

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TWIN CEDARS	STREET ADDRESS, CITY, STATE, ZIP CODE 1456 GLASSBORO ROAD WENONAH, NJ 08090
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: Census: 21 Sample Size: 5</p> <p>TYPE OF SURVEY: Standard Survey of 19 residential units</p> <p>The facility is not in substantial compliance with all of the standards in New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A1041	<p>8:36-14.3(a) Emergency Services and Procedures</p> <p>(a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate</p>	A1041		

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TWIN CEDARS	STREET ADDRESS, CITY, STATE, ZIP CODE 1456 GLASSBORO ROAD WENONAH, NJ 08090
--	---

(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
A1041	<p>Continued From page 1</p> <p>in drills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview it was determined that the facility failed to conduct at least one fire drill monthly for 8 out of 12 month; failed to ensure that four drills occurred during each working shift on an annual basis for 3 out of 12 months on the 1st shift, 1 out of 12 months on the 2nd shift, and 1 out of 12 months on the 3rd shift; failed to conduct a drill other than fire for 12 of 12 months; and failed to ensure that all staff participated in at least one drill annually for 4 of 15 employees. This deficient practice was evidenced by the following:</p> <ol style="list-style-type: none"> 1. Surveyor review of the Physical Environment Inspections form, completed by the Administrator and dated 12/01/2021, revealed the question, "Identify drills performed for disasters other than a fire," was answered as "none." <p>Surveyor review of the last 12 months of fire drills revealed a fire drill on 02/23/2021 during for 1st shift employees, on 05/23/2021 for the 2nd and 3rd shift employees, on 05/24/2021 for the 1st shift employees, on 08/13/2021 for the 2nd shift employees, and on 09/28/2021 for the 1st shift employees. The signatures were reviewed of the attendees, and 4 out of 15 employees did not participate.</p> <p>During surveyor interview with the Administrator on 12/02/2021 at 12:45 p.m., she stated that the</p>	A1041		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TWIN CEDARS	STREET ADDRESS, CITY, STATE, ZIP CODE 1456 GLASSBORO ROAD WENONAH, NJ 08090
--	---

(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
A1041	Continued From page 2 facility did not have a Maintenance Director and had not kept up with the monthly fire drills. The Administrator went on to state that they ensured that all employees participated at least once during the year, or had a drill other than a fire drill. Surveyor review of the undated policy titled, "Drills and Tests." revealed, "1. The facility will conduct at least one (1) drill of the emergency plans every month, 2. The facility will conduct at least one (1) drill per year for emergencies due to a disaster other than fire and all staff will participate in at least one (1) drill annually."	A1041		
A1043	8:36-14.3(b) Emergency Services and Procedures (b) The facility shall request of the local fire department that at least one joint fire drill be conducted annually. Upon scheduling a joint fire drill, the facility shall notify first aid and civil defense agencies of this drill and shall participate in community-wide disaster drills. This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview, it was determined that the facility failed to request the local fire department to attend at least one joint fire drill annually for the last 12 months of fire drills reviewed. This deficient practice had the potential to affect all residents, and was evidenced as follows: Surveyor review of the "Physical Environment Inspections" form, completed by the	A1043		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER TWIN CEDARS	STREET ADDRESS, CITY, STATE, ZIP CODE 1456 GLASSBORO ROAD WENONAH, NJ 08090
--	---

(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
A1043	<p>Continued From page 3</p> <p>Administrator and dated 12/01/2021, revealed the question, "Identify joint drills with the local fire officials," and was answered as "none."</p> <p>During surveyor interview with the Administrator on 12/02/2021 at 12:45 p.m., she confirmed that the facility had not invited the local fire department to participate in any fire drill.</p> <p>Surveyor review of an undated policy, titled, "Drills and Tests," revealed, "3. The facility will request of the local fire department that at least one (1) joint fire drill be conducted annually."</p>	A1043		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 82473	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/29/2022
NAME OF FACILITY TWIN CEDARS	STREET ADDRESS, CITY, STATE, ZIP CODE 1456 GLASSBORO ROAD WENONAH, NJ 08090	

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 A1041	Correction	ID Prefix A1043	Correction	ID Prefix _____	Correction
Reg. # 8:36-14.3(a)	Completed	Reg. # 8:36-14.3(b)	Completed	Reg. # _____	Completed
LSC _____	01/12/2022	LSC _____	01/12/2022	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/1/2021		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		