

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Dwellside Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 Chapel Avenue West Cherry Hill, NJ 08002	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>COMPLAINT #259311 Based on interview, review of medical records and other pertinent facility documentation on 1/6/26, it was determined that the facility failed to maintain an accurate and complete medical record in accordance with acceptable professional standards of practice. This deficient practice was identified for 1 of 4 residents reviewed (Resident #1) and was evidenced by the following: During an interview on 1/6/26, at 12:24 PM, Resident #1 stated that there was a time in August when they ran out of morphine and that the facility did not refill the medication timely. The resident further stated that they received Oxycodone and Percocet as substitute during the period when the morphine was not available. A review of the admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: osteoarthritis of the knee, spinal stenosis, abnormalities of gait, major depressive disorder, and anxiety. The comprehensive Minimum Data Set (MDS), an assessment tool, dated 12/15/25, revealed a Brief Interview of Mental Status (BIMS) of 15 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS indicated that Resident #1 had frequent pain. A review of Resident #1's Order Summary Report indicated that the resident had an active order for Morphine Sulfate Tablet Extended Release. A review of Resident #1's Medication Administration Record (MAR) for August 2025 indicated that the resident was prescribed: Morphine Sulfate Oral Tablet Extended Release 15 mg - Give 1 tablet by mouth every 12 hours for moderate pain. The following was also noted on the specified dates/times: -8/18/25 at 9 AM: #9-8/18/25 at 9 PM: #9-8/19/25 at 9 AM: #9-8/19/25 at 9 PM: #9-8/20/25 at 9 AM: #9-8/20/25 at 9 PM: #5-8/21/25 at 9 AM: #9-8/21/25 at 9 PM: #9-8/22/25 at 9 AM: #9-8/22/25 at 9 PM: #5-8/23/25 at 9 AM: #9 Further review of MAR revealed a Chart Codes section which indicated the following: #5 = Hold/See Nurse Notes #9 = Other/See Nurse Notes A review of Resident #1's Progress Notes (PN) for the corresponding dates revealed the following: -8/18/25 Physician Note (3:30 PM) Resident was seen after a report of pain in the left knee that was slightly better. A Lidocaine patch was ordered. -8/18/25 EMAR Note (11:54 PM) Awaiting pharmacy delivery -8/20/25 APN Note (2:41 PM) Resident was seen for a medication refill. The resident was noted as yelling and cursing and stated that the prescribed morphine had not been received. Nurse reported that they were waiting for the pharmacy delivery. APN provided a script for the morphine sulfate to the nurse. -8/20/25 EMAR Note (9:35 PM) Awaiting pharmacy delivery. -8/22/25 EMAR Note (9:49 PM) Waiting on pharmacy delivery. -8/22/25 EMAR Note (8:00 PM) Med [Out of stock] awaiting order A review of the medical record did not reveal documented evidence that the facility made an attempt to contact Resident #1's medical provider to request a refill for the Morphine Sulfate Oral Tablet Extended Release 15 mg from 8/18/25 until 8/20/25. A review of a grievance dated 8/21/25, revealed that the DON interviewed the resident regarding this concern and that it was resolved as of 8/22/25. On 1/6/26 at 3:35 PM the surveyor attempted to contact Licensed Practical Nurse (LPN #1) via telephone, without success. During an interview with the facility's contracted pharmacy on 1/6/26, at 2:20 PM, the pharmacist</p> <p>(continued on next page)</p>		

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: 315068
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>provided the following timeline regarding the Morphine Sulfate prescribed to Resident #1:8/20/25: -Electronic request from facility received by pharm to refill Morphine Sulfate -Pharm sent fax to MD, stating a script was needed -Pharm received script w/missing info8/21/25: -Pharm spoke w/[staff] at facility advised of clarification needed8/22/25: -Pharm received correct script8/23/25: -Pharm delivered medication During an interview with the Registered Nurse (RN #1) on 1/6/26 at 3:39 PM, RN #1 stated that nurses were to monitor medication counts to ensure that there was no gap in between deliveries. RN #1 further stated that narcotics cannot be re-ordered electronically, a script is needed. RN #1 stated that this made monitoring the counts even more important because the doctor needs to be contacted and that, All of this takes time. RN #1 further stated that all of this should be documented. In the presence of the surveyor RN #1 reviewed Resident #1's August 2025 MAR and confirmed that she entered #9 in the 8/19/25 box at 9 PM. RN #1 also confirmed that there was no corresponding PN for that date explaining any further details. RN #1 stated that she could not recall calling the doctor but that she should have and that she also should have documented it so that everyone was aware that it was done. During an interview with the Director of Nursing (DON) on 1/6/26 at 4:20 PM, the DON stated that as part of the investigation into grievance, the DON interviewed Licensed Practical Nurse (LPN #1) who was assigned to Resident #1 on 8/18/25. The DON stated that LPN #1 informed the DON that an attempt to reach the physician was made during the 8/18/25 day shift and multiple times after that. The DON stated that he was unsure why nurses were not documenting their efforts to obtain a script but that they should have. The DON further stated documentation in the medical record was important to ensure that the record accurately reflects the care being provided to each resident. A review of the facility's undated Charting and Documentation policy revealed that all services provided to residents should be documented and that documentation would be complete and accurate. A review of the facility's Medication Procurement Policy dated January 2025, revealed that all communication with physicians and supervisory staff must be documented in a resident's medical record. N.J.A.C. 8:39-27.1(a)</p>		