STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315060	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary's Center for Rehabilitation & Healthcare	220 St Mary's Drive Cherry Hill, NJ 08003

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT #: 2578601, NJ00183769, NJ00185789 Based on interviews, medical record review, and review of other pertinent facility documents on 08/28/2025 and 09/08/2025, it was determined that the facility failed to notify a provider timely when prescribed treatments and medications were not administered as ordered. This deficient practice was identified for two of three residents (Resident # 1 and Resident #3) reviewed for unadministered medication or treatments. This deficient practice was evidence by the following:Complaint#: 2578601, NJ00183769, NJ00185789 1.) According to the admission Record (AR), Resident #1 was admitted to facility with diagnoses including but not limited to: muscle wasting and atrophy (loss of muscle mass), liver disease, epilepsy (brain disease that causes repeated seizures), malignant neoplasm (cancerous tumor with the ability to spread to other tissues and organs) of the colon, secondary malignant neoplasm of liver and intrahepatic bile duct (canal that carries bile between organs in the digestive system), and unspecified intellectual disabilities. A review of the Resident #1's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/24/2025, reflected the resident's cognitive skills for daily decision making were severely impaired. A review of Resident #1's Order Summary Report (OSR) revealed the following medication orders: Phenobarbital (medication used to treat or prevent seizures, treat insomnia, or as a sedative) oral tablet 32.4 milligrams (MG). Give 1 tablet by mouth at bedtime as a sleep aid. The order start date was 01/24/2025 at 9:00 P.M. The order end date was 01/25/2025. Phenobarbital oral tablet 30 MG. Give 1 tablet by mouth at bedtime as a sleep aid. The order start date was 01/25/2025 at 9:00 P.M. The order end date was 1/28/2025.Phenobarbital oral tablet 30 MG. Give 1 tablet at bedtime for seizures. The order start date was 01/28/2025 at 9:00 P.M. The end date was 02/04/2025. Phenobarbital oral tablet 32.4 MG. Give 1 tablet by mouth at bedtime for partial epilepsy. The order start date was 02/09/2025 at 9:00 P.M. The end date was 03/21/2025.Phenobarbital oral tablet 32.4 MG. Give 1 tablet by mouth at bedtime for anxiety. The start date was 03/21/2025 at 9:00 P.M. The end date was 03/25/2025. A review of Resident #1's Medication Administration Record (MAR) revealed that the Chart Code 9 was entered on Resident #1's MAR for the following medication doses: Phenobarbital oral tablet 32.4 MG. Give 1 tablet by mouth at bedtime for sleep aid on 01/24/2025. Phenobarbital oral tablet 30 MG. Give 1 tablet by mouth at bedtime for sleep aid on 01/25/2025 and 01/26/2025.Phenobarbital oral tablet 30 MG. Give 1 tablet at bedtime for seizures on 01/28/2025, 01/29/2025, 01/31/2025, 02/01/2025, and 02/02/2025. Phenobarbital oral tablet 32.4 MG. Give 1 tablet by mouth at bedtime for partial epilepsy on 02/09/2025, 02/12/2025, 02/13/2025, 02/14/2025, 02/15/2025, 02/16/2025, and 03/8/2025.Further review of the MAR revealed that the Chart Code 9 was used to indicate Other/See Nurses Notes. A review of Resident #1's Progress Notes (PN) for January and February of 2025 revealed PNs indicating that Resident #1's phenobarbital was on order and that the facility was awaiting prescription delivery. There was no further documentation for the aforementioned missed medication doses. Further review of Resident #1's PN for January and February revealed no documentation of provider notification of unavailable or unadministered medications until 02/17/2025 at 4:09 P.M., when a progress note indicated that a Nurse Practitioner (NP #1) was notified. Review of PNs for March revealed no documentation of provider notification for the missed phenobarbital dose on 03/08/2025. A telephone interview was conducted with a Licensed Practical Nurse (LPN #1) on 08/28/2025 at 2:44 P.M. LPN #1 stated that when she documented on order in the PN on 02/13/2025 and 02/14/2025 it meant that the medication had not arrived from the pharmacy and was not administered. LPN #1 stated that if medications were not given, a provider should have been notified. LPN #1 further stated that if she had notified a provider that a resident's medications were not given, she should have documented that in the PNs. An interview was conducted with a Unit Manager (UM #1) on 08/28/2025 at 3:50 P.M. UM #1 stated that when ordered medications were not available the expectation was for nurses to check the medication cart and overflow supply and then call the pharmacy. If medications were still unavailable the next step was to call a provider and document their response. UM #1 stated that if there was no PN made then there is no way to know that a provider was notified. UM #1 identified that the PN on 02/17/2025 was the only documentation that a provider was notified of Resident #1's the missed phenobarbital doses. 2.) According to the admission Record (AR), Resident #3 was admitted to facility with diagnoses including but not limited to: anorexia nervosa (disorder that causes restriction of nutrient intake, significantly low body weight, fear of weight gain, and distorted body image); suicidal ideations (thoughts or feelings about suicide