STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Cadbury of Cherry Hill	2150 Route 38 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)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint Intake # 2740465Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of food served to the residents. This deficient practice was identified during the lunchtime meal service on 3/13/26, on 1 of 2 nursing units ([NAME] 600) and was evidenced by the following:On 3/13/26 at 12:25 PM, in the presence of the Food Service Director (FSD), the surveyor conducted a test tray with a calibrated (calibration ensures that the thermometer is accurate and precise for the measurement of food temperatures) thermometer. The meal tray cart arrived on the unit at 12:20 PM. It was an open, not enclosed, cart. The surveyor tagged the bottom tray for temperature testing. When all the meal trays were delivered to the residents from that truck at 12:25 PM, the temperatures were checked for a regular consistency meal. The temperatures were as follows: Turkey Burger-95 degrees Fahrenheit 4-ounce milk carton: 46 degrees Fahrenheit The surveyor asked the FSD if the temperature of the turkey burger was adequate and he responded, no it is not. The plates did not have metal plate warmers (pellets) underneath the plates to help maintain heat. The FSD stated, We have no bottoms (meaning the plate warmers). The surveyor reviewed the policy titled Food Preparation and Service, dated 4/2019. The section titled cooking and holding time/temperatures revealed that the danger zone for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. Hazardous foods included but were not limited to meat, poultry and seafood. NJAC 8:39-17.4(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

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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 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 observation, interview, and review of pertinent facility documentation it was determined that the facility failed to a.) maintain clean kitchen equipment and b.) store foods in a manner intended to prevent the spread of food borne illness in resident pantries. This deficient practice was evidenced by the following:On 3/11/26 at 09:20 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and observed the following: 1. On a large open stainless-steel shelf, the surveyor observed stacks of stainless-steel pans. The surveyor observed eight stainless steel pans. When the surveyor separated the eight pains there was wet nesting within each pan. One of the pans had a dried yellow substance on the inside. The surveyor asked the FSD if they were clean pans and he stated yes, but he would rewash the pans. The FSD acknowledged the wet nesting within each pan and proceeded to remove them from the shelf. 2. The pellet warmer had paper stored inside the pellet warmer. The FSD said it had not worked for Close to a year. On 3/13/26 at 11:56 AM, the surveyor observed two pantries in the facility. 1. The pantry on the 500 unit had no paper towels at the sink. There was a resident refrigerator and freezer in the pantry. In the freezer the surveyor observed two opened 1/2 gallons of ice cream not labeled or dated. 2. The pantry on the 600 unit had a refrigerator and freezer. The freezer had one gallon of an opened container of ice cream that was not labeled or dated. The refrigerator had two clear plastic bags of food items. The items had a resident name on them but no dates. On 3/17/26 at 9:25 AM, during a meeting with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the LNHA acknowledged the wet nesting and the unlabeled items in the resident pantries. A review of the policy titled, Dining/Labeling of Food items, dated 1/2026 stated the facility adheres to a date marking system to ensure the safety of ready to eat, time/temperature control for food safety. Number two revealed that the food shall be clearly marked to indicate the day or date by which the food shall be consumed or discarded. A review of the policy titled Refrigerators and Freezers, dated 12/2014 stated that supervisors will be responsible for ensuring food items in pantries, refrigerators, and freezers are not expired or past the perish dates. NJAC 8:30-17.2 (g)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to follow a consultant physician's recommendations in a timely manner. This deficient practice was identified for 1 of 1 resident (Resident #47) reviewed for accommodation of needs and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 3/11/26 at 9:59 AM, the surveyor observed Resident #47 awake and alert sitting on the edge of the bed. The resident stated that they had eye surgery and were supposed to get eyeglasses but never received them. Resident #47 stated that they were informed by the previous unit manager that the eyeglasses were ordered but they were never received. On 3/13/26 at 8:54AM, the surveyor conducted a follow up interview with Resident #47 who again confirmed that they never received the eyeglasses and had not had a follow up visit scheduled with the eye doctor as recommended. The resident stated they still had double vision. The surveyor reviewed the electronic medical record and paper chart for Resident #47. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to: combined forms of age-related cataract, bilateral (a clouding of the lens of the eye). A review of the resident's quarterly/comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/10/26, included the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident's cognition was intact. A review of the resident's individual comprehensive care plan (ICCP) did not include a focus area for cataracts or eyeglasses. A review of the progress notes and paper chart revealed that Resident #47 had left eye cataract surgery on 9/18/25 and right eye cataract surgery on 10/24/25. A review of the consultation form, dated 11/20/25, revealed that Resident #47 was stable after cataract surgery with intermittent diplopia (double vision). Recommendations included a prescription for eyeglasses, to follow up in 2 months, and will consider PRISM glasses (specialized prescription lenses designed to correct double vision) if still has diplopia. A review of a nurse's note, dated 11/21/25 at 1:39 PM, revealed that the prescription was given to the ophthalmologist and the resident and doctor were made aware. Further review of the progress notes and the paper chart from 11/21/25 to present did not reveal any documentation that the residents' eyeglasses were ordered or received. There was no documentation that a follow-up visit with the eye doctor was scheduled. On 3/13/26 at 10:52 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that when a resident returned from an outside physician's visit with recommendations, the nurse would contact the attending doctor and get a physicians order for the recommendations. The nurse would then write a progress note and notify the family. LPN #1 further stated that it was the responsibility of the resident's nurse to notify the unit secretary that a follow up visit needed to be scheduled. When asked what happened to Resident #47's prescription for the eyeglasses, LPN #1 stated I don't know. On 3/13/26 at 10:53 AM, the surveyor interviewed the Director of Nursing (DON) who stated that when a resident returned from a doctor's appointment, the paperwork would be given to the nurse or unit clerk. The cart nurse would then call the attending doctor and obtain physician orders per the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommendations. The DON further stated that she did not know about the resident eyeglasses or the follow up appointment. On 3/16/26 at 1:18 PM, the DON, in the presence of the Licensed Nursing Home Administrator (LNHA), and the survey team, acknowledged that the eyeglass prescription should have been completed and a follow up visit with the eye doctor should have been scheduled.A review of the facility's Consultation policy, undated, included that upon completion of the consultation, recommendations from the consulting practitioner will be communicated to the attending physician for review and implemented as appropriate. Consultation finding and related care interventions will be documented in the medical record and incorporated into the president's plan of care as indicated. 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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and review of facility documents, it was determined that the facility failed to consistently provide residents with mail delivery between December 2025 and late February 2026. This deficient practice was identified for 1 of 5 residents (Resident #49) during a resident council group meeting and was evidenced by the following: On 3/12/26 at 10:15 AM, the surveyor conducted a resident council group meeting with five alert and oriented residents (Resident #11, # 22, #49, #65, and #95). The surveyor interviewed the residents regarding mail delivery. All residents stated that the Activities Director (ACD) coordinated mail delivery, but that the facility had no ACD between December 2025 and late February 2026. Resident #49 further stated that he/she did not receive mail between December 2025 and late February 2026 and that an activities aide at that time found a box of undelivered mail. On 3/16/26 at 10:22 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the ACD coordinated mail delivery at the facility and that the previous ACD had left in December 2025. On 3/16/2026 at 10:37 AM, the surveyor interviewed the ACD regarding mail delivery who stated that mail arrived at the facility and was supposed to be distributed to the residents daily. The ACD then confirmed that he began employment with the facility in February 2026, and that there was only one activities aide working in the activities department between December 2025 and February 2026 whose part time schedule covered Mondays, Wednesdays, and Fridays. The ACD stated that it was important for residents to receive their mail upon delivery because mail may contain time sensitive communication. The ACD stated that he did not know what department at the facility would assume responsibility of mail delivery if there was no activities staff available. The ACD explained that a resident council group meeting was held on 2/27/26 after he began employment to discuss resident concerns. The AD stated that he could provide minutes from that resident council group meeting. On 3/16/26 at 11:00 AM, the ACD provided the resident council meeting minutes from 2/27/26 which included interdepartmental concerns. Section five of the meeting minutes indicated a concern for the ACD which revealed, residents would like their mail. On 3/16/26 at 1:17 PM, the surveyor interviewed the Director of Nursing (DON) who stated the activities staff were responsible for delivering the residents' mail but was unable to say how often the mail should be delivered. The DON explained it was important for the residents to receive their mail timely because they might have important mail coming in. On 3/17/26 at 09:50 AM, the Licensed Nursing Home Administrator (LNHA) provided an Ad Hoc QAPI Performance Improvement Plan (PIP) initiated on 3/16/26 by the ACD and LNHA. This PIP document identified the following problem statement: Residents reported not receiving mail over an extended period (December through March). Upon investigation, a box of undelivered mail was identified and subsequently distributed. The lapse was associated with a period in which there was no assigned Activities Aide for mail distribution.This PIP document identified the following items in root cause analysis: Lack of assigned responsibility for mail distribution; Breakdown in oversight during staffing gap; Absence of monitoring processes to ensure daily mail delivery; Failure to identify backlog of undelivered mail in a timely manner. The LNHA also provided timecards for the activities aides employed between 11/30/25 and 3/16/26. These timecards verified that there was only one activities aide working at the facility between 12/27/25 and February of 2026 when the ACD began employment. A review of the facility's mail and electronic communication policy, last revised May 2017, included under Policy Interpretation and Implementation: Mail and packages will be delivered to the resident within 24 hours of delivery on premises or to the facility's post office box (including Saturday deliveries). NJAC 8:39-4.1 (a)(19)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility documents, it was determined that the facility failed to a.) maintain the most recent State of New Jersey inspection results in a place readily accessible to the residents, and b.) post notice of the availability of the inspection results in prominent areas. This deficient practice was identified on 2 of 2 units ([NAME] 5 and [NAME] 6) and was evidenced by the following: On 3/12/26 at 10:15 AM, the surveyor conducted a resident council meeting with five alert and oriented residents. All five residents stated they were not aware of the location of the State Survey results. On 3/13/26 at 11:50 AM, the surveyor toured the [NAME] 5 unit but was unable to locate the most recent State Survey results. There was no signage on the unit to indicate where to find the State Survey results. At that time, the surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM) #1 where the State Survey results were, but he was unable to answer and stated he would get the Licensed Nursing Home Administrator (LNHA). The LNHA approached the surveyor and stated the State Survey results were located in the lobby. On 3/13/26 at 11:55 AM, the surveyor toured the [NAME] 6 unit but was unable to locate the most recent State Survey results. There was no signage on the unit to indicate where to find the State Survey results. At that time, the surveyor asked Licensed Practical Nurse (LPN) #1 where the State Survey results were and the LPN grabbed a binder from behind the nurses' station which was not accessible to residents. The binder contained the most recent recertification survey results. On 3/13/26 at 12:00 PM, the surveyor attempted to enter the facility's lobby from the [NAME] 6 unit, but the doors to the lobby were locked. There was a sign on the lobby doors that indicated to knock on the door to enter. There was also a number keypad next to the lobby doors. After entering the lobby, the surveyor observed a binder on a table which contained the most recent State Survey results with a sign next to it indicating that the State Survey results were located in the lobby. At that time, the surveyor interviewed the receptionist who stated that the lobby doors were locked and that residents had to knock on the door and the receptionist would have to get permission to let the residents into the lobby as elopement risk residents were not allowed in the lobby. On 3/16/26 at 10:22 AM, during a follow-up interview, LPN/UM #1 stated the State Survey results were kept in the lobby and that there were no State Survey results available on the unit. When asked how residents were made aware of the location of the State Survey results, the LPN/UM stated that residents had to ask staff were the results were. The LPN/UM further stated that the doors to the lobby were locked and that residents could not access it without asking staff for assistance. The LPN/UM explained that it was important for the State Survey results to be readily accessible to residents because residents should have knowledge of what's going on in their home. On 3/16/26 at 1:17 PM, the surveyor interviewed the Director of Nursing (DON) and the LNHA in the presence of the survey team. The DON stated the State Survey results were located in the lobby and verified that the State Survey results were not accessible to residents without having to ask for staff to open the lobby doors. The DON and LNHA also verified that the State Survey results located behind the [NAME] 6 nurses' station was not readily accessible to residents and that there should be signage posted on the units to inform residents where to find the State Survey results. A review of the facility's Examination of Survey Results policy, revised April 2017, included the following:Survey reports and plans of correction are readily accessible to the resident, family members, resident representatives, and to the public. A copy of the most recent survey report and any plans of correction are kept in a binder in the residents' day room.Information concerning the rights to examine, the location of and how to request preceding years' survey reports and plans of correction. are posted on the resident bulletin board and at each nurses' station. NJAC 8:39-9.4(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain a homelike environment that was clean, safe, and sanitary. This deficient practice was identified for 1of 2 units ([NAME] 6 Unit). This deficient practice was evidenced by the following: On 3/11/26 at 10:10 AM, in room [ROOM NUMBER]B on the [NAME] 6 Unit, the surveyor observed a personal refrigerator. Inside the refrigerator door, there was an unlabeled, open container of food. [NAME] and red debris were identified on the bottom of the refrigerator, along with a loose piece of a blue paper label. The freezer compartment did not contain a thermometer, and the floor of the freezer was covered in ice. [NAME] and red debris were also visible on the bedroom floor. The wall had areas of missing white paint, exposing the paper layer of the drywall. In the bathroom, black scuff marks appeared on the walls, and the wall trim was hanging adjacent to the toilet, with black residue on the wall behind the trim. On 3/13/26 at 10:59 AM, during an interview with the surveyor, the Director of Maintenance (DOM) stated that the maintenance department was not responsible for cleaning residents' personal refrigerators and was unsure why the freezer compartment did not have a thermometer. The DOM explained that a thermometer should be present to ensure food stored in the freezer was maintained at the proper temperature. The DOM further stated that the wall in room [ROOM NUMBER]B should not have areas of missing paint exposing the paper layer of the drywall, and that the wall trim should not be hanging loose adjacent to the toilet, with black residue visible on the wall behind the trim. He added that the damage may have occurred when a hand sanitizer dispenser was removed a while ago, but he could not confirm the exact time. The DOM reported that the facility had hired a private contractor to complete the repairs but did not know when the repairs would begin. On 3/13/26 at 11:03 AM, during an interview with the surveyor, the Director of Housekeeping and Laundry ([NAME]) stated that housekeepers clean rooms daily and as needed, based on residents' needs. She reported that housekeeping was not routinely responsible for cleaning residents' personal refrigerators but would do so upon request. She further stated that bedroom floors and personal refrigerators should be kept clean to maintain a homelike environment. On 3/13/26 at 11:03 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated that residents' personal refrigerators were cleaned daily by housekeeping and should not contain open, unlabeled, or undated food, debris, or loose trash. These practices were important to maintain a homelike environment and for infection control purposes. On 3/13/26 at 11:03 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that the refrigerator and freezer compartment in room [ROOM NUMBER]B on the [NAME] 6 Unit should have been cleaned and the freezer defrosted by housekeeping, as this was a housekeeping responsibility. Additionally, she reported that maintenance should have ensured a thermometer was present in the freezer compartment for infection control purposes. A review of the facility's undated policy titled Homelike Environment, revealed that Facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a.) a clean, sanitary, and orderly environment. A review of the facility's Food Brought in by Visitors revised policy dated February 2026, revealed that Refrigerated foods must be labeled with the resident's name and date the food was brought in and will be discarded by staff no more than three (3) days after being brought in. N.J.A.C. 8:39-31.4(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to a.) notify the representative of the Office of the State of Long-Term Care Ombudsman about a resident's emergency discharge to the hospital and b.) provide the bed hold policy for 1 of 1 resident (Resident #99) reviewed for hospitalization. This deficient practice was evidenced by:On 3/12/26 at 12:16 PM, the surveyor reviewed the hybrid medical records (combination of electronic and paper medical records) for Resident #99. The resident had a facility-initiated discharge (d/c) and was no longer in the facility. A review of the admission Record (an admission summary) reflected that the resident had diagnoses that included influenza, dysphagia (difficulty swallowing), seizures, heart disease, and dementia. A review of the Progress Notes (PN) revealed the resident was transferred to the hospital on 1/5/26 and admitted with a diagnosis of respiratory distress. A review of the New Jersey Universal Transfer Form (NJUTF) indicated the resident was transferred on 1/5/26 at 11:45 AM. It further indicated that the reason for transfer was increased lethargy (an unusual lack of energy and decreased mental alertness) and low oxygen levels. A further review of the hybrid medical records revealed there was no evidence that the facility notified the representative of the Office of the State of Long-Term Care Ombudsman about a resident's emergency discharge to the hospital or provide the bed hold policy to the resident or the resident's representative. On 3/12/26 at 11:47 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated he could only find the November and December 2025 notifications to the Ombudsman's Office and that he could not find the month of January 2026. He further stated the previous LNHA left the same day he started which was February 16, 2026. He then stated that he could tell the previous LNHA was sending the notification but could not find January. On 3/12/26 at 1:21 PM, during a follow up interview the LNHA stated he still could not find the January 2026 emergency transfer notification to the Ombudsman's Office and was not aware if he was responsible to submit them. He then stated moving forward to ensure it was being submitted monthly he would be sending out the notification. On 3/13/26 at 8:55 AM, the LNHA provided an email that he sent the notification of the emergency transfers. The LNHA confirmed it was not done and acknowledged January 2026 should have been sent prior to surveyor inquiry. On 3/13/26 at 9:54 AM, the surveyor interviewed the LNHA regarding the bed hold notification. The LNHA stated that the previous LNHA sent the bed hold notification and prior to that was the Admissions Director (AD). On 3/13/26 at 10:47 AM, the surveyor interviewed the AD who stated for the emergency transfers she recently started sending out the bed hold notifications by certified mail. The AD explained that the previous LNHA was sending out the bed hold notifications and prior to that was the previous Social Worker. The AD stated she was not sure if the bed hold notification was sent to Resident #99 but would follow up. On 3/13/26 at 12:01 PM, the AD confirmed the bed hold notification was not sent for Resident #99. On 3/17/26 at 9:43 AM, the LNHA stated in the presence of the Director of Nursing (DON), and the survey team that the bed hold would now be done by the AD, and the LNHA would be responsible for notifying the Ombudsman Office. The LNHA confirmed both the bed hold and emergency transfer notifications were not sent until after surveyor inquiry. A review of the facility's Bed-Holds and Returns policy dated revised March 2022, included, 1. All residents/representatives are provided written information regarding the facility bed-hold policies.Residents are provided written information about these policies at least twice: b. at the time of transfer (or, if the transfer was an emergency, within 24 hours). A review of the facility's Transfer or Discharge Emergency policy dated revised August 2018, included, 4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: e. Notify the representative (sponsor) or other family member; g. Others as appropriate or as necessary. A review of the facility's Ombudsman Notification of Transfer/discharged policy dated March 2026, included, 2. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator or designee is responsible for ensuring that Ombudsman notification is completed, coordinated, and documented. 3. Copies of the transfer notice will be sent to the Ombudsman. Notification may be completed individually or through a monthly listing of emergency transfers. 5. The facility may submit a monthly list of emergency transfers to the Ombudsman. The list must include all required elements and copies of resident notices. NJAC 8:39-4.1(a)(32); 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of medical records, and other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 3 of 20 residents reviewed (Residents #1, #5, and #61).1.) On 3/11/26 at 9:54 AM, the surveyor observed Resident #1 awake and alert sitting in a wheelchair in his/her room. The resident stated that he/she did not speak English. The surveyor reviewed the medical record for Resident #1. A review of the admission Record, an admission summary, revealed that the resident had diagnoses which included, but were not limited to: osteomyelitis (an infection in the bone). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/19/26, revealed that in section C for cognitive patterns, the Brief Interview for Mental Status (BIMS) assessment was not assessed. The omission did not reflect the residents' true physical, mental, and psychosocial status. 2.) On 3/12/26 at 12:16 PM, the surveyor observed Resident #5 awake and alert sitting in a wheelchair by the nurse's station. A staff member stated that the resident did not speak English. The surveyor reviewed the medical record for Resident #5. A review of the admission Record, an admission summary, revealed that the resident had diagnoses which included, but were not limited to: nontraumatic subarachnoid hemorrhage from the left middle cerebral artery (a spontaneous bleed not caused by trauma that occurs when an aneurysm on the left middle cerebral artery ruptures), dysphagia (difficulty swallowing), and aphasia (a disorder that affects how you communicate). A review of the resident's comprehensive MDS, dated [DATE], revealed that in section C for cognitive patterns, the Brief Interview for Mental Status (BIMS) assessment was not assessed. The omission did not reflect the residents' true physical, mental, and psychosocial status. 3.) On 3/12/26 at 12:59 PM, the surveyor observed Resident #61 in his/her room. Resident #61 was alert and oriented and conversed with the surveyor regarding his/her care. On the same day, the surveyor reviewed the electronic medical record (EMR). A review of the admission Record, an admission summary, revealed that the resident had diagnoses which included, but were not limited to, acute pulmonary edema, anxiety and depression. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/2/26, revealed that in section C for cognitive patterns, the Brief Interview for Mental Status (BIMS) assessment was not assessed. The omission did not reflect the residents' true physical, mental, and psychosocial status. On 3/13/26 at 12:30 PM, the surveyor conducted a telephone interview with the MDS consulting company. The MDS Consultant (MDSC) stated this was a consulting company that conducted the MDS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments for the facility. She stated that the company had one (1) nurse at the facility and had two (2) remote nurses who completed the assessments for the MDS. The MDSC further stated that MDS assessment was completed based on the Resident Assessment Instrument (RAI) manual and every resident should have a completed BIMS assessment. On 3/16/26 at10:51 AM, the surveyor conducted a follow-up telephone interview with the MDSC who stated that the nurse who had completed the MDS assessments should have communicated to the facility that the BIMS assessments were not completed. The MDSC confirmed that all residents should have a BIMS assessment completed on the MDS, and if non-interviewable, then a staff interview should have been completed. If the residents did not speak English, then a translator would be used to complete the BIMS assessment. During an interview with the survey team, the Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON) on 3/16/26 at 1:28 PM, it was determined that the three residents should have been assessed for mental status as required by RAI guidelines. A review of the facility's Resident Assessments policy, revised March 2022, included that residents' assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the OBRA required assessments and the PPS required assessment. A comprehensive assessment included: a), completion of the Minimum Data Set, b), completion of the care area assessments and c), development of the comprehensive care plan. N.J.A.C 8:39-11.1

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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. Based on interview, record review, and review of facility documents, it was determined that the facility failed to notify the physician of the resident's change in condition for 1 of 23 sampled residents (Resident #99). This deficient practice was evidenced by the following:On 3/12/26 at 12:16 PM, the surveyor reviewed the hybrid medical records (combination of electronic and paper medical records) for Resident #99. The resident had a facility-initiated discharge (d/c) and was no longer in the facility. A review of the admission Record (an admission summary) reflected that the resident had diagnoses that included, influenza, dysphagia (difficulty swallowing), seizures, heart disease, and dementia. A review of the individual comprehensive care plan (ICCP) included a focus, dated 1/2/26, that the resident had influenza. Interventions included: Monitor vital signs as ordered and notify the physician of significant abnormalities. A review of the Progress Notes (PN) dated 1/4/26 at 2:41 PM, revealed the resident refused their medications, refused to eat their breakfast and lunch, and their vital signs included the blood pressure (BP) was 85/55 and the temperature was 94.2 degrees. The PN also indicated the nurse informed the supervisor about the resident, the supervisor monitored the resident, scheduled a speech therapy evaluation and would continue to monitor. There was no evidence that the physician was notified of the resident's low BP and the low temperature. A further review of the PN dated 1/5/26, revealed at approximately 10:30 AM, the resident was noted with increased lethargy, requiring a sternal rub for arousal. Vital signs SpO2 (Peripheral Oxygen Saturation - measures the percentage of oxygen-saturated hemoglobin in the blood) was 67 % and the BP was 64/50. The resident was transferred to the hospital and admitted with a diagnosis of respiratory distress. A review of the New Jersey Universal Transfer Form (NJUTF) indicated the resident was transferred on 1/5/26 at 11:45 AM. It further indicated that the reason for transfer was increased lethargy (an unusual lack of energy and decreased mental alertness) and low oxygen levels. On 3/12/26 at 12:52 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated she would notify the physician for any change in condition. On 3/12/26 at 1:13 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Clinical Consultant and the Licensed Nursing Home Administrator (LNHA). The DON stated that she would expect the nurse to notify the MD of the low BP. On 3/13/26 at 8:59 AM, the surveyor and the Medical Director (MD) reviewed the 1/4/26 and 1/5/26 PN together. In the presence of the survey team, the MD stated that on 1/4/26, when the resident's vital signs were abnormal with a BP of 85/55 and temperature of 94.2, the nurse should have notified the physician. On 3/13/26 at 10:59 AM, during a follow up interview, the DON stated her expectation would be for the nurses to notify the physician of the low BP. She stated it was important to see if the physician wanted any new orders and new interventions for the resident. The DON acknowledged the physician should have been notified on 1/4/26. On 3/17/26 at 9:32 AM, both the DON and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team acknowledged, the nurse should notify the physician for any change in conditions. A review of the facility's Change in a Resident's Condition or Status policy, dated revised February 2021, included, 1. The Nurse will notify the resident's attending physician or physician on call when there has been: d. significant change in the resident's physical/emotional/mental condition; f. refusal of treatment or medication two (2) or more consecutive times; i. specific instructions to notify the physician of changes in the resident's condition. A review of the facility's Resident Examination and Assessment policy dated revised February 2014, included, Reporting: 2. Notify the physician of any abnormalities such as, but not limited to: a. abnormal vital signs. NJAC 8:39-27.1(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure that therapy services and treatment for range of motion limitations were provided for 1 of 2 residents (Resident #9) reviewed for range of motion concerns. This deficient practice was evidenced by the following: On 3/11/26 at 9:45 AM, the surveyor observed Resident #9 in his/her bedroom, seated in a wheelchair next to the bed. The resident stated that he/she had difficulty using the right side of his/her body. The resident's right hand was contracted, and no orthosis or hand splint was in place. On 3/12/26 at 9:14 AM, the surveyor observed Resident #9 in the hallway on the [NAME] 6 Unit, self-propelling in his/her wheelchair. He/she stated to the surveyor that he/she was going outside to smoke. His/her right hand was contracted, and he/she was not wearing an orthosis or hand splint. The surveyor reviewed the electronic medical record for Resident #9. A review of the admission Record, an admission summary, revealed the resident had diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (brain damage resulting in the inability to fully use the right side of the body). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/28/26, included a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderately impaired cognition. A review of the Individual Comprehensive Care Plan (ICCP) dated 10/21/26 included a focus area indicating that Resident #9 presents with right hemiplegia, increased difficulty with transfers, and deficits in postural control. Interventions included, but were not limited to, wearing a right-hand (carrot) (a device placed on the hand to prevent contractures and maintain proper hand positioning) at all times, except during care, with pre- and post-skin checks to maintain skin and joint integrity. A review of the Order Summary Report (OSR), dated 12/15/26, included the following physician order (PO): the resident is to wear a right-hand (carrot) at all times, except during care, for comfort and proper positioning, with skin checks performed before and after each shift. On 3/13/26 at 9:45 AM, the surveyor reviewed Resident #9's Treatment Administration Record (TAR). The TAR revealed that the assigned Licensed Practical Nurse (LPN #3) documented on 3/11/26 and 3/12/26 that the resident was wearing the right-hand roll (carrot); however, the resident was not wearing the device at the time of observation. Additionally, no progress note was documented to explain why the device was not in place. During an interview with the surveyor on 3/13/26 at 10:49 AM, Licensed Practical Nurse / Interim Unit Manager (LPN/IUM #1) on the [NAME] 6 Unit stated she was unsure why LPN #3 documented that Resident #9 was wearing the right-hand roll (carrot) if he/she was not. She explained that documentation indicating the device was in place means the resident was wearing it. She further stated she would follow up with the nurse. During an interview with the surveyor on 3/13/26 at 11:20 AM, the Director of Nursing (DON) stated that nursing staff should not document that the resident was wearing the right-hand (carrot) if it was not in place. She further explained that if the resident was not wearing the device, it should be documented and reported to therapy. During an interview with the surveyor on 3/16/26 at 11:00 AM, LPN #3 stated she was unsure why she documented that the resident was wearing the right-hand (carrot) when she was not. She acknowledged that she should not have documented that the device was in use if it was not in place. During an interview with the surveyor on 3/16/26 at 11:21 AM, the Director of Physical Therapy (DPT) stated that nursing staff should not document that the resident was wearing the right-hand (carrot) if it was not in place. He further stated that staff should document the reason why the resident was not wearing the device and notify Physical Therapy. A review of the facility's undated policy titled Resident Mobility and Range of Motion revealed that Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in range of motion, and residents with limited mobility will receive appropriate (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to provide a nutritional supplement as prescribed by the physician for 1 of 5 residents (Resident #5) reviewed for nutrition. This deficient practice was evidenced by the following: On 3/12/26 at 12:30 PM, the surveyor observed Resident #5 sitting in bed with the lunch tray on the overbed table. The surveyor observed the lunch meal ticket included a [name redacted] nutritional supplement (a fortified protein and calorie dense nutritional frozen dessert designed to fight malnutrition supplement) with the meal. The surveyor observed that the nutritional supplement was not on the lunch tray. At that time, the surveyor interviewed Licensed Practical Nurse (LPN # 1) who confirmed the nutritional supplement was not on the lunch tray. On 3/13/26 at 9:00 am, the surveyor observed Resident #5 sitting in bed with the breakfast meal tray on the overbed table. The surveyor observed the breakfast meal ticket included a [name redacted] nutritional supplement with the meal. The surveyor observed that the nutritional supplement was not on the breakfast tray. At that time the Registered Nurse/Unit Manager (RN/UM#1) confirmed the nutritional supplement was not on the breakfast tray.The surveyor reviewed the medical record for Resident #5.A review of the admission Record, an admission summary, revealed that the resident had diagnoses which included, but were not limited to: nontraumatic subarachnoid hemorrhage from the left middle cerebral artery (a spontaneous bleed not caused by trauma that occurs when an aneurysm on the left middle cerebral artery ruptures, dysphagia (difficulty swallowing), and aphasia (a disorder that affects how you communicate).A review of the comprehensive Minimum Data Set (MDS), dated [DATE], revealed that in section C for cognitive patterns, the Brief Interview for Mental Status (BIMS) assessment was not assessed. Further review of the MDS revealed the resident needed supervision for eating, had a weight loss of 5% or more in the last month, was not on a prescribed weight loss program, and had a diagnosis of dysphagia. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 2/16/26, that the resident was at risk for nutrition alteration. Interventions included: Supplements as ordered.A review of the Order Summary report (OSR), dated as of 3/13/26, included the following physicians' orders (PO):A PO, dated 2/12/26, for [name redacted] supplement with meals record % consumed. DO NOT SUBSTITUTE due to thickened liquids.A PO, dated 2/10/26, for Regular diet, mechanical soft/ground texture, Nectar/level 2 consistency.A review of the Nutrition/Dietary progress note, dated 2/11/26 at 10:47 AM, revealed that the resident had significant weight fluctuations over the past one month, had good intake of 50-75% of meals and received [name redacted] supplement three times a day.On 3/13/16 at 10:10 AM, the surveyor interviewed the Registered Dietician (RD) who stated that she is an agency dietician filling in for the regular RD. The RD stated that supplements such as [name redacted] nutritional supplement and health shakes come from the kitchen and are not stocked on the nursing units. The RD stated that the nutritional supplement should have been on the meal trays as ordered. The RD further stated that the resident's weights were up and down, and the four weeks of weekly weights were not completed yet to determine if a significant weight loss had occurred.On 3/13/26 at 11:17 AM, the surveyor interviewed the Food Service Director (FSD) who stated that the [name redacted] nutritional supplement should have been on each meal tray. The FSD confirmed that the nutritional supplement was on the resident's meal tickets and must have been missed. The surveyor observed that [name redacted] supplements were available in the kitchen.On 3/16/26 at 1l:18 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, who stated that the [name redacted] supplement should have been on the meal trays as ordered. The DON further stated that it is important that supplements were given as ordered for nutritional purposes.A review of the facility's Weight Assessment and Intervention policy, revised March 2022, included interventions for undesirable weight loss are based on careful considerations of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following: a. Resident choice and preferences; b. nutrition and hydration needs of the resident; .g. the use of supplements and or/feeding tubes. NJAC 8:39-17.4(a)1

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) administer oxygen at the prescribed flow rate, and b.) provide the resident with an appropriate oxygen delivery system while ensuring oxygen was handled and dispensed safely for 1 of 1 resident (Resident #14) reviewed for respiratory care.This deficient practice was evidenced by the following: On 3/11/26 at 10:03 AM, the surveyor observed Resident #14 in his/her bedroom lying in a lateral position with the head of the bed flat. The resident was receiving oxygen via a nasal cannula (NC) (a device used to deliver oxygen), connected to a portable oxygen cylinder in a cart. The regulator (a device attached to an oxygen tank or cylinder that controls and monitors the flow of oxygen) was set at 3 liters per minute (LPM), and the pressure gauge was in the red, indicating the tank required refilling. On 3/11/26 at 10:12 AM, the surveyor observed Resident #14 in his/her bedroom sitting in a wheelchair adjacent to the bed. The resident was receiving oxygen via a nasal cannula (NC) connected to a portable oxygen cylinder in a cart. The regulator was set at 3 LPM. The surveyor reviewed the electronic medical record for Resident #14. A review of the admission Record, an admission summary, revealed the resident had diagnoses including, but not limited to, metabolic acidosis (a medical condition in which the body produces too much acid, affecting the function of organs such as the heart, lungs, and kidneys). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/20/26, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. A review of the Individual Comprehensive Care Plan (ICCP), dated 10/30/25, included a focus area indicating that Resident #14 received oxygen therapy. Interventions included oxygen at 2 LPM via NC. A review of the Order Summary Report (OSR), dated 3/11/26, included the following physician orders (PO):A PO dated 3/11/26: Change oxygen tubing and humidifier bottle weekly, and every night shift on Wednesday for oxygen.A PO dated 3/09/26: Oxygen at 2 LPM via NC as needed (PRN) for shortness of breath or hypoxia. During an interview with the surveyor on 3/13/26 at 10:49 AM, the Licensed Practical Nurse/Interim Unit Manager (LPN/IUM #1) on the [NAME] 6 Unit explained that the resident should have an oxygen concentrator (a medical device located at the bedside that delivers oxygen) in his bedroom if oxygen is prescribed by a physician. She stated that the portable oxygen cylinder was intended for emergencies, for transport outside the facility, or when oxygen was required outside the bedroom, including in hallways or during showering. She further indicated that the regulator on the portable oxygen cylinder should be set at 2 LPM as prescribed by the physician, not 3 LPM. She added that if the resident was receiving oxygen for shortness of breath or hypoxia, the portable oxygen cylinder pressure gauge should not be empty.During an interview with the surveyor on 3/13/26 at 11:20 AM, the Director of Nursing (DON) stated that if Resident #14 was prescribed oxygen, an oxygen concentrator should be present in the room at all times. A review of the facility's undated policy titled Oxygen Administration, revealed that Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess any special needs of the resident. Assemble the equipment and supplies as needed. NJAC 8:39-27.1(a)

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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, record review, and review of facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure accurate medication dispensing and administration for 1 of 6 residents (Resident #52) observed during the medication pass. This deficient practice was evidenced by the following: On 3/12/26 at 8:10 AM, the surveyor observed License Practical Nurse (LPN) #2 dispense six medications for Resident #52. As the LPN pulled medications from the medication cart, she handed them to the surveyor. The LPN handed the surveyor an over-the-counter (OTC) pill bottle of calcium carbonate 600 milligrams (mg) - vitamin D 10 micrograms (mcg) and then the LPN dispensed one pill from the bottle into the medicine cup. When the LPN finished dispensing the medications, she locked her medication cart and turned on the privacy screen on the electronic medical record. Before the LPN entered Resident #52's room, the surveyor asked the LPN to review the resident's medications with the surveyor. The LPN verified that the resident had the following physician's order (PO): calcium carbonate 600 mg give one tablet by mouth in the morning for supplement. At that time, the LPN acknowledged she dispensed the incorrect calcium carbonate medication and used a drug buster to destroy the medication. The LPN further stated that she would either have to call the physician to have the calcium carbonate order changed to the OTC medication the facility had in stock, or she would have to see if the correct calcium carbonate OTC medication could be ordered. On 3/12/26 at 8:52 AM, the LPN stated she should have checked the PO multiple times against medication bottle because that is what the doctor ordered and to prevent a reaction. On 3/16/26 at 10:22 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that to ensure the correct medication is administered, the nurses should compare the medication dispensed against the PO in the Medication Administration Record (MAR). The LPN/UM further stated that if the nurse did not have the correct medication, she should call the physician to see if an alternative could be given. On 3/16/26 at 1:17 PM, 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 the nurses should check the medication against the PO in the MAR to ensure the correct medication is administered. The DON explained that if the nurse did not have the correct medication, she should call the physician for instructions. At that time, the surveyor informed the DON of the above medication error and the DON stated the nurse should have checked the medication bottle against the MAR. A review of the facility's Administering Medications policy, revised 4/2019, included the following: Medications are administered in accordance with prescriber orders.The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. NJAC 8:39-27.1(a)NJAC 8:39 - 29.2(d)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility documents, it was determined that the facility failed to ensure recommendations made by the pharmacy consultant were acted upon in a timely manner for 2 of 5 residents (Resident #3 and #61) reviewed for unnecessary medications. This deficient practice was evidenced by: 1.) On 3/12/26 at 12:59 PM, the surveyor interviewed Resident #61 in their room. Resident #61 was alert and oriented and conversed with the surveyor regarding his/her care. The surveyor reviewed the electronic medical record (EMR) for Resident #61. A review of the admission Record, an admission summary, reflected that the resident had diagnoses which included, but were not limited to, acute pulmonary edema, anxiety, and depression. A review of the pharmacy consultant's recommendations for February 2026 revealed the following recommendations: Please clarify the incomplete order for Dulcolax suppository, Fleet enema, Milk of Magnesia. The order lacks FREQUENCY. The manufacturer recommends a maximum dosage of 5 mg (milligrams) of Cetirizine per day in those older than [AGE] years of age. Please review the need for the present dosage. A review of the physician's orders and Medication Administration Record (MAR) included the following: Milk of Magnesia Suspension 7.75 (Magnesium Hydroxide) Give 30 ml (millimeters) by mouth as needed for Constipation Give 30 ml by mouth if no bowel movement in 48 hours, order date 2/2/26. Dulcolax Suppository 10 MG (Bisacodyl) insert 1 suppository rectally as needed for constipation if Milk of Magnesia is ineffective give Dulcolax 10 mg suppository via rectum, order date 2/2/26. Fleet Enema 7-19 GM/1118 ML (sodium Phosphates) insert 1 applicatorful rectally as needed for constipation if no bowel movement after Dulcolax suppository give Fleet Enema via rectum. Cetirizine HCl Oral Tablet 10 MG (cetirizine HCl) Give 1 tablet by mouth one time a day for allergies, order date 2/2/26. During an interview with Licensed Practical Nurse/Unit Manager (LPN/UM) #1 on 3/13/26 at 11:20 AM, he was unable to immediately respond to the process for following up with the pharmacy consultant's recommendations and stated that he would consult with the Director of Nursing (DON) and report back to the surveyor. On 3/13/26 at 12:46 PM, the surveyor located LPN/UM #1 and at that time LPN/UM #1 stated that a call was just made to the physician for a response to the pharmacy consultant recommendations. LPN/UM #1 was unable to provide an explanation as to why the physician was not notified prior to surveyor inquiry, or as to the process and procedure for the Medication Regimen Review (MRR) or regarding the follow-up to pharmacy consultant's recommendations. (continued on next page)

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	315183	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Cadbury of Cherry Hill	2150 Route 38 Cherry Hill, NJ 08002

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/26 at 1:55 PM, in the presence of the survey team, the surveyor reviewed the pharmacy consultant's recommendations and corresponding physician's orders with the DON and the Licensed Nursing Home Administrator (LNHA). When the DON was questioned regarding the process, timing, and steps in the MRR, she was unable to provide a response and stated that she would check because she was not sure. A review of the facility's, Pharmacy Services-Role of the Consultant policy, with a revision date of April 2019, did include the timing of responses. 2.) The surveyor reviewed the medical record for Resident #3. According to the admission Record, an admission summary, Resident #3 had diagnoses which included, but were not limited to, hypothyroidism. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 2/3/26, included the resident had a Brief Interview for Mental Status score of 13 out of 15, which indicated the resident's cognition was intact. A review of the individualized comprehensive care plan included a focus area, dated 7/29/25, that the resident had hypothyroidism. Interventions included: Give thyroid replacement therapy as ordered. A review of the Order Summary Report, as of 3/16/26, included the following physician's order (PO): A PO, dated 11/11/25, for levothyroxine sodium oral tablet 75 micrograms (mcg), give one tablet by mouth in the evening for hypothyroidism. A review of the pharmacy consultant's recommendations, dated 11/12/25, included the following recommendation: Levothyroxine is ideally administered on an empty stomach, preferably before breakfast. A review of the March 2026 Medication Administration Record (MAR) revealed the above levothyroxine order was started on 11/11/25 and was scheduled for 4:30 PM daily through 3/11/26. On 3/12/26, the administration time was changed to 6:00 AM, however the PO still instructed to give the medication in the evening. A review of the progress notes included a nurse's note, dated 3/11/26 and written by the Director of Nursing (DON), which revealed a new PO was obtained from the physician to change the levothyroxine administration time. On 3/16/26 at 10:22 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated after the facility received the pharmacy consultant's recommendations, they would immediately notify the physician to approve the recommendation to prevent a delay in care. On 3/16/26 at 1:17 PM, the surveyor interviewed the DON, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated it was the responsibility of the UM to address the pharmacy consultant's recommendations and follow-up with the physician. When asked what the facility's required timeframe to address the pharmacy consultant's recommendations was, the DON stated she would have to check the facility's policy. At that time, the surveyor notified the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON of the delay in addressing Resident #3's pharmacy consultant recommendations and the DON stated the 11/12/25 recommendation should have been addressed sooner than 3/11/26. A review of the facility's Medication Regimen Reviews policy, revised May 2019, included the following: The goal of the MRR [Medication Regimen Review] is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or the administrator. The policy did not include a timeframe in which the facility should address the pharmacy consultant's recommendations. NJAC 8:39-29.3

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and review of facility documentation it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of debris and failed to cover 1 of 1 dumpsters. This was evidenced by the following: On 3/11/26 during the initial tour of the kitchen with the Food Service Director (FSD), the surveyor observed the dumpster area. The large green dumpster did not have a lid. The FSD told the surveyor it was delivered with no lid. Just past the dumpster in the same enclosed area the surveyor observed two mattresses, four wood pallets, and a reclining chair on the ground. The surveyor asked the FSD who was responsible for the maintenance of the trash surrounding the dumpster and he stated it was the responsibility of the housekeeping department. On 3/17/26 the surveyor, during an interview with the Licensed Nursing Home Administrator (LNHA), asked why it was important for dumpsters to be closed and why there shouldn't be trash on the ground in the area. The LNHA said it was important for dumpsters to be closed so there were no pest and rodent issues, and the same for the dumpster area, To avoid having rodents. A review of the policy titled, Disposal of Garbage and Refusal, dated 12/2025 indicated that refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers and garbage should not accumulate or be left outside of the dumpster. NJAC 8:39-19.7 (b), 31.5 (a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain medical records that were accurately documented by not signing off medications immediately after administration for 3 of 6 residents (Resident #24, #52, and #77) observed during the medication pass. This deficient practice was evidenced by the following: On 3/12/26 at 8:13 AM, the surveyor observed Licensed Practical Nurse (LPN) #2 dispense and administer six medications to Resident #52. The nurse did not sign off the medications as administered when she returned to the medication cart, and instead moved on to the next resident. At 8:22 AM, the surveyor observed LPN #2 dispense and administer five medications to Resident #77. The nurse did not sign off the medications as administered when she returned to the medication cart, and instead moved on to the next resident. At 8:48 AM, the surveyor observed LPN #2 dispense and administer two medications to Resident #24. The nurse did not sign off the medications as administered when she returned to the medication cart, and instead moved on to the next resident. At 8:52 AM, the LPN stated she was going to prepare the next resident's medications, but the surveyor stopped the medication pass. When asked what should be done immediately after administering medications, the LPN stated nurses should sign off the medications as administered because if it's not documented, it's not done. The LPN acknowledged that she did not sign off the three residents' medications after administration and stated that nurses should sign off the medications as soon as they were administered to maintain an accurate record for administration. A review of the Medication Admin Audit Reports for the three residents, dated 3/12/26, revealed the following:Resident #24's medications were signed off as administered at 9:02 AM and 9:03 AM.Resident #77's medications were signed off as administered at 9:03 AM and 9:04 AM.Resident #52's medications were signed off as administered at 9:04 AM. On 3/16/26 at 10:22 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the nurses should sign the medications off as administered immediately after the resident takes the medication so that the facility knows the time the medications was taken. On 3/16/26 at 1:17 PM, 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 that nurses should sign off the medications as administered immediately after the medication was given because it documented that the resident took their medications. The DON further stated that the nurse should not delay signing off the medications because the facility needed to ensure the resident got their medication at the correct time. At that time, the surveyor informed the DON and LNHA that LPN #2 did not sign off medications after administration and the DON stated that the nurse should have signed off the medications as they were given. A review of the facility's Administering Medications policy, revised 4/2019, included the following:As required or indicated for a medication, the individual administering the medication records in the resident's medical record:a. the date and time the medication was administered. A review of the facility's Charting and Documentation policy, revised 7/2017, included the following:The following information is to be documented in the resident medical record: b. Medications administered. NJAC 8:39-35.2 (d)

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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, and review of pertinent facility documentation, it was determined that the facility did not ensure a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to properly store the oxygen nasal cannula (NC) (a device used to deliver oxygen tubing) for 1 of 1 resident (Resident #14) reviewed for respiratory care, leaving the device exposed on a bare mattress. This deficient practice was evidenced by the following: On 3/12/26 at 9:20 AM, the surveyor observed that Resident #14's oxygen NC tubing was exposed to air, lying directly on the resident's bare mattress. The surveyor reviewed the electronic medical record for Resident #14. A review of the admission Record, an admission summary, revealed the resident had diagnoses including, but not limited to, metabolic acidosis (a medical condition in which the body produces too much acid, affecting the function of organs such as the heart, lungs, and kidneys). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/20/26, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. A review of the Individual Comprehensive Care Plan (ICCP), dated 10/30/25, included a focus area indicating that Resident #14 receives oxygen therapy. Interventions included oxygen at 2 liters per minute (LPM) via NC. A review of the Order Summary Report (OSR), dated 3/11/26, included the following physician orders (PO):A PO dated 3/11/26: Change oxygen tubing and humidifier bottle weekly, and every night shift on Wednesday for oxygen.A PO dated 3/09/26: Oxygen at 2 LPM via NC as needed (PRN) for shortness of breath or hypoxia. During an interview with the surveyor on 3/13/26 at 11:15 AM, the Infection Preventionist (IP) stated that the oxygen tubing is changed weekly on Wednesdays and should be kept in a plastic bag when not in use. During an interview with the surveyor on 3/16/26 at 11:20 AM, the Director of Nursing (DON) stated that Resident #14's oxygen tubing should have been stored in a bag and not placed on a bare mattress to maintain infection control. A review of the facility's revised policy, dated 2/26, titled Infection Clinical Protocol, revealed that The physician or provider and staff will identify infection transmission risks and, in conjunction with the infection preventionist, will implement relevant precautions. N.J.A.C. S 8:39-19.4(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, it was determined that the facility failed to provide a safe environment for facility staff. This deficient practice was identified throughout the kitchen and was evidenced by the following:On 3/11/26 at 09:20 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD). During the tour of the kitchen the surveyor observed that the floor was made up of four inch by four inch tiles throughout the kitchen. Tile size was confirmed with the FSD. During the observation of the three basin sink the surveyor noticed that 18 of the ceramic tiles were missing from the floor creating an uneven floor surface. The FSD acknowledged the missing tiles and told the surveyor, Sometimes they place mats over the area to make it safer. The surveyor then observed the steam table area. In front of the steam table the surveyor observed 14 broken tiles. Some had loose pieces, and some had missing pieces, creating an uneven floor surface. The FSD acknowledged the uneven floor surface. On 3/17/26 at 9:25 AM, during an interview with the Licensed Nursing Home Administrator (LNHA), he stated that the facility was going to initiate repair of the floor tiles. This occurred following surveyor inquiry. No additional information was provided to the surveyor. A review of the policy titled Maintenance Service, dated 12/2009 revealed that maintenance service shall be provided to all areas of the building, grounds, and equipment in a safe and operable manner at all times. NJAC 8:39-31.2