STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews and policy review, the facility failed to provide a homelike environment in good repair for six of 21 residents (Resident (R) 4, R5, R23, R72, R114 and R125) residing on the Memory Care Unit. Specifically, the facility failed to maintain cabinets, nightstands, windowsills, heating units, cubicle curtains, baseboards, bedroom doors and overbed table stands in good repair and safe operating condition. The failure to maintain an environment in good repair and homelike had the potential to affect the residents' psychosocial needs. Findings include:Observation of the Memory Care Unit on 12/08/25 at 11:13 AM revealed the following areas of concern:1.R4's room: the cover for the air conditioner/heating unit was missing; two of three drawers inside the closet were broken and would not close leaving the drawer partially open; laminate was missing from the edge of the windowsill; and half of the privacy curtain was not attached to the tract in the ceiling causing the curtain to touch the floor. 2.R5's room: The nightstand in the resident's room had three broken drawers. The drawers were not fitting inside the cabinet and were partially open. The bottom right side of the door to the room was noted with chipped pieces of the wood were missing.3.R23's room: two drawers inside the closet were broken and would not close leaving the drawer partially open. Approximately 6-8 feet of baseboards were missing from the wall between the bathroom and the resident's bed and behind the door of the room to the bathroom door. The door to the resident's room had multiple black marks across the top part of the door. 4.R72's room: Chipped and missing paint on the stand of the overbed table.5.R114's room: The laminate cover across the length of the windowsill was missing and a large piece of laminate was chipped and missing from the bottom shelf in the cabinet next to the closet. 6. R125's room: The top part of the air conditioner/heating unit cover was missing. The stand on the overbed table contained chipped and missing paint. In the common area in front of the Nurse's Station:One of two heating units' cover was missing; two of six chairs positioned in front of the unit, were noted with torn sections of vinyl in the bottom cushion of the chair; and a brown, orange colored dried substance was noted on several areas on the wall under the windowsill, behind the chairs. During an interview with the Maintenance Director on 12/10/25 at 11:20 AM, regarding the areas of concern noted in the residents' rooms and the common area of the Memory Care unit, he/she stated that he/she will fix the furniture, air conditioner vent covers and residents will tear them up again. He/she stated that staff will put the items that need repair in the logbook and he/she and his/her staff review the book every day at the beginning of the shift and indicate when it was completed.During an interview with Licensed Practical Nurse (LPN) 4 on 12/10/25 at 12:00 PM, he/she stated that when anything needs repair, staff will write it in the maintenance logbook, and he/she makes sure it is completed. If he/she had a problem getting resolution, he/she would go to his/her supervisor or the Director of Nursing (DON). During an interview with Certified Nursing Assistant (CNA) 1 on 12/10/25 at 12:30 PM, he/she stated that he/she will put his/her concerns in the maintenance logbook when something is broken and they will fix it. On 12/10/25 at 01:30 PM, the DON confirmed the observations on the unit. Review of the facility's policy titled, Maintenance Service, revised 2009 indicated, 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operatable manner at all times.2.b) maintaining the building in good repair and free from hazards . NJAC 8:39-4.1(a)(11)NJAC 8:39-27.1(a)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff followed physician dietary orders for one of five residents (Resident (R)146 reviewed of 30 sampled residents. This deficient practice has the potential for resident not to receive sufficient calories to prevent further nutritional problems. Findings include:Review of R146's admission Record in the Profile tab of the electronic medical record (EMR) revealed he/she was admitted to the facility on [DATE] with diagnoses of dementia and type II diabetes. Review of R146's quarterly Minimum Data Set (MDS) assessment under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/12/25 revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 indicating severe cognitive impairment. Review of R146's Care Plan located under the Care Plan tab of the EMR dated 12/12/24, revealed R146 has a potential for nutritional problems with intervention to provide Ensure supplement as ordered. Review of R146's Physician Orders located under the Orders tab in the EMR dated 09/10/25 revealed, Ensure plus supplement twice daily at 9:00 AM and 5:00 PM for Protein Calorie Malnutrition (PCM).Observation on 12/09/25 at 6:00 PM, R146 was in bed with the dinner tray in front of him/her. Unit Manager (UM)3 was assisting the resident at bedside. Ensure not provided.During an interview on 12/09/25 at 7:30 PM UM3 stated he/she was unsure why R146 had not been provided his/her 5:00 PM Ensure plus. UM3 stated there was no Ensure plus on the medication cart, so he/she obtained the Ensure plus and gave it to Licensed Practical Nurse (LPN)7. During an interview on 12/09/25 at 7:35 PM LPN7 stated he/she had not given R146 his Ensure Plus because there was none on the medication cart. He/she stated it was the nurse's responsibility to ensure the cart was stocked. During an interview on 12/11/25 at 5:55 PM the Director of Nursing (DON) stated he/she expected staff to follow physician orders and administer timely. NJAC 8:39-27.1(a)