

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway, The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Complaint# NJ2699824 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, by failing to ensure that critical laboratory results obtained on 12/15/25 were immediately conveyed to the physician, which resulted in a three (3) day delay in notification on 12/18/25 and immediate transfer to the hospital for evaluation and treatment. This deficient practice was identified for 1 of 1 resident (Resident #123), reviewed for quality of care. This deficient practice 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 or 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 well-being, and executing medical regimes 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. The surveyor reviewed the electronic medical records for Resident #123. A review of Resident #123's admission Record, an admission Summary, reflected that the resident was admitted to the facility with diagnoses which included acute respiratory failure (a rapid-onset, life threatening condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide), heart failure (a chronic condition where the heart does not pump blood as well as it should), presence of an implanted cardiac defibrillator (a device implanted under the skin that constantly monitors the heart rate to detect irregular heartbeats and delivers electric shocks to restore normal heartbeat), chronic obstructive pulmonary disease (COPD) [progressive irreversible lung disease that restricts airflow, making it hard to breath], and type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel). A review of the progress notes included a physician's progress note (PPN) dated 12/7/25 at 10:17 AM, which included a history and physical for Resident #123. The note indicated that the resident had been admitted to the facility after being hospitalized for respiratory failure and was treated for pneumonia and was currently completing antibiotics. The physician evaluated the resident and identified prior medical history which included generalized weakness, and chronic back pain, with a treatment plan to provide physical, occupational therapy and psychiatry per protocol, complete antibiotics, and trend labs. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/18/25, included the resident had a</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 315210	If continuation sheet Page 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway, The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident's cognition was moderately impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 11/12/25, that the resident was at risk for bleeding and bruising due to use of Plavix (a medication that prevents platelets from sticking together to form a blood clot). Interventions included labs as ordered and report abnormal results to physician asap (as soon as possible). A review of the Order Summary Report (OSR), included the following physician's orders (PO): A PO dated 12/8/25, for CBC (complete blood count; a blood test that measures the number and type of cells in the blood) and BMP (basic metabolic panel; a blood test that assesses overall health, kidney function and electrolyte levels) weekly, one time a day on Mon (Monday). A PO dated 12/18/25, reflected and order to send to ER (emergency room) for low platelet count. A review of the resident's laboratory report dated reported 12/8/25 2:45 PM, and collected 12/8/25 at 8:20 AM, included CBC, auto differential/basic metabolic panel, included, but was not limited to the following: CBC:Hemoglobin: 8.6 g/dl (gram per deciliter) with a reference range of 10.7-15.1Hematocrit: 27% with a reference range of 32-46%Platelets: 59 K/CU.MM with a reference range of 126-400 Basic Metabolic Panel: Creatinine: 0.82 mg/dl with a reference range of 0.60-1.50Glucose: 104 mg/dl with a reference range of 65-99Sodium: 131 mmol/L (micromoles per liter) with reference range of 135-145eGFR (estimated glomerular filtration rate): 79 with a reference range of >59 A further review of the progress notes included a PPN dated 12/9/25 at 5:14 PM, which indicated that the physician had seen the resident at their bedside, and a call was made to the resident's responsible party, and their concerns were addressed, there were no new complaints, and medications were discussed. The residents' vital signs were reviewed, the resident was awake, alert, and in no acute distress. The note also included trend labs as needed, noted 12/8. A further review of the progress notes included a PPN dated 12/14/25 at 11:56 AM, the resident was seen at their bedside, there were no complaints, at baseline. No CP (chest pain), SOB (shortness of breath) or abd (abdominal) pain. Trend labs as needed, noted 12/8. A review of the resident's laboratory results reported 12/15/25 at 8:01 PM, and collected on 12/15/25 at 11:39 AM, included CBC, auto differential/basic metabolic panel, included, but was not limited to the following: CBC:Hemoglobin: 8.7 g/dl with a reference range of 10.7-15.1Hematocrit: 28% with a reference range of 32-46%Platelets: 20 K/CU.MM with a reference range of 126-400 Basic Metabolic Panel: Creatinine: 1.99 mg/dl with a reference range of 0.60-1.50Glucose: 67 mg/dl with a reference range of 65-99Sodium: 130 mmol/L with reference range of 135-145eGFR: 27 with a reference range of >59 A further review of the progress notes included a Nursing Progress Note (NPN) dated 12/16/25 at 6:28 PM, indicating lab (name redacted) called for critically low platelets (20). MD (medical doctor) was notified. No new orders. A continued review of the progress notes included a late entry IDT (Interdisciplinary team) note entered by the social worker and created on 12/21/25 at 4:28 PM (after the resident had been sent to the hospital), with an effective date of 12/18/25 at 1:00 PM, regarding a care plan meeting which indicated the conference was held via telephone with the resident's responsible party to review resident's current status and discharge plan. The resident did not wish to attend the meeting. The therapy note included that the resident was self-limiting in their goals due to lack of participation. Nursing included labs were reviewed with noted low platelets, that MD was aware of labs and advised team to continue monitoring. A NPN dated 12/18/25 at 2:17 PM, revealed there was a care plan meeting held via telephone with resident's responsible party who questioned the resident's lab work and not having received a phone call from the resident's physician. The Licensed Practical Nurse Unit Manager #3 (LPN/UM #3) informed the resident's responsible party she would call the MD regarding their concerns and would call the responsible party back. A follow-up NPN dated 12/18/25 at 2:19</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway, The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PM, indicated LPN/UM #3 had spoken with MD and discussed the resident's responsible party's concern regarding lab results. LPN/UM #3 noted labs from the last 2 (two) draws were compared and MD stated to send the resident to the ER (emergency room) due to the drop in platelet count. The responsible party was informed and was agreeable, resident care was rendered, they were awaiting transport to the hospital, and resident was in no distress at the time. A PPN dated 12/18/25 at 2:51 PM, revealed Called by [LPN/UM #3] regarding labs, I was not called prior about labs, rather results for another patient. I instructed her to send the patient to the ER. I then called the [resident's responsible party] and discussed the case. A NPN dated 12/18/25 at 3:30 PM, included Transport arrived and report was given. MD aware of pick up. A NPN dated 12/19/25 at 12:56 AM, indicated the resident was admitted to the hospital with an admitting diagnosis of septic shock and PNA (pneumonia), and that the MD was notified. On 2/17/26 at 11:36 AM, the surveyor attempted to interview Licensed Practical Nurse #4 (LPN #4) via telephone. A voicemail message was left; however, the surveyor did not receive a return call. On 2/18/26 at 9:10 AM, the surveyor again attempted to interview Licensed Practical Nurse #4 (LPN #4) via telephone. A voicemail message was left; however, no return call was received. On 2/18/26 at 9:30 AM, the surveyor interviewed Resident #123's responsible party, who stated they had attended a meeting with facility staff, including social work, the facility director, and another individual believed to be the Director of Nursing (DON). During the meeting, the resident's responsible party asked whether any recent lab work had been collected, and staff reported that the results had been received three days prior. The resident's responsible party was upset and stated that the facility was expected to provide daily updates and questioned whether the physician had been notified of the results. At that time, the resident's responsible party requested to speak with the physician and asked that the resident be sent to the hospital. The responsible party stated that the physician contacted them and reported that they had not been notified of the lab results. On 2/18/26 at 10:01 AM, the surveyor interviewed the resident's physician (Ph #1) who stated that Resident #123 had multiple comorbidities but had been stable with no new complaints. Ph #1 stated, unfortunately, the resident decompensated quickly, with no clear signs or symptoms of infection identified prior to the decline and the resident succumbed to sepsis or respiratory failure at the hospital with no clear indication of infection, only abnormal blood counts. The physician further stated that the resident had recently completed a course of antibiotics for an infection and had a history of low platelet counts prior to admission to his service. The physician noted that a miscommunication had occurred with the facility nurse. The resident had critical labs that were not called into him. Once the critical labs were communicated, he sent the resident to the hospital. At that time, ph #1 stated the nurse texted the physician the critical lab results regarding the platelets, however, that text was not seen. Ph #1 stated that critical lab results must be directly communicated by speaking with the physician and should not be relayed by text message or voicemail. Ph #1 stated he only became aware of the critical labs when LPN/UM #3 called him on 12/18/25, three days after the lab results were available. The physician stated he never saw the initial text message regarding Resident #123 that was sent around 1:30 AM on 12/16/25 so he did not respond. The nurse then sent another text message regarding a different resident at 5:30 AM, to which he responded at 6:20 AM, but the physician again stated he never saw the 1:30 AM text, as it had gotten buried. The physician further stated on 12/18/25, when Resident #123 was sent to the hospital, there had been no change in the resident's clinical status, the resident was only sent because of the critical labs. Ph #1 further stated that he then called the resident's responsible party and had Resident #123 sent to the hospital. On 2/18/26 at 11:26 AM, the surveyor interviewed Licensed Practical Nurse #5 (LPN #5), who stated that when critical laboratory</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway, The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>results are received, staff were not to leave a text message; rather, the nurse must speak with the physician to communicate the results. LPN #5 emphasized that this process was important because critical laboratory values may be life-threatening. Additionally, LPN #5 stated that the nurse was expected to notify the unit manager or nursing supervisor of the critical results. On 2/18/25 at 11:21 AM, the surveyor interviewed the current third floor LPN/Unit Manager #1 (LPN/JM #1) who stated that upon receipt of critical laboratory results, the nurse was required to telephone the physician directly so the physician could determine whether the resident required transfer to the hospital or required new orders. The nurse should also notify the nursing supervisor and assess the resident. On 2/18/26 at 11:57 AM, the surveyor interviewed the Assistant Director of Nursing /Infection Preventionist (ADON/IP) who stated that critical laboratory results must be communicated regardless of the time of day. The ADON/IP reported that staff had informed her that Resident #123's physician (Ph #1) preferred to receive lab results via text message. When asked how she ensured that Ph #1 received the text messages, the ADON/IP stated that if she had not received a response within 20 minutes, she would send a second text message. If there was still no response, she would telephone the Medical Director, who was available at any hour and was responsible for overseeing all physicians. The IP confirmed that a platelet count of 20 was serious and should have been communicated immediately to Ph #1. On 2/18/26 at 12:24 PM in a later interview with the ADON/IP, she stated that LPN #4 worked overnights. The ADON/IP reported that attempts were made to contact LPN #4 by telephone; however, she was unable to reach her. On 2/18/26 at 12:40 PM, the surveyor interviewed the Director of Nursing (DON), who stated for a critical lab result, the expectation was for the nurse to call or text the physician, because some physicians preferred to be texted. The DON stated if the nurse texted twice without response, then they should call the Medical Director (MD). The DON stated, in addition, the nurse should contact the nursing supervisor, who was to ensure that if a follow up was needed, it was completed. The DON stated the nurse was also expected to write a progress note which included the critical lab, and the call to the physician with their response. When asked when a critical lab should be communicated to the physician, the DON stated as soon as the nurse received the critical lab results. The DON further added depending on the scenario, there could be a negative outcome for the resident if the physician was not contacted immediately. The DON then confirmed that a platelet count of 20 was critical and the physician should have been contacted immediately. On 2/18/26 at 12:56 PM, LPN #4 called the surveyor via telephone. When asked how critical labs were communicated to a physician, LPN #4 stated that staff either called the physician or sent a text message. LPN #4 explained that the method depended on the time of day, as some physicians did not answer their phones late at night, so texts were sometimes used. At that time, when asked how she ensured that a physician received a text message, LPN #4 stated that if she did not receive a response, she would call the physician before the end of her shift. LPN #4 further stated that it was important to ensure the physician was aware of critical lab results and that she would also notify a supervisor. At that time, LPN #4 stated she recalled Resident #123 and that she had sent the resident's critical lab results via text to Ph #1. LPN #4 stated that later in the night, she sent a second text regarding a different resident. LPN #4 reported receiving two text message responses and assumed that the first response noted referred to Resident #123, while the second response referred to the other resident. LPN #4 stated that she had also notified her supervisor about the critical lab results. When asked if she followed up with Ph #1, she responded no, that in her experience, Ph #1 did not respond immediately. LPN #4 further stated that she had endorsed to the day shift that Resident #123 had critical lab values and that she had contacted Ph #1, who responded noted with no new orders and believed that Ph #1 would be in</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway, The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>to see Resident #123 that day. On 2/18/26 at 3:13 PM the DON provided the surveyor a screenshot of the text conversation between LPN #4 and Ph #1 dated Tuesday, 11/25/26 at 1:28 AM, which included Hi Doc. This is (name redacted, LPN #4) from facility name (redacted). Just received a critical lab result for Resident #123 (name redacted) . platelet count is critically low (20). Any orders? There was no response. At 5:26 AM, LPN #4 sent another message, this time for another unsampled resident which indicated FYI. (name redacted) has dark red urine output. There were two text messages sent at 6:23 AM from Ph #1 which indicated Noted and a second text which indicated Hold Eliquis (a blood thinner). On 2/19/26 at 9:42 AM, the surveyor reviewed Resident #123's New Jersey Universal Transfer Form (NJUTF), [a mandatory document designed to standardize the transfer of clinical information between healthcare facilities, such as hospitals and long-term care facilities, to reduce errors]. The form was dated 12/18/25 at 3:55 PM. The documented reason for transfer to the hospital was, drop in platelet count. On 2/19/26 at 10:19 AM, the surveyor re-interviewed Ph #1 via telephone in the presence of the survey team. When asked if he would have done anything differently had he been made aware of the laboratory results immediately, Ph #1 stated that, at the very least, additional actions would have been considered, including ongoing laboratory surveillance, escalation of care to a higher level, or evaluation in an acute care hospital. When asked about a possible emergency room evaluation, Ph #1 stated that it would depend on the circumstances, as a patient could be very stable or very ill. He noted that Resident #123's condition had been stable, but would have warranted further consideration if he had been aware of the critical lab results. Ph #1 repeated that no nurse had called him with any concerns. He stated that the labs were a concern and would have warranted further action. During his last visit with the resident, there were no new concerns. He further stated that he would have needed to speak directly with the nurse at the time to obtain a complete understanding of the resident's condition. He confirmed that he received a phone call two days later from the nurse reporting that the resident's representative was concerned, and he believed it was reasonable to send the resident to the hospital for evaluation. Ph #1 stated that critical laboratory results must be called in to the physician emergently. If the nurse was unable to reach the physician, the nurse should contact the Medical Director. On 2/19/26 at 10:34 AM, Ph #1 called the surveyor in the presence of the survey team. He stated that during the earlier interview, he did not have Resident #123's chart open or accessible. After speaking with the surveyor, he reviewed the resident's medical chart and noted a substantial decline in renal function (kidney functions) as well, which had not been included in the initial text message and would have prompted emergency medical intervention. Ph #1 stated that when the nurse called on 12/18/25, he opened the resident's chart and personally reviewed the laboratory results. He emphasized that he was highly accessible and had received multiple phone calls regarding other residents. He further stated that Resident #123 had been seeing a nephrologist (kidney specialist), though he did not currently have access to the nephrology note. Ph #1 stated that once he was made aware of the critical laboratory results, he took immediate action and sent the resident to the hospital for evaluation. He then discussed the situation with the resident's responsible party, who agreed with the decision to transfer the resident to the hospital. On 2/19/26 at 10:52 AM, the surveyor attempted to interview the former Unit Manager Licensed Practical Nurse #3 (LPN/UM #3) via telephone in the presence of the survey team. However, LPN/UM #3 did not answer her phone. On 2/19/26 at 11:08 AM, the surveyor interviewed the Medical Director (MD) in the presence of the survey team. The MD stated that he expected all nurses, including night shift nurses, to communicate critical lab results by calling him directly. He emphasized that nurses may call him at any time, nights, weekends, or holidays. He further stated he informed the previous administration the nurses needed</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway, The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>education, that critical labs required a phone call, not a text message. The MD cited a prior incident at the facility involving another physician which created a lot of mess, in the sense the physician texted the nurse back, the nurse thought the issue was addressed, and the resident did not do well. There was a delay in treatment. The MD further stated he held a meeting with the facility staff within the last few months and communicated that any critical results, including labs, radiology, or ultrasounds, must be communicated by phone rather than text message. As a result of this incident, we needed to change the policy to state that critical results required a phone call and not a text message. A text was just a short message and can create confusion. however, a phone call would allow for discussions, questions, and review of previous labs. When asked whether sending the resident to the hospital immediately would have made a difference, the MD stated he could not determine the outcome. However, he noted that investigation of the labs at the hospital was the appropriate course of action. He further stated that the resident's condition could have continued to decline, so transferring the resident to the hospital was the right decision. On 2/19/26 at 12:36 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Assistant Director of Nursing/Infection Preventionist (ADON/IP). The LNHA stated that he was unable to locate an investigation regarding Resident #123's critical laboratory results. The ADON/IP stated that when Resident #123 was sent to the hospital, it was considered an acute discharge, and the facility reviewed all acute discharges. The ADON/IP further stated that she had reviewed all of the resident's medical records and had looked into the incident, which was how she was able to provide the surveyor with a copy of the text messages between LPN #4 and Ph #1. The ADON/IP acknowledged that there had been a delay in care. The DON also acknowledged that there was a delay in treatment. The LNHA stated that the ADON/IP's work represented a follow-up on the acute transfer and was not necessarily a formal, required investigation. A review of the facility Lab and Diagnostic Test results- Clinical Protocol policy, revised November 2018, included: . A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results. whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification. A physician should respond within one hour regarding a lab result requiring immediate notification. If the attending or covering physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. Physician decisions. When responding to notification of test results, the physician and staff will discuss the implications of the test results for the resident, as well as subsequent actions; for example, obtaining additional tests, new or modified medication orders, additional monitoring, etc. A review of the Acute Condition Changes- Clinical Protocol policy, revised March 2018, included: . The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications. the nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less).The attending physician (or practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. The</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway, The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. The nurse and the physician will discuss and evaluate the situation. The physician should request information to clarify the situation; for example, vital signs, physical findings, a detailed sequence of events and description of symptoms. NJAC 8:39-27.1(a)</p>		