

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER South Jersey Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 99 Manheim Avenue Bridgeton, NJ 08302	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to store utensils in a clean, dry location; not exposed to splash, dust, or other contaminations, and failed to keep utensils covered or inverted to maintain sanitation in a safe, consistent manner. This deficient practice was evidenced by the following: On 11/19/25 at 10:30 AM, the surveyor, in the presence of the Food Service Director (FSD), observed in the facility kitchen, a white bin labeled Flour, with a clear top. Inside of the container, the surveyor noted a white powder and a clear plastic scoop utensil resting within the powder. When asked whether the scoop utensil was normally kept within the product, the FSD responded no, they should not be left in the flour, they should be cleaned and placed in the drying area after use for sanitary reasons. On 11/20/25 at 1:53 PM, a pink wash basin was observed sitting on top of the ice machine on the C/D unit. One clear plastic and one metal ice scoop utensil were each noted within the wash basin. The ice machine appeared to be locked at the time. On 11/21/25 at 12:34 PM, the surveyor observed a pink wash basin sitting on top of the ice machine on the C/D unit. The clear plastic and metal ice scoop utensils were observed resting within the wash basin. On 11/24/25 at 10:19 AM, the surveyor noted the metal and plastic ice scoop utensils located within the pink wash basin on the C/D unit ice machine. At that time, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 regarding the use and storage of the ice scoop utensils. LPN #1 confirmed that residents were given ice from the machine using the scoops each shift and as requested for their personal cups and pitchers of water. When asked if the ice scoop utensils were usually kept in the wash basin, LPN #1 replied yes and explained they were kept in the pink basin because the metal scoop did not fit in the hanger and neither did the plastic scoop since the ice machine was changed out. When asked who was responsible for cleaning the machine and the ice scoop utensils, LPN #1 replied that the Housekeeping Department maintained them. The surveyor then asked LPN #1 if any potential problems could arise with storing the ice scoops in an open wash basin; LPN #1 replied that moisture could sit with no place to go, which could harbor bacteria. On 11/24/25 at 10:52 AM, the surveyor observed the ice machine on the A/B unit in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM) #2, a plastic ice scoop utensil resting within a protective hanger laying horizontally on top of the ice machine. The surveyor interviewed LPN/UM #2 who confirmed that residents were given ice from the machine using the scoop utensil each shift and as needed, like on the C/D unit. When asked if the holder was usually laying horizontal with the ice scoop utensil inside, LPN/UM #2 stated she was unsure of when it was taken from the wall, but it used to be hanging and was unsure why it was not replaced. When asked if any potential problem could arise from storing the ice scoop utensil horizontally within the holder on top of the ice machine instead of inverted on the wall as designed, LPN/UM #2 replied that without proper drainage, bacteria could grow and potentially make people sick. On 11/24/25 at 11:37 AM, the surveyor toured with the Director of Environmental Services and Maintenance (DESM) to observe the storage of the ice scoop utensils and address concerns regarding their sanitary storage. The DESM stated that while he had a cleaning log and maintenance log for the ice machine, no specific log was kept for the ice scoop utensil cleaning; he stated that he was unsure when they were last cleaned and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 315061
		If continuation sheet Page 1 of 11

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that the Certified Nursing Assistants (CNA) could clean them but could not offer any evidence that they were ever cleaned. When asked about the sanitary storage of the ice scoop utensils and what potential problems could arise from their storage in a wash basin or a cover placed horizontally on top of an ice machine the DESM responded, there could be contamination, cross-contamination, or even a legionnaires risk. On 11/25/25 at 10:20 AM, the surveyor's concerns were presented to the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA). In the presence of the survey team, both acknowledged that scoop utensils should not be stored within the product, a wash basin, or horizontally within its cover to prevent the spread of infection. A review of a facility's Food Storage/Labeling policy, undated, included: Scoops must be provided for bulk foods (such as sugar, flour.). Scoops should be kept covered in a protected area near the containers rather than in the containers. Scoops should be washed and sanitized on a regular basis. A review of a facility's Care, Cleaning and Storage of Equipment policy, undated, included: Equipment found to be in disrepair (e.g. paper towel dispensers, hand soap dispensers, etc.) should be reported to the supervisor on the day it is noted. NJAC 8:39-17.2 (g); 19.7 (d)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to complete reference checks on employees before their start date. The deficient practice was identified for 6 of 107 employees (Employee #1, Employee #2, Employee #3, Employee #4, Employee #5, and Employee #6), reviewed and was evidenced by the following: On 11/19/25 at 10:24 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) the personnel files of all the new employees who were hired since the last standard survey (6/19/2024), whether currently employed or terminated, for review by the survey team. A review of the employee personnel files revealed the following: For Employee #1, a Housekeeper with a start date of 8/20/24, there was no evidence of a reference check prior to the start of employment. For Employee #2, a Registered Nurse (RN) with a start date of 11/6/24, there was no evidence of a reference check prior to the start of employment. For Employee #3, a Certified Nursing Assistant, with a start date of 9/12/24, there was no evidence of a reference check prior to start of employment. For Employee #4, a Licensed Practical Nurse (LPN) with a start date of 4/9/25, there was no evidence of a reference check prior to the start of employment. For Employee #5, a LPN with a start date of 9/24/24, there was no evidence of a reference check prior to the start of employment. For Employee #6, a RN with a start date of 8/16/24, there was no evidence of a reference check prior to the start of employment. On 11/25/25 at 10:31 AM, the surveyor interviewed the Director of Human Resources (DHR), in the presence of the survey team about the facility's screening process for new hires. The DHR stated the facility completed reference checks prior to the first day of employment to ensure that the potential employee had nothing bad against them, such as abuse against a resident. She further stated that if the employee did not have reference checks completed prior to the hire date, then the employee would not be hired. A review of the facility's Abuse, Neglect and Exploitation policy, revised 1/3/25, included, .potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. Background, reference, and credential's checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. the facility will maintain documentation of proof that the screening occurred . NJAC 8:39-4.1(a)(5); 9.3(b)		

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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. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a safe, comfortable, and home-like environment for a.) residents who required the use of a wheelchair (Resident #5, #15, #29, #37, #50, #52, #and #56) and b.) a resident who required the use of an over the toilet commode (Resident #5). This deficient practice was identified on 2 of 2 units, A/B Unit and C/D Unit, and was evidenced the following: On 11/19/2025 at 11:33 AM, the surveyor observed Resident #74 in the hallway, seated in a wheelchair on a seat cushion. The seat cushion had a large amount of residue buildup on the sides and a rip along the right lateral side of the cushion. The wheelchair contained a large amount of thick residue on the seat and the frame. On 11/21/2025, at 8:29 AM, during a follow-up visit with Resident #74, the wheelchair remained heavily soiled. On 11/21/2025, at 9:23 AM, the surveyor interviewed the Housekeeper/Maintenance staff member (HKM), who stated that two (2) days per week, the wheelchairs were taken apart and cleaned. He further stated that at the time of cleaning, the wheelchairs were checked to ensure that they were intact and in proper working condition. On 11/21/2025 at 9:32 AM, the surveyor interviewed the DESM, who stated that the wheelchairs should be cleaned every 2 weeks or as needed. He further noted that the wheelchairs should be kept clean and in good working condition. On 11/21/2025 at 10:12 AM, the surveyor interviewed the Director of Nursing (DON), who stated that wheelchairs and seat cushions should be kept clean, and in good repair. She further stated that if a seat cushion was torn or ripped, the Therapy department should be notified so that the seat cushion could be replaced by the facility. On 11/21/2025 at 11:15 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that there was a monthly wheelchair cleaning schedule posted on each unit. He further stated that wheelchairs should be cleaned as scheduled and as needed. The LNHA stated that the wheelchairs should be clean, safe, and functioning properly. On 11/24/2025, the surveyor conducted an environmental tour and observed the following: At 8:45 AM, Resident #5 was observed in the hallway of the C/D Unit, seated in a wheelchair. The wheelchair frame was rusty and contained a large buildup of dirt, dust, and residue on the frame and wheels. At that time, the resident stated, Look at this, I need a new seat, it's ripped. The surveyor observed a big rip on the right side of the seat of the wheelchair. At 8:51 AM, Resident #15 was observed in the hall near the activity area, seated in a wheelchair. The wheelchair contained rust, a buildup of dust, and residue. At 8:54 AM, Resident #29 was observed near the activity room, seated in a wheelchair. The wheelchair was rusty in multiple areas on the frame. Dust was also noted on the wheels and frame. At that time, Resident #29 stated that they cleaned the wheelchair themselves. At 9:01 AM, Resident #37 was observed in the activity area, seated in their wheelchair. The wheelchair was noted with a buildup of dust and dirt on various areas of the frame. At 9:07 AM, Resident #52 was observed in the activity area, seated in their wheelchair. The wheelchair was noted with a large amount of residue buildup on the frame. At that time, Resident #52 stated that their wheelchair was cleaned approximately every six (6) months by the facility. At 9:12 AM, Resident #50 was observed seated in their wheelchair. The wheelchair was noted with a buildup of residue on the frame. At that time, Resident #50 stated that they could not recall the last time their wheelchair was cleaned by the facility. At 9:16 AM, the surveyor was joined by the Director of Environmental Services and Maintenance (DESM) on the tour, and he confirmed the findings. He stated that he was disappointed in the condition of the wheelchairs because an employee was scheduled to work 2 days per week to clean them. At 9:18 AM, Resident #56 was observed in the activity room, seated in their wheelchair. The wheelchair was noted with a significant amount of residue buildup on the frame. At that time, the resident stated that they could not recall the last time their wheelchair was cleaned by the facility. At 9:35 AM, Resident #79 was observed seated in their wheelchair. The wheelchair had a large buildup of rust and residue on the frame. At 1:20 PM, the surveyor made a follow-up visit with (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5, as the surveyor was exiting the resident's room, an over-the-toilet commode was noted with rust on the legs and arms. On 11/24/2025 at 12:48 AM, the surveyor interviewed the Regional Nurse/Infection Preventionist (RN/IP), who stated that the wheelchairs should be cleaned every 2 weeks and as needed. She further stated that it was important that wheelchairs were cleaned so the residents did not get sick and develop health concerns and spread viruses. A review of the wheelchair cleaning schedule for July, August, September, October, and November 2025 revealed that each wheelchair was scheduled for cleaning once per month. A review of the facility's policy, Wheelchair 2025, undated, included, Wheelchair cleaning and sanitation requirements. A monthly wheelchair cleaning schedule is posted at each nurse's station for your reference. All resident wheelchairs must be: Thoroughly cleaned and sanitized twice per month (every other week). Cleaned according to the posted schedule for each unit. Fully wiped down, including arm rests, seat cushions, back supports, frames, footrests, wheels, and push handles using facility -approved disinfectants. Inspected during cleaning for any signs of damage, loose parts, unsafe wheels, or malfunctioning brakes. Proper wheelchair cleaning is an important part of resident safety, infection control, and daily comfort. All staff are expected to follow the posted schedule and complete all required documentation after each cleaning. NJAC 8:39-31.4 (a)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, it was determined that the facility failed to complete the Comprehensive Minimum Data Set (MDS), a periodic and federally mandated standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 10 residents (Resident #6) reviewed for Resident Assessment and was evidenced by the following: Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or look back) period that the assessment covered for the resident. At a minimum, facilities are required to complete a comprehensive assessment for each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident, where 12 months refers to a period within 366 days. A review of Resident #6's electronic medical record revealed the following: Resident # 6: The Significant Change in Status- Comprehensive MDS ARD was dated 10/6/25 and was not completed until 11/19/25. On 11/24/25 at 10:41 AM, the surveyor conducted a telephone interview with the MDS Coordinator (MDSC) who stated that she was the only MDSC for two (2) buildings and that she was out sick during that timeframe with no other employee covering for her. The MDSC further stated that she would send a list of residents whose MDS assessments were due to the facility and once completed, a Registered Nurse (RN) such as the Director of Nursing (DON) or Regional Nurse/Infection Preventionist (RN/IP) would sign the assessments prior to transmitting them to the Centers for Medicare and Medicaid Services (CMS). The MDSC confirmed that Resident #6's Significant Change MDS was completed after the required date. On 1/24/25 at 11:59 AM, the surveyor interviewed the DON who stated that the RN/IP signed the completed assessments prior to submission to CMS. The DON further stated that she would expect the MDS to be completed in a timely fashion within the timeframe. On 11/24/25 at 12:05 PM, the surveyor interviewed the RN/IP who stated that the MDSC would normally send her a schedule of the residents' ARDs and when the MDS needed to be completed. She further stated that since the MDSC was a Licensed Practical Nurse (LPN), the RN/IP would sign the completed assessments prior to transmitting to CMS. The RN/IP stated it was important to complete the MDS assessments as scheduled to capture an accurate assessment of the resident. On 11/25/25 at 10:12 AM, in the presence of the survey team, the DON and the Licensed Nursing Home Administrator (LNHA) acknowledged that the MDS assessment for Resident #6 was completed late. A review of facility's MDS 3.0 Completion policy, implemented 10/25/25, reflected: d. Significant Change in Status Assessment (SCSA) -a comprehensive assessment completed within 14 days of the identification of status change that meets the requirements outlined in Chapter 2 of the Version 3.0 RAI manual. NJAC 8:39-11.2 (e)		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on interview and record review, it was determined that the facility failed to complete the Quarterly Minimum Data Set (MDS), a periodic and federally mandated standardized assessment tool, within the required timeframe. This deficient practice was identified for 4 of 10 residents (Resident #5, #12, #18, and #35) reviewed for Resident Assessment and was evidenced by the following: Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or look back) period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1). The Assessment Reference Date (ARD) of the Quarterly MDS was within 92 days after the ARD of the previous MDS and 2). the completion date was no later than 14 days after the ARD. The following resident records were identified to be deficient with completion dates: 1. Resident #5: The Quarterly MDS ARD of 10/5/25 was completed on 11/19/25 and accepted on 11/19/25. 2. Resident #12: The Quarterly MDS ARD of 10/14/25 was completed on 11/19/25 and accepted on 11/19/25. 3. Resident #18: The Quarterly MDS ARD of 10/7/25 was completed on 11/19/25 and accepted on 11/19/25. 4. Resident #35: The Quarterly MDS ARD of 10/13/25 was completed on 11/19/25 and accepted on 11/19/25. On 11/24/25 at 10:41 AM, the surveyor conducted a telephone interview with the MDS Coordinator (MDSC) who stated that she was the only MDSC for two (2) buildings and she was out sick during that time with no other employee covering for her. The MDSC further stated that she would normally send a list of residents whose MDS assessments were due to the facility and once completed, a Registered Nurse (RN), such as the Director of Nursing (DON) or Regional Nurse/Infection Preventionist (RN/IP) would sign the assessments, then transmit them to the Centers for Medicare Services (CMS). The MDSC confirmed that Residents #5, #12, #18, and #35's Quarterly MDS were completed late. On 11/24/25 at 11:59 AM, the surveyor interviewed the DON who stated that the RN/IP signed the completed assessments prior to submission to CMS. The DON further stated that she would expect the MDS to be completed in a timely fashion within the timeframe. On 11/24/25 at 12:05 PM, the surveyor interviewed the RN/IP who stated that the MDSC would send her a schedule of the resident ARDs and when the MDS needed to be completed. She further stated that since the MDSC was a Licensed Practical Nurse (LPN), the RN/IP would sign the completed assessments prior to transmitting to CMS. The RN/IP stated it was important to complete the MDS assessments as scheduled to capture an accurate assessment of the resident. On 11/25/25 at 10:12 AM, in the presence of the survey team, the DON and the Licensed Nursing Home Administrator (LNHA) acknowledged that the Quarterly MDS assessments were completed late. A review of the facility's MDS 3.0 Completion policy, implemented 10/25/25, reflected e. Quarterly Assessments-completed using the ARD no > 92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD). N.J.A.C. 8:39-11.2		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, it was determined that the facility failed to transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 4 of 10 residents reviewed for resident assessment (Resident #2, #4, #8 and #11). This deficient practice was evidenced by: The MDS is a comprehensive federal mandated process for clinical assessment of all residents that must be completed and submitted to the Quality Measure System. The facility must electronically transmit the MDS no later than 14 days of assessment completion. After transmitting the MDS a quality measure is generated to enable a facility to monitor a resident's decline and progress. The following residents were identified as having late assessment completions: 1. Resident #2: the Quarterly MDS was completed on 9/15/25 and was transmitted and accepted on 11/19/25. 2. Resident #4: the Annual MDS was completed on 9/15/25 and was transmitted and accepted on 10/19/25. 3. Resident #8: the Quarterly MDS was completed on 9/15/25 and was transmitted and accepted on 11/19/25. 4. Resident #11: the Quarterly MDS was completed on 9/22/25 and was transmitted and accepted on 11/19/25. On 1/24/25 at 10:41 AM, the surveyor conducted a telephone interview with the MDS Coordinator (MDSC) who stated that she was the only MDSC for two (2) buildings and she was out sick during that time, and no other employee was covering her. The MDSC further stated that the MDS assessments should be transmitted to the Centers for Medicare and Medicaid Services (CMS) within 14 days after completion. The MDSC confirmed that Resident # 2, #4, #8 and #11's completed MDS assessments were transmitted late. On 11/24/25 at 11:59 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she would expect the MDS be completed in a timely fashion and transmitted within the timeframe. On 11/24/25 at 12:05 PM, the surveyor interviewed the RN/IP who stated that the MDSC would send her a schedule of the residents ARDs and when the MDS assessments needed to be completed. She further stated that the since the MDSC was a Licensed Practical Nurse (LPN), the RN/IP would sign the completed assessments prior to transmitting to CMS. The RN/IP stated that she would expect the MDS assessments would be completed and transmitted within the timeframe. On 11/25/25 at 10:12 AM, in the presence of the survey team, the DON and the Licensed Nursing Home Administrator (LNHA) acknowledged that the MDS assessments were transmitted to CMS late. A review of facility's MDS 3.0 Completion policy, implemented 10/25/25, reflected under 7. Transmission Assessments- all assessments shall be transmitted to the designated CMS system (name redacted) within 14 days of completion all assessments. NJAC 8:39-11.2		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: accurately account for and document the administration of controlled medications. This deficient practice was identified on 1 of 2 medication carts reviewed for medication storage, and was evidenced by the following: During medication storage review on 11/21/25 at 11:10 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #1), reviewed the C/D unit long hall nursing unit's medication cart's which revealed the following: the individual resident Controlled Drug Record log (declining inventory log) for Resident #29 indicated the 9:00 AM (9 AM) dose of pregabalin (a controlled medication used to treat pain) 100 milligram (mg) tablet was not signed out on the declining inventory log. The declining inventory log was missing Nursing Administering signatures for 11/21/25 9 AM dose. A further review revealed that the individual resident Controlled Drug Record log for Resident #23 indicated the 9:00 AM (9 AM) dose of lacosamide oral tablet 200 mg (a controlled substance used to treat seizures) was not signed out on the declining inventory log. The declining inventory log was missing Nursing Administering signatures for 11/21/25, 9 AM dose. At the time of observation, the surveyor interviewed LPN #1, who stated she administered the 9 AM dose of pregabalin that morning (11/21/25) but did not sign the declining inventory log for Resident #29. She further stated that she administered the 9 AM dose of lacosamide that morning but did not sign the declining inventory log for Resident #23. LPN # 1 confirmed that the 9 AM dose was signed out as being administered in the electronic Medication Administration Record (eMAR) but was not accounted for on the declining inventory log. LPN #1 further acknowledged that declining inventory logs should be completed upon dispensing the medication to keep track of the narcotic count. LPN #1 indicated the importance of signing the declining inventory log is to ensure resident safety, ensure the medication was not given twice, and to keep the medication count correct. On 11/21/25 at 11:25 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) on unit C/D, who stated that she expected the nurse who was administering medications to sign the narcotic (controlled substance) declining inventory log when they pop it out of the bingo card. On 11/24/25 at 1:03 PM, the surveyor interviewed the Director of Nursing (DON), who stated nurses were to sign the declining inventory log as soon as it was taken from the medication cart to administer to the resident. She further stated that the importance of signing the declining inventory log was to avoid drug diversion and to ensure the resident received the medication as ordered. On 11/25/25 at 10:09 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, acknowledged that the declining inventory logs should be completed and filled out for each narcotic dose dispensed immediately at the time the medication was removed from inventory. She further stated there should not be any blanks on the narcotic declining inventory logs. A review of the facility's Medication Administration policy with a revision date 1/3/25, included medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. if medication is a controlled substance, sign narcotic book. NJAC 8:39-29.4, 29.7(c)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER South Jersey Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 99 Manheim Avenue Bridgeton, NJ 08302	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a). remove unwanted medication from the resident's bedside table (Resident #27), and b). properly secure medication within the medication cart for 1 of 2 nurses observed during the medication administration pass. This deficient practice was evidenced by the following: 1.) On 11/20/2025 at 8:16 AM, the surveyor observed Licensed Practical Nurse (LPN) #2 prepare medications for Resident #27, which included polyethylene glycol 3350 powder (used to treat constipation) 17 grams mixed with eight (8) ounces of water, and fluticasone-salmeterol 250-50 micrograms/actuation (MCG/ACT) aerosol powder inhaler (used to treat chronic obstructive pulmonary disease). LPN #2 then locked the medication cart and took the medications into the resident's room. Resident #27 took two swallows of the water containing the polyethylene glycol, then placed the cup on the overbed bedside table and stated that they did not want the remainder of the medication. The LPN encouraged the resident to finish the rest of the medication, however, the resident asserted that they would be throwing the medication away because they did not want it. The LPN then walked out of the resident's room with the resident's breakfast tray and inhaler in her hands. LPN #2 left the cup of water containing the polyethylene glycol on the resident's overbed bedside table. At that time, the surveyor interviewed LPN #2, who insisted that the resident would eventually drink the polythene glycol, and that she would periodically check back with the resident to see if the cup was empty. When asked if medications could be left on a resident's bedside table, the LPN #2 stated that she did not leave pills at the bedside. The surveyor continued to interview LPN #2 who stated, yes, polyethylene glycol was considered a medication. LPN #2 then went back into the resident's room, removed the medication from the overbed table, discarded it and LPN #2 then returned to the medication Cart. 2.) On 11/20/25 during the medication administration task with LPN #2, the surveyor noted that two blister pill packs (a form of pharmaceutical packaging that organizes medications into individual, sealed compartments) of Lisinopril 10 milligrams (mg - used to treat high blood pressure) that belonged to another resident (Resident #1) was left unattended on top of the medication cart while LPN #2 was in Resident #27's room administering their medication. One (1) blister pack contained eight (8) tablets of Lisinopril, and the other blister pack contained 1 tablet. Immediately upon the discovery, the surveyor interviewed LPN #2 who stated that when she administered Resident #1's medications earlier that morning, she realized that the Lisinopril was discontinued, so she removed the two blister packs from the medication cart drawer and placed them on top of the cart, where they remained, so that she could remember to get rid of them. She further stated that all medications should be secured when the nurse was away from the medication cart. On 11/20/2025 at 11:49 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #2, who stated that medications should never be left at the resident's bedside. She further stated that if a resident refused their medication, it should be discarded immediately. LPN/UM #2 also stated that medications should be kept secured within the medication cart or medication room and should never be left unattended on the medication cart, because other residents could have access to it. On 11/21/2025 at 10:15 AM, the surveyor interviewed the Director of Nursing (DON), who stated that during medication administration, the nurse should stay with the resident to ensure that all the medications were swallowed, and it should never be left at the bedside. She further stated that another resident could go into the resident's room and take the medication. The DON also stated that medications should be locked when the medication cart was out of sight because the medicine could become a danger to wandering residents. A review of the facility's Medication Storage policy, dated 10/10/24, included, .During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. NJAC 8:39-29.4(h)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER South Jersey Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 99 Manheim Avenue Bridgeton, NJ 08302	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and review of facility documents, it was determined that the facility failed to ensure that a Certified Nursing Assistant (CNA) received at least 12 hours of mandatory in-service training annually for 1 of 5 CNAs reviewed (CNA #1). The deficient practice was evidenced by the following: On 11/24/25, at 11:00 AM, the surveyor reviewed the provided in-service education for five (5) randomly selected CNAs for the years 2024 and 2025, which revealed the following: CNA #1, with a date of hire of 6/30/15, had 9.25 hours of in-service training from date of hire anniversary dates (June 2024 - June 2025). On 11/25/25 at 10:00 AM, the surveyor interviewed the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated she was responsible for the CNA in-service training and that it was important for CNAs to complete 12 hours of education annually to ensure the CNAs know how to properly care for the facility's residents. At that time, the DON confirmed that CNA #1 did not meet requirement for 12 hours of education from date of hire anniversary date, nor did the CNA meet the requirements for the 2024 calendar year. A review of the facility's policy, Required Training, Certification and Continuing Education of Nurse Aides, dated 5/1/25, included, The facility will provide at least 12 hours of in-service training annually. Further review of the policy revealed, Documentation of the in-services will be maintained in the employee's personnel file, and It is the responsibility of the employee to attend required in-service trainings to maintain employment status with the facility. N.J.A.C. 8:39-43.17(b)		