STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, it was determined that the facility failed to provide necessary treatment services consistent with professional standards of practice by not ensuring a resident received blood sugar monitoring and insulin medication according to a physician's order for 1 of 5 residents (Resident #24) reviewed for unnecessary medications. The deficient practice was evidenced by the following.On 8/15/2025 at 11:45 AM, the surveyor observed Resident #24 self-propelling in the hallway, was talking to themselves, and appeared confused. The surveyor attempted to interview Resident #24, but they did not respond. A review of the medical record revealed the following:A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included Dementia with agitation, major depressive disorder and Type 2 diabetes mellitus (DM).A review of the most recent comprehensive Minimum Data Set (MDS), (an assessment tool used to facilitate the management of care), dated July 23, 2025, reflected that the Brief Interview for Mental Status score was 0/15, which indicated that the resident's cognition was severely impaired. A further review of the MDS revealed the resident was receiving a hypoglycemic (including insulin) (medication that lowers blood sugar) during the last seven days or since admission. A review of the Order Summary Report (OSR) (physician's order sheet) dated August 2025 included the following Physician's orders (PO):-Insulin Lispro (medication used to lower blood sugar), inject as per sliding scale: if 151-200 [blood sugar levelgm/dl] = 2 units; 201-250 [blood sugar level] = 4 units; 251-300 [blood sugar level gm/dl]= 6 units; 301-350 [gm/dl blood sugar level] = 8 units; 351-400 [gm/dl blood sugar level]=10 units, subcutaneously (under the skin) before meals for DM call MD if BS < 70 or > 400 [blood sugar level gm/dl]; dated 7/1/25.-Basaglar (insulin glargine) inject 12 units subcutaneously at bedtime for DM; dated 7/28/25.-Blood sugar checks BID (twice per day) and call < 70 or > 250 two times a day for DM2. Dated 6/24/25.A review of the July 2025 and August 2025 electronic medication administration record (eMAR) revealed an order dated 7/2/25 for insulin Lispro sliding scale with the above referenced scale. The eMAR was plotted to record the blood sugar level and the corresponding insulin dose based on that blood sugar level. The times indicated were 7:30 AM, 8:00 AM and 11:00 AM. On 8/19/25 at 12:00 PM, the surveyor interviewed Resident #24's day shift Licensed Practical Nurse (LPN #1) who confirmed the resident had diabetes and was prescribed sliding scale insulin Lispro. LPN #1 stated the resident would have their blood sugar checked before meals, and then given their insulin dose based on the blood sugar level. When asked when mealtimes were on the unit the LPN #1 stated breakfast was between 8:00 AM and 8:15 AM, lunch was between 11:50 AM and 12:00 PM, and she was unsure when dinner was scheduled because she did not work the evening shift. At that time the surveyor and LPN #1 reviewed the resident's eMAR. LPN #1 acknowledged the eMAR administration times for insulin lispro did not coincide with the timing of the PO to be given before meals. LPN #1 further acknowledged there was no area designated to document the dinner time blood sugar level, or the corresponding dose of the insulin lispro that was provided. LPN #1 stated eMAR needed to be changed to reflect the appropriate times according to the PO. On 8/19/25 at 12:26 PM, the surveyor interviewed the acting LPN Unit Manager (LPN/UM) who confirmed the resident was on a sliding scale insulin lispro before meals. Together the surveyor and LPN/UM reviewed the (continued on next page)

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.

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
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 - Minimal harm or potential for actual harm Residents Affected - Some	resident's order for insulin lispro and compared it to their eMAR. LPN/UM acknowledged the timing on the eMAR did not reflect mealtimes and there wasn't a area designated to document the dinner time blood sugar level, or the corresponding insulin lispro dose. The LPN/UM could not locate any documentation on the eMAR that would reflect the medication being provided per the PO.On 8/19/25 at 12:50 PM the surveyor interviewed the Director of Nursing (DON) who confirmed the eMAR timing for insulin lispro did not reflect the appropriate mealtime schedule according to the PO. Together the DON and the surveyor next reviewed the CP reports for May, June and July of 2025. The DON stated the CP report was emailed monthly to the Licensed Nursing Home Administrator (LNHA) the unit managers (UM) and himself, and that the UM was responsible for following up on the reports with the physicians. The DON acknowledged the CP reports had not been reviewed for the three months until surveyor inquiry. After further review of the July 2025 eMAR the DON confirmed the resident did not receive their dinner time dose of insulin lispro 30/31 days, and confirmed after review of the August 2025 eMAR the resident did not receive their dinner time insulin lispro 18/18 days. The DON added there was no way to know if the resident had received a 4:00 PM (dinner time) dose of insulin lispro, because there was no 4:00 PM plotting area to document the BS or the administration of the insulin. The eMAR should have a block [an area designated] to record the BS and another to document the amount of insulin given. The DON added the nurse on the night shift was supposed to do a chart check, which was a review of the orders that were entered for that day, this included medications or lab orders, etc. The DON was unable to provide a copy of the chart check for the time period indicated, and acknowledged he was unable to confirm the chart check had been performed. On 8/19/25 at 1:44 PM, the survey team met with the facility Administration and the Chief Nursing Officer (CNO) for the facility. The CNO acknowledged the plotting for the insulin lispro on the eMAR was incorrect. The DON and the CNO acknowledged the way the order was plotted made it difficult to tell if the resident had been receiving a dose at dinner. On 8/19/25 at 3:08 PM, the surveyor interviewed the resident's evening Licensed Practical Nurse (LNP #2) who confirmed the resident had PO for insulin glargine at bedtime and insulin lispro for before meals. LPN #2 stated the insulin lispro dose at 4:00 PM was just started back up again, she stated she believed for the last month they were only monitoring the resident's blood glucose levels, and she had not been administering a dinnertime dose of insulin lispro. LPN #2 stated she had on the eMAR to only check blood sugar levels at 4:00 PM and confirmed she was only monitoring the resident's blood sugar and not giving a dose of insulin lispro. On 8/20/25 at 9:05 AM, the surveyor interviewed the consultant pharmacist via telephone. The CP confirmed she had made recommendations to give insulin lispro within 15 minutes of meals in her May 2025 report. The CP stated the typical timing should be 7:30 AM, 11:30 AM and 4:30 PM. The CP stated it was important to follow that schedule, especially sliding scale, because you didn't want the resident's blood sugar to bottom out (have the resident's blood sugar fall to a dangerous level). The CP stated it looked like to her that they had plotted the incorrect times for that insulin lispro order. They needed to make it for breakfast, lunch and dinner. The CP confirmed it did not look like the nurse was giving the dinner time dose. On 8/20/25 at 10:30 AM the surveyor attempted to interview via telephone the resident's physician and left a message with the service, the physician could not be contacted.On 8/20/25 at 12:32 PM the surveyor interviewed the facility 's Medical Director (MD) who stated he had spoken to the DON that morning and was informed Resident #24 had an incorrect insulin order. He reviewed the orders with the DON and admitted the order was confusing. The MD stated he would call the resident's physician to discuss the insulin dose error tomorrow. A review of the facility's Insulin Administration policy reviewed 10/24 included. insulin administration must be based on a physician's order, which includes the type of insulin, dosage and administration schedule.A review of the facility's Medication Transcription policy dated reviewed 10/24 revealed An accurate and current patient medication administration record (MAR) is critical for accurate medication administration and patient safety.Any apparent discrepancies between the MAR and the prescriber's orders will be communicated by nursing to the MD and clarification order sent to the pharmacy as (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 - Minimal harm or potential for actual harm Residents Affected - Some	needed.A review of the facility's Medication Administration policy dated reviewed 10/24 revealed .Medication ordered before a meal should be specific to manufacturer's recommendation and administered prior to the start of the meal. 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
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview and document review, it was determined that the facility failed to respond in a timely manner to the Consultant Pharmacist's (CP) monthly recommendations from May, June and July 2025, for 1 of 5 residents (Resident #24) reviewed for unnecessary medications. The deficient practice was evidenced by the following: On 8/15/2025 at 11:45 AM, the surveyor observed Resident #24 seated in a wheelchair self-propelling with their feet down the hallway. The resident was talking to themselves and appeared confused. The surveyor attempted to interview the Resident #24, but they did not respond.A review of the medical record revealed the following information: The admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included dementia with agitation, major depressive disorder and Type 2 diabetes (DM). A review of the Order Summary Report (OSR) (physician's order sheet) dated August 2025 revealed a Physician's order (PO) dated 7/1/25 for insulin lispro (medication used to lower blood sugar), inject as per sliding scale: if 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 =10 units, subcutaneously (under the skin) before meals for DM call MD if BS < 70 or > 400.A review of the July 2025 and August 2025 electronic medication administration record (eMAR) revealed an order dated 7/2/25 for insulin lispro sliding scale with the above referenced scale. The eMAR was plotted to record the blood sugar level and the corresponding insulin dose based on that blood sugar level. The times indicated were 7:30 AM, 8:00 AM and 11:00 AM. A review of the Consultant Pharmacist (CP)- Nursing Summary Reports dated 5/15/25, 6/13/25 and 7/15/25 recommended insulin lispro (Ademelog/Humalog) should be administered within 15 minutes before a meal or immediately after a meal. On 8/19/25 at 12:00 PM, the surveyor interviewed Resident #24's day shift Licensed Practical Nurse (LPN #1) who confirmed the resident had diabetes and was prescribed sliding scale insulin lispro. LPN #1 stated the resident would get their blood sugar checked before meals and then given their insulin dose based on the blood sugar level. When asked when mealtimes were on the unit the LPN #1 stated breakfast was between 8:00 AM and 8:15 AM, lunch was between 11:50 AM and 12:00 PM, and she was unsure when dinner was scheduled because she did not work the evening shift. At that time the surveyor and LPN #1 reviewed the resident's eMAR. LPN #1 acknowledged the eMAR administration times for insulin lispro did not coincide with the timing of the PO to be given before meals. LPN #1 further acknowledged there was no spot to document the dinnertime blood sugar or the dose of the insulin lispro given and the eMAR should be changed to reflect the appropriate times according to the PO. On 8/19/25 at 12:50 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed the eMAR timing for insulin lispro did not reflect the appropriate mealtime schedule according to the PO. Together the DON and the surveyor reviewed the CP reports for May, June and July of 2025. The DON stated the CP report was emailed monthly to the Licensed Nursing Home Administrator (LNHA) the unit managers (UM) and himself, and that the UM was responsible for following up on the CP reports with the physicians. The DON acknowledged the CP reports had not been reviewed for the three months until surveyor inquiry. On 8/20/25 at 12:32 PM, the surveyor interviewed the facility's Medical Director (MD) who stated he had spoken to the DON that morning and was informed Resident #24 had an incorrect insulin order. He reviewed the orders with the DON and admitted the order was confusing. The MD stated he would call the resident's physician to discuss the incorrect insulin order tomorrow. A review of the facility policy titled Consultant Pharmacist during regular monthly visits reviewed 1/2025 included.The consultant pharmacist shall review and perform a drug regimen review for all residents monthly.The nursing and attending physician (or licensed designee) shall respond to the recommendations in a timely manner, per facility policy for non- urgent recommendations.Clinically significant irregularities. will be brought to the attention of nursing and addressed while the consultant is in the facility, as well as included in the monthly report. Nurses should promptly communicate with the prescriber to facilitate obtaining an answer by midnight of the next day. NJAC 8:39-29.3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to inform and offer educational material regarding Advance Directives (AD) written instruction including but not limited to living will, medication restrictions, and treatment restriction for the provision of healthcare when an individual is incapacitated) with a resident and/or legal representative. This deficient practice was identified for 2 of 2 residents (Resident #24, and Resident #25) reviewed for AD and was evidenced by the following: On 8/12/2025 at 10:31 AM, the surveyor observed Resident #25 in bed with tube feeding (food provided via a tube into the stomach) infusing. in room [ROOM NUMBER]-1. The surveyor attempted to talk to the resident, but the resident did not respond. On 8/12/2025 at 10:31 AM the surveyor reviewed the medical record for Resident #25 which revealed the following: A review of the admission Record (an admission summary) reflected that the resident was admitted with diagnoses which included but was not limited to; Epilepsy (neurological disorder), Diabetes Mellitus (disease that affects how the body uses blood sugar), Altered Mental Status (disruption of how your brain works), Cerebral Infarction (stroke). The admission Record indicated the resident was listed as a Full Code (all lifesaving care will be provided if their heart stops). There was no New Jersey Practitioner Orders for Life-Sustaining Treatment (POSLT- is not an AD and is used as a portable medical order in an emergency) in the medical record. There was no information that determined upon admission whether the resident had an advanced directive, or any documentation as to whether the resident or Resident Representative wished to formulate an advanced directive. A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 5/28/2025, the resident had a Brief Interview for Mental Status (BIMS) score of 9/15, indicating that the resident had a moderately impaired cognition. A physician's order (PO) dated 8/08/25, revealed Resident #25 was a Full Code, Order Type: Advanced Directive. A review of the resident's individualized care plan focus area indicated [Resident #25] has an advanced directive with a code status of FULL CODE. On 8/12/2025 at 12:35 PM the surveyor reviewed the medical record for Resident #24.A review of the admission Record (an admission summary) reflected that the resident was admitted to the with diagnoses which included, but was not limited to; Atrial fibrillation (irregular, rapid heart rhythm) and Cerebral Infarction (stroke). The admission Record indicated the resident was listed as a full code. There was a POSLT in the medical record, that indicated full code signed by the RR on 6/2/2025. There was no documented evident upon on admission regarding whether the resident had an advanced directive, and if not, determined whether the resident was offered to formulate an advanced directive. A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 7/26/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating that the resident was cognitively intact. A physician's order (PO) dated 7/19/24, revealed: Full Code, Order Type: Advanced Directive A review of the resident's individualized care plan focus area indicated [Resident #24] had a status of FULL CODE.On 8/19/2025 at 9:16 AM the surveyor interviewed Resident #24 who stated that no one had spoken to them about Advanced Directives. The resident further stated, I heard about it, but I don't know what it is. I would like to have information about it. On 8/13/2025 at 8:58 AM, the surveyor interviewed the Director of Nursing (DON) who stated the POLST could take the place of the advanced directive. He further stated that typically residents do not get admitted with an advanced directive from the hospital. We rely on the POLST if they have one. The code status orders were entered from the POLST form. He then stated that he was not aware of documentation or education that the facility provided about AD if no AD existed. He stated that Social Services should have met with new admissions by the next day. The DON that the Social Worker (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have met with Resident #24 and Resident #25 to discuss the AD On 8/14/2025 at 8:42 AM, the DON confirmed that there was no discussion and/or planning upon admission regarding AD with either Resident #24 or Resident #25 and/or the RP. In addition, he stated that resident #25's RP worked at the facility, and confirmed that no one had spoken with them regarding the AD. The DON stated that the Social Worker was responsible for discussing AD with residents upon admission. The surveyor was informed that the Social Worker resigned on Friday August 8th, 2025, and was unavailable for an interview. On 8/19/2025 at 1:41pm, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Chief Nursing Officer (CNO). The LNHA acknowledged that Residents #24 and #25 did not have an advance directive and there was no documentation that the resident/resident representative was provided education. The CNO added that residents should be asked if they have an AD, and if so the facility should request a copy, or if they did not have an AD, they should ask if they would like information to formulate an AD. The CNO further stated that residents also have the right to refuse. LNHA, DON and CNO acknowledged that AD were not addressed with residents #24 and #25 and should have been addressed upon admission. A review of the facility's policy Advanced Directives revised date of 1/2025, included: Policy: it is the policy of this facility to offer every resident, or their resident representative, the opportunity to make decisions about their own health by means of preparing an Advance Directive. Procedure: Upon admission, residents and/or their responsible party are asked if an Advanced Directive or Living Will exists. If an Advanced Directive or Living Will exists, it is reviewed and will be placed in the resident's chart. 1.Upon admission, residents and/or their responsible party are asked if an Advanced Directive or Living Will exists. 2. If an Advanced Directive or Living Will exists, it is reviewed and will be placed in the resident's chart. 3. If the resident is mentally competent, and an Advanced Directive/Living Will does not exist, he/she will be asked if he/she wishes to complete an Advanced Directive. Information pertaining to his/her rights regarding Advanced Directive/Living Will will also be given to the resident .NJAC 8:39-9.6 (a)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and review of facility documentation, the facility failed to maintain a resident's wheelchair, wheelchair right armrest, and bathroom in a clean and homelike condition. This deficient practice was identified for 1 of 2 residents reviewed for equipment and environmental care (Resident #44), and was evidenced by the following:Based on observation, interviews, record review, and review of facility documentation, it was determined that the facility failed to maintain a resident's wheelchair, wheelchair right armrest, and bathroom in a clean and homelike manner. This deficient practice was identified for 1 of 2 residents reviewed for environment (Resident #44), and was evidenced by the following:On 8/12/2025 at 9:32 AM, during the initial tour, the surveyor interviewed Resident #44 in their room and was seated in their wheelchair. The resident stated that their wheelchair was pretty dirty and was unsure when it was last cleaned. The surveyor observed visible debris and food-like particles on the wheelchair and noted that the right armrest was worn through, and the padding was exposed. On 8/13/2025 at 8:50 AM, the surveyor observed the rubber-like floor molding approximately eight inches was hanging off the wall toward the floor in Resident #44's bathroom.A review of Resident #44's medical record revealed that the resident was admitted with diagnoses including hemiplegia (paralysis one side of the body), hemiparesis (weakness one side of the body), cerebral infarct (stroke) and major depressive disorder(depression). The Quarterly Minimum Data Set (QMDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 13/15, reflecting that the resident was cognitively intact. On 8/13/2025 at 9:35 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to Resident #44. The CNA stated that wheelchairs were cleaned regularly, and that the resident's wheelchair had been cleaned a few days prior. She then stated, she did not notice any dirt or damage to the wheelchair and was unaware of the worn armrest. When inquired regarding the hanging molding in the bathroom, the CNA stated that she did not notice it. She added that dirty wheelchairs were reported to Housekeeping and damaged wheelchairs were reported to Maintenance.On 8/13/2025 at 10:33 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) caring for Resident #44. The LPN stated that wheelchairs were washed weekly and acknowledged that the resident's wheelchair was soiled, and the armrest needed repair. The LPN also acknowledged the hanging molding in the bathroom and submitted a maintenance request in the presence of the surveyor.On 8/13/2025 at 10:44 AM, the surveyor observed the Maintenance Director stapling the hanging molding back onto the bathroom wall. Upon interview, he stated that room audits were conducted weekly however, he confirmed he was not made aware of the lifted molding. On 8/14/2025 at 8:46 AM, the surveyor interviewed the Housekeeping Director (HD), he stated that she maintained a wheelchair cleaning schedule. Resident #44's wheelchair was scheduled for cleaning on 8/13/2025 and the resident had previously refused cleaning on 7/16/2025. The HD stated that refusals are verbally reported to Nursing but are not documented. She also noted that she was out for two weeks in June and could not confirm whether the wheelchair was cleaned during that time.On 8/15/2025 at 8:51 AM, the surveyor interviewed the Director of Physical Therapy (PT) who stated that she works closely with Housekeeping and Maintenance to coordinate wheelchairs cleaning and repairs. If a resident arrived at therapy with a dirty or broken wheelchair, a work order was submitted, or the resident was transferred to a temporary chair so their chair could be cleaned by housekeeping. If the resident refused, Housekeeping and Nursing were notified. She stated that she does not document wheelchair cleaning refusals. She noted that Resident #44 last attended therapy the previous week and she did not notice any issues with the wheelchair.On 8/19/2025 at 9:03 AM, the surveyor interviewed resident #44 who stated, I would never refuse to have my wheelchair cleaned, I want it cleaned more. On 8/19/2025 at 9:12 AM the surveyor interviewed again the LPN who cared for Resident #44. The LPN stated that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident #44 never refused to have his wheelchair washed to me, if he did, I would document it. Review of the Maintenance logs for June 2025 indicated the following:Checklist-room [ROOM NUMBER]:Item listed to be checked included Main Door, Bed, T.V./Remote, Call Bell, Telephone, Clock, Nightstand, Over the bed table, Light switches/Electric Plugs. wheelchairs and floor molding were not included on the list. Review of June, July and August 2025 wheelchair cleaning schedule indicated the following: room [ROOM NUMBER] was scheduled to have his wheelchair cleaned on June 18th 2025, July 16th 2025, and August 13th 2025. On 8/19/2022 at 10:43 AM, the Administrator provided the policy titled, Cleaning and Disinfection of Resident- Care Items and Equipment reviewed 12/2024 The policy Statement indicated the following:Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The policy did not address wheelchair armrest replacement. NJAC 8: 39 -31.4 (c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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. Based on interview and record review, the facility failed to immediately report an allegation of misappropriation of resident property for 1 of 1 residents (Resident #11) reviewed for personal property to the New Jersey Department of Health (NJDOH). This deficient practice was evidenced by the following: A review of the admission Record (admission summary) indicated that Resident #11 was admitted to the facility with the diagnoses which included but was not limited to end stage renal disease (kidney failure) and hypertension (high blood pressure). A review of the quarterly Minimum Date Set (MDS) and assessment that facilitates a resident's care dated 8/8/25, reflected that Resident #11 scored a 10 of 15 on the basic interview for mental status (BIMS) which indicated that the resident had moderate cognitive impairment and exhibited behaviors such as refusal of care. A review of the Care Plan (CP) did not reflect that the resident had accusatory behavior or fabricated stories.On 8/13/2025 at 8:45 AM, the surveyor interviewed Resident #11 who stated that agency Certified Nursing Assistances (CNAs) were breaking into the resident's locked drawer and stealing personal belongings such as perfume and soap. The resident stated that the administration and nurses were aware, but no one was doing anything about it. The surveyor observed the lock that was hanging on the drawer, and it was broken. The resident stated that they reported the missing soap the other morning (did not specify a date) to the nurse and the CNAs but did not know their last names. The resident stated that the police were not notified and the items that were stolen were not replaced. The resident stated that the missing perfume happened a couple months ago, and the perfume was not replaced by the administration at the facility. Stated that the family was aware of the missing items. On 8/13/2025 at 9:29 AM, the surveyor interviewed Resident #11's Resident Representative (RP) and asked the RP if they were aware of any issues that Resident #11 was having in the facility and the RP stated, What, the stealing that's going on. The RP stated that Resident #11 told her that an agency staff member was getting into the resident's locked drawer and stealing soap and perfume. She stated that the stealing started in May of 2025 and was reported to the Licensed Nursing Home Administrator (LNHA) in May. The RP stated that she bought Resident #11 a bottle of perfume that cost 100$ at Christmas and the perfume went missing. The RP stated that she had reported the missing perfume to the primary care nurse and to administration. She stated that the facility was supposed to replace the perfume but did not. The RP stated that the Administration did not have Resident #11 or RP fill out any paperwork or statements regarding the missing perfume. She stated that the police were not notified and that no one from the facility followed up with the RP with any conclusion of an investigation. She stated that Resident #11 was provided with a locked drawer after the perfume went missing but was not notified that the drawer lock was currently broken. She stated the on Monday 8/11/25, Resident #11 told the RP that soap was missing from the drawer in the resident's room.On 8/13/2025 at 10:05 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that Resident #11 was alert and oriented and able to express their needs and wants. The CNA revealed that the resident did not report that someone was stealing soap and perfume to her however that the day before yesterday another CNA (CNA #2) was looking for the resident's missing soap. CNA #1 stated that she was not aware of any other complaints from the resident regarding missing items. On 08/13/2025 at 10:12 AM, the surveyor interviewed Resident #11's primary care Registered Nurse (RN) who stated that Resident #11 reported to her this morning that soap was missing and that someone stole it. The RN stated that the LNHA was in this morning to see the resident about the complaint. The RN revealed that in the past, the resident reported that perfume was stolen. The RN stated that the Social Worker (SW) and the LNHA were handling the issue. She stated that she was not sure if police were notified however the LNHA gave the resident a lock for the drawer after the resident reported that the perfume was missing. The RN stated that the resident was not consistently using the lock on the drawer because it was not convenient. She (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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	continued to add that if the resident complained of theft or missing personal items to her, she would report it to the administration, and they would handle the investigation. On 8/13/2025 at 10:24 AM, the surveyor interviewed the residents primary care CNA #2 who stated that Resident #11 reported that perfume was missing from the resident's drawer a couple months ago and she thought there was an investigation was being done by the Administrator. She stated that the LNHA was supposed to replace the perfume but was not replaced as far as she knew. She stated that after the resident reported that the perfume was missing, the administration put a lock on the resident's drawer. She confirmed that the resident did not consistently use the lock on the drawer and always needed someone to unlock it. She stated that she was not aware that the lock was broken at this time. She added that the resident reported to her on 8/11/25 that soap was now missing. CNA #2 stated that she reported the missing soap to an agency nurse and was not sure if the nurse told the administration. She stated Resident #11 called their RP and reported that their soap was stolen.On 8/13/2025 at 11:23 AM, the surveyor interviewed the Director of Nursing (DON) who stated that he was not aware and was not notified that the resident had complaints of missing or stolen items. He then added that he was made aware that Resident #11 stated that they had soap stolen from their room. He stated that the LNHA was investigating the complaint of stolen item that was reported this morning (8/13/25). The surveyor asked the DON if he was made aware about missing perfume a couple months ago. The DON stated that the missing perfume was not reported to him however was reported to the LNHA and that the LNHA was handling that investigation. The surveyor asked the DON what the process was for reporting misappropriation of resident property, and he stated that an investigation would be conducted which included completing an incident report, interviewing staff, obtaining written statements from resident and staff or any other witnesses. He stated that the staff were to contact family members and report the incident to the Department of Health (DOH) within 2 hours. On 8/13/2025 at 11:36 AM, the surveyor interviewed the Director of Maintenance (DOM) who stated that the LNHA usually instructed the DOM to put the locks on the resident's drawers if the resident requested. The MOD stated that the LNHA instructed the DOM to put the lock on Resident #11's drawer a couple months ago. The DOM spoke with the resident and the resident told him that the lock had to be put on because something about perfume. The DOM did not remember the date the lock was installed on the drawer. On 8/13/2025 at 11:54 AM, the LNHA stated that he did not investigate and did not report the allegation of missing perfume because he did not have a time frame. He stated that he should have reported the allegation to the NJDOH within two hours and called the police. He continued to admit that he should have obtained statements from the staff, resident and other alert and oriented residents in the area. He stated that he did not recall if the resident was reimbursed for the missing perfume. He stated that it would that been important to follow the process for investigating and reporting abuse/misappropriation of personal property to protect the resident and other residents. The LNHA stated that he was the abuse officer for the facility and was aware that he should have reported and investigated the residents compliant of missing personal items.The facility policy dated 9/2024 and titled, Abuse, Neglect, and Mistreatment of Residents Policy indicated that each resident had the right to be free from mistreatment, neglect and misappropriation of property. The policy indicated that misappropriation of property was defined as deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The policy indicated that the facility would ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown origin source and misappropriation of a resident's property would be reported immediately to the Administrator/designee or the facility and to other officials in accordance with state law including the state survey and certification agency.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
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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. Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy and thoroughly and timely investigate an allegation of misappropriation of property by 1 of 1 resident (Resident #11) who reported missing property to the Licensed Nursing Home Administrator (LNHA). This deficient practice was evidenced by the following:A review of the admission Record (admission summary) indicated that Resident #11 was admitted to the facility with the diagnoses which included but was not limited to end stage renal disease (kidney failure) and hypertension (high blood pressure). A review of the quarterly Minimum Date Set (MDS) and assessment that facilitates a resident's care dated 8/8/25, reflected that Resident #11 scored a 10 of 15 on the basic interview for mental status (BIMS) which indicated that the resident had moderate cognitive impairment and exhibited behaviors such as refusal of care. A review of the Care Plan (CP) did not reflect that the resident had accusatory behavior or fabricated stories.On 8/13/2025 at 8:45 AM, the surveyor interviewed Resident #11 who stated that agency Certified Nursing Assistances (CNAs) were breaking into the resident's locked drawer and stealing personal belongings such as perfume and soap. The resident stated that the administration and nurses were aware, but no one was doing anything about it. The surveyor observed the lock that was hanging on the drawer, and it was broken. The resident stated that they reported the missing soap the other morning (did not specify a date) to the nurse and the CNAs but did not know their last names. The resident stated that the police were not notified and the items that were stolen were not replaced. The resident stated that the missing perfume happened a couple months ago, and the perfume was not replaced by the administration at the facility. Stated that the family was aware of the missing items. On 8/13/2025 at 9:29 AM, the surveyor interviewed Resident #11's Resident Representative (RP) and asked the RP if they were aware of any issues that Resident #11 was having in the facility and the RP stated, What, the stealing that's going on. The RP stated that Resident #11 told her that an agency staff member was getting into the resident's locked drawer and stealing soap and perfume. She stated that the stealing started in May of 2025 and was reported to the Licensed Nursing Home Administrator (LNHA) in May. The RP stated that she bought Resident #11 a bottle of perfume that cost 100$ at Christmas and the perfume went missing. The RP stated that she had reported the missing perfume to the primary care nurse and to administration. She stated that the facility was supposed to replace the perfume but did not. The RP stated that the Administration did not have Resident #11 or RP fill out any paperwork or statements regarding the missing perfume. She stated that the police were not notified and that no one from the facility followed up with the RP with any conclusion of an investigation. She stated that Resident #11 was provided with a locked drawer after the perfume went missing but was not notified that the drawer lock was currently broken. She stated the on Monday 8/11/25, Resident #11 told the RP that soap was missing from the drawer in the resident's room.On 8/13/2025 at 10:05 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that Resident #11 was alert and oriented and able to express their needs and wants. The CNA revealed that the resident did not report that someone was stealing soap and perfume to her however that the day before yesterday another CNA (CNA #2) was looking for the resident's missing soap. CNA #1 stated that she was not aware of any other complaints from the resident regarding missing items. On 08/13/2025 at 10:12 AM, the surveyor interviewed Resident #11's primary care Registered Nurse (RN) who stated that Resident #11 reported to her this morning that soap was missing and that someone stole it. The RN stated that the LNHA was in this morning to see the resident about the complaint. The RN revealed that in the past, the resident reported that perfume was stolen. The RN stated that the Social Worker (SW) and the LNHA were handling the issue. She stated that she was not sure if police were notified however the LNHA gave the resident a lock for the drawer after the resident reported that the perfume was missing. The RN stated that the resident was not consistently using the lock on the drawer because it was not convenient. She (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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	continued to add that if the resident complained of theft or missing personal items to her, she would report it to the administration, and they would handle the investigation. On 8/13/2025 at 10:24 AM, the surveyor interviewed the residents primary care CNA #2 who stated that Resident #11 reported that perfume was missing from the resident's drawer a couple months ago and she thought there was an investigation was being done by the Administrator. She stated that the LNHA was supposed to replace the perfume but was not replaced as far as she knew. She stated that after the resident reported that the perfume was missing, the administration put a lock on the resident's drawer. She confirmed that the resident did not consistently use the lock on the drawer and always needed someone to unlock it. She stated that she was not aware that the lock was broken at this time. She added that the resident reported to her on 8/11/25 that soap was now missing. CNA #2 stated that she reported the missing soap to an agency nurse and was not sure if the nurse told the administration. She stated Resident #11 called their RP and reported that their soap was stolen.On 8/13/2025 at 11:23 AM, the surveyor interviewed the Director of Nursing (DON) who stated that he was not aware and was not notified that the resident had complaints of missing or stolen items. He then added that he was made aware that Resident #11 stated that they had soap stolen from their room. He stated that the LNHA was investigating the complaint of stolen item that was reported this morning (8/13/25). The surveyor asked the DON if he was made aware about missing perfume a couple months ago. The DON stated that the missing perfume was not reported to him however was reported to the LNHA and that the LNHA was handling that investigation. The surveyor asked the DON what the process was for reporting misappropriation of resident property, and he stated that an investigation would be conducted which included completing an incident report, interviewing staff, obtaining written statements from resident and staff or any other witnesses. He stated that the staff were to contact family members and report the incident to the Department of Health (DOH) within 2 hours. On 8/13/2025 at 11:36 AM, the surveyor interviewed the Director of Maintenance (DOM) who stated that the LNHA usually instructed the DOM to put the locks on the resident's drawers if the resident requested. The MOD stated that the LNHA instructed the DOM to put the lock on Resident #11's drawer a couple months ago. The DOM spoke with the resident and the resident told him that the lock had to be put on because something about perfume. The DOM did not remember the date the lock was installed on the drawer. On 8/13/2025 at 11:54 AM, the LNHA stated that he did not investigate and did not report the allegation of missing perfume because he did not have a time frame. He stated that he should have reported the allegation to the NJDOH within two hours and called the police. He continued to admit that he should have obtained statements from the staff, resident and other alert and oriented residents in the area. He stated that he did not recall if the resident was reimbursed for the missing perfume. He stated that it would that been important to follow the process for investigating and reporting abuse/misappropriation of personal property to protect the resident and other residents. The LNHA stated that he was the abuse officer for the facility and was aware that he should have reported and investigated the residents compliant of missing personal items.The facility policy dated 9/2024 and titled, Abuse, Neglect, and Mistreatment of Residents Policy indicated that the facility was to ensure timely and thorough investigation of abuse, neglect or mistreatment of residents. Observances, complaints or evidence of alleged abuse, neglect and or mistreatment are thoroughly investigated and reported to the appropriate parties. The policy describes misappropriation of property the deliberate misplacement, exploitation or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. The policy indicated that an accident incident report form would be used for residents, witnesses if any would be documented on the report and an investigation would be conducted including but not limited to statements form staff in the area where alleged incident occurred, the resident and any other individual that may have information regarding the 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
	315013	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barclays Rehabilitation and Healthcare Center	1412 Marlton Pike East Cherry Hill, NJ 08034

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to provide the necessary care and services for one (1) of 1 resident (Resident #71) reviewed for respiratory care and was evidenced by the following:Review of the admission Record (admission summary) reflected that Resident #71 was admitted to the facility with the diagnoses that included but was not limited to; chronic obstructive pulmonary disease (COPD) (a chronic lung condition that makes breathing difficult) and depression.A review of the admission Minimum Data Set (MDS), an assessment that facilitates a resident's care dated 6/25/2025, indicated that Resident #71 had a Brief Interview for Mental Status (BIMS) of 10 out of 15 which indicated that the resident had moderate cognitive impairment. The MDS also indicated Resident #71 was dependent on staff for all activities of daily living (ADLs) and was not on continuous and intermittent oxygen (O2) treatments.On 8/13/2025 at 8:39 AM, Surveyor #1 observed Resident #71 in their room on oxygen (O2) via (by way of) nasal cannula (tubing that supplies O2) set at 3.5 liters/minute. On 8/13/2025 at 8:30 AM, Surveyor #2 observed Resident #71 in their room with the head of bed up and neck cushion on. The resident was pleasant and had no issues with breathing. The resident's respirations were even and unlabored. Surveyor #2 observed that the resident was on O2 via nasal cannula at 3.5 liters. The resident stated that she was not sure how much O2 should be administered. On 8/14/2025 at 10:38 AM, Surveyor #2 had a third observation that Resident #71 continued 3.5 liters of O2.A review of the physician order summary (POS) dated 7/1/25, reflected a physician's order for O2 at 2 liters/minute via nasal cannula continuously every shift for O2 therapy.A review of the Treatment Administration Record (TAR) dated 7/1/25, reflected an order for O2 at 2 liters via nasal cannula continuously. Review of the TAR dated 7/1/25 until 7/14/25 reflected that Resident #71's pulse Ox (measures the amount of oxygen in the blood) was within normal range.A review of the progress notes (PN) dated 6/20/2025 at 20:09 (9:09 PM) revealed that the resident was admitted on O2 at 2 liters via nasal cannula, however a physician's order was not obtained until 7/1/25.A review of the Care Plan (CP) dated 6/21/25, reflected that the resident was oxygen therapy with the settings at 2 liters/minute.On 8/14/2025 at 10:47 AM, Surveyor #2 interviewed the Licensed Practical Nurse (LPN) who read the resident's physician orders in the presence of the surveyor and confirmed that the order read to administer O2 at 2 liters via nasal cannula continuously. The LPN accompanied the surveyor to the resident's room and confirmed that the resident's O2 concentrator was set to 3.5 liters of O2. The LPN stated that since the resident's pulse Ox's have been stable on 3.5 liters that he would reassess the resident and call the MD for a possible change in oxygen orders. The LPN did confirm that if the order indicated that the resident should have been given O2 at 2 liters then the resident should not be on O2 at 3.5 liters. He stated that 3.5 liters was the wrong dosage of oxygen. He also stated that the oxygen order should have been obtained on 6/20/25 when the resident was admitted to the facility.On 8/15/25 at 9:10 AM, the surveyor interviewed the MDS Coordinator Registered Nurse (MDSC/RN) who stated that he completed Resident #71's admission MDS dated [DATE]. The surveyor asked the MDSC/RN why the MDS did not indicate that the resident was on continuous O2. The MDSC/RN reviewed the resident's medical record in the presence of the surveyor and confirmed that the progress notes (PN) reflected that the resident was provided with O2 since 6/20/25, however the staff did not obtain a PO until 7/1/25. He stated that the resident was receiving O2 from 6/20/25 until 7/1/25 without a physician's order.The facility policy titled, Oxygen Administration and dated 12/2024 which indicated that it was the policy and procedure to provide oxygen to residents in compliance with their physician orders and upon receiving an order for oxygen from the resident's physician the nurse will place the order in (electronic medical record) to be carried out. NJAC 8:39-19.4(a)