STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 434 and NJ 637 Based on observation, interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to follow professional clinical nursing standards with respect to a.) following physician orders [REDACTED].) implementing Speech Therapy diet recommendations. These deficient practices were noted for 2 of 8 residents reviewed (Resident #1 and #4) and was evidenced by the following: Reference: New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist: Reference New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; The practice of nursing as a licensed practical nurse is defined as performing task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1.) a.) According to Resident #1's Admission Record, the resident was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), an assessment tool dated 2/20/2020, indicated that Resident #1 had cognitive impairment and exhibited both physical and verbal behaviors directed toward others. It also indicated that Resident #1 required total assistance with bathing and transfers, required extensive assistance with toilet use and personal hygiene and was always incontinent of bladder and bowel. The MDS indicated that the resident was at risk for pressure ulcers, but did not have any during this MDS assessment period. The MDS also indicated that the resident received daily insulin injections for DM. The Braden Scale for Predicting Pressure Sore Risk, an assessment too used to determine a resident's risk for development of pressure sores, reflected a score of 12 which indicated that Resident #1 was at high risk for developing a pressure ulcers. According to the Nursing Progress Notes (NPN) dated 3/11/2020 at 07:30 am, the Licensed Practical Nurse (LPN #1) documented that she checked Resident #1's blood sugar (normal blood sugar = 80-130) and was low at 35. LPN #1 also documented that the she attempted to administer glucose gel, a concentrated form of sugar, two times and that the resident spit out the medication. The LPN then attempted to administer the glucose gel for the third time and was only partially successful. There was no documentation in the NPN that the nurse re-checked Resident #1's blood sugar after administration of the glucose gel, however subsequent documentation on 3/11/2020 at 10:09 pm reflected that the resident had a blood sugar of 105 and consumed 75% of dinner. The Physician order [REDACTED]. The nurse was then to recheck the blood sugar in 20 minutes and if the blood sugar is still less than 60 and the resident is symptomatic repeat Glucose gel and notify the physician. The surveyor reviewed Resident #1's Medication Administration Record (MAR) dated 3/11/2020 at 07:30 am, which reflected the aforementioned Glucose gel order. There was no documentation on the MAR for 3/11/2020 at 7:30 am that LPN #1 administered glucose gel as ordered by the physician for blood sugar less that 60. On 8/5/2020 at 3:25 pm, the surveyor interviewed the Director of Nursing (DON) who stated that LPN #1 should have documented on the MAR that Resident #1 was administered oral Glucose gel for a blood sugar of 35. The LPN then should have rechecked the resident's sugar and called the medical doctor (MD). On 8/7/2020 at 1:45 pm, the surveyor interviewed LPN #1 who admitted that she did not document on the MAR that she administered Glucose Gel on 3/11/2020 at 7:30 am to Resident #1 for a blood sugar of 35 because there was a lot of commotion going on at the time when she administered the medication to the resident and that the resident was reassigned to another nurse. On 8/7/2020 at 3:00 pm, the surveyor interviewed the Registered Nurse Unit Manager (RN UM) who stated that the expectations of all nurses were to follow physician orders [REDACTED]. The RN UM stated that she could not recall this event dated 3/11/2020 at 7:30 am. According to the NPN dated 3/12/2020 at 08:17 AM, Registered Nurse (RN#1) documented in the NPN that a nurse went to check Resident #1's blood sugar and noted that Resident #1 was not responding to verbal stimuli. The resident was pale and had a fingerstick blood sugar of 50. 911 was notified and the resident left the facility to hospital at 8:15 am. According to the Medication Administration Record (MAR) dated 3/12/2020 at 07:30 am, there was no documentation that Resident #1 had a blood sugar of 50. The code on the MAR reflected the number 6 which on the code ledger indicated that the resident went to the hospital. According to the POSR dated 2/18/2020, [MEDICATION NAME] HCL 1 mg was to be injected intramuscularly (IM) as needed for [DIAGNOSES REDACTED] if the resident's blood sugar was less than 60 and the resident was unresponsive and unable to take anything by mouth. Then the nurse was to recheck the blood sugar in 20 minutes. If the blood sugar remains less than 60 and was unresponsive, repeat [MEDICATION NAME] 1mg and notify the physician. There was no documentation in the NPN or MAR that reflected that the Registered Nurse (RN #1) administered [MEDICATION NAME] 1 mg IM to Resident #1 who was unresponsive with a low blood sugar of 50 as ordered by the physician. On 8/5/2020 at 2:30 PM, the surveyor interviewed the Registered Nurse Unit Manager (RNUM) who stated that she could not recall when Resident #1 was sent out to the hospital on [DATE] for unresponsiveness, low blood sugar of 50. She revealed that when a resident's blood sugar was low, the nurse should follow physician orders [REDACTED]. She also stated that the nurse should then recheck the blood sugar and call the physician. On 8/5/2020 at 3:25 pm, the surveyor interviewed the DON who stated that based on the NPN dated 3/12/2020 at 08:17 am, the nurse should have administered [MEDICATION NAME] 1mg IM that was ordered by the physician when she found the resident unresponsive with a blood sugar of 50, rechecked the blood sugar and called the MD. On 8/7/2020 at 10:30 AM, the surveyor interviewed RN #1 who stated that on 3/12/2020 at 08:17 am, she documented that a nurse reported to her that Resident #1 was unresponsive and had a blood sugar of 50. She added that she assessed Resident #1 at that time, but did not administer [MEDICATION NAME] 1mg IM. She stated that the LPN assigned to Resident #1 on 3/12/2020 at 08:17 am, should have administered the [MEDICATION NAME] IM as ordered for a blood sugar of 50 and should have documented as such. The LPN that was scheduled on 3/12/2020 at 08:17 am was not available for interview. The surveyor reviewed the Medical Doctor Progress Note (MD PN) dated 3/17/2020 at 6:17 pm, which indicated that Resident #1 was admitted to the hospital on [DATE] to 3/16/2020 for pneumonia, [DIAGNOSES REDACTED] and new onset [MEDICAL CONDITION] Fibrillation. The MD PN also included that Resident #1 was treated in the hospital with an [MEDICATION NAME] of [MEDICATION NAME] 50% (D50) for [DIAGNOSES REDACTED] and Intravenous (IV) antibiotics for pneumonia. Resident #1's Care Plan dated 7/24/2019, indicated that Resident #1 was at risk for complications associated with [DIAGNOSES REDACTED]. -Monitor/document /report to MD sign and symptoms of [DIAGNOSES REDACTED]. The facility policy titled, Medication Administration Guidelines Policy 6.1 and dated November 2010, indicated that the nurse will sign medication administration by initialing on the MAR in the appropriate space allotted immediately following medication administration for each resident. b.) Resident #1's Clinical Physician order [REDACTED]. According to Resident #1's Treatment Administration Record (TAR) there was a physician's orders [REDACTED]. There were nursing signatures on the TAR to indicate that the skin assessments were completed, however there were no documented skin assessment forms completed in the Electronic Medical Record (EMR) from 3/27/2019 to 3/18/2020. On 8/5/2020 at 11:30 am, the surveyor interviewed the Minimum Data Set Coordinator (MDSC) who

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

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

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) stated that the facility process was to complete skin assessments in the assessment section of the EMR weekly for all residents. On 8/5/2020 at 1:00 pm, the surveyor interviewed a Certified Nursing Assistant (CNA) who stated that residents in the facility are required to have skin assessments once a week on the days that they are scheduled to receive a shower or bath. She added that Resident #1 had no skin issues that she remembered. On 8/5/2020 at 1:05 pm, the surveyor interviewed RN #2 who stated that she did not remember if Resident #1 had any skin issues but did explain to the surveyor that skin assessments were done weekly and signed out in the TAR after completed. The nurse then completes the actual form in the assessment section of the patient's EMR. On 8/5/2020 at 1:30 pm, the surveyor interviewed RN #3 who stated that according to Resident #1's assessment section of the EMR there were no skin assessments done for Resident #1 from 3/27/2019 to 3/18/2020. She indicated that the facility policy indicated that skin assessments were to be completed weekly but could not find any for Resident #1 in the EMR. On 8/5/2020 at 2:30 pm, the surveyor interviewed the RN UM who stated that skin assessments were done weekly and that she does not know why Resident #1 had no skin assessments recorded in the EMR. On 8/5/2020 at 3:25 pm, the surveyor interviewed the Director of Nursing (DON) who stated that nurses were expected to do weekly skin assessment according to the facility policy and that the nurses were to document on the TAR that the skin assessment was completed and then go into the assessment section of the EMR to fill out the skin assessment form. The DON admitted that there were no skin assessments completed for Resident #1 from 3/27/2019 to 3/18/2020 and could not provide them to the surveyor. Resident 1's Care Plan dated 8/30/2019 indicated that the resident was at risk for pressure ulcer development/impaired skin integrity related to incontinence, refusal of care and combativeness. Interventions included: -Administer treatments as ordered and monitor effectiveness. The facility policy titled, Pressure Ulcer: Risk Assessment and Prevention dated 8/2016 overview indicated that prevention of pressure ulcers require early intervention of at risk residents and implementation of prevention strategies. The policy specifies that skin assessments are to be done by a licensed nurse weekly. 2. (c) According to Resident #4's Admission Record the resident was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (an assessment tool) dated 05/10/20, indicated that Resident #4 was cognitively intact and was independent with feeding. Further review of the document revealed that the resident was ordered a mechanically altered diet (required change in texture of foods or liquids e.g., pureed food, thickened foods) and ambulated independently with a walker. According to a Nutrition/Dietary Note (N/DN) dated 11/07/2019 at 10:10 AM, Dietician #1 documented that Resident #4 recently had teeth pulled at the dentist office and the resident reported that he/she was having a hard time chewing meat. The Dietician offered the resident the option of changing the diet to chopped or ground and the resident agreed to try chopped first and would change to ground later if necessary. The Dietician noted that the diet was changed and the recommendation was placed in the chart. According to a N/DN dated 6/18/20 at 3:17 PM, Resident #4 was readmitted to the facility after hospitalized from [DATE]-06/17/20 with [DIAGNOSES REDACTED]. Dietician #2 documented that the resident complained of difficulty chewing and swallowing, diet downgraded to regular, mechanical soft/ground with thin liquids and specified that the Speech Language Pathologist (SLP) was aware. The Dietician noted that the resident continued with poor oral intake and would continue to provide supplements as ordered, monitor weight, encourage/monitor oral intake, diet tolerance, weight, skin and labs. According to the Order Summary Report (OSR) on 06/19/20, Resident #4 was ordered a Regular diet with mechanical soft (ground meat) texture, and thin consistency liquids. Further review of the OSR revealed that on 07/01/20, Resident #4 was ordered Hospice Services. Further review of the document indicated that on 07/02/20, the resident's diet order was changed to pureed texture, thin consistency liquids. According to a N/DN dated 07/02/20 at 12:50 PM, Dietician #2 documented that Resident #4 was readmitted to the facility after hospitalized from [DATE]-07/01/20 for a [DIAGNOSES REDACTED]. The resident returned to facility on Hospice services and intake continued to be poor with trouble/painful chewing/swallowing. Dietician #2 noted that Resident #4's diet was downgraded to puree and thin liquids as recommended by the Speech Language Pathologist. On 08/05/20 at 11:55 AM, the surveyor interviewed Dietician #2 who reportedly began working at the facility in November 2019. She stated that Dietician #1 was no longer employed at the facility. Dietician #1 stated that when a resident who was alert and oriented reported issues with chewing and swallowing that she communicated the issue with the Speech Language Pathologist (SLP) who would assists. with evaluation of a resident's ability to tolerate individual food textures. On 08/07/20 at 12:39 PM, the surveyor interviewed Dietician #2 who stated that on 06/18/20, the SLP evaluated Resident #4 and made dietary recommendations. She further stated that the SLP was not available for interview. On 08/07/20 at 1:56 PM, the surveyor interviewed the Director of Therapy (DOT) who stated that the all SLP Screens were done on paper and all evaluations were completed on Rehab computer software. She explained that when Resident #4 returned from the hospital Dietician #2 recommended that the SLP do a screening and there was some talk of the resident's wish to possibly pursue Hospice (end of life care). The DOT stated a formal evaluation was not done because the insurance would not authorize it. She stated that the SLP just made sure that what was done at the hospital was carried out at the facility and it wasn't a formal evaluation. The DOT agreed to furnish the Screening that was completed by the SLP on 06/18/20. On 08/07/20 at 3:50 PM, the Director of Nursing (DON) agreed to forward a copy of Resident #4's SLP Screening via e-mail. On 08/10/20 at 9:41 AM, the surveyor received a copy of a Screen/Referral Form completed by the SLP that was dated 06/18/20. The Reason documented on the for Screen was New/Readmit Screen for diet. The SPT documented, recommended (sic.) to nursing diet to be puree and thins. On 08/10/20 at 1:39 PM, the surveyor conducted a post-survey telephone interview with the SLP, who stated that Resident #4 was sent out to the hospital a couple of times and had difficulty chewing and swallowing. She further stated that when she went to see the resident on 06/18/20, she recommended a ground mechanical diet with thin liquids. The SLP stated that she thought that the date on the Screen/Referral Form that was sent via e-mail was incorrect because she did not recommend that the diet be changed to pureed with thin liquids until 07/02/20 after the resident returned from the hospital (06/27/20 through 07/01/20). She further stated that the Resident's Representative informed her that the hospital had the resident on a pureed diet and recommended that the change be made. She stated that she did not have an explanation as to why the date on the Screen/Referral Form was dated 06/18/20 instead of 07/02/20. On 08/10/20 at 2:20 PM, the surveyor interviewed the DON who stated that if the SLP notified nursing of a dietary recommendation nursing was expected to get an order from the physician or practitioner for the recommended diet. She further stated that she thought that the Screen/Referral Form that she sent via e-mail was wrong and the date was wrong. The DON stated that the SLP provided her with the Screen/Referral Form and she thought that the form was written today because the SLP wasn't here last week. The DON was unable to furnish the surveyor with a policy that detailed the responsibility of the facility to carry out the recommendations of the SLP after Screen/Referral Form completed for Diet Evaluation. N.J.A.C 27.1(a)