STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315201	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Rehabilitation and Healthcare Center	255 East Main St Moorestown, NJ 08057

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of pertinent documents it was determined that the facility failed to ensure a thorough investigation was conducted to identify the causal factor of a fall for a severely cognitively impaired resident who was found lying on the floor in a pool of blood, that resulted in a hematoma and laceration to the head, and required emergent transfer to the hospital on 9/5/25. This deficient practice occurred for 1 of 3 residents (Resident #2) reviewed for accidents and incidents, and was evidenced by the following:On 11/6/25 at 11:30 AM, the surveyor reviewed the closed medical record (Electronic and Paper) for Resident #2.According to the admission Record, Resident #2 was admitted to the facility with diagnoses which included but were not limited to; Parkinson's disease, need for assistance with personal care, hemiplegia unspecified affect, muscle wasting and atrophy, unspecified dementia.A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/21/25, revealed that Resident #2 scored 07 out of 15 on the Brief Interview for Mental Status (BIMS), indicative of severe cognition. Further review of the MDS indicated that Resident # 2 was totally dependent on staff for care, required a Hoyer mechanical lift transfer with 2 or more people assist. Had impairments on both upper and lower extremities. A review of the QAPI Report dated 9/5/25, provided by the facility, reflected that Resident #2 sustained a fall with injuries which included, hematoma, and laceration to the scalp and required an emergent transfer to the hospital for treatment.The investigation concluded that the resident rolled out of bed. The CNA performed tasks properly according to protocol.On 11/6/25 at 11:15 AM the surveyor reviewed the MDS assessment dated [DATE] which revealed that Resident #2 was totally dependent on staff for care, had limitation on both upper and lower extremities and required two persons physical assist with care.On 11/6/25 12:15 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident although immobile was able to hold onto the bedrails and assist with turning during care. That same day at 1:30 PM the DON informed the survey team that Resident #2 did not have bedrails in use. On 11/6/25 at 12:40 PM, during a telephone interview with the Licensed Practical Nurse (LPN) who cared for Resident #2 at time of the fall, she stated that Resident #2 was fully dependent on staff, required two-persons assist with care.On 11/6/25 at 1:22 PM, the surveyor interviewed the MDS coordinator regarding the MDS coding. She explained to the surveyor that the data to complete the MDS was obtained from communication from the nursing staff and the CNA Plan of Care. The MDS Coordinator provided the Plan of Care for Resident #2. The Plan of Care revealed that the resident was unable to perform the activity (Roll from side to side) the helper does the work. Or 2 or more assists were required to perform the activity. On 11/6/25 at 1:26 PM, the surveyor interviewed a random CNA (CNA #3) on the unit where Resident #2 resided. Upon inquiry, CNA# 3 stated that she was familiar with the resident's care routine. The CNA stated that Resident #2 got out of bed only for hair care. Resident #2 was fully dependent on staff and required 2 persons physical assist for care and transfer. The surveyor asked the CNA where the documentation regarding the care required by Resident #2 could be located. The CNA stated that the care was entered on the Plan of care. CNA #3 showed the resident the Kardex and verified that Resident #2 was dependent on staff for care, the resident could not assist with turning/rolling from side to side. CNA #3 informed the surveyor that she had been taking care of the resident for the last three years. The CNA stated that Resident #2 was a FULL complete. When asked to elaborate she stated, Resident #2 was bedridden, she required 2 persons assist with care. Resident #2 could not turn on their own as they were immobile. She cared for the resident with her hallway partner daily. The CNA further stated that the day of the fall she was about to leave the unit when she observed the resident on the floor bleeding and both CNA #1 and CNA #2 were in the room. She went to the nursing station and informed the nurse.The facility did not provide any statement from CNA #3.On 11/6/25 at 2:00 PM, the surveyor interviewed the DON regarding the plan of care implemented for Resident #2. The DON stated again that she did not look at the MDS coding yet and could not comment on the plan of care.On 11/6/25 at 2:05 PM, the surveyor reviewed the MDS coding with the DON and asked if the CNA should have followed the plan of care. In the presence of the survey team, the DON stated, yes. The CNAs should have followed the plan of care.The facility concluded that CNA #1 performed tasks properly per protocols. Resident #2 moved their arm which shifted their weight and they loss trunk balance, landing on the floor. Root Cause: Resident rolled out of bed, which caused a fall during incontinent and linen change while in bed. On 11/6/25 at 2:18 PM, during a telephone

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure a resident's plan of care was followed and communicated to all facility staff to prevent falls. Resident #2 fell and sustained head trauma with a laceration to the head with active bleeding which required transferring Resident #2 to the hospital. This deficient practice was identified for one of three residents (Resident #2) reviewed for accidents and incidents. This deficient practice was evidenced by the following:On 11/6/25 at 10:15 AM, the surveyor reviewed Resident #2's closed electronic Medical Record (EMR).A review of the Face Sheet (an admission summary) reflected that Resident #2 was admitted to the facility with diagnoses which included but were not limited to; Parkinson's disease, need for assistance with personal care, hemiplegia unspecified affect, muscle wasting and atrophy and unspecified dementia.A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 7/21/25, reflected that Resident #2 scored 7 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident had severe cognitive impairment.Section GG of the MDS addressed Functional Abilities and indicated that Resident #2 was assessed as being totally dependent on staff for care. Resident #2 received a score of 01 which indicated that the helper completed the activity or the assistance of 2 or more helpers were required for the resident to complete the activity.Section GG 0115 of the MDS referred to Functional Limitation in Range of Motion and indicated that Resident #2 had impairment on both upper and lower extremities. A review of the interdisciplinary comprehensive care plan (ICCP) initiated on 1/21/2025, revealed a focus area that Resident #2 was at risk for falls related to deconditioning, weakness, impaired mobility and incontinence. The ICCP goal was that Resident #2 would be free of fall related injury through the next review date of 10/15/2025.The 1/21/2025 ICCP interventions included; to assist and /or remind the resident to change position and get up from sitting or lying slowly due to orthostatic blood pressure problems. Be sure call light is within reach and provide reminders to use call light for assistance as needed. Create a safe environment, floors clear of clutter, clean up spills, adequate lighting. Educate resident, involved family members, and caregivers about safety reminders, fall prevention, and what to do if a fall occurs. Monitor for safety due to dizziness, lethargy, and poor safety awareness. Document findings and interventions. The ICCP was revised on 9/5/25, after a fall and included the following: Determine and address causative factors of the fall.Review of the ICCP for ADL (Activities of Daily Living) Self Care Performance Deficit related to Activity Intolerance, impaired mobility, Parkinson's disease, initiated on 10/15/2024, revealed that the resident was dependent on staff for bathing, used a Geri-chair when out of bed, required staff assistance with grooming/personal hygiene, a total mechanical lift with two person assistance with transfers, and to educate resident, involved family members, and caregivers about safety reminders. A review of the Certified Nursing Assistant (CNA) plan of care revealed that Resident #2 was dependent on staff for all care. Resident #2 had impairments on both upper and lower extremities. Review of the nursing progress notes (PN) dated 09/05/25 timed 20:16 (4:16) PM, indicated the following: Writer notified by Aide at 16:00 PM (4:00 PM) that Resident #2 was on the floor, resident noted lying on the floor on their left side, able to respond to commands, eyes open, blood noted on the floor to the left side of head, Unit Manager notified, Resident Representative notified. Resident transferred to emergency room for further evaluation.An additional PN dated 09/06/25 at 6:52 AM, revealed, admitted for observation. Large hematoma (collection of blood outside the blood vessels similar to a bruise) and laceration to the back of the head. Bleeding stopped and controlled. Remains conscious .A review of the nursing PN dated 09/15/ 25 and timed 13:02 (1:02 PM), indicated the following: Resident Representative reported that Resident #2 had a decline since hospitalization in the trauma unit. Resident #2 was not eating, not responding verbally to others and had bruises, and stated, she is black and blue all over.On 11/06/25 at 10:30 AM, the surveyor requested all investigations for Resident #2 for the past six months and their ICCP from the Director of Nursing (DON).On 11/06/25 at 11:15 AM, the DON provided an incident report (IR) dated 9/5/25 at 4:00 PM, which revealed that Resident #2 sustained a fall during incontinence care. The following details were included: Resident #2 was found on the floor in the room. Resident #2 sustained a head trauma with laceration to the scalp and a hematoma. First Aid initiated; vital signs obtained. No neuro checks initiated; 911 called emergently. The physician and the Resident Representative were notified. Resident #2 was transferred to the hospital for evaluation and treatment The facility's IR conclusion revealed, that during incontinent and linen change, Resident #2 rolled out of bed, which caused a fall. The nurse was notified by the assigned Certified Nursing Assistant (CNA) that the resident had a witnessed fall. Upon entering the

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review and review of other pertinent facility documentation it was determined that the facility failed to treat and manage a resident's pain consistent with professional standards of practice. This was identified for 1 of 4 residents (Resident #1) reviewed for pain and was evidenced by the following:A review of the resident admission Record (admission summary) indicated that Resident #1 was admitted to the facility with the diagnoses which included but was not limited to Alzheimer's Disease, chronic obstructive pulmonary disease (COPD-a group of lung diseases that cause airflow obstruction and breathing difficulty) and osteoporosis (causes bones to become thinner, weaker and more likely to fracture). A review of the quarterly Minimum Data Set (MDS)-an assessment that facilitates a resident's care) dated 9/10/25, indicated that Resident #1 scored a 3 (three) out of 15 on the Basic Interview for Mental Status (BIMS) which indicated that the resident had severe cognitive impairment. The MDS also reflected that Resident #1 required maximum assistance with all aspects of activities of daily living (ADLs).A review of the Facility Reportable Event (FRE) dated 8/25/25 revealed that on 8/23/25, Resident #1's responsible party (RP) informed the nursing staff that the resident had pain in the right shoulder. The physician was notified, and an x-ray was obtained on 8/24/25 which showed that the resident had osteopenia and a non-displaced humerus fracture. The physician was updated, and the resident had a history of pathological fractures. Further review of the Situation, Background, Assessment and Recommendation (SBAR-change of condition) form dated 8/23/25 at 6:44 PM, reflected that Resident #1's complained of right shoulder pain rated 8 out of 10 (with 10 being the worst). The nurse documented noted tenderness and limited range of motion in the affected shoulder. However, there was no follow-up documentation which indicated that any pain medication or intervention was administered at that time to address or manage the resident's pain.A review of the facility summary and conclusion indicated the resident was medicated with Tylenol for pain and that the medication was effective. The surveyor reviewed Resident #1's nursing progress notes and the Medication Administration Record (MAR) and there was no documentation that the resident had received any pain medication.The surveyor reviewed the MAR dated 8/24/25 which indicated that Resident #1's pain was being monitored each shift. On the night shift documentation reflected that the resident complained of pain at a rate of 5 out of 10 on the pain scale. However, there was no follow-up documentation to indicate whether the resident was administered pain medication or interventions to address or manage the resident's discomfort.On 11/6/25 at 10:20 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who reviewed Resident #1's MAR in the presence of the surveyor. The ADON confirmed that on 8/23/25 at 6:44 PM and again on 8/24/25 during the night shift, when the resident had complained of pain, there was no documentation that pain medication was administered. The ADON stated that the nursing staff did not appear to administer any pain medication or implement interventions to manage the resident's pain. The ADON stated that the physician should have been notified, and appropriate pain medication should have been provided.On 11/6/25 at 12:46 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who cared for the resident on 8/23/25 at 6:44 PM. The LPN stated that she could not recall whether she administered pain medications to Resident #1 at that time. She reported that she may have given the resident Tylenol but may have failed to document the administration. She acknowledged that she should have notified the physician and obtained an order for pain medication, administered the prescribed medication and then documented both the administration and effectiveness of the medication.On 11/6/25 at 1:20 PM, the surveyor interviewed the Director of Nursing (DON) simultaneously with the Licensed Nursing Home Administrator (LNHA) who were both in agreement that when a nurse assessed a resident for pain, the nurse would be responsible to document the level of pain, location and description of the pain. The DON stated that the nurse would also be responsible to call the provider to obtain an order for pain medications. The DON continued to explain that nurses were expected to follow-up with the provider for further interventions to manage the pain and to document the effectiveness of the interventions.The facility policy titled, Pain Assessment and Management dated April 2025 indicated that the purpose of this procedure were to help staff identify pain in the resident, development of interventions and address the underlying cause of pain. General guidelines indicated that staff were to identify underlying causes, intensity, duration, type and characteristics of pain and to address the underlying cause of pain. The policy reflected that non-pharmacological interventions may be appropriate alone or in conjunction with medications. The medication regimen is implemented as ordered and results of the interventions are documented and communicated to the provided when appropriate.NJAC 8:39-27.1(a)