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	04/30/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to revise a care plan when there was a change in the physician's orders for fluid restrictions for 1 of 3 residents sampled for dialysis (a treatment that removes waste products from the blood), (Resident #232).This deficient practice was evidenced by the following:During the initial tour on 04/23/2026 at 11:47 AM, the surveyor observed Resident #232 resting in bed.A review of the admission Record revealed Resident #232 was admitted to the facility with diagnoses including, but not limited to, end-stage renal disease (a medical condition where the kidneys stop functioning) and hypertension (high blood pressure).A review of Resident #232's electronic medical record (EMR) revealed the resident was on a fluid restriction of 1500 milliliters (ml) daily prior to hospitalization on 03/02/2026. Resident #232 was readmitted on [DATE], and per the hospital discharge summary, there were no fluid restrictions.A review of Resident #232's care plan revealed a focus for risk of alteration in hydration related to fluid restriction initiated on 12/11/2025. No revision was made to the care plan when Resident #232 was readmitted .During an interview on 04/29/2026 at 09:58 AM with the surveyor, the Unit Manager (UM) on the St. Mary's unit said that care plans are reviewed every three months and as needed if changes occur. When asked if Resident #232's care plan should have been updated, the UM replied, Yes.During an interview on 04/29/2026 at 1:18 PM with the surveyor, the Director of Nursing (DON) said care plans are updated quarterly or during audits, and should be updated upon readmission as orders and care can change.A review of a facility-provided policy titled Resident Evaluation/Assessment revealed, under Monitoring results and adjusting interventions, the following requirement: Periodically reviewing progress and adjusting treatments based on provider orders/guidance.NJAC 8:39-11.2(i)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review it was determined that the facility failed to ensure an environment was free from accident hazards by failing to place assistive devices, specifically bilateral floor mats, to prevent avoidable accidents for 2 of 2 residents (Resident #43 and #147) investigated for Accidents.The deficient practice was evidenced by the following:1) On 04/23/2026 at 10:28 AM, during the initial tour of the facility, the surveyor observed Resident # 147 in their room in bed. The surveyor observed one floor mat on its side leaning against the wall on the far side of the room. On 04/24/2026 at 09:42 AM, the surveyor observed Resident #147 sleeping on his/her left side in bed. The surveyor observed one brown floor mat on its side leaning against the wall on the far side of the room.A review of Resident # 147's Electronic Medical Record (EMR) revealed diagnosis of but not limited to repeated falls and other abnormalities of gait and mobility (alteration in walking patterns and movements).A review of Resident # 147's EMR revealed a physician's order for bilateral floor mats every shift with a start date of 01/23/2026. A review of Resident # 147's EMR revealed under Care Plan a focus for risk of falls related to medication side effects, unsteady gait and history of falls. The focus revealed an initiated date of 06/29/2022. The care plan revealed an intervention for bilateral floor mats at bedside. The intervention revealed an initiated date of 01/23/2026. 2) On 04/23/2026 at 10:42 AM Resident #43 was observed in bed with visitors. At that time the family member of Resident #43 stated that the resident #43's floor mat in the past, had been found behind the resident's bed while they were in bed. On 04/24/2026 at 09:40 AM Resident #43 was observed sleeping in bed. At that time the surveyor observed one floor mat on the side of the bed between the resident and the roommate, no mat was observed on the other side of the bed.On 04/28/2026 at 09:43 AM Resident #43 was observed sleeping in bed. At that time the surveyor observed one floor mat on the side of the bed between the resident and the roommate, no mat was observed on the other side of the bed.A review of Resident # 43's EMR revealed diagnosis of but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (limited or no movement to one side of the body after a sudden loss of blood supply to the brain) and unspecified fall.A review of Resident #43's most recent Minimum Data Set (MDS) (an assessment tool), dated 04/02/2026, revealed under section J that Resident #43 had a fall since prior assessment. A review of Resident # 43's EMR revealed a physician's order for bilateral floor mats every shift with a start date of 01/23/2026.A review of Resident # 43's EMR revealed under Care Plan a focus for risk of falls due to history of falls. The focus revealed an initiated date of 05/25/2023. The care plan revealed an intervention for bilateral floor mats at bedside. The intervention revealed an initiated date of 03/12/2026.On 04/28/2026 at 12:59 PM during an interview with the surveyor, the Unit Manager (UM) stated that the floor mats should be on both sides of the bed while the resident is in bed. The UM further stated that this was necessary to prevent injury in the event of a fall. On 04/29/2026 1:18 PM during an interview with the surveyor, the Director of Nursing (DON) stated that residents floor mats should not be on their sides against the wall. The DON further stated that when ordered bilaterally, the fall mats should be on floor to both sides of the resident's bed while they are in bed. The DON further stated this was necessary for resident safety. A review of the facility provided policy titled Fall and Fall Risk Management revealed under Resident-Centered Approaches to Managing Galls and Fall Risk, number 4, .staff will identify and implement relevant interventions to try to minimize serious consequences of falling. NJAC 8:39-27.1(a)

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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. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice specifically by not having a physician's order for oxygen administration. The deficient practice was identified for 1 of 6 (Resident # 5) residents reviewed for Respiratory Care. The deficient practice was evidenced by the following:On 04/23/2026 at 9:58 AM, during the initial tour, the surveyor observed Resident #5 in their room lying in bed. At that time, the surveyor observed a nasal cannula (tube that delivers oxygen through the nares) applied to Resident #5. At that time the survey observed the oxygen condenser to be on and the resident was receiving 3L of oxygen through the nasal cannula.A review of Resident #5's admission record revealed that Resident #5 had a diagnosis of but not limited to, heart failure (Inability of the heart to pump enough blood) and comfort care (care focused on relieving symptoms to improve quality of life).A review of Resident #5's Electronic Medical Record (EMR) revealed an order for and comfort care (care focused on relieving symptoms to improve quality of life) and did not reveal a physician's order for oxygen. During an interview on 04/28/2026 at 1:04 PM, with the surveyor, Unit Manager (UM) #1 stated that oxygen must be administered under a physician's order. UM #1 further stated that resident #5 had been receiving oxygen for awhile and acknowledged that Resident did not have a physician's order.During an interview on 04/29/2026 1:18 PM, the Director of Nursing (DON) stated yes when asked if there should be a physician's order for oxygen if a resident is being administered oxygen. A review of the facility-provided policy titled Oxygen Administration - Resident with a revision date of 12/2024, failed to mention the need for a physician's order.A review of the facility provided policy titled Medication and Treatment Orders with an effective date 3/2020, revealed a policy statement, Orders for medications and treatments will be consistent with principles of safe and effective order writing. N.J.A.C. S 8:39-27.1

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility staff failed to ensure that respiratory equipment was stored in a manner that prevented contamination, in accordance with infection prevention and control standards, for 3 of 6 residents reviewed for respiratory care (Resident #5, Resident #79, and Resident #86).The deficient practice was evidenced by the following: On 04/23/2026 at 10:22 AM, during the initial tour, surveyor #1 observed Resident #86's nebulizer mask (a medical device that converts liquid medication into a fine mist for inhalation into the lungs) lying in the nightstand drawer, open to air. A review of Resident #86's admission Record revealed the resident was admitted to the facility with, but not limited to, hypertension (high blood pressure) and palliative care (care focused on relieving symptoms to improve quality of life). A review of Resident #86's Electronic Medical Record (EMR) revealed a physician's order for Ipratropium-Albuterol Solution (a medication that relaxes the muscles in the airway) every 8 hours for 5 days with a start date of 04/20/2026. During an interview on 04/28/2026 at 10:49 AM with surveyor #1, the Infection Preventionist (IP) said that the nebulizer mask should be stored in a plastic bag when not in use. During an interview on 04/29/2026 at 1:18 PM with surveyor #1, the Director of Nursing (DON) said that after the nebulizer mask is cleaned and dried, it should be stored in a bag for infection control purposes. A review of the facility-provided policy titled Respiratory Equipment failed to mention how respiratory equipment should be stored when not in use. NJAC 8:39-19.4 (k) On 4/23/2026 at 9:58 AM during initial tour, Surveyor #2 observed Resident #5's nebulizer (a machine that aerosolizes medications for inhalation) with the nebulizer mask beside it on top of the bedside table open to air. A review of Resident #5's admission record revealed that Resident #5 had a diagnosis of but not limited to, heart failure (Inability of the heart to pump enough blood). A review of Resident #5's Electronic Medical Record (EMR) revealed a physician's order for Albuterol Sulfate Nebulization solution 0.083%, inhale 1 vial via nebulizer every four hours as needed for shortness of breath and wheezing and comfort care (care focused on relieving symptoms to improve quality of life). A review of Resident #5's Care Plan in the EMR revealed a nursing focus of Comfort Care due to Terminal/End-stage disease initiated on 01/28/2026. On 04/23/2026 at 10:50 AM during initial tour, Surveyor #2 observed Resident #79 Continuous Positive Airway Pressure (CPAP) machine (Device that creates positive pressure to assist in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breathing). A review of Resident 79's admission record revealed that Resident #79 was admitted with but not limited to chronic obstructive pulmonary disease (COPD), (a progressive lung disease that makes it difficult to breathe) and chronic respiratory failure (chronic condition that makes it difficult to breathe). A review of Resident #79's Electronic Medical Record (EMR) revealed a physician's order, Apply CPAP (pressure setting 5) via mask at bedtime and remove per schedule. A review of Resident #79's Care Plan in the EMR revealed a nursing focus of altered respiratory status/difficulty breathing r/t sleep apnea with intervention that included the use of residents CPAP initiated on 02/04/2026. During an interview on 04/29/2026 at 1:18 PM, the Director of Nursing (DON) stated when not in use, masks are cleaned and dried and stored in a labeled bag, for infection control purposes. A review of the facility-provided policy titled Respiratory Equipment failed to mention how respiratory equipment should be stored when not in use. NJAC 8:39-19.4 (k)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and review of documentation provided by the facility, it was determined that the facility failed to maintain acceptable standards of essential kitchen equipment in a safe and operable condition. This deficient practice was evidenced by the following:During initial tour of the kitchen on 04/23/2026 at 10:05 AM, the surveyor observed the following in the kitchen with the Food Service Director (FSD):The stove had no knobs. The FSD stated that the knobs had been broken for 1 month and ordered more. FSD stated we are supposed to be getting a new stove. On the portable holding temperature box, the gaskets (rubber seal) were falling off. The FSD stated the box is new, but this can happen because of the high heat. During an interview with the surveyor on 04/23/2026 at 11:48 AM, FSD acknowledged that there should be knobs on the stove top. He also stated that the gaskets on the portable temperature box should be replaced. A review of the facility provided policy titled, Facility Equipment, reflected that if an equipment in the facility is not functioning as designed, the maintenance department will work with the department head to correct the concern of that piece of equipment. Maintenance Department will orchestrate the overall maintenance of facility equipment. NJAC 8:39 31.7(d)