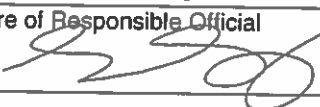


**New Jersey State Department of Health
Acute Care Survey
COMPLAINT AND SURVEILLANCE REPORT**

Facility Cherry Hill Women's Center		Date 7/16/19	Case Number NJ00124488
Administrator/CEO Jennifer Groves		Type Facility Acute	Time Required to Correct
Type of Survey <input type="checkbox"/> Revisit <input type="checkbox"/> Investigation <input type="checkbox"/> For Immediate Attention <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Surveillance		Matter Under Consideration <i>Pharmaceutical Services</i>	
Census/Bed Capacity	Units Toured	Charts Reviewed	Number of Patients Affected
Facility Representatives/Titles <i>Susan Sperry Deputy Administrator</i>		Remarks/Issues <i>NOT VALID</i>	
<p>When this form is utilized for a survey, the following needs to be addressed: This survey was reviewed with the Administrator or his/her authorized representative at the conclusion of the survey. He/she was advised of the areas where standards were not met in violation with the rules and regulations promulgated under the authority of N.J.S.A. 26:2H-5(b). He/she was further advised that it was necessary to correct conditions which do not meet the standards and that failure to correct those deficiencies may result in a fine of up to \$5,000.00 per violation per day in accordance with N.J.S.A. 26:2H-14 as amended. Refusal to sign does not negate the facility's responsibility to correct deficiencies.</p>			
Signature of Responsible Official 		Signature of Investigator <i>Hortense Xenakis</i>	

NARRATIVE

A Visit was made to this facility in response to the above referenced complaint. Administrative staff was made aware of the visit and the nature of the complaint.

The investigation included:

- Tour.
- Staffing reports.
- Medical record review.
- Staff interviews.
- Patient interviews.
- Review of other facility documentation.
- Meal/Medication pass observation.
- Water/Room temperature.

An exit conference was held with administrative staff (discussed findings and concerns). An addendum may follow after review by the Department of Health and Senior Services.

Comments:

ENTERED *ONE 11/15/19*
BY:



State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360

COPY

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

www.nj.gov/health

JUDITH M. PERSICILLI, RN, BSN, MA
Acting Commissioner

October 10, 2019

Jenifer Groves
Administrator
Cherry Hill Womens Center
502 Kings Highway North
Cherry Hill, NJ 08034

Re: Complaint #NJ00124488

Dear Ms. Groves:

Thank you for the courtesy and cooperation extended during the Complaint Investigation conducted July 16, 2019 by a surveyor from the New Jersey Department of Health.

Enclosed is a copy of the State deficiency form indicating that no deficiencies were found during the survey. Please sign the first page of the State deficiency form and return the original copy to my attention. It is important to return the form promptly to this office.

If you have questions concerning this letter, please do not hesitate to contact me at (609) 292-9900.

Sincerely,

Hortense Xenakis, RPh, CCP
Field Rep. Pharmaceuticals 2
Survey and Certification

Encl.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHERRY HILL WOMENS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>INITIAL COMMENTS</p> <p>The facility is in substantial compliance with 8:43A- Standards for Licensure of Ambulatory Care Facilities for this complaint only (C# NJ00124488).</p>	A 000		

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: 22445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER CHERRY HILL WOMENS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	INITIAL COMMENTS The facility is in substantial compliance with 8:43A- Standards for Licensure of Ambulatory Care Facilities for this complaint only (C# NJ00124488).	A 000			

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

TITLE

(X6) DATE

STATE FORM

6889

BYP811

If continuation sheet 1 of 1



State of New Jersey

DEPARTMENT OF HEALTH

PO BOX 367

TRENTON, N.J. 08625-0367

www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICILLI, RN, BSN, MA

Acting Commissioner

October 21, 2019

Complaint #NJ00124488

A representative from Health Facility Survey and Field Operations conducted an investigation of your complaint concerning possible drug theft at Cherry Hill Womens Center. The investigation included a tour, document review, and staff interview.

After evaluating this information, the surveyor was unable to identify a citable deficient practice related to your concerns based on State regulations. The results of this investigation were presented to and reviewed with administrative staff for continued monitoring of patient care.

If you have questions concerning this letter, please do not hesitate to call (609) 292-9900 and ask to speak to a supervisor.

Thank you for forwarding your concerns to this office.

Sincerely,

The Acute Care Program
Survey and Certification