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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 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 [NAME] 500 Dining Room. This deficient practice was evidenced by the following: On 11/6/24 at 12:03 PM, the surveyor observed residents who were seated in the [NAME] 500 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 Licensed Practical Nurse/Infection Preventionist (LPN/IP) stated that the resident's food cart was not there yet and that the other residents were served from the first food cart. The LPN/IP 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 LPN/IP stated that 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. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. Building 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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 2:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) 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. NJAC 8:39-4.1(a)12

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40041 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 Licensed Practical Nurse (LPN), with a date of hire of 8/6/24, did not have a reference check on file. Employee #6 a Certified Nurse Aide (CNA), with a date of hire of 1/24/24, did not have a reference check on file. Employee #8, a CNA, with a date of hire of 10/30/24, did not have a reference check on file. Employee #10, a Registered Nurse (RN) with the hire date of 7/29/24, did not have a reference check on file. On 11/12/24 at 1:03 PM, the surveyor interviewed the Human Resource Director (HRD), who stated two (2) references were done on every employee. The HRD 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 HRD 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

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41260 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 resident-to resident altercation for 1 of 4 residents (Resident #310) reviewed for abuse. This deficient practice was evidenced by the following: 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: Alzheimer's Disease, dementia, major depressive disorder, unspecified mood [affective] disorder, persistent mood [affective] disorder, post-traumatic stress disorder (PTSD), insomnia, cognitive communication deficit, and generalized anxiety disorder. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 2/25/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred one to three days during the review period. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 2/20/24 that the resident's room was changed. Further review of the ICCP included a focus area, dated 2/24/24, that the resident had the potential to be verbally aggressive (cursing) related to dementia. Interventions included: staff to intervene before agitation escalates; guide resident away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. A review of the Progress Notes (PN) included a Nurses Note (NN), dated 2/19/24 at 11:23 PM, which revealed Resident #310 was walking down the hallway and began cursing at another resident. The NN further revealed Resident #310 charged at the other resident, 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 down to the floor to refrain them from causing any harm to themselves or other residents, and that 911 was called for the resident to be sent to crisis at the hospital. Further review of the PN included a Room Change Notification note, dated 2/20/24 at 1:45 PM, which indicated Resident #310 had a room change to a different nursing unit. A review of the Psychiatry Evaluation (psych eval), dated 2/26/24, revealed the resident was seen for an initial evaluation. Further review of the psych eval included the resident was sent to crisis on 2/19/24 for agitation and aggression, and that the resident admits he/she continued to experience anxiety, depression, and mood swings. The psych eval also included recommendations from the psychiatrist to adjust Resident #310's psychiatric medications. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 resident-to-resident altercation that took place on 2/19/24. On 11/12/24 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 who stated resident-to-resident altercations were reportable events and that the state has to be aware of the people fighting. On 11/12/24 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated resident-to-resident altercations were reported to the state. On 11/12/24 at 12:50 PM, the surveyor interviewed the Director of Nursing (DON) who stated a resident-to-resident altercation could be verbal or physical. The DON further stated verbal altercations were reported to the physician and the resident's family. When asked whether Resident #6's resident-to-resident altercation on 2/19/24 should have been reported to the NJDOH, the DON 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. NJAC 8:39-5.1(a)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41260 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 resident-to-resident altercation, and b.) an injury of unknown origin. This deficient practice was identified for 2 of 4 residents (Resident #6 and #310) reviewed for abuse, 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: Alzheimer's Disease, dementia, major depressive disorder, unspecified mood [affective] disorder, persistent mood [affective] disorder, post-traumatic stress disorder (PTSD), insomnia, cognitive communication deficit, and generalized anxiety disorder. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 02/25/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred one to three days during the review period. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 2/20/24 that the resident's room was changed. Further review of the ICCP included a focus area, dated 2/24/24, that the resident had the potential to be verbally aggressive (cursing) related to dementia. Interventions included: staff to intervene before agitation escalates; guide resident away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. A review of the Progress Notes (PN) included a Nurses Note (NN), dated 2/19/24 at 11:23 PM, which revealed Resident #310 was walking down the hallway and began cursing at another resident. The NN further revealed Resident #310 charged at the other resident, 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 down to the floor to refrain them from causing any harm to themselves or other residents, and that 911 was called for the resident to be sent to crisis at the hospital. Further review of the PN included a Room Change Notification note, dated 2/20/24 at 1:45 PM, which indicated Resident #310 had a room change to a different nursing unit. A review of the Psychiatry Evaluation (psych eval), dated 2/26/24, revealed the resident was seen for an initial evaluation. Further review of the psych eval included the resident was sent to crisis on 2/19/24 for agitation and aggression, and that the resident admits he/she continued to experience anxiety, depression, and mood swings. The psych eval also included recommendations from the psychiatrist to adjust Resident #310's psychiatric medications. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 resident-to-resident altercation that took place on 2/19/24. On 11/12/24 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 who stated when there was a resident-to-resident altercation, the residents were immediately separated. LPN #3 further stated that any staff present on the unit during the altercation should complete a written statement. LPN #3 added that it was important to thoroughly investigate resident-to-resident altercations to document the resident's behavior and determine how the facility could better handle the resident's behavior. On 11/12/24 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated when there was a resident-to-resident altercation, the residents were immediately separated, the aggressor was sent to crisis 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 nothing gets missed. LPN/UM #1 added that resident-to-resident altercations 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 Director of Nursing (DON) who stated a resident-to-resident altercation could be verbal or physical. The DON further stated for a physical altercation, the nurse should complete an incident report, but for a verbal altercation, the nurse would only need to write a NN. When asked if a verbal altercation resulting in a resident being sent to crisis would require an incident report, the DON verified that an incident report should be completed. At that time, the surveyor informed the DON of the missing incident report for Resident #310's resident-to-resident altercation on 2/19/24, and the DON confirmed that an incident report should have been completed. The DON added that it was important to thoroughly investigate resident-to-resident altercations 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. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: dementia, Alzheimer's Disease, major depressive disorder, schizophrenia, nondisplaced intertrochanteric fracture of left femur (left hip fracture), and unspecified fall. A review of the quarterly Minimum Data Set (MDS), an assessment tool used, dated 4/3/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident had one fall. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 3/20/24, that the resident had a left hip fracture related to a fall. Interventions included: anticipate and meet needs, be sure call light is within reach, and modify environment as needed to meet current needs. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the PN included an Alert Note (AN), dated 3/4/24 at 11:06 PM, which revealed the resident had two falls (one witnessed and one unwitnessed) without injuries. Further review of the AN revealed the resident was confused 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 no complaints of pain or discomfort post fall on the following dates: On 3/5/24 at 3:24 PM On 3/5/24 at 7:28 PM On 3/6/24 at 7:11 AM On 3/6/24 at 3:28 PM On 3/6/24 at 9:07 PM On 3/7/24 at 4:40 AM A review of a Nurse Practitioner Progress Note, dated 3/6/24 at 9:30 AM, revealed the resident had two falls recently but had no recall of the falls and remained pleasantly confused. Further review of the PN included a NN, dated 3/19/24 at 2:20 PM (15 days after the falls on 3/4/24), revealed the resident complained of pain in the left leg when moved up or when sitting up in the wheelchair. Further review of the NN revealed an order for an x-ray of the left hip and knee was obtained. A review of a NN, dated 3/20/24 at 2:13 PM, revealed the resident's x-ray results showed a fracture and the resident was sent to the hospital for further evaluation. A review of a NN, dated 3/27/24 at 10:23 PM, included the resident returned from the hospital post left hip surgery. On 11/8/24, the surveyor requested the complete investigation related to Resident #6's injury of unknown origin on 3/19/24. 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 injury of unknown origin which revealed the following: On 3/4/24, the resident was found on the floor next to his/her bed laying on the floor mat. Resident was confused at baseline, however did not complain of any pain. On 3/19/24, the resident informed staff that he/she was having pain in his/her left leg when being moved and sitting in the wheelchair. An x-ray was ordered for the left hip and knee. On 3/20/24, the x-ray came back positive for a left hip fracture and the resident was sent to the hospital. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The FRE did not include an incident report for the injury of unknown origin and the investigation did not include statements from staff for the shifts leading up to the resident's hip fracture on 3/19/24. On 11/12/24, the surveyor requested the incident report for the 3/19/24 injury of unknown origin, however the facility was only able to provide an incident report for the resident's falls on 3/4/24. On 11/12/24 at 11:50 AM, the surveyor interviewed LPN #3 who stated any injuries of unknown origin 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 an injury of unknown origin to find out where it came from and to rule out abuse. On 11/12/24 at 12:03 PM, the surveyor interviewed LPN/UM #1 who stated when there was an injury of unknown origin, 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 an injury of unknown origin to ensure nothing else is going on that is preventable, such as a fall or abuse. On 11/12/24 at 12:50 PM, the surveyor interviewed the DON who stated when there was an injury of unknown origin, 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 DON of the missing incident report and statements for Resident #6's injury of unknown origin on 3/19/24, and the DON confirmed that there should have been an investigation into whether something happened to the resident between the 3/4/24 falls and the fracture on 3/19/24. The DON further stated that statements should be obtained to rule out abuse. 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. NJAC 8:39-4.1(a)(5)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37547 Based on interview, record review, and review of facility documents, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman 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 summary, revealed the resident had diagnoses which included: chronic obstructive pulmonary disease (COPD, a condition that makes it difficult to breathe), acute respiratory failure, and tobacco use. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated 4/4/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 9/26/24, that the resident had COPD related to smoking. Interventions included: monitor for signs/symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath (SOB) at rest, cyanosis (a bluish color of the skin or lips), somnolence (sleepiness/drowsiness). Notify medical doctor of changes. A review of the Progress Notes (PN) included a Nurse's Note (NN), dated 5/6/24 at 5:56 AM, which included that the resident was admitted to the hospital for pneumonia. Further review of the PN included a Social Services (SS) note dated 5/6/24 at 2:57 PM, 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 Director of Social Services (DSS) who stated that she sent out the Bed Hold Notices and the nurses notified the resident's representative of the hospitalization . On 11/8/24 at 12:33 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he was responsible for the notification of the State Long-Term Care Ombudsman and agreed to furnish the notification. On 11/12/24 at 8:42 AM, the LNHA stated that a former employee who worked in medical records was responsible to notify the Ombudsman 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: (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. NJAC 8:39-4.1(a)3

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41260 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 accidents. 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. 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: vascular dementia, muscle wasting and atrophy, and other abnormalities of gait and mobility. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 8/7/24, included the resident had a Brief Interview for Mental Status score of 1 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident had one fall with injury since the prior assessment. A review of the individualized comprehensive care plan (ICCP) included a focus area, dated 4/15/24, that the resident had an actual fall or was at risk for falls related to new and unfamiliar environment, deconditioning and weakness, cognitive impairment, and poor safety awareness. All interventions for that focus area were dated 4/15/24. A review of the Progress Notes (PN) included a Nurses Note (NN), dated 6/11/24 at 2:29 PM, which revealed a nurse witnessed the resident fall while the resident was walking around the nurses' station. Further review of the NN revealed the resident fell on his/her left side, was holding his/her left shoulder, and had a bruise under his/her left eye. The NN further included the Nurse Practitioner was notified and an order for a left shoulder x-ray was obtained. Further review of the ICCP did not include any new interventions related to the resident's fall on 6/11/24. A review of the incident report (IR), dated 6/11/24 at 2:05 PM, revealed Resident #87 was observed agitated at the nurses' station and staff attempted to redirect the resident without success. The IR further revealed a nurse witnessed the resident fall on his/her left side and the immediate action taken was the Nurse Practitioner was notified and an order for a left shoulder x-ray was obtained. The IR did not indicate whether the resident's ICCP was updated to include new interventions related to the fall. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Supervisor Fall Incident Investigation, dated 6/11/24, 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 fell , 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 falls. 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 fell , 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 interviewed the Director of Nursing (DON) who stated that if a resident fell , the interdisciplinary team or nursing staff would update the resident's ICCP as soon as possible to prevent additional falls. At that time, the surveyor informed the DON that Resident #87's ICCP was not updated with new interventions after the resident's fall on 6/11/24, and the DON confirmed that the ICCP should have been revised to include new interventions after the fall. 43308 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: muscle wasting and atrophy, other abnormalities of gait (a person's manner of walking) and mobility and vascular dementia. A review of the admission Minimum Data Set (MDS), an assessment tool, dated 1/24/24, included the resident had a Brief Interview Mental Status score of 3 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident has one (1) fall with injury since admission. A review of the individualized comprehensive care plan (ICCP) included a focus area, dated 1/23/24, that the resident was a high risk for falls related to confusion, gait/balance problems, and unaware of safety needs. All interventions for that focus area were dated 1/23/24. A review of the Progress Notes (PN) included a Nurses Note (NN), dated 1/26/24 at 4:08 PM, which revealed the resident was found on the floor by a Certified Nursing Assistant (CNA). 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 fall on 1/26/24. A review of the incident report (IR), dated 1/26/24 at 4:00 PM, revealed Resident #309 had an unwitnessed fall and was found lying on the floor. The IR did not indicate whether the resident's ICCP was updated to include the new interventions related to the fall. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 11:46 AM, the surveyor interviewed LPN #4 who stated that that the care plan was updated by the Unit Manager (UM). She stated she was unsure if was it was updated after each fall since the UM 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 Director of Nursing (DON) 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 DON wanted the care plan to be updated immediately after each incident. On 11/12/24 at 12:05 PM, the surveyor interviewed the DON in the presence of the Licensed Nursing Home Administrator (LNHA) who stated the nurses, MDS, UM, 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 IDT reviewed the incident and updated the interventions accordingly. The DON confirmed there should be interventions in place after each fall to prevent additional falls. On 11/12/24 at 12:12 PM, the surveyor interviewed the LNHA in the presence of the DON who stated they had issues with the previous DON and the care plans was one of the issues. The LNHA 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 LNHA and DON acknowledged there were no interventions in place for Resident #309 after the 1/26/24 fall and that there should have been interventions put into place after each fall. 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). NJAC 8:39-27.1(a)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 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 emergency services/911 for a resident (Resident #103) who was found unresponsive and was a full-code status (all resuscitation procedures will be provided when a person stops breathing or their heart stops beating) in accordance with the Basic Life Support (BLS) for Healthcare Providers. This deficient practice was identified for 1 of 4 residents (Resident #103) reviewed for a death in the facility. A review of the Progress Notes (PN) and interviews with the licensed nursing staff revealed that on [DATE] at 4:30 AM, the Certified Nursing Assistant (CNA #1) found Resident #103 unresponsive and reported it to the Licensed Practical Nurse (LPN #1) who began performing cardiopulmonary resuscitation (CPR). LPN #1 stopped CPR, did not call 911 and did not notify the Registered Nurse (RN #1) until 5:50 AM (one hour and ten minutes after Resident #103 was found unresponsive). RN #1 did not perform CPR or call 911, and pronounced Resident #103 deceased at 5:55 AM The facility's failure to ensure their emergency response system was activated including calling 911 posed a likelihood that serious injury, harm, impairment, or death could occur to all residents who were a full code. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on [DATE] at 4:30 AM, when Resident #103 was found unresponsive, and the facility failed to call 911. The facility Administration was notified of the IJ on [DATE] at 4:17 PM. The facility submitted an acceptable Removal Plan (RP) on [DATE] at 10:34 AM. The survey team verified the implementation of the RP during the continuation of the on-site survey on [DATE]. 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. On [DATE] at 11:25 AM, the surveyor reviewed the closed medical record of Resident #103. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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; essential hypertension (high blood pressure), hemiplegia (one sided weakness) and hemiparesis (one sided paralysis) following unspecified cerebrovascular disease (affects blood flow and the blood vessels in the brain) affecting left non-dominant side, dysphagia (difficulty swallowing) following unspecified cerebrovascular disease, cognitive communication deficit, and a personal history of nicotine dependence. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [DATE], included the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated a fully intact cognition. A review of Resident #103's Order Summary Report (OSR) revealed a physician's order dated [DATE], which indicated that the resident was a full-code. A review of the New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) dated [DATE], revealed that the resident wanted full treatment which included but was not limited to; a defined trial period of artificial nutrition (a form of nutrition that is given through a tube inserted into a vein, under the skin, or into the stomach or small intestine), attempt resuscitation/CPR, and intubate (insert a tube into the trachea (wind pipe)/use artificial ventilation as needed for ventilation. A review of the individual comprehensive care plan (ICCP) included a focus area dated [DATE], 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 to be a full-code 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 [DATE] 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 (,d+[DATE]) shift, Resident #103 was found sleeping with slight movement. CNA #1 completed rounds at 2:00 AM and turned and repositioned the resident. At that time, the resident was still breathing, and the resident reported no pain or discomfort. Around 4:30 AM, CNA #1 reported something was wrong with the resident, and upon LPN #1 assessing the resident, the resident had no pulse and CPR was initiated until RN #1 was called to assess (the resident). RN #1 pronounced the resident deceased , and the family and doctor were immediately notified. During an interview with the surveyor on [DATE] 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 code blue (a medical emergency, usually cardiac or respiratory arrest), she stated the aide got the nurse and emergency equipment, and the Unit Manager (UM) 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with the surveyor on [DATE] at 10:39 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1) stated that during a code blue, the nurse obtained vital signs (blood pressure, pulse, respirations, and pulse oximetry (oxygen level in the blood detected by placing a probe on the person's finger)), performed an assessment, got the code cart, called 911, and performed CPR 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 CPR and RN #1 should have been assisting LPN #1 with CPR. 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 [DATE] at 11:32 AM, the Director of Nursing (DON) stated that during a code blue, the aide would notify the nurse and the nurse would complete a full assessment. The DON stated the nurse checked the resident's code status, and they went straight to work and added that the nurse called an alert, assessed the resident, and if there was no pulse, 911 was called and CPR was performed until emergency medical services (EMS) came to the facility and took over. The DON 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 DON stated that RN #1 was ultimately responsible for ensuring 911 was called and was disciplined and received education for that on [DATE]. The DON confirmed RN #1 was certified in CPR. On [DATE] at 12:35 PM, the surveyor reviewed an Employee Counseling Record dated [DATE], in RN #1's employee file which revealed that RN #1 failed to follow procedure for the incident on [DATE] at 5:50 AM. The document was signed by RN #1, the DON, and the Licensed Nursing Home Administrator (LNHA). On [DATE] at 8:33 AM, the facility provided the surveyor with copies of Basic Life Support (BLS) Certification (CPR and AED) Program Certificates that were issued to LPN #1 on [DATE], and RN #1 on [DATE]. During a phone interview with the surveyor on [DATE] at 12:41 PM, RN #1 stated that on the morning of [DATE], at around 5:50 AM, he was passing out medications on the 600 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 did not respond when he called the resident's name. RN #1 stated, I tried to sit the resident up and there were no heart sounds, and no pulse and the resident was cold. RN #1 stated that the resident was not breathing, and their chest was not rising. RN #1 stated that he tried unsuccessfully to feel a pulse on the resident's neck, and he put the blood pressure cuff on the resident, and it did not register. RN #1 stated that he pronounced the resident dead and notified the physician. RN #1 stated that the BLS protocol was when someone was unresponsive, you had to start CPR and called 911. RN #1 stated that 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 CPR, and the resident was dead. RN #1 stated, she called me after the fact. RN #1 stated when he went to assess Resident #103, the resident was unresponsive and already dead so I did not call 911. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with the surveyor on [DATE] at 12:54 PM, LPN/UM #1 stated that if the aide informed the nurse that the resident was not breathing, the nurse should have checked the pulse, called a code, called 911, got the crash cart, and AED. When the surveyor asked if an AED was used on Resident #103 during CPR, 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 [DATE] at 1:58 PM, the surveyor asked the DON if LPN #1 used the AED during CPR for Resident #103, the DON responded it was not documented as used. During an interview with the surveyor on [DATE] at 1:05 PM, the surveyor was unable to reach CNA #1, who was assigned to care for Resident #103 on [DATE], during the ,d+[DATE] shift, by phone and instead interviewed CNA #5 who also worked on the 500 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 code, 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. During an interview with the surveyor on [DATE] at 1:13 PM, in the presence of the survey team, the DON stated that she did not do an investigation and did not question the time lapse from when CNA #1 found the resident unresponsive at 4:30 AM and notified LPN #1, to LPN #1 notifying RN #1 at 5:50 AM. The DON stated that she did not focus on the time and just asked RN #1 about CPR and why 911 was not called. The LNHA who was present stated, RN #1 thought that it was an ethical issue to keep CPR going. During an interview with the surveyor on [DATE] at 2:38 PM, the Medical Director stated that when there was a code blue and someone stopped breathing who was a full-code, he expected whoever was in the building to call the nursing supervisor, perform BLS and call 911. Emergency Medical Services (EMS) would arrive to the facility with Advanced Cardiac Life Support (ACLS- protocols beyond BLS, to treat cardiac emergencies such as cardiac arrest with CPR, airway management, and/or the use of an AED). The Medical Director stated that EMS took over the care of the resident and pronounced them if indicated. The Medical Director stated that he was notified of the scenario and clearly, 911 should have been notified. An acceptable Removal Plan (RP) on [DATE] at 10:34 AM, indicated the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the facility's Code Blue/CPR policy was updated to reflect staff are to call 911 during emergency response; LPN #1 and RN #1 will be educated by the DON on the facility's Code Blue/CPR policy prior to working next shift; all licensed nurses will be educated on the facility's Code Blue/CPR policy; and the Staffing Coordinator will ensure at least 50% of all licensed nurses in the building at all times are CPR certified. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on [DATE]. NJAC 8:,d+[DATE].1 (3), 9.6 (g),14.2(b)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41072 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 right shin tear was implemented without a 23-day delay which resulted in the wound worsening with a necrotic (death of cells in your body tissues) wound infection that required a seven-day antibiotic treatment. This deficient practice was identified for 1 of 4 residents (Resident #305) reviewed for pressure ulcer 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; Alzheimer's disease, dementia, heart failure, diabetes mellitus, and muscle weakness. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/10/24, included the resident's cognition was severely impaired; the resident needed minimal assistance with eating, moderate assistance with mouth care; and dependent in all other activities of daily living and mobility. Further review revealed the resident had two (2) unstageable pressure ulcers (full-thickness tissue loss) with wound treatment and received hospice care. A review of the Progress Notes (PN) included a Nurses Note (NN) dated 4/23/24 at 2:18 PM, which revealed that the nurse was notified by the resident's Hospice Nurse that the resident had a new wound on the right shin. The resident was assessed for a stage 2 wound (an open wound that breaks the skin), 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 5/15/24 at 5:16 PM, which revealed a late entry for worsening wounds. The PN included that the resident developed a right shin wound which was now enlarging with necrotic (dead) tissue and malodorous (foul smelling) drainage with surrounding erythema (reddening of the skin). Assessment and plan included that the right shin wound had necrotic and infected tissue; to cleanse the right shin with 1/4 strength Dakin's, apply Medihoney (honey-based ointment), Flagyl (an antibiotic) powder, Abdominal pad (ABD; wound dressing) pad and [gauze] wrap daily. To start doxycycline (an antibiotic) 100 milligrams (mg) by mouth twice a day for seven days. A review of the Order Summary Report (OSR) dated as of 5/1/24, included the following physician orders (PO): A PO dated 4/23/24, to cleanse sacral wound (lower back) with Normal Saline Solution (NSS); apply Medihoney; cover with ABD and paper tape one time a day for sacral wound. This order did not address the right shin wound which was documented on the 4/23/24 Progress Notes. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the April and May 2024 Physician's Order Sheet (POS) and Treatment Administration Record (TAR) did not include any PO for the new right shin skin tear until 5/16/24, which was 23 days after. A review of the OSR dated as of 6/1/24, included the following PO: A PO dated 5/16/24, to clean right shin wound with 1/4 strength Dakin's (a topical antiseptic used to treat and prevent infections in wounds); apply Medihoney, then Flagyl powder; cover with ABD pad and wrap with [gauze] wrap daily one time a day for right shin wound. A PO dated 11/14/23, for weekly skin 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 right shin skin tear identified on 4/23/24. On 11/8/24 at 12:40 PM, the facility was unable to provide the hospice nursing notes but provided the hospice care plans that included the following: A hospice care plan dated 4/22/24, included a stage 3 (a full-thickness tissue loss that extends through the skin into the fatty tissue below, but does not expose bone, tendon, or muscle) on the middle of the right shin to clean with wound spray; apply Medihoney and apply four-by-four (4 x 4) adhesive pad. Wound care to be provided daily; facility to provide care on non-hospice days. A hospice care plan dated as of 6/1/24, included a right shin (stage 3) wound to cleanse with Dakin's 1/4 strength, pat dry; apply Medihoney to wound bed; cover with ABD pad, [gauze] wrap daily and secure with paper tape by facility nurse daily. A review of the Incident Report (IR) for a skin tear to the right shin dated 4/23/24, included that the treatment order was placed in the EMR for wound care and that the care plan was updated. The IR did not include any measurements or description of the right shin skin tear. The IR included the risk management form dated 4/23/24 at 2:23 PM. The risk management form did not include any wound measurements or description of the right shin skin tear. A review of the weekly skin assessment dated [DATE], included that the resident did not have any open areas or marks on the skin but also identified that the resident's right lower leg had a stage 2 skin tear to the right middle shin. The weekly skin assessment did not include the measurements of the skin tear, the color, the odor, or if the skin tear had any drainage. There was no documented evidence of weekly skin assessments completed after 4/23/24, through 5/25/24. A review of the weekly skin assessment dated [DATE], included that a right shin wound had a treatment currently in place. There was no description or measurement of the right shin wound. On 11/12/24 at 10:08 AM, the surveyor interviewed the Director of Nursing (DON), who confirmed that the Licensed Practical Nurse (LPN) who wrote the Progress Note on 4/23/24, and the Nurse Practitioner (NP) who signed the PO on 4/23/24, for the sacral wound treatment were not employed at the facility anymore. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	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 hospice. CNA#2 stated the Hospice Aid came in early to wash, dress and feed the resident, then then she cared for the resident the rest of the shift. CNA#2 could not recall if the resident had any open areas or wounds. On 11/12/24 at 10:37 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM#1), who stated that that if a new skin tear or wound was identified, the nurse completed a risk management form in the EMR; completed an Incident Report; measured the wound; contacted the doctor; and obtained treatment orders. The weekly skin assessments were completed by the medication nurse and included the location, measurements, if there was any drainage or smell, how the skin around the wound appeared and any treatments that were ordered. LPN/UM#1 further stated that when a resident was on hospice, the Hospice Nurse assessed the wounds and gave recommendations for a treatment. The staff nurse obtained a PO for the treatment and completed the wound treatments as ordered. LPN/UM#1 stated that the ICCP should be updated with interventions when a new wound or pressure ulcer was identified. At that time, the surveyor and LPN/UM#1 reviewed the Progress Notes, the PO, the ICCP, and the weekly skin assessments in the EMR. LPN/UM #1 confirmed that she had entered the PO on 4/23/24, in the EMR and it should have been for the right shin skin tear and not the sacral wound. LPN/UM#1 stated that weekly skin assessments should have been completed weekly and should have included location, measurements, and any drainage or foul odor of the wound. LPN/UM#1 confirmed that a treatment order for the right shin skin tear was not on the POS or the TAR until 5/16/24. LPN/UM#1 further stated that on 5/16/24, when the right shin skin tear had worsened, a skin assessment should have been completed. After reviewing the Progress Notes, LPN/UM#1 could not recall if the Hospice Nurse had notified her about the right shin skin tear between April to May 2024. LPN/UM #1 stated that the Hospice Nurse usually visited the resident twice a week. On 11/12/24 at 11:56 PM, the surveyor interviewed Resident #305's Attending Medical Doctor (AMD), who stated that if the nurse identified a new wound or pressure ulcer, they called the AMD, and a wound treatment would be ordered as well as a wound consultation (consult) if needed. The AMD stated that Resident #305 was on hospice so a wound consult would not have been ordered. The surveyor and the AMD reviewed the Progress Notes and POs for Resident #305. The AMD confirmed that the treatment PO on 4/23/24, had been entered wrong and should have been for the right shin skin tear. The AMD reviewed the weekly skin assessments and confirmed that the assessments were not completed weekly and did not include measurements, or identifiable assessments such as drainage or foul order. The AMD stated that it was important to complete wound care as recommended or the wound could get worse or infected. The AMD further stated, I think that when a resident is on hospice, the staff relies too much on the hospice aides and nurses for the resident's care. On 11/12/24 at 1:11 PM, the surveyor interviewed the Director of Nursing (DON), who stated that when a new wound or pressure ulcer was identified, the nurse assessed the wound, completed an Incident Report, called the doctor, obtained new treatment orders, updated the ICCP, and notified the resident's representative. The DON further stated that weekly skin assessments were completed by the medication nurse or unit managers and the weekly skin assessments should include the location, wound measurements, type of wound and details about the wound. The DON stated that it was important to obtain a PO for wound treatment and complete the wound treatment as ordered because it could prevent any deterioration and worsening of the wound. When a resident was on hospice, the Hospice Nurse made wound care recommendations and the staff nurse obtained a PO from the attending physician. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 11/13/24 at 1:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that he was made aware of Resident #305's right shin wound infection by the Hospice Nurse and by the local ombudsman. The LNHA 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 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. NJAC 8:39-27.1(a)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41072 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 carrot hand splints (a type of splint that provides a barrier between the fingers and the palm to prevent injury to the palm from finger contracture) to the both hands, and b.) follow a physician's order for the application of a carrot hand splints to both hands, and c.) document in the Treatment Administration Record (TAR). This deficient practice was identified for 1 of 1 resident (Resident #91) reviewed for positioning and mobility and was evidenced by the following: On 11/6/24 at 10:21 AM, during the initial tour, the surveyor observed Resident #91 awake and alert, lying in bed with bilateral hands bent towards the chest and both hands clenched in a fist position without carrot hand splints in both fists. The surveyor observed two (2) orange carrot shaped hand splints lying on the overbed table. On 11/7/24 at 9:03 AM, the surveyor observed Resident # 91 awake and alert lying in bed, with both hands clenched in a fist position without carrot hand splints in both hands. The surveyor observed 2 orange carrot shaped hand splints lying on the overbed table. Resident # 91 stated that they used the carrots sometimes but just did not want them on at this time. On 11/8/24 at 10:02 AM, the surveyor observed Resident # 91 awake and alert lying in bed, with both hands clenched in a fist position without carrot hand splints in both hands. The surveyor observed 2 orange carrot shaped hand splints 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: spastic quadriplegic cerebral palsy, muscle wasting, and epilepsy. A review of the quarterly Minimum Dats Set (MDS), an assessment tool, dated, 10/10/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident dependent in all activities of daily living and mobility. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 7/13/24, that the resident had contractures and weakness and a decline in functional mobility. Interventions included: bilateral carrot hand splints to hands for contracture management at all times except for routine care and skin checks. A review of Resident # 91's Occupational Therapy (OT) Discharge Summary, dated 8/22/24, revealed recommendations to donn (apply) carrot splints in bilateral (B/L) hands at all times, except during care with skin checks. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Order Summary Report (OSR) included a physician's order (PO), dated 8/22/24, to donn B/L hand carrot splints, at all times, except during care. A review of the August, September, October, and November 2024 Treatment Administration Record (TAR) did not reveal a corresponding PO to donn B/L hand carrot splints, at all times, except during care. A review of Resident #91's Progress Notes (PN) did not reveal any documentation that the B/L hand carrot splints, at all times, except during care were applied as ordered. The PN did not reveal any documentation of the resident's refusal of the hand splints. 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 positioning wedges for repositioning the resident in bed. CNA #4 stated I do not apply the carrot splints; I think therapy does that. I was not taught how to use the carrot hand splints. On 11/9/24 at 10:14 AM, the surveyor interviewed the Registered Nurse (RN#2) who stated that Resident # 91 only uses wedges and pillows for repositioning but does not use any splints for contractures. At that time, the surveyor and RN #2 reviewed the active TAR and RN #2 confirmed there was no PO on the TAR for B/L carrot hand splints. On 11/9/24 at 10:18 AM, the surveyor interviewed the Assistant Director of Rehabilitation (ADoR) and the Director of Rehabilitation (DoR). The ADoR stated that Resident #91 was discharged from OT services on 8/21/24 with recommendations to donn B/L hand carrot splints, at all times, except for hygiene care. The DoR stated that the therapist would enter the therapy recommendations PO into the electronic medical record (EMR). At that time, the surveyor reviewed the PO for the carrot hand splints with the ADoR and the DoR. The DoR confirmed that the PO was entered into the EMR incorrectly, without directions and never transferred to the TAR. The DoR further stated that the importance of the B/L hand splints were for contracture and skin integrity management. On 11/9/24 at 10:18 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #2) who stated that when therapy recommended a positioning or splint device, the therapist would enter the PO into the EMR. LPN/UM #2 confirmed that the PO for the hand splints were entered incorrectly and were not transferred to the MAR or TAR. LPN/UM #2 stated that the importance of the B/L carrots hand splints were to prevent contractures. On 11/9/24 at 10:18 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the therapist entered the PO for splints into the EMR and the nurse would acknowledge the PO. The DON acknowledged that the PO were entered incorrectly in the EMR. The DON further stated that it was important to follow the recommendation for the B/L carrot hand splints and document in the TAR to prevent skin damage and contractures. On 11/12/24 at 3:12 PM, surveyor reviewed the concern with the Licensed Nursing Home Administrator (LNHA). A review of the undated facility's Splints- Clinical policy, included that splints should be in [the EMR] as order under the TAR. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41260 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 resident's fall 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: vascular dementia, muscle wasting and atrophy, and other abnormalities of gait and mobility. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 8/7/24, included the resident had a Brief Interview for Mental Status score of 1 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident had one fall with injury since the prior assessment. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 4/15/24, that the resident had an actual fall or was at risk for falls related to new and unfamiliar environment, deconditioning and weakness, cognitive impairment, and poor safety awareness. Interventions included to be sure that the call bell and personal items were within reach, encourage a clutter free environment, and bed in the lowest position at all times except during care. A review of the Progress Notes (PN) included a Nurses Note (NN), dated 3/22/24 at 3:05 PM, revealed the nurse was notified that Resident #87 fell in the physical therapy gym and was observed lying on the floor face down. Further review of the NN revealed the resident had swelling to his/her right eye and was sent to the hospital for further evaluation. On 11/12/24 at 11:30 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a copy of the fall packet for Resident #87's fall on 3/22/24. The fall packet consisted of a statement from the nurse, a statement from a therapy staff member, and a copy of the NN, dated 3/22/24 at 3:05 PM. The fall packet did not include an incident report with details of the incident, nor did it include an investigation detailing potential causes of the fall, interventions to prevent reoccurrence, or evidence that the fall 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 fell , there was a fall packet the nurse would complete which included completing an incident report. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 fell , there was a fall 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 fall to develop interventions and maintain the safety of the resident. On 11/12/24 at 12:50 PM, the surveyor interviewed the Director of Nursing (DON) who stated that if a resident fell , the nurse should complete an incident report and investigation. At that time, the surveyor informed the DON of the missing incident report and investigation for Resident #87's fall on 3/22/24 and the DON confirmed that an incident report and investigation should have been completed at the time of the fall. 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. NJAC 8:39-27.1 (a)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37547 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 weight loss of five pounds or more for 1 of 5 residents (Resident #304) reviewed for nutritional status and was evidenced by the following: A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: anemia (a lack of healthy, red blood cells), dysphagia (difficulty swallowing) unspecified, major depressive disorder, recurrent without psychotic features, generalized anxiety disorder, muscle wasting and atrophy (to waste away), not elsewhere classified, muscle weakness, and tobacco use. A review of the resident's annual Minimum Data Set (MDS), an assessment tool, dated 7/12/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed the resident was 68 inches tall and weighed 149 pounds and had not experienced a weight (wt) loss of five percent (5%) or more in the last month or loss of 10% or more in the last six months. Further review of the MDS revealed that the resident was ordered a therapeutic diet. A review of the resident's individual comprehensive care plan (ICCP) included a focus area of: I have a nutritional problem or potential nutritional problem. Interventions included: Monitor/record/report to medical doctor as needed signs/symptoms of malnutrition: Emaciation (abnormally thin), Cachexia (weakness and wasting of the body), muscle wasting, significant weight loss: 3 pounds in 1 week, greater than (>)5% in 1 month, >7.5% in 3 months, >10% in 6 months, Provide and serve diet/supplement as ordered. A review the Order Summary Report (OSR), included the following physician orders (PO): A PO, dated 8/28/24, for Carb Consistent Diet Regular texture, thin liquids. A PO dated 8/28/24, for Boost Glucose Control (dietary supplement) one time a day record % consumed, may substitute with facility equivalent. A PO dated 8/28/24 to weigh monthly every day shift every 1 (one) month (s) starting on the 1st for 10 day (s) for weight. Start date 9/1/24. A PO dated 8/28/24 to Obtain resident's weight weekly x 4 (four) post admission every day shift every Wednesday for Baseline for 4 weeks. Obtain resident' weight weekly x 4 post admission beginning 1 week post admission (Start date 9/4/24, End Date 10/2/24). (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Progress Notes (PN) included a Nutrition/Dietary Note dated 4/9/24 at 12:05 PM, which included .Skin intact per nursing. No current labs to review continues on controlled carbohydrate diet (CCD) with boost glucose control supplementation. Intake is variable. Food preferences updated frequently. Observed resident skip lunch at times to not miss his/her smoke break. March weight 163.9# suggesting a 4. 5% gain x 1 (one) month, stable x 3 (three) and 6 (six) months. continue (cont.) to monitor and encourage intake, monitor meds, labs, weights and skin. Follow quarterly and as needed (PRN). Further review of the PN included a Nutrition/Dietary Note dated 7/23/24 at 10:27 AM, which included July monthly weight continues to trigger for weight loss x six (6) months. Currently stable x 1 month cont. to monitor. Discussed with resident, encouraged stable weight. A review of the Weights and Vitals Summary revealed the following: 12/5/23 169. (pounds - lbs) (wheelchair) 1/12/24 166.5 lbs. (wheelchair) 2/8/24 156.9 lbs. (wheelchair) 2/15/24 157.6 lbs. (wheelchair) 3/11/24 163.9 lbs. (wheelchair). There was no reweigh to confirm a 6.3 lb. weight gain. There was no documented weight for April 2024. 5/10/24 153.4 lbs. (standing) 6/12/24 152.9 lbs. (wheelchair) 7/10/24 148.9 lbs. (wheelchair) 8/4/24 151.8 lbs (wheelchair) 8/14/24 156.4 lbs. (wheelchair) 8/21/24 158.6 lbs. (wheelchair) 8/29/24 156.9 lbs. (wheelchair) 8/30/24 163.7 lbs. (wheelchair) 9/9/24 160.5 lbs. (wheelchair) (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/24 at 8:49 AM, the surveyor interviewed the Registered Dietician (RD) who stated that the resident was independent with choosing meals, and ordered out. The RD stated that the resident dropped weight and the rationale for the weight loss was never explained. The RD stated that the resident was ordered supplements and his/weight fluctuated. The RD stated that in December we met and discussed food preferences and the resident only wanted soup and sandwiches due to an upset stomach. The RD stated that the resident was ordered Pepcid (used for Gastrointestinal Reflux Disease, a condition that caused acid reflux). The RD further stated that in January of 2024 the resident weighed 166.5 lbs. Then in February there was a 6 % weight loss in one month, a significant weight loss, and was 156.9 lbs and a re-weight was 156 lbs. The RD stated that the resident was starting to dislike the food. The RD stated that Boost Glucose Control was ordered daily in addition to a selective menu. The RD stated that the residents meal intake was not documented unless the resident was ordered a calorie count. the RD stated that the resident skipped meals to attend smoking breaks. The surveyor asked the RD why in April of 2024 the resident's weight was not recorded under the Weights and Vitals Summary? The surveyor also asked why there was no documented reweigh to confirm a 6.3 lb. weight gain that was recorded when the resident's weight fluctuated from 157.6 lbs. on 2/15/24 to 163.9 lbs. 3/11/24? The RD stated that she did not know why it was not done. The RD stated that the recorded weight loss from 163.9 lbs. on 3/11/24 to 153.4 lbs. on 5/10/24 was not considered significant because there was no recorded weight in April to trend x one month, so I trended x three months which was considered stable. The RD stated that no changes were made. The RD stated that nothing needed to be done. The resident was not actively losing significant weight. The RD stated that there was no special accommodation made for smoking. The RD stated that the resident was told to have their meal and then go out and smoke. On 11/8/24 at 10:29 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #3 who stated that resident smoking breaks were scheduled after meals. CNA #3 stated that she documented the amount of food consumed 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 accommodate smoke times as the smoke breaks were usually scheduled after meals. LPN/UM #1 stated that in April our scale may have had a missing battery because weights were not usually missed. On 11/8/24 at 11:56 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she noticed when she started working here in July that there were complaints of the scales not working and the weights were not obtained at one point. On 11/12/24 at 1:45 PM, the surveyor interviewed the DON who stated that the nurse, unit manager and the dietician were responsible to ensure that monthly weights 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. NJAC 8:3927.2(a)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41260 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 dialysis times, and b.) obtain a physician's order to monitor dialysis fistula sites (surgical connection between an artery and vein) for bruit and thrill (sound and vibration which indicates good blood flow in a dialysis fistula). This deficient practice was identified for 2 of 2 residents (Resident #9 and #306) reviewed for dialysis 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: end stage renal (kidney) disease and dependence on renal dialysis. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 9/28/24, included the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident received dialysis while a resident at the facility. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 8/6/24, that the resident needed dialysis related to renal failure and that the resident went to dialysis on Mondays, Wednesdays, and Fridays with a chair time (appointment time) of 5:10 AM. Interventions included: Monitor/document/report to the physician as needed of any signs/symptoms of infection to the dialysis access site, such as redness, swelling, warmth, or drainage. The ICCP did not include any interventions to schedule medications around the resident's scheduled dialysis times, or to monitor the resident's dialysis fistula site for bruit and thrill. A review of the Order Summary Report (OSR), dated as of 11/12/24, included the following physician orders (PO): A PO, dated 12/30/23, for hemodialysis on Mondays, Wednesdays, and Fridays with a chair time of 5:10 AM and a pickup time of 4:50 AM. A PO, dated 12/30/23, to monitor the left arm fistula for signs and symptoms of infection or bleeding every shift. A review of the November 2024 Medication Administration Record (MAR) included the following PO: A PO, dated 12/30/23, for Protonix delayed release 40 mg (milligrams) one tablet by mouth in the morning for GERD (reflux) which was scheduled to be administered at 6:00 AM. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PO, dated 12/30/23, for Hydralazine 100 mg one tablet by mouth every eight hours for hypertension (high blood pressure) which was scheduled to be administered at 6:00 AM. A PO, dated 5/20/24, for Clonidine 0.3 mg one tablet by mouth every eight hours for hypertension which was scheduled to be administered at 6:00 AM. A review of the November 2024 Treatment Administration Record (TAR) did not include a PO to monitor the resident's dialysis fistula site for bruit and thrill. A review of the Pharmacy Consultant's Comments Report for the previous six months revealed a recommendation, dated 5/24/24, to please be sure that medication times are changed to accommodate resident's dialysis times. On 11/12/24 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 who stated dialysis residents received their medications before they left for dialysis and that if a medication was scheduled to be administered during dialysis, the nurse should notify the physician to see if the medication administration time could be adjusted to accommodate the resident's dialysis 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 dialysis fistula site for bruit and thrill to ensure the fistula site was working. LPN #3 reviewed Resident #9's PO and confirmed that the resident did not have an order for the nurse to monitor the resident's fistula site for bruit and thrill. On 11/12/24 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated dialysis residents' medication administration times were scheduled around their dialysis times to prevent missed doses, and that if there was a conflict in medication time and dialysis 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 dialysis center. At that time, LPN/UM #1 further stated that there should be a PO for the nurse to monitor a resident's dialysis fistula site for bruit and thrill to ensure the site was patent. 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 fistula site for bruit and thrill. On 11/12/24 at 12:50 PM, the surveyor interviewed the Director of Nursing (DON) who stated dialysis residents' medication administration times should be scheduled either before or after their dialysis times to prevent missed medication doses. The DON further stated that there should be a PO for nurses to monitor residents' dialysis fistula sites for bruit and thrill to ensure there were no complications with the site. At that time, the surveyor informed the DON of Resident #9's medication administration times that were scheduled during the resident's dialysis times, and that Resident #9 did not have a PO to monitor for bruit and thrill. The DON stated the nurse should have contacted the physician to reschedule the medication administration times, and there should have been a PO to monitor the fistula site for bruit and thrill. 37547 (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: acute osteomyelitis (bone infection), right ankle and foot, anemia (a low number of red blood cells) in chronic kidney disease, dependence on renal dialysis (a procedure to remove waste products and excess fluid when the kidneys stop working properly). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated 5/27/24, included that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed the resident received dialysis while a resident at the facility. A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 5/24/24, which indicated that the resident had a nutritional problem related to presents for right ankle wound; prior medical history diabetes mellitus (DM), end stage renal (kidney) disease (ESRD) on hemodialysis (HD - a method of dialysis treatment), hypertension (HTN- high blood pressure). Interventions included: provide early/late trays as needed on dialysis days Tuesday, Thursday, Saturday), monitor weights as ordered and monitor before and after (pre/post) HD weights. A review of the Order Summary Report (OSR), dated 5/23/24, revealed there was no PO for the resident to attend HD, and there was no order to monitor the resident's dialysis fistula site for function both prior to and after dialysis treatments. Further review of the OSR revealed an order dated 5/23/24 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 Medical Doctor/Doctor of Osteopathic Medicine (MD/DO) Admission/Readmission Note dated 5/24/24 at 6:35 PM, Addendum: ESRD on hemodialysis with Hyperkalemia (elevated potassium level) HD via right arm arteriovenous fistula (AVF). Further review of the PN included a Nurse's Note (NN), dated 5/29/24 at 9:12 PM, which included that the resident was leaving for dialysis tomorrow morning and requested to have hot cereal and coffee 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 dialysis treatments. On 11/8/24 at 9:17 AM, the surveyor interviewed the Registered Dietician (RD) who stated that the resident went to dialysis on Tuesday, Thursday and Saturday and received an early breakfast tray. The RD stated that the residents were weighed weekly for the first month x 4 and then monthly. The RD stated that dialysis obtained a pre and post dialysis treatment weight on dialysis days. The RD stated that there was a sheet that the nurses filled out that were maintained in the resident's closed record. The RD further stated that the resident weighed 111 pounds and she had no concerns because she communicated with dialysis. A review of the resident's Treatment Administration Record (TAR) revealed that the resident was weighed on 5/23/24 and weighed 111 pounds. There were no other documented weights within the resident's electronic health record. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 dialysis on Tuesday, Thursday and Saturday 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 dialysis. 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 dialysis center via a Communication Sheet that required the resident's vital signs (blood pressure, pulse, heart rate, respirations, and pulse oximetry rate (measured the amount of oxygen in the blood via a probe placed on the finger), 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 Director of Nursing (DON) who stated that the 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 DON who stated that she phoned the dialysis center and confirmed that the resident's pick up time was likely 8:15 AM and his/her dialysis time was at 9:45 AM. The DON stated that there should have been an order for the resident to go to the dialysis center with the time and location included, an order to check the resident's dialysis fistula site for bruit and thrill, an order for the resident's weights and vital signs. The DON stated that the orders were not in the resident's medical chart. The DON stated that without orders, you can not assess the resident's fistula for complications. The DON stated that if ordered, the orders would have been reflected upon the resident's TAR. The Licensed Nursing Home Administrator (LNHA) was present at that time. On 11/13/24 at 8:52 AM, the DON provided the surveyor with copies of the Dialysis Communication Forms that she reportedly obtained from the dialysis center via fax that were dated 5/25/24, 5/28/24, 5/30/24, and 6/1/24. The DON confirmed that the Dialysis 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 the resident had for dialysis treatment and any medications that were administered prior to his/her dialysis appointments on any of the forms in the space provided. A review of the facility's Medication 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 . (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43308 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: 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 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-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 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 (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41072 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) psychotropic 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, awake and alert, lying in bed with a family member at the bedside. The resident's spouse stated that the resident has been depressed and had started on Zoloft (anti-depressant) medications and has been getting seen by psychiatry doctor. On 11/7/24 at 8:50 AM, the surveyor observed Resident # 39 lying in bed awake and alert with their breakfast tray on the over bed table. No behaviors observed at that time. On 11/7/24 at 11:58 AM, the surveyor reviewed 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: dementia, cerebral infarct (a stroke), generalized anxiety disorder, and major depressive disorder. A review of Resident #39's quarterly Minimum Data Set (MDS), dated [DATE], included the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated the resident's cognition was moderately impaired. The MDS further revealed that the resident was on an anti-anxiety medication and refused to respond to the mood interview. A review of the resident's individual comprehensive care plan (ICCP), included a focus area, dated 3/25/24, of I have anxiety. Interventions included: Administer medications as ordered. Monitor/document for side effects and effectiveness. The surveyor reviewed the residents November active physician's orders (PO) which reflected that Resident # 39 was on the following psychoactive medication: A PO, dated 9/9/24, for Ativan Oral tablet 1 milligram (mg) (Lorazepam) give 1 mg by mouth every 8 hours as needed for anxiety, hold/monitor for lethargy. NO STOP DATE. A review of the September, October, and November 2024 Medication Administration Record (MAR) did not reveal a stop date for the Ativan PO. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Psychiatry Note, dated 9/9/24, revealed that resident continued with mood swings, agitation, irritability, anxiety, and restlessness. Both the resident and the wife agreed to prn (as needed) Ativan be restarted for the time being. The psychiatric Advance Practice Nurse (APN) recommended to start Ativan 1 mg every 8 hours prn (as needed, anxiety x 14 days (hold/monitor for lethargy). A review of the Consultant Pharmacy (CP) recommendations, dated 9/16/24 and 10/25/24, revealed the CP recommended that duration must be specified for PRN psychoactive medications. First order limited to only 14 days, but if rationale documented by prescriber to continue order, then next duration may be longer, i.e. 30, 60, or 90 days. Please update order for Ativan 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 Ativan should have a 14 day stop date. The surveyor and LPN/UM #2 reviewed the CP recommendations and LPN/UM #2 stated that she had called the attending doctor who stated that the Ativan 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 Ativan needed a 14 day stop date but was unaware that after the 14 days, the Ativan needed a rationale and a duration date. On 11/13/24 at 12:21 PM, the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA), stated that the Ativan should have had a 14 day stop date and 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)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Complaint #NJ174562 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure palatable temperature of food for 1 of 1 lunch meal served on 1 of 2 units ([NAME] 600). 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 [NAME] 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 [NAME] 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 Assistant Dining Director (ADD) as she left the kitchen with Food Cart #1 and delivered it to the [NAME] 600 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 ADD 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 ADD stated that all food temperatures should have been above 140 F. On 11/12/24 at 11:57 AM, the ADD obtained food 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 ADD who stated that we could have done better on the timing of the meal distribution. The ADD 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 ADD 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 Licensed Nursing Home Administrator (LNHA) 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 . (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-17.4(a)(2)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 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 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 Assistant Dining Director (ADD) who stated that there was a snack book on the nursing units with a list of all residents who received snacks. The ADD 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 [NAME] 6, Cart 5 dinner meal was delivered to the unit at 5:42 PM and on 11/12/24 the [NAME] 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 [NAME] 600 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. On 11/12/24 at 12:43 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) #6 during an inspection of the [NAME] 500 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 2:51 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) 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 LNHA stated that the supervisor went around and offered snacks. The LNHA further stated that snacks should be available in the pantry with a bare minimum of cookies, crackers and cereals. The surveyor then informed the LNHA that there were no cookies, crackers or cereals observed during the inspection of the [NAME] 600 Pantry. NJAC 8:39-17.2(f)(1)(i-ii)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 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 [DATE] from 9:46 AM to 10:50 AM, the surveyor observed the following in the kitchen in the presence of the Dining Director (DD): 1. The DD demonstrated use of the high temperature dish machine. The DD 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 Temperature Log and PPM (Parts per Million) Log (LTDMTL/PPM) revealed that the dish machine log was not filled in on [DATE] prior to the dinner meal and on [DATE] 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 DD stated that the Dietary Manager (DM) 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 ,d+[DATE] PPM. The values filled in on the form for the breakfast, lunch, and dinner meals on [DATE] through [DATE], with the exception of the dinner meal on [DATE], indicated that the wash temperature was 165 at all meals, and the PPM was 180. At that time, The Food Service Manager (FSM) 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 DD told the FSM to run a second tray through the dish machine and the gauges did not move. The DM was present and stated that the gauges were working last night. The surveyor asked why he 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 DM 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DD 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 [DATE]. The DD stated that he did not know that there was an expiration date on the test strips. The DD then proceeded to hand the surveyor a second container of test strips which had expired in November of 2023. The surveyor noted that the PPM that were completed on the form all indicated a value of 180, which did not coincide with the expected values of (,d+[DATE]) on the log. The DM then stated that Monday, [DATE], 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 DM stated that the value recorded in the space provided for PPM, referred to the temperature gauge that was on the booster beneath the dish machine. The DD stated that he could not say that everything that was washed in the dish machine was sanitized. He further stated, The dish machine is out of service. The DD 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 DD 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 DD stated that wet nesting was identified. The DD 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 DD 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 DD stated that they must have collapsed. The DD confirmed that wet nesting was present. 4. In the galley of the kitchen, the surveyor observed an oven that was heavily soiled with debris. The DD stated that the oven was not in use. The DD 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 DD stated that the grease trap was cleaned daily. When the DD 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 DD stated that they cooked 300 hash browns today. The DD stated that they cleaned the deep fryer every three days. At that time, the surveyor asked to see the cleaning schedule. The DD stated, I have no cleaning schedule. He further stated, We communicate with each other. 7. The ice machine had a service date of [DATE]. The DD stated that the ice machine was serviced quarterly and should have been serviced in August. The DD 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 DD stated that it was cleaned nightly, but was hard to clean. The DD stated that it depended who was working and who cleaned up. The DD further stated, Some cooks are [NAME] 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 DD stated that he cleaned it last on [DATE]. The DD stated that it should have been cleaned monthly. There was food cooking in the oven at the time. The DD stated that management should have ensured that it was cleaned. The DD stated that he thought that it was burned on food, which does not contaminate the food that was cooked in the oven. The DD 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 DD 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 DD 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 DD stated that the eggs were kept for one week after opening. The DD stated that the container should have been dated when opened. 14. In the dry storage area, a six pound container of peaches was dented in the can rack. The DD 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 [DATE]. The DD stated that it should have been removed when we had a milk delivery yesterday. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the surveyor on [DATE] at 12:39 PM, the Licensed Practical Nurse/Infection Preventionist (LPN/IP) stated that the DM should have informed us that the dish machine gauges were broken and addressed it immediately. The LPN/IP stated that it was an issue if the dishware were not properly cleaned. The LPN/IP stated, How would you track chemical sanitizer level if it were not on the form? The LPN/IP stated the temperature log should not have been filled in if the gauges were not working. The LPN/IP stated, It is a big issue because it throws everything off. The LPN/IP stated that if the chemical sanitizer strips were expired, they were not accurate, or not up to date. The LPN/IP stated that the dish machine must be fixed. On [DATE] at 9:04 AM, the surveeyor interviewed the Licensed Nursing Home Administrator (LNHA) 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 LNHA stated that the facility would continue to serve meals on paper products until the repair was completed. On [DATE] at 8:33 AM, during a follow-up interview the LNHA stated that the facility continued to serve meals on paper products due to the dish machine being out of service. The LNHA stated that he expected the thermometer probe to be installed today. On [DATE] 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 Assistant Dining Director (ADD): 1. During the tray line observation, the [NAME] doffed his gloves after he obtained food temperatures. The [NAME] 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 ADD was observed in the galley of the kitchen with long strands of hair protruding from her hair net bilaterally. The ADD then proceeded to assist with the tray line. 3. A Dietary Aide (DA) was observed with a hairnet that covered only the back of her that was pulled up on top of her head. the DA wore a head band to cover the middle section of her head. The front of portion of the DA's 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 DA stated that her hair net probably slipped up. The ADD was present and stated, Is mine out too? The ADD then proceeded to push the long strands of hair (bangs) back into her hair net bilaterally. During a later interview with the surveyor on [DATE] at 12:06 PM, the ADD 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 ADD stated that when the [NAME] 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 ADD stated that hand hygiene should be performed properly so that nothing gets in the food and for both your protection and the residents. The ADD stated that the [NAME] should have waited for the other person to finish at the hand washing sink before he washed his hands. The ADD further stated, that he should have washed his hands for ,d+[DATE] seconds. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] from 12:32 PM to 12:37 PM, the surveyor observed the [NAME] 600 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 bottom of the wall mount. LPN/UM #2 looked inside the wall mount and stated that the ice scoop was contaminated. On [DATE] from 12:43 PM to 12:48 PM, the surveyor observed the [NAME] 500 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 [DATE] at 1:32 PM, the surveyor interviewed the ADD who stated that the kitchen management was responsible for the nourishment rooms. The ADD 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 ADD 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 ADD stated that if the item was not labeled and dated, then it had to go into the trash. The ADD further stated that the refrigerator should be cleaned every two to three days. The ADD further stated that there should have been a maintenance log on the outside of the ice machines. The ADD further stated that they must have gotten wet. The ADD stated that the facility maintained the outside of the ice machine and a company maintained the inside. The ADD was unsure of the frequency that the inside of the ice machine was cleaned. On [DATE] at 1:55 PM, the surrveyor interviewed the LNHA who stated that he performed walking rounds in the kitchen the Friday ([DATE]), prior to survey and had concerns with the facility's cleaning schedule. In a later interview with the LNHA in the presence of the survey team on [DATE] at 4:15 PM, the LNHA stated that the dish machine repair was delayed due to receipt of the wrong part and was scheduled for repair tomorrow. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. FSD (Food Service Director) 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 [DATE], 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 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 [DATE], 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 [DATE], 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 [DATE], included: Ice machine will be cleaned monthly following the manufacturers instructions for cleaning, 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 [DATE], included: The staff will properly sweep and mop the floor to ensure cleanliness . (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's Hairnets policy revised [DATE], 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 [DATE], 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:,d+[DATE].2(G), 19.4

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43308 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) 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: 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 [DATE] at 9:55 AM, the LNHA stated that he was the LNHA from [DATE] to [DATE] and returned back to the facility in October of 2023 and the Director of Nursing (DON) started at the facility in July of 2024. 1.) On [DATE] at 11:25 AM, the surveyor reviewed the closed medical record of Resident #103. A review of the Progress Notes (PN) and interviews with the licensed nursing staff revealed that on [DATE] at 4:30 AM, the Certified Nursing Assistant (CNA #1) found Resident #103 who was a full code (all resuscitation procedures will be provided when a person stops breathing or their heart stops beating in accordance with the Basic Life Support (BLS) for Healthcare Providers) unresponsive and reported it to the Licensed Practical Nurse (LPN #1) who began performing cardiopulmonary resuscitation (CPR). LPN #1 did not call 911 and did not notify the Registered Nurse (RN #1) until 5:50 AM of the resident's code. RN #1 did not perform CPR or call 911 and pronounced Resident #103 deceased at 5:55 AM. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1:13 PM, the surveyor interviewed the DON who stated that she did not do an investigation and did not question the time lapse from then CNA #1 found the resident unresponsive at 4:30 AM and notified LPN #1, to LPN #1 notifying RN #1 at 5:50 AM. The DON stated that she did not focus on the time and just asked RN #1 about CPR and why 911 was not called. The DON stated that she was just screaming and angry. The LNHA who was present stated that, RN #1 thought that it was an ethical issue to keep CPR going. On [DATE] at 2:38 PM, the surveyor interviewed the Medical Director (MD) who stated that when there was a code blue and someone stopped breathing who was a full code, he would expect whoever was in the building to call the nursing supervisor, do Basic Life Support (BLS) and call 911. EMS came to the facility with Advanced Cardiac Life Support (ACLS- protocols beyond BLS, to treat cardiac emergencies such as cardiac arrest with CPR, airway management, and/or the use of an AED). The Medical Director stated that EMS took over the care of the resident and pronounce them if indicated. The Medical Director stated that he was notified of the scenario and clearly, 911 should have been notified. 2.) A review of the April and [DATE] Physician's Order Sheet (POS) and Treatment Administration Record (TAR) did not include any physician's order (PO) for the new right shin skin tear until [DATE]. The PO was started 23 days after the initial treatment was ordered on [DATE]. On [DATE] 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 weekly skin assessments in the electronic medical record (EMR). LPN/UM #1 confirmed that she had entered the [DATE] PO in the EMR and it should have been for the right shin skin tear and not the sacral wound. LPN /UM#1 confirmed that a treatment order for the right shin skin tear was not on the POS or the TAR until [DATE]. LPN/UM#1 further stated that on [DATE], when the right shin skin tear had worsened, a skin assessment should have been completed. After reviewing the Progress Notes, LPN/UM#1 could not recall if the Hospice Nurse had notified her about the right shin skin tear between April to [DATE]. On [DATE] at 1:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he was made aware of Resident # 305's right shin wound infection by the Hospice Nurse and by the local ombudsman. The LNHA stated he could not remember the exact date, but it was when the resident was still in the facility. 3.) On [DATE] 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 bilateral (B/L) hand carrot splints, at all times, except during care were applied as ordered. The Progress Notes did not reveal any documentation of the resident's refusal of the hand splints. On [DATE] at 10:18 AM, the surveyor interviewed the Director of Nursing (DON) 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 DON acknowledged that the PO were entered incorrectly in the EMR. The DON further stated that it was important to follow the recommendation for the B/L carrot hand splints and document in the Treatment Administration Record (TAR) to prevent skin damage and contractures. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 3:12 PM, surveyor reviewed the concern with the Licensed Nursing Home Administrator (LNHA). 4.) On [DATE] at 10:30 AM, the surveyor reviewed the medical record for Resident #9. A review of the individual comprehensive care plan (ICCP) included a focus area, dated [DATE], that the resident needed dialysis related to renal failure and that the resident went to dialysis on Mondays, Wednesdays, and Fridays with a chair time (appointment time) of 5:10 AM. Interventions included: Monitor/document/report to the physician as needed of any signs/symptoms of infection to the dialysis access site, such as redness, swelling, warmth, or drainage. The ICCP did not include any interventions to schedule medications around the resident's scheduled dialysis times, or to monitor the resident's dialysis fistula site for bruit and thrill. A review of the [DATE] Treatment Administration Record (TAR) did not include a PO to monitor the resident's dialysis fistula site for bruit and thrill. A review of the Pharmacy Consultant's Comments Report for the previous six months revealed a recommendation, dated [DATE], to please be sure that medication times are changed to accommodate resident's dialysis times. On [DATE] at 12:50 PM, the surveyor interviewed the Director of Nursing (DON) who stated dialysis residents' medication administration times should be scheduled either before or after their dialysis times to prevent missed medication doses. The DON further stated that there should be a PO for nurses to monitor residents' dialysis fistula sites for bruit and thrill to ensure there were no complications with the site. At that time, the surveyor informed the DON of Resident #9's medication administration times that were scheduled during the resident's dialysis times, and that Resident #9 did not have a PO to monitor for bruit and thrill. The DON stated the nurse should have contacted the physician to reschedule the medication administration times, and there should have been a PO to monitor the fistula site for bruit and thrill. 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 [DATE] to [DATE], 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 [DATE] to [DATE], 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 [DATE] 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. 6.) On [DATE] 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:42 AM, the surveyor observed the Assistant Dining Director (ADD) as she left the kitchen with Food Cart #1 and delivered it to the [NAME] 600 Unit where the nursing staff awaited meal delivery. On [DATE] at 12:03 PM, the surveyor interviewed the ADD who stated that we could have done better on the timing of the meal distribution. The ADD 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 ADD further stated, We handled it if the residents stated that the food was not warm enough. On [DATE] at 2:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the facility had complaints of cold food and addressed it with the residents. 7.) On [DATE] 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. On [DATE] at 2:51 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) 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 LNHA stated that the supervisor went around and offered snacks. The LNHA further stated that snacks should be available in the pantry with a bare minimum of cookies, crackers and cereals. The surveyor then informed the LNHA that there were no cookies, crackers or cereals observed during the inspection of the [NAME] 600 Pantry. 8.) On [DATE] from 9:46 AM to 10:50 AM, the surveyor, accompanied by the Dining Director (DD) 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 [DATE] at 9:04 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) 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 LNHA stated that the facility would continue to serve meals on paper products until the repair was completed. On [DATE] at 8:33 AM, during a follow-up interview the LNHA stated that the facility continued to serve meals on paper products due to the dish machine being out of service. The LNHA stated that he expected the thermometer probe to be installed today. On [DATE] at 1:55 PM, the surveyor interviewed the LNHA who stated that he performed walking rounds in the kitchen the Friday ([DATE]) prior to survey and had concerns with the facility's cleaning schedule. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1:44 PM, the surveyor interviewed the LNHA in the presence of the DON 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 LNHA 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 [DATE] at 1:56 PM, the LNHA acknowledged the concerns that were brought to his attention in the presence of the DON and the survey team. NJAC 8:,d+[DATE].2(a); 9.3(a); 27.1(a)