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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, staff interviews and review of the facility policy, the facility failed to promote a dignified dining experience by serving resident meals on an overbed table in a small common area in front of the nurse's station for four residents (Resident (R)5 R23, R72 and R125) out of 21 residents residing in the memory care unit and reviewed for dignity while dining.Findings include:Observation of the evening meal on 12/09/25 at 05:30 PM in the Memory Unit revealed residents were seated in front of the Nurse's Station in a small common area that served as the dining room, activity room, and TV room. The room did not have a dedicated dining table or chairs to encourage or promote dignity during their meals. A Christmas movie was loudly playing on the television in the room during the evening meal. The following residents were observed: R5 was seated in a Geri chair in front of the nurse's station with his/her evening meal placed on an overbed table. The table was positioned in front of him/her and across the arms of his/her chair. The back of the resident's chair was not placed in an upright position which forced the resident to lean up to reach his food. Food spills were noted on the resident's shirt. R23 and R72 were seated in chairs in front of the window with their evening meal placed on an overbed table in front of his/her. The resident ate his/her meal without any interaction from staff or other residents. R125 was seated in his/her wheelchair with his/her meal tray on an overbed table in front of him/her. The table was placed across the arms of the chair. His/her chair was positioned in front of the nurse's station next to R5 and facing the television. The resident was slowly feeding himself/herself, looking down and was not engaging with any staff or other residents during the meal. During an interview with Unit Manager (UM)1 on 12/09/25 at approximately 06:00 PM, he/she stated that the resident dining area in the Memory Unit has always been this way. During an interview with Licensed Practical Nurse (LPN) 4 on 12/10/25 at 12:35 PM, he/she stated that the residents always had their meals in the same area because they did not have a dining room. During an interview with the Administrator on 12/11/25 at 09:52 AM, he/she stated that there was not a dining room in the Memory Unit and that he/she was not aware it was a concern. Review of the facility's policy titled, Preparing the Resident for a Meal dated 2001, indicated, The purpose of the procedure is to prepare the resident and the environment in order to help make mealtime pleasant for the resident.3. Residents should be encouraged but not forced to eat in the dining room. This provides each resident with an opportunity to socialize and make new friends.5. Be sure that the room is comfortable (i.e., Not too cold or warm) and has a relaxing environment (i.e., free of unpleasant odors, loud noises, bright lights, etc.) NJAC 8:39-4.1(a)NJAC 8:39-27.1(a)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails; documented discussion related to risk versus benefits; and signed informed consent prior to bed rail use for one of four residents (Resident (R)146 reviewed for side rails out of 30 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment. 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 diagnosis of dementia. 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 revised 12/04/25, revealed R146 used enablers for increased independence and mobility. Review of R146's Physician Orders located under the Orders tab in the EMR dated 04/05/24 revealed, 1/2 rails while up in bed as a mobility enabler.Review of R146's Side Rail/Enabler/Entrapment Evaluation located under Assessments tab in the EMR dated 05/22/25 and 10/31/25 revealed no documentation that alternates were explored prior to bed rail/side rail use. Observation of R146 on 12/09/25 at 8:00 PM, revealed R146 lying in bed with side rails in the up position. During an interview on 12/10/25 at 5:04 PM, Unit Manager (UM)3 stated residents used side rails for bed mobility and not as a restraint. He/she stated that he/she was unsure if there was signed informed consent and that they did not explore alternatives prior to bed rail use. He/she stated that maintenance assessed for risk of entrapment. During an interview on 12/11/25 at 4:07 PM, Registered Nurse Supervisor (RNS)2 said staff did not look at alternates prior to bedrail use. He/she was also unsure about risk for entrapment or who assessed it for that. During an interview on 12/11/25 at 5:55 PM, the Director of Nursing (DON) stated he/she expected staff to explore alternates prior to bedrail use for residents. The DON stated that he/she expected staff to document in the EMR risk versus benefits and a signed consent obtained.Review of the facility's policy titled Bed Safety and Bed Rails dated August 2022 revealed that resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. NJAC 8:39-27.1(a)