		

NJ Exec Order 26.4b1 ? The surveyor also asked why there was no documented NJ Exec Order 26.4b to confirm a NJ Exec Order 26.4b1 that was recorded when the resident's NJ Exec Order 26.4b1 ? The US FOIA stated that she did not know why it was not done. The US FOIA stated that the recorded NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 was not NJ Exec Order 26.4b1 because there was no recorded NJ Exec Order 26.4b1 , so I trended NJ Exec Order 26.4b1 which was considered NJ Exec Order 2 The US FOIA stated that no changes were made. The US FOIA stated that nothing needed to be done. The resident was not actively NJ Exec Order 26.4b1 . The US FOIA stated that there was no special accommodation made for NJ Exec Order 26.4b1 The US FOIA stated that the resident was told to have their NJ Exec Orc and then go out and NJ Exec Order 26.

On 11/8/24 at 10:29 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #3 who stated that residen NJ Exec Order 26.4b1 were scheduled after meals. CNA #3 stated that she documented the amount of NJ Exec Or NJ Exec Order 26.4b1 in the Plan of Care (POC) and alerted nursing if the resident was not eating.

On 11/8/24 at 10:51 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that smoking breaks were scheduled around 9:30 AM and 1:30 PM, after lunch. LPN/UM #1 stated that she was unaware of any resident skipping meals to NJ Exec Order 26.4b1 were usually scheduled after meals. LPN/UM #1 stated that in " NJ Exec Or our scale may have had a missing battery" because NJ Exec Order 26.4 were not usually missed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 692	Continued From page 60 On 11/8/24 at 11:56 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that she noticed when she started working here in NJ Exec O that there were complaints of the scales not working and the NJ Exec Order 26.A were not obtained at one point. On 11/12/24 at 1:45 PM, the surveyor interviewed the U.S. FOIA (b) who stated that the nurse, US FOIA (b)(6) and the US FOIA (b)(6) were responsible to ensure that monthly NJ Exec Order 26.A were done. A review of the facility's policy, "Weight Taking and Recording" revised 3/28/23, included: ...Monthly weights will be taken for each resident and will be recorded in the weight record sheet provided by the dietician. Monthly weights are due by the 5th of each month. Reweights are due by the 8th of each month. All weights should be recorded in the individual's medical record by the 10th of each month. Any weight changes of 5 (five) lbs +/- or more since the last weight assessment will require a reweight confirmation. The dietician will review individual weight trends over time. Negative trends will be evaluated by the interdisciplinary team, whether or not the criteria for "significant" weight change has been met. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month-5% weight gain or loss is significant b. 3 months-7.5% weight gain or loss is significant c. 6 months-10% weight gain or loss is significant.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 692	Continued From page 61 NJAC 8:3927.2(a)	F 692		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Complaint #: NJ174562 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) adjust medication administration times to accommodate for scheduled [NJ Exec Order 26] times, and b.) obtain a physician's order to monitor [NJ Exec Order 26.4b1] [redacted] This deficient practice was identified for 2 of 2 residents (Resident #9 and #306) reviewed for [U.S. FOIA (b)(6)] and was evidenced by the following: 1.) On 11/6/24 at 10:09 AM, the surveyor observed that Resident #9 was not in their room. On 11/7/24 at 10:30 AM, the surveyor reviewed the medical record for Resident #9. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: [NJ Exec Order 26.4b1] [redacted].	F 698	Tag 0698 Element One Corrective Actions Resident #9 The facility immediately adjusted the medication administration times to accommodate [NJ Exec Order 26] times and obtained an physician's order t [NJ Exec Order 26.4b1] [redacted] Resident #306 The facility immediately obtained an order for the resident to go to the [NJ Exec Order 26.4b] center with the time and location included, an order to check the resident's [NJ Exec Order 26] [redacted] an order for the resident's [NJ Exec Order 26.4] and vital signs Element Two Identification of at Risk Residents All dialysis Residents were at risk. All dialysis residents were assessed for medication, and physician orders to monitor dialysis fistula sites for bruit and thrill, order for the resident to go to the dialysis center with the time and location include and an order for the resident's weights and vital signs.	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 698	Continued From page 62 A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b included the resident had a Brief Interview for Mental Status score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed the resident received NJ Exec Order 26 while a resident at the facility. A review of the individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4 that the resident needed NJ Exec Order 26.4b1 and that the resident went to NJ Exec Order 26 on U.S. FOIA (b)(6) Interventions included: Monitor/document/report to the physician as needed of any signs/symptoms of infection to the NJ Exec Order 26 NJ Exec Order 26. The ICCP did not include any interventions to schedule medications around the resident's scheduled NJ Exec Order 26 times, or to monitor the resident's NJ Exec Order 26.4b1 A review of the Order Summary Report (OSR), dated as of NJ Exec Order 26.4b, included the following physician orders (PO): A PO, dated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. A PO, dated NJ Exec Order 26.4b1 to monitor the NJ Exec Order 26.4 for signs and symptoms of NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) included the following PO: A PO, dated NJ Exec Order 26.4b1 delayed	F 698	Element Three Systemic Change The facility "Medication Administration" policy was reviewed which addresses providing medications in a timely manner. The facility "Dialysis Care" policy was reviewed which addresses checking the residents fistula for bruit and thrill. Nursing staff were re-educated regarding both policies by the Director of Nursing. The nursing staff is to now meet bi-monthly to to review the pharmacy consultant report and ensure it's completed in full. Element Four Quality Assurance The Unit Managers or Designee will audit all dialysis Residents to assure medication times accommodate dialysis times, physician orders to monitor dialysis fistula sites for bruit and thrill, order for the resident to go to the dialysis center with the time and location include and an order for the resident's weights and vital signs weekly for 4 weeks then monthly for 3 months. Results will be provided to the Director of Nursing (DON) who will review the findings and provide direction as appropriate. The Director of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for 4 months. Facility Educator will be responsible for maintaining education for staff on administering medications for dialysis patients and checking for bruit and thrill and the Director of Nursing (DON) for the correction of deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 698	Continued From page 63 NJ Exec Order 26.4b1 . A PO, dated NJ Exec Order 26.4b1 [redacted] review of the NJ Exec Order 26.4b1 Treatment Administration Record (TAR) did not include a PO to monitor the resident's NJ Exec Order 26.4b1 [redacted] A review of the Pharmacy Consultant's Comments Report for the previous six months revealed a recommendation, dated [redacted], to "please be sure that medication times are changed to accommodate resident's [redacted] times." On 11/12/24 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 who stated [redacted] residents received their medications before they left for [redacted] and that if a medication was scheduled to be administered during [redacted], the nurse should notify the physician to see if the medication administration time could be adjusted to accommodate the resident's [redacted] schedule to prevent missed doses of medication. At that time, LPN #3 further stated that there should be a PO for the nurse to monitor a resident's NJ Exec Order 26.4b1 [redacted] to ensure the [redacted] was working. LPN #3	F 698	The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0698 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 698	Continued From page 64 reviewed Resident #9's PO and confirmed that the resident did not have an order for the nurse to monitor the resident's NJ Exec Order 26.4b1 [redacted] On 11/12/24 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated NJ Exec Order 26 residents' medication administration times were scheduled around their NJ Exec Order 26 times to prevent missed doses, and that if there was a conflict in medication time and [redacted] time, the nurse should reach out to the physician to change the medication times. LPN/UM #1 reviewed Resident #9's PO and confirmed the resident had medications scheduled for 6:00 AM on days the resident would be at the NJ Exec Order 26.4b1. At that time, LPN/UM #1 further stated that there should be a PO for the nurse to monitor a resident's NJ Exec Order 26.4b1 [redacted] to ensure the NJ Exec Order 26.4b1. LPN/UM #1 reviewed Resident #9's PO and confirmed the resident should have had a PO for the nurse to monitor the resident's NJ Exec Order 26.4b1 [redacted]. On 11/12/24 at 12:50 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) who stated NJ Exec Order 26 residents' medication administration times should be scheduled either before or after their NJ Exec Order 26 times to prevent missed medication doses. The U.S. FOIA (b) further stated that there should be a PO for nurses to monitor residents' NJ Exec Order 26.4b1 [redacted] to ensure there were no complications with the site. At that time, the surveyor informed the U.S. FOIA (b) of Resident #9's medication administration times that were scheduled during the resident's NJ Exec Order 26.4b times, and that Resident #9	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 698	Continued From page 65	F 698		

did not have a PO to monitor for NJ Exec Order 26.4b1. The [redacted] stated the nurse should have contacted the physician to reschedule the medication administration times, and there should have been a PO to monitor the NJ Exec Order 26.4b1

2. On 11/7/24 at 12:51 PM, the surveyor reviewed the closed medical record of Resident #306.

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 [redacted].

A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated [redacted], included that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated that the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed the resident received [redacted] while a resident at the facility.

A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated [redacted], which indicated that the resident had a nutritional problem related to presents for NJ Exec Order 26.4b1; prior medical history NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted] Interventions included: provide early/late trays as needed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 698	Continued From page 66 NJ Exec Order 26. days Tuesday, Thursday, Saturday), monitor NJ Exec Order 26.4b as ordered and monitor before and after NJ Exec Order 26.4b1 A review of the Order Summary Report (OSR), dated NJ Exec Order 26., revealed there was no PO for the resident to attend HD, and there was no order to monitor the resident's NJ Exec Order 26.4b1 site for function both prior to and after NJ Exec Order 26. treatments. Further review of the OSR revealed an order dated NJ Exec Order 26.4 to obtain resident's weight on shift of admission and then on day shift x 2 (two) days. Every day shift for baseline for 2 (two) days. A review of the Progress Notes (PN) included a NJ Exec Order 26.4b1 Admission/Readmission Note dated NJ Exec Order 26.4b1, Addendum: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . Further review of the PN included a Nurse's Note (NN), dated NJ Exec Order 26.4b1, which included that the resident was leaving for NJ Exec Order 26. tomorrow morning and requested to have NJ Exec Order 26.4b1 before he/she leaves for treatment. There was no documented evidence within the PN that detailed the resident's care and assessment both prior to and after U.S. FOIA (b)(6) . On 11/8/24 at 9:17 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the resident went to NJ Exec Order 26. on NJ Exec Order 26.4b1 and received an NJ Exec Order 26.4b1 . The U.S. FO stated that the residents were weighed weekly for the first month x 4 and then monthly. The U.S. FO stated that NJ Exec Order 26.4b obtained a	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 698	Continued From page 67	F 698		

pre and post [redacted] treatment weight on [redacted] days. The [redacted] stated that there was a sheet that the nurses filled out that were maintained in the resident's closed record. The [redacted] further stated that the resident weighed [redacted] pounds and she had no concerns because she communicated with [redacted].

A review of the resident's Treatment Administration Record (TAR) revealed that the resident was weighed on [redacted] and weighed [redacted] pounds. There were no other documented weights within the resident's electronic health record.

On 11/8/24 at 11:08 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that the resident went to [redacted] on NJ Exec Order 26.4b1 mornings. LPN/UM #1 reviewed the resident's medical record in the presence of the surveyor and stated that there was no order for the resident to receive [redacted]. LPN/UM #1 further stated that there was usually an order that specified the scheduled days and chair times but I am not seeing it.
LPN/UM #1 stated that the facility communicated with the [redacted] center via a Communication Sheet that required the resident's vital signs NJ Exec Order 26.4b1 [redacted] medications received, if the resident ate, and the resident's condition before they left the building. The surveyor requested to view the resident's Communication Sheets at that time.

On 11/12/24 at 1:50 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 698	Continued From page 68	F 698		

Communication Log for HD should have been maintained but neither the resident's weights or the Communication Sheets were found, but they should have been documented.

On 11/13/24 at 1:59 PM, the surveyor interviewed the [U.S. FOIA (b)] who stated that she phoned the [NJ Exec Order 26] center and confirmed that the resident's pick up time was likely [NJ Exec Order 26.4b1] and his/her [NJ Exec Order 26.4b1] [redacted]. The [U.S. FOIA (b)] stated that there should have been an order for the resident to go to the [NJ Exec Order 26] center with the time and location included, an order to check the resident's [redacted] NJ Exec Order 26.4b1 [redacted], an order for the resident's weights and vital signs. The [U.S. FOIA (b)] stated that the orders were not in the resident's medical chart. The [U.S. FOIA (b)] stated that without orders, you can not assess the resident's fistula for complications. The [U.S. FOIA (b)] stated that if ordered, the orders would have been reflected upon the resident's TAR. The U.S. FOIA (b)(6) [redacted] was present at that time.

On 11/13/24 at 8:52 AM, the [U.S. FOIA (b)] provided the surveyor with copies of the [U.S. FOIA (b)(6)] Communication Forms that she reportedly obtained from the [U.S. FOIA (b)(6)] center via fax that were dated NJ Exec Order 26.4b1 [redacted]. The [U.S. FOIA (b)] confirmed that the [NJ Exec Order 26.4] Communication Forms should have been accessible within the resident's closed record. The surveyor reviewed the forms which revealed that the facility failed to document the type of access the resident had for [NJ Exec Order 26] treatment and any medications that were administered prior to his/her [NJ Exec Order 26] appointments on any of the forms in the space provided.

A review of the facility's "Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 698	Continued From page 69 Administration" policy, revised July 2016, included, "Medications must be administered in a timely manner and in accordance with physician's orders," and, "Medications may not be prepared in advance and must be administered within one hour of the prescribed time." A review of the undated facility's "Pharmacy Consultant Review" policy, included, "Consultant pharmacist submits admission reviews and monthly reviews," and, "These should be completed promptly and filed in the review binder." A review of the facility's "Dialysis Care" policy, revised January 2023, included, "All residents receive dialysis treatment will have their access site checked Q shift [every shift] and document on the MAR. Check the following: a. For Peripheral access, AV [arteriovenous] Graft, or AV Fistula: Check bruit and thrill ..." A review of the facility's "Hemodialysis" policy, revised January 2023, included, "The nurse will ensure that the dialysis access site is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill." The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding and complications. NJAC 8:39-11.2(b) NJAC 8:39-27.1(a) NJAC 8:39-29.2(a)(d)	F 698		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 725	Continued From page 70 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint NJ #'s: 170567 and 171267 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following:	F 725	Tag 0725 Element One Corrective Actions A staffing analysis was completed to identify by shift the minimum amount of direct care staff and licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on the daily census. The staffing schedule was reviewed by the DON with the staffing coordinator to identify by shift	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 725	Continued From page 71 1.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports (AAS-11 and AAS-12) for the 11/20/2024 Standard survey revealed the following: A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: 1. For the 3 weeks of Complaint staffing from 01/21/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 15 of 21	F 725	the required numbers of staff. Agencies are contacted to fill vacant direct care certified nurse aide and licensed nurse positions while the facility advertised for new staff. Facility nursing staff are offered bonuses for picking up extra shifts when needed. The Facility continues to run Online Ads, offers sign on bonus and generous referral bonuses to attract new staff. Interviews are being conducted daily as applicants apply both scheduled or walk-ins. The staffing coordinator reviews the daily, weekly, and monthly staff schedules with the DON to assure staffing levels meet regulatory requirements and to offer extra shifts to cover vacation and days off in advance. Element Two Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three Systemic Change DON/ADON review staffing daily and weekly to ensure all resources have been used to staff the facility as per state mandates on an ongoing basis. Agencies are sent all staffing needs in advance and additional staff requested to cover in the event of callouts. The Facility continues to work with a recruiter and use digital and social media	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 725	Continued From page 72 day shifts, and deficient in total staff for residents on 1 of 21 evening shifts as follows: -01/21/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/22/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/23/24 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/27/24 had 8 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/28/24 had 6 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/29/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/30/24 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/30/24 had 9 total staff for 101 residents on the evening shift, required at least 10 total staff. -01/31/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/01/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/02/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/03/24 had 7 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/04/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/05/24 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/08/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/10/24 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of staffing prior to survey from	F 725	to staff the facility in compliance with regulations. Administration has formed a staffing committee and has conducted salary analyses and implemented creative strategies for attracting new employees to minimize the use of agency personnel. The staffing committee includes frontline staff and managers to identify ways the facility can improve the work environment to retain and attract new employees. The committee recommendations are shared with regional and corporate staff for review and implementation. The committee will meet weekly. Bonuses and incentive programs have been implemented to attract and to retain current staff. The facility is utilizing all types of digital media as well as headhunters to identify and hire new staff. Element Four Quality Assurance Daily staffing levels are reported to administrator and if there are any shortages additional incentives are provided to employees to work an extra shift. The success of bonuses and incentives is being analyzed by the facility Administrator and DON who make recommendations to the ownership regarding what incentives or bonuses are working. Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 725	Continued From page 73 10/20/2024 to 11/02/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts and deficient in total staff of residents on 1 of 14 overnight shifts as follows: -10/20/24 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/21/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/23/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/25/24 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/26/24 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/27/24 had 8 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/27/24 had 5 total staff for 105 residents on the overnight shift, required at least 7 total staff. -10/28/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/31/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -11/01/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -11/02/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs On 11/12/24 at 1:31 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was aware of the staffing ratios and that most of the facility's callouts occurred on the weekends. On 11/13/24 at 1:47 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] who stated, "No staffing is perfect, I feel pretty confident about our staffing." He stated that they offered bonuses to the in-house staff and a	F 725	new hires to fill vacant positions. HR and staffing coordinator/designee will track efforts and success of initiatives above and report findings to the administrator weekly for four months or until minimum staffing levels have been met on a consistent basis. The administrator will communicate findings to corporate staff for assistance and further direction as appropriate. Days and shifts where facility did not meet staffing requirement along with incentives used to attract staff for the days and shifts will be brought to QAPI on a monthly basis by DON x3 months. Also, recruitment efforts for the month x3 months will be submitted to the Administrator to evaluate progress of recruitment and retention efforts. Findings will be reported to the QAPI committee monthly for 6 months and recommendations will be made based upon outcomes. The HR Director tracks monthly hiring and retention efforts which are reviewed at the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 725	Continued From page 74 full-time schedule for the agency staff. A review of the facility's "Staffing" policy dated revised September 2023, included, 1. Facility will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs. 2.) The facility was deficient for Registered Nurse staffing as submitted for the 2 weeks of AAS-12 staffing from10/20/2024 to 11/02/2024. For the week of 10/20/24 Required Total Staffing Hours: 302.25 -10/20/24 had 272 actual staffing hours, for a difference of -30.25 hours. -10/26/24 had 280 actual staffing hours, for a difference of -22.25 hours. For the week of 10/27/24 Required Total Staffing Hours: 305.50 -10/27/24 had 256 actual staffing hours, for a difference of -49.5 hours. A review of the facility's "Staffing" policy, dated revised September 2023, included, "Facility will ensure qualified employees will be scheduled to meet operational requirements and the needs of the residents." Refer to F550D, F678J and F684G NJAC 8:39-5.1(a); 27.1(a)	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 758	Continued From page 75	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 758	Continued From page 76 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure an as needed (PRN) NJ Exec Order 26.4b1 medication was prescribed with a 14-day duration and re-evaluated for continued use for 1 of 5 residents (Resident #39) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 11/6/24 at 10:20 AM, the surveyor observed Resident # 39, NJ Exec Order 26.4b1, lying in bed with a family member at the bedside. The resident's NJ Exec Order 26 stated that the resident has been NJ Exec Order 26.4b1 and had started on NJ Exec Order 2 NJ Exec Order 26.4b1 medications and has been getting seen by NJ Exec Order 26.4b1 doctor. On 11/7/24 at 8:50 AM, the surveyor observed Resident # 39 lying in bed NJ Exec Order 26.4b1 with their breakfast tray on the over bed table. No NJ Exec Order 26.4b1 observed at that time. On 11/7/24 at 11:58 AM, the surveyor reviewed	F 758	Tag 0758 Element One Corrective Actions Resident #39 The facility immediately re-evaluated the resident to see if the medication needed to be extended or stopped. Facility reviewed notes with primary physician and it was decided that the medication would be extended with a stop date. Element Two Identification of at Risk Residents All Residents that are at risk for receiving psychotropic drugs have the potential to be affected by this practice. Element Three Systemic Change The facility "Psychotropic Medication Review" policy was reviewed which addresses orders for PRN psychotropic medications will be time limited (no more than 14 days) and only for specific clearly documented circumstances. The facility "Pharmacy Consult Review" policy was reviewed which addresses that the consultant pharmacist submits admission	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 758	Continued From page 77 the medical record for Resident # 39. A review of the Admission Record, an admission summary, revealed that Resident #39 was admitted to the facility with diagnoses which included: NJ Exec Order 26.4b1 [redacted] A review of Resident #39's quarterly Minimum Data Set (MDS), dated NJ Exec Order 26. , included the resident had a Brief Interview for Mental Status (BIMS) score of U.S. FOIA (b)(6) which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. The MDS further revealed that the resident was on an NJ Exec Order 26.4b1 medication and refused to respond to the NJ Exec Order 26.4b1. A review of the resident's individual comprehensive care plan (ICCP), included a focus area, dated NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1." Interventions included: Administer medications as ordered. NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the residents November active physician's orders (PO) which reflected that Resident # 39 was on the following NJ Exec Order 26.4b1 medication: A PO, dated NJ Exec Order 26. , for NJ Exec Order 26.4b1 [redacted] NO STOP DATE. A review of the NJ Exec Order 26.4b1 [redacted] Medication Administration Record (MAR) did not reveal a stop date for the NJ Exec Order 2 PO.	F 758	reviews and monthly reviews to the staff. Nursing staff were re-educated regarding these policies by the Director of Nursing. The nursing staff was educated that any PRN psychotropic medication will be time limited and the pharmacy consult report needs to be completed and reviewed by the Director of Nursing (DON). Element Four Quality Assurance The Unit Managers or Designee will conduct daily audits of the current PRN psychotropic medications to assure 100 percent compliance for one week and then weekly for three months to assure stop dates. Results will be provided to the Direct of Nursing (DON) who will review the findings and provide direction as appropriate. The Direct of Nursing (DON) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on ensuring end dates for all PRN psychotropic medications and the Director of Nursing (DON) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0758 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 758	Continued From page 78	F 758		

A review of the [NJ Exec Order 26.4b1] Note, dated [NJ Exec Order 26] revealed that resident continued with [NJ Exec Order] [redacted] Both the resident and [NJ Exec Order 26.4] agreed to prn (as needed) [NJ Exec Order 2] be restarted for the time being. The [NJ Exec Order 26.4b1] Advance Practice Nurse (APN) recommended to start [redacted]).

A review of the U.S. FOIA (b)(6) recommendations, dated NJ Exec Order 26.4b1, revealed the [U.S. FO] recommended that duration must be specified for PRN [NJ Exec Order 26.4b1] medications. First order limited to only [NJ Exec] days, but if rationale documented by prescriber to continue order, then next duration may be longer, i.e. [redacted] days. Please update order for [NJ Exec Order 2] per CMS regulations.

On 11/13/24 at 11:51 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #2) who stated that a new order for [NJ Exec Order 26] should have a 14 day stop date. The surveyor and LPN/UM #2 reviewed the [U.S. FO] recommendations and LPN/UM #2 stated that she had called the attending doctor who stated that the [NJ Exec Order 2] could be continued but she did not document in the Electronic Medical Record or update the PO. LPN/UM #2 further stated that she knew that the [NJ Exec Order 2] needed a 14 day stop date but was unaware that after the 14 days, the [NJ Exec Order 2] needed a rationale and a duration date.

On 11/13/24 at 12:21 PM, the U.S. FOIA (b)(6) [redacted]), in the presence of the U.S. FOIA (b)(6) [redacted], stated that the [NJ Exec Order 26] should have had a 14 day stop date and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 758	Continued From page 79 then a note with the rationale for the medication to be extended with a 30, 60, or 90 days stop date. A review of the facility's "Psychotropic Medication Review" policy, dated October 2017, included that orders for PRN psychotropic medications will be time limited (no more than 14 days) and only for specific clearly documented circumstances. A review of the undated facility's "Pharmacy Consult Review- Clinical Protocol" policy, included that consultant pharmacist submits admission reviews and monthly reviews, these should be completed promptly and filed in the review binder, and the completed pharmacy consult shall be reviewed by the DON. NJAC 8:39-27.1(a) NJAC 8:39-29.2(d)	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint #NJ174562 Based on observation, interview, record review, and review of facility documents, it was	F 804	Tag 0804 Element One Corrective Actions The facility immediately discarded food that the residents felt as though was not	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 804	Continued From page 80 determined that the facility failed to ensure palatable temperature of food for 1 of 1 lunch meal served on 1 of 2 units [NJ Exec Order 26.4b1]). This deficient practice was evidenced by the following: On 11/7/24 at 10:52 AM, the surveyor conducted a meeting with the Resident Council which included five residents (Residents #9, #3, #48, #64, and #81). Four of the five residents informed the surveyor that the food was not served hot and was described as "cool" on both nursing units. On 11/12/24 at 11:10 AM, the surveyor observed the [US FOIA (b)(6)] who calibrated (process to make sure the instrument is taking an accurate temperature reading) a thermometer to 32 degrees Fahrenheit (F) before he proceeded to obtain food temperatures from the steam table. The [US FOIA (b)(6)] failed to document the food temperatures after he obtained them from the steam table. On 11/12/24 at 11:42 AM, the surveyor observed the [U.S. FOIA (b)(6)]) as she left the kitchen with Food Cart #1 and delivered it to the [NJ Exec Order 26.4b1] Unit where the nursing staff awaited meal delivery. On 11/12/24 at 11:52, the last meal tray was passed. On 11/12/24 at 11:53 AM, the [U.S. FOIA (b)] obtained food temperatures from a pureed tray using a calibrated thermometer which included: pureed tuna 123 F, mashed potatoes 125 F, pureed bread 132 F, and pureed peas 119 F. The [U.S. FOIA (b)] stated that all food temperatures should have been above 140 F. On 11/12/24 at 11:57 AM, the [U.S. FOIA (b)] obtained food	F 804	hot enough for their liking and provided a new tray with adequate food hot food temperatures (135F and above). Dietary staff was immediately educated on importance of hot food temperatures and the nursing staff was educated on the importance of passing out trays when they immediately arrive on the floor by the nursing home administrator. Element Two Identification of at Risk Residents All Residents who receive meals have the potential to be affected by this practice. Element Three Systemic Change The facility "Hot Food" policy was reviewed which addresses appropriate serving temperatures of 135 degrees or above. The facility "Food Temperature" policy was reviewed which addresses proper hot and cold food temperatures and transporting food as quickly as possible to maintain temperatures for delivery. Dietary staff were re-educated regarding these policies by the nursing home administrator. The dietary staff was educated on a new meal temperature log that was introduced to dietary in which food temperatures must be documented prior to leaving the kitchen and on the floor for every meal to assure proper temperatures throughout the facility. Element Four Quality Assurance The Dietary Director or Designee will conduct daily audits of the food temperature logs every morning and test trays for one meal per day too assure 100	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 804	Continued From page 81 temperatures from a regular tray which included: tuna melt 122 F, sweet peas 119 F, and rice 113 F. On 11/12/24 at 12:03 PM, the surveyor interviewed the [redacted] who stated that we could have done better on the timing of the meal distribution. The [redacted] stated that the facility had plate warmers that were not presently utilized due to the food being served on paper products while the dish machine was out of service. The [redacted] further stated, "We handled it if the residents stated that the food was not warm enough." On 11/12/24 at 2:56 PM, the surveyor interviewed the [redacted] who stated that the facility had complaints of cold food and addressed it with the residents. A review of the undated facility's "Hot Foods" policy, included: The kitchen will assure that hot foods are held so that all parts of the food meet current temperature regulations for hot holding. Procedure: 1. Potentially hazardous foods must be held and served at 135 F or above (or at the temperature dictated by local health regulations). Dietary staff records temperatures of hot foods on the service line immediately prior to service. Dietary staff follows standard corrective procedures for hot foods not at the appropriate temperatures. Dietary staff will serve all hot foods at 135 F or above... NJAC 8:39-17.4(a)(2)	F 804	percent compliance for one week and then weekly for three months to assure proper food temperatures. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on proper food temperatures and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0804 will not reoccur.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3)	F 809		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 809	Continued From page 82 §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: This is a repeat deficiency Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to serve residents a nourishing snack when there was more than a 14-hour span of time between the dinner and breakfast meal times. This deficient practice was identified for 5 of 5 residents (Residents #9, #33, #48, #64, and #81) interviewed during a meeting with the Resident Council and was evidenced by the following: On 11/7/24 at 10:30 AM, the surveyor conducted a resident council meeting with five (5) awake, alert, and oriented residents. During the meeting, 5 out of 5 residents stated that snacks were kept	F 809	Tag 0809 Element One Corrective Actions The dietary department immediately put together snack trays that were to be served between meals throughout the day. The dietary staff were immediately counseled and re-educated regarding providing a nourishing snack to all resident when meal times eclipse 14 hours and offering snacks throughout the day between meals by the nursing home administrator. Element Two Identification of at Risk Residents All Residents that are at risk for eclipsing 14 hours between meals and requesting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 809	Continued From page 83 in the pantry and were not accessible during the evening shift to the residents. One resident stated, " If we don't like our dinner, then we are hungry and need a snack at night." On 11/12/24 at 10:49 AM, the surveyor interviewed the[U.S. FOIA (b)(6)]) who stated that there was a snack book on the nursing units with a list of all residents who received snacks. The[U.S. FOIA (b)(6)] stated that she was unable to provide the surveyor with any documented evidence of snack delivery to the nursing units. A review of the facility's "Cart Delivery Log" revealed that on 11/11/24 the[NJ Exec Order 26-481] Cart 5 dinner meal was delivered to the unit at 5:42 PM and on 11/12/24 the[U.S. FOIA (b)(6)] Cart 5 breakfast meal was delivered to the unit at 8:35 AM, a duration of 14 hours and fifty-three minutes. On 11/12/24 at 12:27 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that during the day snacks were available and included extra sandwiches. LPN/UM #2 stated that snacks were offered to different residents in between meals. LPN/UM #2 stated that the kitchen brought up a tray of snacks that were labeled for specific residents and the supervisor signed for it and handled it. LPN/UM #2 stated that there was no book on the unit that identified which residents received snacks. On 11/12/24 at 12:37 PM, during an inspection of the pantry on the[U.S. FOIA (b)(6)] Unit in the presence of LPN/UM #2 the surveyor noted that there were no snacks available for distribution in the pantry cupboards or refrigerator. LPN/UM #2 stated, "Snacks are usually in here."	F 809	snacks between meals have the potential to be affected by this practice. Nursing Supervisors were re-educated by the Director of Nursing to remind staff to push snacks after dinner for all residents within the facility. Residents were encouraged if there's a certain snack they would like we could put in a standing order for it. Element Three Systemic Change The facility "ADL Care; Dining - Snack" policy was reviewed which addresses providing snacks three times daily between meals based on their individual needs or request that will be delivered to the nursing units labeled with the resident's name. The facility "ADL Care; Dining - Snack" policy was also updated to reflect providing all residents with a nourishing snack if the time span between dinner and breakfast exceeds more then fourteen hours. Nursing and Dietary staff were re-educated regarding the policy by the nursing home administrator. Nursing and Dietary staff were re-educated about providing labeled snacks based up the needs or request of the resident and to also encourage the other residents to participate in the snack trays that are provided to each healthcare unit between meals throughout the day by the nursing home administrator. Element Four Quality Assurance The Food Service Director will conduct daily rounds and audit labeled and provided snacks for one week and then weekly for three months to assure residents are receiving their snacks. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 809	Continued From page 84 On 11/12/24 at 12:43 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) #6 during an inspection of the [NJ Exec Order 26.4b1] Unit Pantry, who stated that snacks were delivered to the nursing unit between 5:00 PM and 6:00 PM and consisted of sandwiches, graham crackers and fruit cups. CNA #6 stated that the snacks were not usually labeled. CNA #6 stated that the residents usually asked for snacks. When asked how she knew what to give the residents if the snacks were not labeled, CNA #6 stated residents who were on a pureed diet were given apple sauce or pudding. On 11/12/24 at 2:51 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that the facility addressed snack distribution monthly at Resident Council to confirm receipt of snacks. The surveyor asked how the facility accounted for residents who could not speak for themselves and did not attend Resident Council, the [U.S. FOIA (b)(6)] stated that the supervisor went around and offered snacks. The [U.S. FOIA (b)(6)] further stated that snacks should be available in the pantry with a bare minimum of cookies, crackers and cereals. The surveyor then informed the [U.S. FOIA (b)(6)] that there were no cookies, crackers or cereals observed during the inspection of the [NJ Exec Order 26.4b1] Pantry.	F 809	Registered Dietician will conduct daily audit on the timeframe between lunch and Dinner for one week and then weekly for three months to assure residents are not eclipsing a fourteen hour window without a nourishing snack. The Night Nursing supervisor will conduct nightly rounds to ensure snacks are being provided for one week and then weekly for three months to assure residents are receiving their snacks. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on snacks and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0809 will not reoccur.	
F 812 SS=F	NJAC 8:39-17.2(f)(1)(i-ii) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 85 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: This is a repeat deficiency Based on observations, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 11/6/24 from 9:46 AM to 10:50 AM, the surveyor observed the following in the kitchen in the presence of the U.S. FOIA (b)(6) 1. The U.S. FOIA demonstrated use of the high temperature dish machine. The U.S. FOIA stated that the facility used a booster for the dish machine to reach the required rinse temperature of 180 degrees Fahrenheit (F) but sometimes the booster does not work so we always use a chemical sanitizer. The surveyor requested to see the dish machine temperature/sanitizer log. A review of log, "Low Temp Dish Machine	F 812	Tag 0812 Element One Corrective Actions 11/06/2024 #1 The facility immediately shut down the dish washer, called a vendor to review the issue and provided the resident's with paper products. The dietary staff were immediately counseled and re-educated about notifying administration whenever the dishwasher temperature gauges are not working by the nursing home administrator. All test strips were reviewed for expiration dates and the ones that expired were immediately discarded. #2 The facility immediately rewashed all items on the drying rack due to the wet nesting and cleaned the floor around the drying rack. The dietary staff were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 86 Temperature Log and PPM (Parts per Million) Log (LTDMTL/PPM)" revealed that the dish machine log was not filled in on 11/5/24 prior to the dinner meal and on 11/6/24 the lunch meal was pre-filled in for the lunch meal which had not yet been served. When the surveyor questioned why the form was already filled in the [U.S. FOI] stated that the [U.S. FOIA (b)(6)] had accidentally filled it in. Further review of the LTDMTL/PPM indicated that the required wash standard temperature was required to be 120 F or greater and the PPM were required to be 20-100 PPM. The values filled in on the form for the breakfast, lunch, and dinner meals on 11/1/24 through 11/6/24, with the exception of the dinner meal on 11/5/24, indicated that the wash temperature was 165 at all meals, and the PPM was 180. At that time, The [U.S. FOIA (b)(6)]) pushed a tray of dirty dishes into the dish machine to demonstrate function. The surveyor watched the three gauges on the front of the dish machine which reflected the wash tank temperature, rinse tank temperature, and the final rinse (which had 180 F printed over the gauge for reference). The tray was processed through the dish machine and none of the three gauges moved as the tray moved through the wash, rinse, and final rinse cycles to reflect temperature of the dish machine at each cycle and remained fixed in place. The wash cycle temperature remained at 116 F, the rinse cycle temperature remained at 0 F, and the final rinse cycle temperature remained at 202 F. The [U.S. FO] told the [U.S. FOIA (b)] to run a second tray through the dish machine and the gauges did not move. The [U.S. FOIA] was present and stated that the gauges were working last night. The surveyor asked why he	F 812	immediately counseled and re-educated about wet nesting and cleaning the floor after every meal service by the nursing home administrator. #3 The facility immediately rewashed all items on the drying rack due to the wet nesting. The dietary staff were immediately counseled and re-educated about wet nesting by the nursing home administrator, #4 The facility immediately cleaned the oven that was not in use and educated the dietary staff about maintaining a clean and sanitary environment by the nursing home administrator. #5 The facility immediately cleaned the grill and grease trap. A company was also called out to pump the facilities grease trap. The dietary staff were immediately counseled and re-educated about maintaining a clean and sanitary environment along with keeping up with the grease trap by the nursing home administrator. #6 The facility immediately cleaned the deep fryer. The dietary staff were immediately counseled and re-educated about maintaining a clean and sanitary environment by the nursing home administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 87 had not documented the temperature readings at the dinner meal he stated, "The gauges were not moving this morning." The surveyor asked why both the breakfast and lunch values were filled in if the gauges had not moved? The [U.S. FOIA] confirmed that he had not notified maintenance of the issue as required. At the bottom of the LTDMTL/PPM it instructed the user to: "Notify supervisor immediately if temperatures are below the standard." The [U.S. FOIA] then proceeded to demonstrate the sanitizer level by running a tray through the dish machine, collecting water in a bowl, and dipping a test strip into the water and then compared the color of the test strip to a legend on the side of the test strip container. The surveyor requested to see the test strip container and noted that the test strips expired on September 1 2024. The [U.S. FOIA] stated that he did not know that there was an expiration date on the test strips. The [U.S. FOIA] then proceeded to hand the surveyor a second container of test strips which had expired in November of 2023. The surveyor noted that the [U.S. FOIA (b)] that were completed on the form all indicated a value of 180, which did not coincide with the expected values of (20-100) on the log. The [U.S. FOIA] then stated that Monday, 11/4/24, was the last time that he saw the gauges working. He stated that he did not document the sanitizer level because there was no space provided on the form to record the sanitizer level. The [U.S. FOIA] stated that the value recorded in the space provided for [U.S. FOIA (b)], referred to the temperature gauge that was on the booster beneath the dish machine. The [U.S. FOIA] stated that he could not say that everything that was washed in the dish machine was sanitized. He further stated, "The dish	F 812	#7 The facility immediately called out a vendor to perform a bi-annual service on the ice machine. The dietary director was counseled and re-educated regarding having the ice machine serviced bi-annual and monthly inhouse cleaning by the nursing home administrator. #8 The facility immediately cleaned the eight top burner stove. The dietary staff were immediately counseled and re-educated about maintaining a clean and sanitary environment by the nursing home administrator. #9 The facility immediately discarded the rags and gloves from the new steamer and cleaned out the interior. The dietary staff were immediately counseled and re-educated about maintaining a clean and sanitary environment by the nursing home administrator. #10 The facility immediately cleaned the dual convection oven. The dietary staff were immediately counseled and re-educated about maintaining a clean and sanitary environment by the nursing home administrator. #11 The facility immediately discarded the bacon. The dietary staff were immediately counseled and educated on proper food storage by the nursing home	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 88 machine is out of service." The [NJ Exec C] further stated that he would order the test strips now and have the technician come out to the facility today to service the dish machine. 2. On the lower shelf, second shelf, and third shelf of a four-tiered drying rack, wet nesting (a build up of bacteria caused by stacking wet dishes) was evident as water dripped from the shelves above. The [U.S. FOO] stated that a six inch shallow pan, and a two inch perforated strainer that were on the second shelf from the top, had both moisture and wetness between them when pulled apart. On the third shelf from the top, six inch chafing pans were stored inside of one another and had water beaded up on the outside, outer edges, and in between the chafing pans. The [U.S. FOO] stated that wet nesting was identified. The [U.S. FO] stated that wet nesting "harbors bacteria." At that time, the surveyor noted that the flooring in front of the drying rack was heavily soiled with dirt, debris, and food particles. The [U.S. FO] stated that staff were required to clean the floor after the meal service. 3. On the third shelf from the top of a four-tiered pot rack, the surveyor observed wet nesting between three sheet pans. There were three two-inch hotel pans that were wet nested together over top of the sheet pans. On the second shelf from the top, multiple sheet pans were wet nested inside of one another. The [U.S. FO] stated that they must have collapsed. The [U.S. FOO] confirmed that wet nesting was present. 4. In the galley of the kitchen, the surveyor observed an oven that was heavily soiled with	F 812	administrator. #12 The facility immediately had the maintenance department put a new light bulb in walk in freezer. The dietary director was counseled and educated that it any items in the kitchen are not working properly to notify administration and maintenance immediately by the nursing home administrator. #13 The facility immediately discarded the eggs. The dietary staff were immediately counseled and educated on proper food storage by the nursing home administrator. #14 The facility immediately discarded the dented peaches can. The dietary staff were immediately counseled and educated on ensuring all dented cans are stored separately by the nursing home administrator. #15 The facility immediately discarded the cottage cheese. The dietary staff were immediately counseled and educated on proper food storage by the nursing home administrator. 11/12/2024 #1 The facility immediately educated the Cook and dietary staff on infection control and proper hand washing by the nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 89 debris. The [U.S. FOOD] stated that the oven was not in use. The [redacted] stated that the inside of the oven was cleaned two months ago and the burners on the top of the stove were cleaned nightly. 5. In the galley of the kitchen, the grill was heavily soiled with a thick layer of yellow liquid and solid matter on the top, front, and on the shelf beneath the grill which had a thick layer of yellow, orange, and brown liquid and dried matter on it. The [U.S. FO] stated that the grease trap was cleaned daily. When the [U.S. FO] pulled out the grease trap, a thick layer of yellow and white solid food matter was present, around a yellow, brown, and orange liquid with a thick layer of black charring was noted. 6. In the galley of the kitchen, a deep fryer had a very thick layer of food particles present in the dark colored oil within the fryer. The [NJ Exec] stated that they cooked 300 hash browns today. The [U.S. FOO] stated that they cleaned the deep fryer every three days. At that time, the surveyor asked to see the cleaning schedule. The [U.S. FO] stated, "I have no cleaning schedule." He further stated, "We communicate with each other." 7. The ice machine had a service date of 4/11/24. The [U.S. FO] stated that the ice machine was serviced quarterly and should have been serviced in August. The [U.S. FOO] stated that he was not sure why it was not done. 8. On an eight top burn stove, the left front burner was heavily coated with food debris. The [U.S. FOO] stated that it was cleaned nightly, but was hard to clean. The [redacted] stated that it depended who was	F 812	home administrator. #2 The facility immediately educated the Assistant Dietary Director and the dietary staff on proper hair net usage by the nursing home administrator. #3 The facility immediately educated the Dietary Aide and the dietary staff on proper hair net usage by the nursing home administrator. 11/12/2024 Nelson 6 Nourishment Room #1 The facility immediately discarded the juice. The nursing staff were immediately counseled and educated on proper food storage by the nursing home administrator. #2 The facility immediately discarded the frozen dinner. The nursing staff were immediately counseled and educated on proper food storage by the nursing home administrator. #3 The facility immediately cleaned the ice scooper and maintenance ensured it was self draining moving forward. The nursing staff were immediately educated on wet nesting and infection control by the nursing home administrator. 11/12/2024 [redacted] Nourishment Room #1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 90 working and who cleaned up. The [U.S. FOO] further stated, "Some cooks are messier than others." 9. Inside of a "new steamer" there were multiple rags and gloves stored inside. When the surveyor asked why flammable items should not be stored within the steamer he stated, "It is dirty." 10. Inside of a dual convection oven, there was a thick build up of black matter and food debris. the [U.S. FO] [U.S. FO] stated that he cleaned it last on 9/1/24. The [U.S. FO] stated that it should have been cleaned monthly. There was food cooking in the oven at the time. The [U.S. FO] stated that management should have ensured that it was cleaned. The [U.S. FOO] stated that he thought that it was burned on food, which does not contaminate the food that was cooked in the oven. The [redacted] stated, "We could do a better job, it is not dirty, it is forty years old." 11. In walk-in refrigerator #2, on the third shelf from the top of a four-tiered wired rack, a ten pound box of bacon was partially opened with the plastic opened and exposed the bacon to air. The [NJ Exec D] stated that the plastic should have covered the bacon. 12. In the walk-in freezer, there was no light. The surveyor used a flash light to perform the inspection. The [U.S. FO] stated, it needed a light bulb. 13. In walk-in refrigerator #1, there was a twenty pound container of hard boiled eggs that was opened, and was not dated with an opened date or a used by date. The [U.S. FO] stated that the eggs were kept for one week after opening. The [NJ Exec D] stated that the container should have been dated when opened.	F 812	The facility immediately cleaned the ice scooper and maintenance ensured it was self draining moving forward. The nursing staff were immediately educated on wet nesting and infection control by the nursing home administrator. #2 The facility immediately cleaned the refrigerator door. The nursing staff were immediately educated on infection control by the nursing home administrator. Element Two Identification of at Risk Residents #1 All Residents that are at risk for receiving food items have the potential to be affected by this practice. No residents were effected as items were discarded. #2 All Residents have the potential to be at risk for wet nesting exposure. No residents were effected as item were pulled aside and re-washed / ice scooper was properly cleaned and setup with a drain. #3 All Residents have the potential to be at risk due to sanitation of the kitchen and equipment. No residents were effected as kitchen floor was addressed and all equipment was cleaned. #4 All Residents have the potential to be at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 91 14. In the dry storage area, a six pound container of peaches was dented in the can rack. The U.S. FOIA stated that it was probably dropped and placed in the rack. 15. In the milk box, a sealed five pound container of cottage cheese, had an expiration date of 10/16/24. The U.S. FO stated that it should have been removed when we had a milk delivery yesterday. During an interview with the surveyor on 11/06/24 at 12:39 PM, the U.S. FOIA (b)(6) stated that the U.S. FOIA should have informed us that the dish machine gauges were broken and addressed it immediately. The U.S. FOIA (b)(6) stated that it was an issue if the dishware were not properly cleaned. The U.S. FOIA (b)(6) stated, "How would you track chemical sanitizer level if it were not on the form?" The U.S. FOIA (b)(6) stated the temperature log should not have been filled in if the gauges were not working. The U.S. FOIA (b)(6) stated, "It is a big issue" because it throws everything off. The U.S. FOIA (b)(6) stated that if the chemical sanitizer strips were expired, they were not accurate, or not up to date. The U.S. FOIA (b)(6) stated that the dish machine must be fixed. On 11/7/24 at 9:04 AM, the surveeyor interviewed the U.S. FOIA (b)(6) who stated that the vendor determined that there was a problem with the dish machine thermometer (temperature probe) and was scheduled for repair tomorrow. The U.S. FOIA (b)(6) stated that the facility would continue to serve meals on paper products until the repair was completed. On 11/12/24 at 8:33 AM, during a follow-up	F 812	risk due to the dishwasher thermometer not working properly. No residents were effected as the dish machine was shut down until fixed by a vendor and the facility provided meals on paper in the meantime. #5 All Residents have the potential to be at risk due to the ice machine not having the bi annual service completed. No residents were effected as the vendor was called out to perform the bi annual service and dietary will be keeping logs of the monthly cleaning moving forward. #6 All Residents have the potential to be at risk due to improper usage of hair nets. No residents were effect as the facility purchased larger hair nets for our employees with more hair. #7 All Residents have the potential to be at risk due to receiving food items and ice from the nursing unit pantries. Element Three Systemic Change #1 The facility "Labeling and Dating System" policy was reviewed which addresses expiration date on all un-opened produce, dating all fresh/frozen food and discarding all foods that expire immediately. Dietary staff were re-educated regarding this policy by the nursing home administrator. Dietary staff were re-educated about the possible risks that expired food items and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 92 interview the [redacted] stated that the facility continued to serve meals on paper products due to the dish machine being out of service. The [redacted] stated that he expected the thermometer probe to be installed today. On 11/12/24 from 10:49 AM to 11:42 AM during a follow-up visit to the kitchen, the surveyor observed the following in the kitchen in the presence of the [redacted]): 1. During the tray line observation, the [redacted] doffed his gloves after he obtained food temperatures. The [redacted] then proceeded to go to the hand washing sink where another employee washed their hands and placed his hands beneath the running water and rubbed them together for eight seconds, dried his hands before he donned gloves. 2. The [redacted] was observed in the galley of the kitchen with long strands of hair protruding from her hair net bilaterally. The [redacted] then proceeded to assist with the tray line. 3. A [redacted] was observed with a hairnet that covered only the back of her that was pulled up on top of her head. the [redacted] wore a head band to cover the middle section of her head. The front of portion of the [redacted] hair was not covered as she assisted in the tray line assembly and covered plates of food with domed lids. When interviewed at that time, the [redacted] stated that her hair net probably slipped up. The [redacted] was present and stated, "Is mine out too?" The [redacted] then proceeded to push the long strands of hair (bangs) back into her hair net bilaterally.	F 812	improper storage of food items pose on our residents. #2 The facility "Wet Nesting" policy was reviewed which addresses how pooling water harbors bacteria. Dietary staff were re-educated regarding this policy by the nursing home administrator. Dietary staff were re-educated that all pots and pan must be free of water pooling on the drying racks to avoid any potential bacteria growth. #3 The facility "Sanitation" policy was reviewed which addresses maintaining the sanitation of the kitchen through compliance with a written, comprehensive, cleaning schedule. Cleaning and sanitation tasks for the kitchen will be recorded. Tasks will be assigned to be the responsibility of specific positions. Frequency of cleaning for each task will be defined and a cleaning schedule will be posted. Employees will be trained on the cleaning schedule on how to perform duties. Dietary staff were re-educated regarding this policy by the nursing home administrator. Dietary staff were re-educated that all equipment, flooring and food prep areas must be maintained to ensure a safe working environment for our residents by the nursing home administrator. #4 The facility "Dishwashing" policy was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 93 During a later interview with the surveyor on 11/12/24 at 12:06 PM, the [redacted] stated that hair was to be kept covered so that it did not get into the food and also for infection control purposes. At that time, the [redacted] stated that when the [redacted] doffed his gloves, he should have rinsed his hands, applied soap, and washed his hands for 20 to 30 seconds or bacteria could build up on the hands and food may be under the finger nails. The [redacted] stated that hand hygiene should be performed properly so that nothing gets in the food and for both your protection and the residents. The [redacted] stated that the [redacted] should have waited for the other person to finish at the hand washing sink before he washed his hands. The [redacted] further stated, that he should have washed his hands for 20-30 seconds. On 11/12/24 from 12:32 PM to 12:37 PM, the surveyor observed the [redacted] Nourishment Room in the presence of Licensed Practical Nurse/Unit Manager (LPN/UM) #2. 1. In the refrigerator, A 64 ounce container or prune juice was opened and was not dated. LPN/UM #2 stated, "This is trash because it is not dated." She then proceeded to discard the container of prune juice. 2. In the freezer, a frozen dinner was marked with initials and "Do not touch." LPN/UM #2 stated that it should have been dated and properly labeled with the resident's name and date. 3. An ice scoop was stored in a wall mount that was not self-draining. There was brown matter in the base of the wall mount and the ice scoop was in direct contact with the water that pooled in the	F 812	reviewed which addresses maintaining the proper high temp (wash 150F / rinse 180F) and the use of a chlorine test strip after each use using a 50 part per million solution. Dietary staff were re-educated regarding this policy by the nursing home administrator. Dietary staff were re-educated that if at any time there is a question regarding the performance of the facilities dishwasher to notify the administrator and maintenance immediately by the nursing home administrator. #5 The facility "Ice Machine" policy was reviewed which addresses monthly cleanings that are perform in-house and to be serviced by a vendor bi-annually. Dietary staff were re-educated regarding this policy by the nursing home administrator. Dietary staff were re-educated that logs must be kept for all monthly and bi-annual cleaning/service by the nursing home administrator. #6 The facility "Hairnets" policy was reviewed which states all food handlers are required to wear effective hair restraints that cover all exposed body hair. Dietary staff were re-educated regarding this policy by the nursing home administrator. Dietary staff were re-educated that hairnets effectively prevent hair contact with food, equipment, utensils and food contact surfaces for infection control by the nursing home administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 94 bottom of the wall mount. LPN/UM #2 looked inside the wall mount and stated that the ice scoop was contaminated. On 11/12/24 from 12:43 PM to 12:48 PM, the surveyor observed the [redacted] Nourishment Room in the presence of Certified Nursing Assistant (CNA) #6 until LPN/UM #1 arrived. 1. An ice scoop was stored in a wall mount that was not self-draining. The ice scoop was in direct contact with the water that pooled in the bottom of the wall mount. LPN/UM #3 stated that it was an infection control issue if the ice scoop mount were not self-draining and were placed in the ice machine. 2. On the top shelf inside the door of the refrigerator, a large amount of dried brown matter was noted. On 11/12/24 at 1:32 PM, the surveyor interviewed the [redacted] who stated that the kitchen management was responsible for the nourishment rooms. The [redacted] stated that if the ice scoop mount were not self-draining it could get bacteria on the scoop and if it were used to scoop ice, germs may spread. The [redacted] further stated that resident's food may be kept in the refrigerator for up to three days and should be labeled with the resident's name and date. The [redacted] stated that if the item was not labeled and dated, then it had to go into the trash. The [redacted] further stated that the refrigerator should be cleaned every two to three days. The [redacted] further stated that there should have	F 812	#7 The facility "Wet Nesting" policy was reviewed which addresses how pooling water harbors bacteria. Nursing staff were re-educated regarding this policy by the director of nursing. It was explained that ice machine scoops that are sitting in water can spread bacteria. The facility "Labeling and Dating System" policy was reviewed which addresses expiration date on all un-opened produce, dating all fresh/frozen food and discarding all foods that expire immediately by the director of nursing. Element Four Quality Assurance #1 The Dietary Director will conduct daily rounds and audit all food items to ensure they are dated and have not expired for one week and then weekly for three months to assure 100 percent compliance. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on proper food storage and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #2 The Dietary Director will conduct daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 95 been a maintenance log on the outside of the ice machines. The [redacted] further stated that they must have gotten wet. The [redacted] stated that the facility maintained the outside of the ice machine and a company maintained the inside. The [redacted] was unsure of the frequency that the inside of the ice machine was cleaned. On 11/13/24 at 1:55 PM, the surrveyor interviewed the [redacted] who stated that he performed walking rounds in the kitchen the Friday (11/15/24), prior to survey and had concerns with the facility's cleaning schedule. In a later interview with the [redacted] in the presence of the survey team on 11/13/24 at 4:15 PM, the [redacted] stated that the dish machine repair was delayed due to receipt of the wrong part and was scheduled for repair tomorrow. A review of an undated facility's,"Dishwashing (mechanical)" policy included: ...High Temp (Wash 150 degrees F, Rinse 180 F). Low Temp (Wash 120 degrees F, Rinse 120 degrees F). Must use a chlorine test strip after each use using a 50 parts per million (PPM) solution.U.S. FOIA (b)(6) [redacted]) or designee will spot check and log temperature and PPM reading prior to each usage. A review of the facility's "Sanitation" policy #506, revised 8/1/18, included: The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive, cleaning schedule. Cleaning and sanitation tasks for the kitchen will be recorded. Tasks will be assigned to be the responsibility of specific positions. Frequency of cleaning for each task will be defined.....A cleaning schedule will be	F 812	rounds and audit pots and pans for one week and then weekly for three months to assure 100 percent compliance that no wet nesting is taking place. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on avoiding wet nesting and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #3 The Dietary Director will conduct daily rounds and audit the kitchen for one week and then weekly for three months to assure all floors, equipment and surfaces are cleaned and free from build up. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on proper infection control and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 96 posted. Employees will be trained on the cleaning schedule and how to perform duties. Employees will be trained on the cleaning schedule and how to perform duties. Employees will initial and date tasks when completed. A review of the facility's "Pot Washing and Air-Drying Policy" revised May 2021, included: ...Air dry all clean and sanitized pots and wares...Pots and Pans must be stored in such a way as to allowthetotal [sic.] air-drying process to be achieved. Once air dried, all pots and pans must be stored inverted (upside down). All pots and pans must be dry to the touch and sight prior to being put into production and/or properly stacked/stored together. A review of the facility's "Labeling and Dating System Protocol" policy revised 10/20/24, included: Follow manufacturers expiration date on all un-opened product...All fresh and frozen foods must be dated with the date it was received into the kitchen unless it has a Purveyor shipping label on it. Make sure to not date over or cover up the manufacture's expiration date on the product. Day 1 (one) is first day of labeling. ...Hard boiled eggs, 3 (three days)... A review of an undated facility's "Dating and Labeling Policy" included: ...Discard all foods that expire immediately. A review of the facility's "Ice Machine" policy revised 3/28/24, included: Ice machine will be cleaned monthly following the manufacturers instructions for cleaning,	F 812	The Dietary Director will conduct daily rounds and audit dishwasher temperature gauges for one week and then weekly for three months to assure they are in proper working order. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on proper dishwasher temperatures and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #5 The Dietary Director will conduct daily rounds and audit the condition of the ice machine for one week and then weekly for three months to assure its in a clean and proper working order along with the maintenance schedule. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on ice machine maintenance and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 97 disinfecting, draining, and sanitizing....Ice machine will be serviced bi-annually... A review of an undated facility's "Dented Can Policy" included: Identify all unacceptable dented cans....Place all dented cans on a designated shelf marked "Dented Cans." A review of the facility's "Floor Cleaning" policy revised 11/10/23, included: The staff will properly sweep and mop the floor to ensure cleanliness... A review of the facility's "Hairnets" policy revised 3/28/24, included: All food handlers are required to wear effective hair restraints that cover all exposed body hair. Hair restraints must effectively prevent contact with food, clean food service equipment, utensils and food contact surfaces. A review of the facility's "Hand Hygiene" policy revised 10/27/22, included: The facility considers hand hygiene the primary means to prevent the spread of infections. Practicing hand hygiene is a simple and effective way to prevent infections....Soap and water for the following situations: ...Immediately after removing gloves...Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds... NJAC 8:39-17.2(G), 19.4	F 812	#6 The Dietary Director or designee will conduct daily rounds and audit the hairnet compliance of the kitchen for one week and then weekly for three months to assure all employees are properly wearing their hairnets. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for maintaining education for staff on how to properly wear hairnets and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency #7 The Unit Manager or designee will conduct daily rounds and audit the compliance of the nursing unit pantry for one week and then weekly for three months to assure the pantries are clean and no expired food / unlabeled food is present. Results will be provided to the Licensed Nursing Home Administrator (LNHA) who will review the findings and provide direction as appropriate. The Licensed Nursing Home Administrator (LNHA) will report the findings in aggregate at the monthly QAPI meeting for 3 months. Facility Educator will be responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 812	Continued From page 98	F 812	maintaining education for staff on clean and orderly pantries and the Licensed Nursing Home Administrator (LNHA) for the correction of deficiency The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0812 will not reoccur.	
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility's U.S. FOIA (b)(6) [redacted]) failed to ensure staff implemented facility policies and procedures to ensure a.) residents were provided with care and services to achieve their highest practical wellbeing and, b.) the minimum State staffing requirements were met. This deficient practice was identified for and 2 out of 2 nursing units, and was evidenced by the following: Refer to F678, F684, F688, F698, F725, F804, F809, and F812 A review of the Administrator's job description provided by the facility revealed the following:	F 835	Tag 0835 Element One Corrective Actions Facility administrator was immediately educated by the corporate consultant on his job description, roles, and responsibilities to ensure that policies and procedures and effective systems were implemented to assure services are provided. All policies reviewed included Weekly Skin Observation, Pressure Ulcer, Medication Administration, Dialysis Care, Staffing, Hot Food / Food Temperature, Snack, Labeling and Dating Food, Wet Nesting, Sanitation, Dishwashing, Ice Machine and Hair Nets. Element Two Identification of at Risk	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 99 The Administrator's primary purpose is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guideline, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to the residents at all times. Duties and Responsibilities included but not limited to: plan, develop, organize, implement, evaluate, and direct the facility's programs and activities. Meet with department directors to discuss use of departmental policies and procedures and establish a rapport in and among departments so that each can realize the importance of teamwork. Review the facility's policies and procedures periodically, at least annually and make changes as necessary to assure continued compliance with current regulations. Assure that an adequately number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents. Assure that each resident receives the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan. During the entrance conference on 11/6/24 at 9:55 AM, the U.S. FOIA (b)(6) stated that he was the U.S. FOIA (b)(6) from January 2023 to August 2023 and returned back to the facility in October of 2023 and the U.S. FOIA (b)(6)) started at the facility in U.S. FOIA (b)(6). 1.) On 11/07/24 at 11:25 AM, the surveyor reviewed the closed medical record of Resident	F 835	Residents All residents have the potential to be affected by these deficient practices. Element Three Systemic Change The corporate consultant educated the entire department head team on Weekly Skin Observation, Pressure Ulcer, Medication Administration, Dialysis Care, Staffing, Hot Food / Food Temperature, Snack, Labeling and Dating Food, Wet Nesting, Sanitation, Dishwashing, Ice Machine and Hair Nets. The Director of Nursing (DON) or designee educated all nursing staff on Weekly Skin Observation, Pressure Ulcer, Medication Administration and Dialysis Care, Snacks. The Facility administrator or designee educated all dietary staff on Hot Food / Food Temperature, Snack, Labeling and Dating Food, Wet Nesting, Sanitation, Dishwashing, Ice Machine and Hair Nets. The Facility administrator and or designee educated all department heads on Staffing. Element Four Quality Assurance The Facility administrator, Director of Nursing (DON) and or designee will conduct monthly education on these policies for the next six months. The Facility administrator, Director of Nursing (DON) and or designee will audit compliance with the education on these policies by conducting a random 5 staff assessment and test them to assure staff have a true understanding of our policies for the next six months. This education will become part of our orientation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 100 #103. A review of the Progress Notes (PN) and interviews with the licensed nursing staff revealed that on NJ Exec Order 26.4b1, the Certified Nursing Assistant (CNA #1) found Resident #103 who was a NJ Exec Order 26.4b1 and reported it to the Licensed Practical Nurse (LPN #1) who began NJ Exec Order 26.4b1 LPN #1 did not call 911 and did not notify the Registered Nurse (RN #1) until NJ Exec Order 26.4b1 of the resident's code. RN #1 did not perform NJ Exec Or or call 911 and NJ Exec Order 26.4b1 Resident #103 NJ Exec Order 26.4b1 On 11/13/24 at 1:13 PM, the surveyor interviewed the U.S. FOIA (b) who stated that she did not do an investigation and did not question the time lapse from then CNA #1 found the resident NJ Exec Order 26.4b1 and notified LPN #1, to LPN #1 notifying RN #1 at NJ Exec Order 26.4b. The U.S. FOIA (b) stated that she did not focus on the time and just asked RN #1 about U.S. FOIA (b) and why 911 was not called. The U.S. FOIA (b) stated that she was just NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) who was present stated that, "RN #1 thought that it was an ethical issue to keep NJ Exec Orde going". On 11/13/24 at 2:38 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that when there was a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 who was a NJ Exec Order 26.4b, he would expect whoever was in the building to call the nursing supervisor, do NJ Exec Order 26.4b1 and call 911. EMS came to the facility with Advanced	F 835	education as well as our annual education. The Corporate Consultant will conduct weekly audits on random facility policies and procedures for four weeks and then monthly for six months. The results of these audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. All audits will be presented to the corporate CEO monthly to ensure the nursing home administrator job description is being followed. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0835 will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 101	F 835		

NJ Exec Order 26.4b1 to treat NJ Exec Order 26.4 emergencies such as NJ Exec Order 26.4b1 with NJ Exec Ord NJ Exec Order 26.4b1, and/or the use of an NJ Exec Order The U.S. FOIA (b)(6) stated that EMS took over the care of the resident and NJ Exec Order 26.4b1 them if indicated. The U.S. FOIA (b)(6) stated that he "was notified of the scenario and clearly, 911 should have been notified."

2.) A review of the NJ Exec Order 26.4b1 Physician's Order Sheet (POS) and Treatment Administration Record (TAR) did not include any physician's order (PO) for the new NJ Exec Order 26.4b1 until NJ Exec Order 26.4.

The PO was started 23 days after the initial treatment was ordered on NJ Exec Order 26.

On 11/12/24 at 10:37 AM, the surveyor and the Licensed Practical Nurse/Unit Manager (LPN/UM#1) reviewed the Progress Notes, the PO, the ICCP and the NJ Exec Order 26.4b1 assessments in the electronic medical record (EMR). LPN/UM #1 confirmed that she had entered the NJ Exec Order 26.4 PO in the EMR and it should have been for the NJ Exec Order 26.4b1 and not the NJ Exec Order 26.4b1. LPN /UM#1 confirmed that a treatment order for the NJ Exec Order 26.4b1 was not on the POS or the TAR until NJ Exec Order 26.4. LPN/UM#1 further stated that on NJ Exec Order 26.4, when the NJ Exec Order 26.4b1 had NJ Exec Order 26.4b1 a NJ Exec O assessment should have been completed. After reviewing the Progress Notes, LPN/UM#1 could not recall if the NJ Exec Order 26.4b1 had notified her about the NJ Exec Order 26.4b1 between NJ Exec Order 26.4b1.

On 11/13/24 at 1:56 PM, the surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 102	F 835		

the U.S. FOIA (b)(6) who stated that he was made aware of Resident # 305's NJ Exec Order 26.4b1 NJ Exec Order by the NJ Exec Order 26.4b Nurse and by the U.S. FOIA (b)(6) . The U.S. FOIA (b)(6) stated he could not remember the exact date, but it was when the resident was still in the facility.

3.) On 11/8/24 at 9:08 AM, the surveyor reviewed the medical record for Resident #91.

A review of Resident #91's Progress Notes did not reveal any documentation that the NJ Exec Order 26.4b at all times, except during care were applied as ordered. The Progress Notes did not reveal any documentation of the resident's NJ Exec Order 26.4b1 .

On 11/9/24 at 10:18 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that the therapist entered the physician's order (PO) for splints into the electronic medical record (EMR) and the nurse would acknowledge the PO. The U.S. FOIA (b) acknowledged that the PO were entered incorrectly in the EMR. The U.S. FOIA (b) further stated that it was important to follow the recommendation for the NJ Exec Order 26.4b1 and document in the Treatment Administration Record (TAR) to prevent NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

On 11/12/24 at 3:12 PM, surveyor reviewed the concern with the U.S. FOIA (b)(6)).

4.) On 11/7/24 at 10:30 AM, the surveyor reviewed the medical record for Resident #9.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 103	F 835		

A review of the individual comprehensive care plan (ICCP) included a focus area, dated [redacted], that the resident needed [redacted] related to [redacted] and that the resident went to [redacted]

Interventions included: Monitor/document/report to the physician as needed of any [redacted] to the [redacted] such as [redacted] The ICCP did not include any interventions to schedule medications around the resident's scheduled [redacted] times, or to monitor the resident's [redacted] and [redacted]

A review of the [redacted] Treatment Administration Record (TAR) did not include a PO to monitor the resident's [redacted] for [redacted].

A review of the Pharmacy Consultant's Comments Report for the previous six months revealed a recommendation, dated [redacted], to "please be sure that medication times are changed to accommodate resident's [redacted] times."

On 11/12/24 at 12:50 PM, the surveyor interviewed the [redacted] who stated [redacted] residents' medication administration times should be scheduled either before or after their [redacted] times to prevent missed medication doses. The [redacted] further stated that there should be a PO for nurses to monitor residents' [redacted] sites for [redacted] to ensure there were no complications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 104 with the site. At that time, the surveyor informed the [U.S. FOIA (b)] of Resident #9's medication administration times that were scheduled during the resident's [NJ Exec Order 26] times, and that Resident #9 did not have a PO to monitor for [NJ Exec Order 26.4b1] The [U.S. FOIA (b)] stated the nurse should have contacted the physician to reschedule the medication administration times, and there should have been a PO to monitor the [NJ Exec Order 26.4b1]. 5.) A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: For the 3 weeks of Complaint staffing from 01/21/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 15 of 21 day shifts, and deficient in total staff for residents on 1 of 21 evening shifts. For the 2 weeks of staffing prior to survey from 10/20/2024 to 11/02/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts and deficient in total staff of residents on 1 of 14 overnight shifts. On 11/13/24 at 1:47 PM, the surveyor interviewed the [U.S. FOIA (b)(6)]) who stated, "No staffing is perfect, I feel pretty confident about our staffing." He stated that they offered bonuses to the in-house staff and a full-time schedule for the agency staff. 6.) On 11/7/24 at 10:52 AM, the surveyor	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 105 conducted a meeting with the Resident Council which included five residents (Residents #9, #3, #48, #64, and #81). Four of the five residents informed the surveyor that the food was not served hot and was described as "cool" on both nursing units. On 11/12/24 at 11:42 AM, the surveyor observed the [redacted] as she left the kitchen with Food Cart #1 and delivered it to the [redacted] Unit where the nursing staff awaited meal delivery. On 11/12/24 at 12:03 PM, the surveyor interviewed the [redacted] who stated that we could have done better on the timing of the meal distribution. The [redacted] stated that the facility had plate warmers that were not presently utilized due to the food being served on paper products while the dish machine was out of service. The [redacted] further stated, "We handled it if the residents stated that the food was not warm enough." On 11/12/24 at 2:56 PM, the surveyor interviewed the [redacted]) who stated that the facility had complaints of cold food and addressed it with the residents. 7.) On 11/7/24 at 10:30 AM, the surveyor conducted a resident council meeting with five (5) awake, alert, and oriented residents. During the meeting, 5 out of 5 residents stated that snacks were kept in the pantry and were not accessible during the evening shift to the residents. One resident stated, " If we don't like our dinner, then we are hungry and need a snack at night."	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 106 On 11/12/24 at 2:51 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the facility addressed snack distribution monthly at Resident Council to confirm receipt of snacks. The surveyor asked how the facility accounted for residents who could not speak for themselves and did not attend Resident Council, the U.S. FOIA (b)(6) stated that the supervisor went around and offered snacks. The U.S. FOIA (b)(6) further stated that snacks should be available in the pantry with a bare minimum of cookies, crackers and cereals. The surveyor then informed the U.S. FOIA (b)(6) that there were no cookies, crackers or cereals observed during the inspection of the NJ Exec Order 26.4b1 Pantry. 8.) On 11/6/24 from 9:46 AM to 10:50 AM, the surveyor, accompanied by the U.S. FOIA (b)(6) toured the kitchen and it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. On 11/7/24 at 9:04 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the vendor determined that there was a problem with the dish machine thermometer (temperature probe) and was scheduled for repair tomorrow. The U.S. FOIA (b)(6) stated that the facility would continue to serve meals on paper products until the repair was completed. On 11/12/24 at 8:33 AM, during a follow-up interview the U.S. FOIA (b)(6) stated that the facility continued to serve meals on paper products due to the dish machine being out of service. The	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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) COMPLETION DATE
F 835	Continued From page 107 [redacted] stated that he expected the thermometer probe to be installed today. On 11/13/24 at 1:55 PM, the surveyor interviewed the [redacted] who stated that he performed walking rounds in the kitchen the Friday (11/15/24) prior to survey and had concerns with the facility's cleaning schedule. On 11/13/24 at 1:44 PM, the surveyor interviewed the [redacted] in the presence of the [redacted] and the survey team who stated that the role of the Administrator was to oversee the operations of the facility to ensure they are following the regulations for the skilled nursing facility. He further stated to ensure the residents were taken care of and had a home like environment. The [redacted] stated that he was a resource for the staff, assisted and initiate any concerns with grievances from the family or residents and to be an advocate for the staff and the residents. On 11/13/24 at 1:56 PM, the [redacted] acknowledged the concerns that were brought to his attention in the presence of the [redacted] and the survey team. NJAC 8:39-9.2(a); 9.3(a); 27.1(a)	F 835		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #170567 and 171267 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift, evening shift and night shifts as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	Tag 0560 Element One Corrective Actions A staffing analysis was completed to identify by shift the minimum amount of direct care staff and licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on the daily census. The staffing schedule was reviewed by the DON with the staffing coordinator to identify by shift the required numbers of staff. Agencies are contacted to fill vacant direct care certified nurse aide and licensed nurse positions while the facility advertised	1/3/25

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

Electronically Signed | 12/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: 1. For the 3 weeks of Complaint staffing from 01/21/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 15 of 21 day shifts, and deficient in total staff for residents on 1 of 21 evening shifts as follows: -01/21/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/22/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/23/24 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs.	S 560	for new staff. Facility nursing staff are offered bonuses for picking up extra shifts when needed. The Facility continues to run Online Ads, offers sign on bonus and generous referral bonuses to attract new staff. Interviews are being conducted daily as applicants apply both scheduled or walk-ins. The staffing coordinator reviews the daily, weekly, and monthly staff schedules with the DON to assure staffing levels meet regulatory requirements and to offer extra shifts to cover vacation and days off in advance. Element Two Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three Systemic Change DON/ADON review staffing daily and weekly to ensure all resources have been used to staff the facility as per state mandates on an ongoing basis. Agencies are sent all staffing needs in advance and additional staff requested to cover in the event of callouts. The Facility continues to work with a recruiter and use digital and social media to staff the facility in compliance with regulations. Administration has formed a staffing committee and has conducted salary analyses and implemented creative strategies for attracting new employees to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S 560	Continued From page 2 -01/27/24 had 8 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/28/24 had 6 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/29/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/30/24 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/30/24 had 9 total staff for 101 residents on the evening shift, required at least 10 total staff. -01/31/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/01/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/02/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/03/24 had 7 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/04/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/05/24 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/08/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/10/24 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of staffing prior to survey from 10/20/2024 to 11/02/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts and deficient in total staff of residents on 1 of 14 overnight shifts as follows: -10/20/24 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/21/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/23/24 had 12 CNAs for 105 residents on the	S 560	minimize the use of agency personnel. The staffing committee includes frontline staff and managers to identify ways the facility can improve the work environment to retain and attract new employees. The committee recommendations are shared with regional and corporate staff for review and implementation. The committee will meet weekly. Bonuses and incentive programs have been implemented to attract and to retain current staff. The facility is utilizing all types of digital media as well as headhunters to identify and hire new staff. Element Four Quality Assurance Daily staffing levels are reported to administrator and if there are any shortages additional incentives are provided to employees to work an extra shift. The success of bonuses and incentives is being analyzed by the facility Administrator and DON who make recommendations to the ownership regarding what incentives or bonuses are working. Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions. HR and staffing coordinator/designee will track efforts and success of initiatives above and report findings to the administrator weekly for four months or until minimum staffing levels have been met on a consistent basis. The administrator will communicate findings to corporate staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S 560	Continued From page 3 day shift, required at least 13 CNAs. -10/25/24 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/26/24 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/27/24 had 8 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/27/24 had 5 total staff for 105 residents on the overnight shift, required at least 7 total staff. -10/28/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -10/31/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -11/01/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -11/02/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 11/12/24 at 1:31 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was aware of the staffing ratios and that most of the facility's callouts occurred on the weekends. On 11/13/24 at 1:47 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated, "No staffing is perfect, I feel pretty confident about our staffing." He stated that they offered bonuses to the in-house staff and a full-time schedule for the agency staff. A review of the facility's "Staffing" policy dated revised September 2023, included, 1. Facility will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs. ...8. The facility will staff according to the following regulations a. One CNA to every 8 Resident for the day shift b. One direct care staff member (RN, LPN or CNA) to every 10 residents for the	S 560	for assistance and further direction as appropriate. Days and shifts where facility did not meet staffing requirement along with incentives used to attract staff for the days and shifts will be brought to QAPI on a monthly basis by DON x3 months. Also, recruitment efforts for the month x3 months will be submitted to the Administrator to evaluate progress of recruitment and retention efforts. Findings will be reported to the QAPI committee monthly for 6 months and recommendations will be made based upon outcomes. The HR Director tracks monthly hiring and retention efforts which are reviewed at the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S 560	Continued From page 4 evening shift c. One direct care staff member (RN, LPN or CNA) to every 14 Residents for the night shift d. These ratios can increase due to the populations acuities and/or regulations"	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide physical health examinations to newly hired employees within the required time frame for 3 of 10 new employees reviewed.	S1405	Tag 1405 Element One Corrective Actions The facility immediately audited the employee files to ensure no current employees were working at the facility	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S1405	Continued From page 5 The deficient practice was evidenced by the following: On 11/12/24 the surveyor reviewed the employee health files of 10 random newly hired facility employees, including their pre-employment physical examinations. Employee #5's date of hire (DOH) was [redacted]. Their physical was performed on [redacted]. Employee #7's DOH was [redacted]. Their physical was performed on [redacted]. Employee #10's DOH was [redacted]4. Their physical was performed on [redacted] On 11/12/24 at 1:46 PM, the surveyor interviewed the Licensed Practical Nurse/ Infection Preventionist (LPN/IP), who stated that physicals are done onsite once a month. She further stated the new employee would not be permitted to work without a physical. The LPN/IP confirmed that Employee #7 remained on the schedule and he was permitted to work from DOH to [redacted]. On 11/12/24 at 2:51 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that new employees were permitted to work before a physical was performed. He further stated that the new hire should have a physical examination within 30 days of hire. A review of an undated facility policy "New Employee References/Physicals - Protocol," included, "...4. An employee can opt to bring in	S1405	without an up to date physical. Element Two Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three Systemic Change The facility "New Employee References/Physicals-Protocol" policy was adjusted to reflect if the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. Department Heads were re-educated regarding this revised policy by the nursing home administrator. Element Four Quality Assurance Human Resources or Designee will audit all new hires to assure they either have a recent physical from their primary care physician, a nursing assessment by a registered professional nurse upon employment that will defer them for 30 days or a physical from the facilities medical director for six months to assure compliance. Results will be provided to facility administrator who will review the findings and provide direction as appropriate. The facility administrator will report the findings in aggregate at the monthly QAPI meeting for 6 months. Human Resources will be responsible for maintaining education on all new hires physicals.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S1405	Continued From page 6 their own most recent physical from their primary care physician, if this is not provided upon hire the employee will receive a physical that is conducted by the facilities Medical Director within 30 days of employment."	S1405	The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 1405 will not reoccur.	
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day	S1680		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S1680	Continued From page 7 Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 10/20/2024 and 11/02/2024, it was determined that the facility failed to provide at least minimum staffing levels for 3 of 14 days. The required staffing hours and actual staffing	S1680	Tag 1680 Element One Corrective Actions The facility immediately audited the resident roster to establish how many residents are receiving wound care, nasogastric tube feedings/or gastrostomy,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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
S1680	Continued From page 8 hours are as follows: For the week of 10/20/24 Required Total Staffing Hours: 302.25 -10/20/24 had 272 actual staffing hours, for a difference of -30.25 hours. -10/26/24 had 280 actual staffing hours, for a difference of -22.25 hours. For the week of 10/27/24 Required Total Staffing Hours: 305.50 -10/27/24 had 256 actual staffing hours, for a difference of -49.5 hours. On 11/13/24 at 1:47 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated, "No staffing is perfect, I feel pretty confident about our staffing." He stated that they offered bonuses to the in-house staff and a full-time schedule for the agency staff. A review of the facility's "Staffing" policy, dated revised September 2023, included, "Facility will ensure qualified employees will be scheduled to meet operational requirements and the needs of the residents."	S1680	oxygen therapy, tracheostomy, intravenous therapy, use of respirator and head trauma stimulation/advanced neuromuscular/orthopedic care. Element Two Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three Systemic Change The facility "Staffing" policy was adjusted to reflect total number of residents multiplied by 2.5 hours/day plus residents receiving wound care, nasogastric tube feedings/or gastrostomy, oxygen therapy, tracheostomy, intravenous therapy, use of respirator and head trauma stimulation/advanced neuromuscular/orthopedic care. Department Heads were re-educated regarding this revised policy by the nursing home administrator. Element Four Quality Assurance The Staffing Coordinator or Designee will audit all staffing for the prior day daily for 7 days then weekly for 6 months to assure proper nursing staff is being provided to our residents. Results will be provided to facility administrator who will review the findings and provide direction as appropriate. The facility administrator will report the findings in aggregate at the monthly QAPI meeting for 6 months. The Facility Educator will be responsible for maintaining education on the new Staffing Policy changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060409	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38 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
S1680	Continued From page 9	S1680	The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 1680 will not reoccur.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315183 Y1	A. Building B. Wing Y2	1/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0657	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025
ID Prefix F0684	Correction	ID Prefix F0689	Correction	ID Prefix F0692	Correction
Reg. # 483.25	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025
ID Prefix F0698	Correction	ID Prefix F0725	Correction	ID Prefix F0804	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025
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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/20/2024	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315183 Y1	A. Building B. Wing Y2	1/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0550	Correction	ID Prefix F0607	Correction	ID Prefix F0609	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025
ID Prefix F0610	Correction	ID Prefix F0623	Correction	ID Prefix F0657	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025
ID Prefix F0678	Correction	ID Prefix F0684	Correction	ID Prefix F0688	Correction
Reg. # 483.24(a)(3)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	11/21/2024	LSC	01/03/2025	LSC	01/03/2025
ID Prefix F0689	Correction	ID Prefix F0692	Correction	ID Prefix F0698	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(l)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025
ID Prefix F0725	Correction	ID Prefix F0758	Correction	ID Prefix F0804	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060409 Y1	A. Building B. Wing Y2	1/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/03/2025	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 01/03/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 01/03/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
11/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315183 Y1	A. Building B. Wing Y2	1/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0809	Correction	ID Prefix F0812	Correction	ID Prefix F0835	Correction
Reg. # 483.60(f)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70	Completed
LSC	01/03/2025	LSC	01/03/2025	LSC	01/03/2025

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 11/20/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	**11/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38** **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) COMPLETION DATE
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 11/20/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 11/20/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Premier Cadbury of Cherry Hill is a one-story building built in 1980's. It is composed of Type II protected construction. The facility is divided into four - smoke zones. The generator does approximately 75 % of the building per Maintenance Director. The current occupied beds are 107 of 118.	K 000		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		1/3/25

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

Electronically Signed | 12/20/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	**11/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38** **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) COMPLETION DATE
K 355	Continued From page 1 by: Based on observations and interview, the facility failed to ensure that one out of 30 fire extinguishers located at the [NJ Exec Order 26] room of the facility was fully charged and had been inspected to ensure its operable condition in accordance with NFPA 10, Standard for Portable Fire Extinguishers (2010 Edition) Section 6.1.2. The facility further failed to ensure one of 30 fire extinguishers was installed properly. This deficient practice had the potential to affect all 107 residents who resided at the facility. Findings include: An observation on 11/20/24 at 12:33 PM revealed the fire extinguisher near the main entrance was hanging by its nozzle (hose). Portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means: (1) Securely on a hanger intended for the extinguisher (2) In the bracket supplied by the extinguisher manufacturer (3) In a listed bracket approved for such purpose (4) In cabinets or wall recesses An observation on 11/20/24 at 12:45 PM revealed no inspection tag on the CO2 fire extinguisher in the mechanical room. Review of "[VENDOR NAME] Fire Extinguisher Inspection" report provided by the facility did not indicate the CO2 fire extinguisher as being inspected. During an observation on 11/20/24 at 1:16 PM, the fire extinguisher in the [NJ Exec Order 26] Room was on the discharge side. Portable fire extinguishers shall be maintained in a fully charged and	K 355	Tag 0355 Element One Corrective Actions The facility immediately replaced the fully charged extinguisher, the extinguisher with no inspection tag and properly rehung the fire extinguisher near the main entrance. Element Two Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three Systemic Change The facility re-educated the maintenance department regarding placing an extinguisher securely on a hanger, ensuring all extinguishers are inspected and ensuring all extinguishers are immediately replaced after being discharged. Element Four Quality Assurance The Maintenance Director or Designee will audit all fire extinguishers weekly for 4 weeks then monthly. Results will be provided to facility administrator who will review the findings and provide direction as appropriate. The facility administrator will report the findings in aggregate at the monthly QAPI meeting for further action as required. The Facility Educator will be responsible for maintaining education on the fire extinguishers. The facility will be in compliance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING **01** B. WING _____	**11/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	**2150 ROUTE 38** **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) COMPLETION DATE
K 355	Continued From page 2 operable condition and shall be kept in their designated places at all times when they are not being used. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the above observations. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0355 will not reoccur. submitted photo. 01-08-2025	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure nonmetallic sheathed cable was concealed within walls, floors, or ceilings that provided a thermal barrier of material that had at least a 15-minute finish rating as identified in listings of fire-rated assemblies and extension cords shall not be attached to buildings in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 334.10 (3) (5). and NFPA 1 Fire Code (2012 Edition) 11.1.7.5 This deficient practice had the potential to affect all	K 511	Tag 0511 Element One Corrective Actions The facility immediately concealed the three nonmetallic sheathed cables that were exposed going to the electrical panel on the South wall, as well as concealed the one nonmetallic sheathed cable that was exposed going to the 220V panel on the South wall, and removed the extension cord connecting the CTA30/550 to the outlet.	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING 01 B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 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) COMPLETION DATE
K 511	Continued From page 3 107 residents who resided at the facility. Findings include: An observation on 11/20/24 at 1:10 PM revealed three nonmetallic sheathed cables going to the electrical panel (panel not identified) on the South wall and one nonmetallic sheathed cable was exposed going to the 220V panel on the South wall in the electrical room. An observation on 11/20/24 at 1:20 PM revealed a CableTrax model CTA 30/550 plugged into an extension cord attached to the wall and plugged into an electrical outlet near the exit door. Extension cords and flexible cords shall not be affixed to structures; extend through walls, ceilings, or floors, or under doors or floor coverings; or be subject to environmental or physical damage. During an interview at the time of the observations, the U.S. FOIA (b)(6) verified the nonmetallic sheathed cable was not protected by a 15-minute fire rating and the extension cord was attached to the wall. NJAC 8:39-31.2(e) NFPA 70	K 511	Element Two Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element Three Systemic Change The facility re-educated the maintenance director, ensuring nonmetallic sheathed cables are concealed and provided a thermal barrier of material and not to utilize extension cords within the facility. Element Four Quality Assurance The Maintenance Director or Designee will audit all panels to ensure they meet the current regulations weekly for 4 weeks and then monthly for 6 months. Results will be provided to facility administrator who will review the findings and provide direction as appropriate. The facility administrator will report the findings in aggregate at the monthly QAPI meeting for further action as required. The Facility Administrator will be responsible for maintaining education on proper panel regulations. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 01/03/2025 to ensure the deficient Tag 0511 will not reoccur. submitted photo 01/08/25	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315183 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 Reg. # NFPA 101 LSC K0355	Correction Completed 01/03/2025	ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 01/03/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
11/20/2024	