STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center for Rehab & Nursing Washington Township	535 Egg Harbor Road Sewell, NJ 08080

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to initiate and complete a thorough investigation after a cognitively impaired resident made an allegation of staff-to-resident physical abuse. This deficient practice was identified for 1 of 2 residents (Resident #123) reviewed for abuse.During an interview on 2/3/26 at 10:11 AM, with Certified Nursing Assistant (CNA #1), revealed Resident #123 made an allegation of physical abuse about one week ago and that CNA #1 reported the allegation to Licensed Practical Nurse (LPN #1) who didn't want to get involved. CNA #1 admitted she did not notify anyone else of the allegation after receiving that response from the LPN. On 2/3/26 at 10:45 AM, the surveyor interviewed Resident #123 who at first stated they were unable to recall the incident. The resident then stated, I can't honestly say, too much time has gone by, but I did get a couple punches from her. The resident then stated that CNA #1 probably knew who the perpetrator was and that the incident happened less than a month ago. An interview, on 2/3/26 at 11:23 AM, with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), revealed they were not aware of Resident #123's allegation of physical abuse and an investigation had not yet been started. According to a statement written by CNA #1, dated 2/3/26, Resident #123 reported the allegation of physical abuse to her on 1/23/26 at 9:15 AM. The facility's failure to implement their abuse policy by immediately investigating an allegation of physical abuse placed Resident #123, as well as all residents at risk for abuse. This posed the likelihood of serious physical and psychosocial harm, or impairment, and resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 1/23/26 at 9:15 AM when CNA #1 received an allegation of physical abuse from Resident #123 and did not report it to a supervisor. The facility's administration was notified of the IJ on 2/3/26 at 4:00 PM. The facility submitted an acceptable Removal Plan (RP) on 2/4/26 at 12:37 PM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 2/4/26 at 1:15 PM. The evidence is as follows:Refer to F600 A review of the facility's Abuse Prevention Program policy, revised January 2025, included that the residents had the right to be from abuse, neglect, misappropriation of resident property, and exploitation. The policy further included, as part of the resident abuse prevention, that the administration would do the following:6. Identify and assess all possible incidents of abuse.7. Investigate and report any allegations of abuse within timeframes required by federal requirements.8. Protect residents during abuse investigations. A review of the facility's Abuse Investigation and Reporting policy, revised February 2026, included that all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be thoroughly investigated by facility management. The policy further included, Any allegation, regardless of how mild or severe it may seem, should be reported to administration so that an investigation can be initiated. The surveyor reviewed the medical record for Resident #123. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to; insomnia, major depressive disorder, generalized anxiety disorder, and other symptoms and signs involving cognitive functions and awareness. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/15/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which (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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident did not experience hallucinations or delusions and did not have any physical or verbal behaviors directed towards others. A review of the Individual Comprehensive Care Plan (ICCP), included the following focus areas:-Cognitive loss related to a BIMS of 8 upon admission. Interventions included: Allow adequate time to respond, do not rush or supply words, approach/speak in a calm, positive/reassuring manner, and identify self when speaking with the resident.-Right to a safe, home-like environment and to be treated with dignity and respect and to be free from neglect, abuse, and discrimination. Interventions included: Staff will encourage and inform the resident of the right to be free from discrimination.-Resistive/noncompliant with treatment/care related to cognitive impairment. Interventions included: If resisting care, leave (if safe to do so) and return later. A review of the Progress Notes (PN) dated 1/20/26 through 2/3/26, did not include any allegations of abuse. On 2/3/26 at 10:00 AM, the surveyor conducted staff interviews on the 100 unit related to the facility's abuse investigation and reporting policy. On 2/3/26 at 10:11 AM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated she was in-serviced on abuse monthly and that if she heard about a resident being abused, she would immediately report it to the Supervisor, Director of Nursing (DON), and the Licensed Nursing Home Administrator (LNHA). The CNA then stated that about a week ago, Resident #123 reported to her that a nightshift CNA punched the resident in the ribs. The CNA stated she immediately notified Licensed Practical Nurse (LPN #1), but that he told her he didn't want to get involved. When the surveyor asked CNA #1 if she reported the allegation of abuse to anyone else after receiving that response from LPN #1, the CNA stated, no. CNA #1 then stated she believed the perpetrator was CNA #2, who worked overnight shifts and had gotten in trouble in the past related to resident care. The CNA explained it was important to report allegations of abuse to keep residents safe. On 2/3/26 at 10:45 AM, the surveyor interviewed Resident #123 who at first stated they were unable to recall the incident. The resident then stated, I can't honestly say, too much time has gone by, but I did get a couple punches from her. The resident then stated that CNA #1 probably knew who the perpetrator was and that the incident happened less than a month ago. On 2/3/26 at 10:50 AM, the surveyor interviewed CNA #6, who stated if she received an allegation of abuse she would report it to the Unit Manager (UM) to prevent further abuse. The CNA also stated Resident #123 was confused, but had never made any false accusations towards staff. On 2/3/26 at 10:55 AM, the surveyor interviewed LPN #2, who stated if she received an allegation of abuse, she would go through the chain of command and report it to the UM. The LPN then stated Resident #123 was alert and oriented, but confused and forgetful at times. The LPN further stated the resident did not make false accusations towards staff. On 2/3/26 at 11:00 AM, the surveyor interviewed CNA #7, who stated if she received an allegation of abuse she would immediately report the allegation to the nurse otherwise the investigation would be delayed. On 2/3/26 at 11:23 AM, the surveyor, in the presence of the survey team, interviewed the DON and LNHA who stated that staff were supposed to report any allegations of abuse immediately to their supervisor so that an investigation could be started. The DON and LNHA added that any staff accused of abuse should be suspended to protect the residents. At that time, the surveyor notified the DON and LNHA of Resident #123's allegation of abuse. The DON and LNHA stated they were unaware of the allegation and verified that CNA #1 should have reported the allegation of abuse to a supervisor. On 2/3/26 at 12:18 PM, the surveyor, accompanied by the Director of Social Services (DSS), conducted a follow-up interview with Resident #123, who stated an employee punched him/her in the side/back. The resident further stated that CNA #1 was aware, but all this time went by and nothing came of it, and, if it had been reported earlier, it would have been better. On 2/3/26 at 12:34 PM, the surveyor attempted to call LPN #1 and left a voicemail for him to call the surveyor back. On 2/3/26 at 12:35 PM, the surveyor attempted to call CNA #2 and left a voicemail for her to call the surveyor back. On 2/3/26 at 12:40 PM, the surveyor conducted a phone interview with the Licensed Practical Nurse/Supervisor (LPN/S), who stated she supervised the overnight shift. The LPN/S stated that if staff received an allegation of abuse, they (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	should immediately report it to the DON and LNHA to protect the resident and initiate an investigation. The LPN/S then stated she was not familiar with Resident #123, but that she had not received any allegations of abuse. On 2/3/26 at 12:45 PM, the surveyor conducted a phone interview with CNA #9, who stated if she received an allegation of abuse, she would report it to the nurse in charge so that it could be investigated. On 2/3/26 at 1:00 PM, the surveyor conducted a follow-up interview with the DON and LNHA, who stated after becoming aware of Resident #123's allegation of abuse, they immediately started an investigation which included obtaining staff statements, assessing the resident, suspending the alleged staff, notifying the police, and initiating abuse in-service training. A review of CNA #1's written statement, signed 2/3/26, revealed Resident #123 reported the allegation to the CNA on 1/23/26 at 9:15 AM. Further review of the statement included CNA #1 reported the allegation to LPN #1, who didn't want to get involved and she did not report the allegation to anyone else. A review of the 100 Unit Daily Assignment Sheet revealed CNA #2 worked the night of 1/22/26 into the morning of 1/23/26. A review of CNA #2's personnel file revealed a written warning, dated 11/13/25, for poor customer service, ineffective communication, providing care to resident without verbalizing what she was doing, which CNA #2 refused to sign, but signed that she received education related to the write up. On 2/3/26 at 3:16 PM, during a follow-up interview with the DON and LNHA, the DON stated the abuse investigation process was overseen by the DON and LNHA and included the following: identifying the perpetrator and removing them from the schedule, assessing the resident for safety, collecting statements, notifying the police if applicable, notifying the ombudsman, and reporting the allegation to the New Jersey Department Of Health (NJDOH) within two hours. The LNHA stated it was important to investigate abuse allegations to determine if the allegation was substantiated. The LNHA further stated that staff should report allegations higher up if they felt they were not being taken seriously because everyone was responsible for safeguarding the residents. On 2/4/26 at 9:00 AM, LPN #1 returned the surveyor's phone call and stated if he received an allegation of abuse, he would report it to the supervisor to protect the residents. He further stated that reporting allegations of abuse included following the chain of command to ensure the allegation was investigated. LPN #1 denied receiving any allegations related to Resident #123 and stated Resident #123 could be difficult for the overnight staff, but had never had any behaviors of false accusations towards staff. On 2/4/26 at 12:14 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated if she received an allegation of abuse, she would report it immediately to the DON so that the DON and LNHA could investigate the allegation and ensure the resident was safe. The facility submitted an acceptable Removal Plan (RP) on 2/4/26 at 12:37 PM, which indicated the action the facility would take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice which included: -An investigation was initiated on 2/3/26 at 11:23 AM.-LPN #1, CNA #1, and CNA #2 were suspended on 2/3/26, pending investigation.-Resident #123 was assessed on 2/3/26, for any signs of physical or psychosocial injury or distress with no visible injuries noted at the time of assessment.-Resident #123 was provided with a trauma screen on 2/3/26, emotional support, and a psychology consult was requested. -All alert and oriented residents who received care from CNA #2 were interviewed on 2/3/26, to confirm resident safety.-The facility's Abuse Investigation policy was revised on 2/3/26, by the DON and LNHA to clarify that any allegation, regardless of severity level or resident's cognition level, triggers an immediate investigation.-Facility-wide training on Abuse Investigation was initiated on 2/3/26, by the DON. The survey team verified the implementation of the RP on-site during the continuation of the survey on 2/4/26 at 1:15 PM. NJAC 8:39-4.1(a)(5)

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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 documents, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 1/29/26 at 11:43 AM, the surveyor, accompanied by the Food Service Director (FSD), conducted a spot-check of dishes in the large dining area prior to meal service. Three (3) 8 ounce (oz) blue coffee cups with brown debris and one (1) black bowl with white debris were observed. The surveyor donned a glove on her right hand and used a white paper towel to inspect the interior surfaces of the dishes intended for service. Upon inspection, brown debris from the three (3) 8 oz blue coffee cups transferred onto the white paper towel. On 1/30/26 at 9:46 AM, the surveyor observed, on the 200 Unit pantry, that the refrigerator freezer contained an open, exposed package of three lemon-flavored glycerin swab sticks (pre-moistened sticks used to moisten the mouth). On the floor between the unused ice machine and the closed dietary cart, there was brown sticky debris, an open 0.1 oz sugar packet, and an open straw. The trash can lid was partially closed and had brown sticky debris on it, exposing loose trash, and the plastic liner covered only one side of the trash can. On 1/30/26 at 12:15 PM, the surveyor observed the 400 Unit pantry area and noted that the walls had splatters of brown debris and the steam trays contained white debris. On 1/30/26 at 12:20 PM, the surveyor observed the 500 Unit pantry area. The walls and pipes had splatters of brown debris, and the floor contained loose white paper along with white and black particles. In the space between the wall and the refrigerator, there was a loose plastic cup, additional white paper, and white debris. A cabinet also had brown sticky debris, and the steam table trays contained white debris. On 1/29/26 at 11:55 AM, during an interview with the surveyor, the Food Service Director (FSD), who has worked at the facility for 2 years, stated that at times the dishwasher may not remove all residue. Dietary staff used multiple fail-safe processes, including spot-checking dishes after the dishwasher cycle. If residue was observed, items were scrubbed, rewashed, and reinspected before being served to residents. The dietary department was responsible for cleaning, stocking, and monitoring the temperatures of refrigerators and freezers in the pantries and nourishment rooms on the units. The FSD emphasized that all dishes must be thoroughly cleaned for infection control purposes. He also noted that the lemon-flavored glycerin swab sticks should not have been stored in the freezer as it was inconsistent with proper storage practices. On 2/6/26 at 9:46 AM, during an interview with the surveyor, the Housekeeping Director (HKD), who has worked at the facility for 10 months, stated that housekeeping staff were responsible for cleaning the floors, walls, and trash, including trash cans, in the pantry areas. Floors and trash cans were cleaned daily, and walls were cleaned monthly; the pantry walls were last cleaned on 1/15/26. She further stated that there was no formal cleaning schedule in place for the pantries, and the steam tables in the pantries were currently not used by the facility. She added that the current condition of the pantries and steam tables was not consistent with infection control standards or a homelike environment and should have been cleaned. A review of the facility's policy, dated 9/25, 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 policy, dated 5/25, titled Labeling and Dating Food Items, revealed that, A designated dietary worker will be responsible for checking the refrigerators for expiration dates. The facility was unable to provide a policy regarding the dishwashing procedures. N.J.A.C 8:39-17.2 (g)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observations, interviews, record review, and review of other facility documentation, it was determined that the facility failed to consistently administer pain medication according to the physician's order and Consultant Pharmacy recommendations for 1 of 5 residents (Resident #4) reviewed for unnecessary medications. This deficient practice was evidenced by: On 1/29/26 at 1:15 PM, the surveyor observed Resident #4 sitting in his/her room. When asked about pain, the resident stated that he/she has chronic pain in both shoulders and arthritis (joint inflammation causing pain and stiffness). The resident reported that pain is typically seven (7) out of ten (10) but is manageable with as needed medication. Resident #4 also stated that he/she receives oxycodone when pain reaches seven (7) or above. On 1/29/26 at 9:58 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #4 and the following was revealed: A review of the admission Record, an admission summary, revealed that Resident #4 had diagnoses which included, but were not limited to: Dementia with mild cognitive impairment (memory and thinking decline), Osteoarthritis (joint pain and stiffness), Major Depressive Disorder (persistent sadness), and Anxiety Disorder (excessive worry). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/25/26, included that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed Resident #4 had occasional pain with a numerical rating of seven (7) out of ten (10), the intensity was not indicated. A review of the individual comprehensive care plan (ICCP) included a focus of pain medication therapy, (oxycodone) related to severe pain, with a revision date of 11/18/24. Interventions included: administer analgesic (relieves pain) medications as ordered by physician and monitor/document/report adverse reactions. A review of the Order Summary Report (OSR), dated as of 2/6/26, included the following physician order (PO):oxycodone HCl oral tablet 5 mg (milligrams) give 1 tablet by mouth every 8 hours as needed (PRN) for severe pain. A review of the Consultant Pharmacist's Monthly Report (CPMR) dated 9/17/25 included the following recommendation: Documented pain level of 0, 2, 3, and 4 does not match PRN oxycodone indication of severe. Please follow specific order. The recommendation was initialed by BC with a completion date of 10/15/25. There was no Action Taken documented. A review of the 9/25 Medication Administration Record (MAR) revealed a PO for oxycodone 5 mg give 1 table by mouth every 8 hours as needed for severe pain. The oxycodone 5 mg was signed out as administered for the following pain levels on the following dates: -9/4/25 at 10:00 PM for a pain level of 4-9/6/25 at 10:00 PM for a pain level of 3-9/7/25 at 10:00 PM for a pain level of 4-9/8/25 at 10:00 PM for a pain level of 3-9/11/25 at 10:11 PM for a pain level of 6-9/12/25 at 9:51 AM for a pain level of 2-9/12/25 at 11:22 PM for a pain level of 0-9/13/25 at 10;00 PM for a pain level of 3-9/14/25 at 9:53 PM for a pain level of 4-9/20/25 at 10:00 PM for a pain level of 4-9/21/25 at 10:00 PM for a pain level of 4-9/23/25 at 10:00 PM for a pain level of 3-9/25/25 at 10:20 PM for a pain level of 6 A review of the CPMR, dated 10/15/25 included the following recommendation: Documented pain level of 0, 2, 3, and 4 does not match PRN oxycodone indication of severe. Please follow specific order. The recommendation was initialed by BC with a completion date of 11/15/25. There was no Action Taken documented. A review of the 10/25 MAR revealed a PO for oxycodone 5 mg give one tablet by mouth every 8 hours as needed for severe pain. The oxycodone 5 mg was signed out as administered for the following pain levels on the following dates: -10/1/25 at 11:43 PM for a pain level of 5-10/2/25 at 10:00 PM for a pain level of 4-10/4/25 at 11:43 PM for a pain level of 3-10/6/25 at 12:27 AM for a pain level of 0-10/9/25 at 1:11 AM for a pain level of 6-10/10/25 at 11:42 PM for a pain level of 5-10/14/25 at 10:00 PM for a pain level of 5-10/21/25 at 11:37 PM for a pain level of 5-10/25/25 at 8:41 PM for a pain level of 6-10/29/25 at 11:03 PM for a pain level of 0 A review of the CPMR, dated 11/13/25 revealed, No new medication irregularities are noted at this time. The recommendation was initialed by BC with a completion date of 12/10/25. There was no Action Taken documented. A review of the 11/25 MAR revealed a PO for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxycodone 5 mg, give one tablet by mouth for severe pain. The oxycodone 5 mg was signed out as administered for the following pain levels on the following dates: -11/15/25 at 10:00 PM for a pain level of 6-11/16/25 at 9:27 PM for a pain level of 6-11/23/25 at 1:00 AM for a pain level of 5-11/24/25 at 10:30 PM for a pain level of 6 A review of the CPMR dated 12/17/25 did not have recommendations. A review of the 12/25 MAR revealed a PO for oxycodone 5 mg, give one tablet by mouth for severe pain. The oxycodone 5 mg was signed out as administered for the following pain levels on the following dates: -12/11/25 at 8:38 PM for a pain level of 6-12/22/25 at 10:43 PM for a pain level of 6 A review of the CPMR dated 1/18/26, revealed, Missing indication for moderate pain with current PRN pain orders. Please clarify or update orders so that all levels of pain are covered. Please note there is only acetaminophen for mild pain and oxycodone for severe. oxycodone has been administered with documented pain levels of 0 and 6. Further review of the CPMR revealed that no initial or completion date or Action Taken was documented. A review of the 1/26 MAR revealed a PO for oxycodone 5 mg, give one tablet by mouth for severe pain. The oxycodone 5 mg was signed out as administered for the following pain levels on the following dates: -1/7/26 at 10:33 PM for a pain level of 5-1/9/26 at 12:03 AM for a pain level of 6-1/9/26 at 9:09 PM for a pain level of 6-1/11/26 at 11:12 AM for a pain level of 0-1/12/26 at 10:00 PM for a pain level of 6-1/13/26 at 11:31 PM for a pain level of 6-1/20/26 at 9:07 PM for a pain level of 6-1/22/26 at 11:37 PM for a pain level of 5-1/31/26 at 9:45 PM for a pain level of 6 For the month of 2/26 there was no CPMR available. A review of the 2/26 MAR revealed a PO for oxycodone 5 mg, give one tablet by mouth for severe pain. The oxycodone 5 mg was signed out as administered for the following pain levels on the following dates: -2/3/26 at 9:07 PM for a pain level of 5 On 1/29/26 at 1:30 PM, the surveyor interviewed Licensed Practical Nurse (LPN) 1 who stated that severe pain was seven (7) and above. LPN #1 also indicated that he/she only had one resident on an opioid narcotic (Resident #4). When LPN #1 reviewed the PO with the surveyor, he/she commented, I see there is no numeric pain scale related to severe pain for administration. On 1/30/26 at 10:40 AM, the surveyor interviewed LPN #6. LPN #6 stated that his/her expectation of a physician order for pain medication was that he/she would expect to see pain levels mild, moderate, and severe. LPN #6 stated that severe pain was considered a level of seven to ten (7-10), severe pain was always seven (7) and above. LPN #6 continued, we just know these levels as a nursing practice. I had a resident today that rated her pain at six (6), so I gave her acetaminophen. On 2/5/25 at 12:43 PM, the survey team conducted an interview with the Director of Nursing (DON) who stated that there was no policy that addressed pain levels with associated numerical ratings. The DON added that a PO should have pain levels with prescribed pain medications, such as acetaminophen for mild pain. The DON stated that mild pain was zero to four (0-4) pain level, moderate pain five to six (5-6), and severe pain seven to ten (7-10). On 2/6/26 at 11:01 AM, the surveyor conducted an interview with LPN/Unit Manager (LPN/UM) #1 who indicated that severe pain was a pain level of seven to 10 (7-10). When asked how the staff knew the pain levels associated with mild, moderate, and severe pain, the LPN/UM #1 stated that he/she had placed laminated pain scales on each medication cart. LPN/UM #1 also stated that he/she was responsible for reviewing the CPMR and that he/she reviewed them once a month. Furthermore, once the Pharmacy Consultant reports were available, they were posted on the portal, and he/she got an alert. LPN/UM #1 added that he/she reviewed the recommendations, initialed, and dated, and if necessary, called the physician with recommendations. On 2/6/26 at 12:32 PM, the survey team conducted an interview with the DON and Licensed Nursing Home Administrator. The DON stated that his/her expectations of a physician order for a controlled substance/narcotic/pain medication should include medication dose, indications for use, and any additional information, as well as defining mild, moderate, and severe pain. When asked by the surveyor if a pain medication should be administered for a pain scale of zero (0) the DON replied it depended on the situation and if the resident requested pain medication with a pain scale of 0, the nurse should call the doctor, and document why the pain medication was administered in contrary to the physician order. A review of the facility policies related to pain medication did not address or define pain scale levels. NCAC 8:39-27.1(a)

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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 2 of 5 units (200 and 300 units).Complaint # 2578091 This deficient practice was evidenced by the following: On 1/30/26 at 9:46 AM, the surveyor observed the following on the 200 Unit. In room [ROOM NUMBER], the bedroom window had a thin linear crack across the windowpane, allowing air to pass through, and the walls contained multiple areas patched with white spackling. In the hallway, several areas were also patched with white spackling, and a drop ceiling tile was brown-stained. Above the shower room entrance door, a crack was noted, and above the nursing supplies room entrance door, two cracks were present and covered with white spackling. In the shower room, one shower stall had white debris on the shower bed, and items stored on the floor included, but were not limited to, eight uncovered pillows, two pillows wrapped in plastic, a black metal device, and an air-pressure mattress pad. Additionally, near the sink next to the soap dispenser, a piece of wall paint had been ripped away. On 1/30/26 at 12:05 PM, the surveyor observed two brown-stained drop ceiling tiles in the hallway leading to the 300 Unit, with white material coming through the ceiling tiles. On 1/29/26 at 1:00 PM, during an interview with the surveyor, the Maintenance Director (MD), who had worked at the facility for 28 years, stated that cracks above doorways were settled cracks that occurred annually. Spackling observed in room [ROOM NUMBER] and throughout the unit was related to planned painting, while spackling in the hallways and areas of ripped wall paint in the shower room resulted from relocating and replacing hand sanitizer dispensers; repairs had begun one to two months earlier. A replacement window for room [ROOM NUMBER] had been ordered six months prior but was delayed due to required financial approval and partial vendor payment. The delivered window had incorrect measurements, and a replacement was still pending. The MD stated that the necessary repairs were needed to maintain a homelike environment. He further indicated that limited maintenance staffing, consisting of three employees, had slowed repair progress, which remained ongoing at the time of the interview. On 2/6/26 at 9:46 AM, during an interview with the surveyor, the Housekeeping Director (HKD), who had worked at the facility for 10 months, stated that housekeeping staff were responsible for cleaning the shower rooms daily and that nursing staff were responsible for cleaning the shower room after each resident use. The condition of the shower room was not consistent with infection control standards and did not meet the requirements for a homelike environment. A review of the facility's policy dated 9/25, 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. N.J.A.C. 8:39-31.4(a)

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	315231	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center for Rehab & Nursing Washington Township	535 Egg Harbor Road Sewell, NJ 08080

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Complaint #: 2731697 Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy to ensure residents were protected after a cognitively impaired resident made an allegation of staff-to-resident physical abuse. This deficient practice was identified for 1 of 2 residents (Resident #123) reviewed for abuse. The evidence is as follows:Refer to F610 The surveyor reviewed the medical record for Resident #123. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to; insomnia, major depressive disorder, generalized anxiety disorder, and other symptoms and signs involving cognitive functions and awareness. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/15/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident did not experience hallucinations or delusions and did not have any physical or verbal behaviors directed towards others. A review of the Individual Comprehensive Care Plan (ICCP), included the following focus areas:-Cognitive loss related to a BIMS of 8 upon admission. Interventions included: Allow adequate time to respond, do not rush or supply words, approach/speak in a calm, positive/reassuring manner, and identify self when speaking with the resident.-Right to a safe, home-like environment and to be treated with dignity and respect and to be free from neglect, abuse, and discrimination. Interventions included: Staff will encourage and inform the resident of the right to be free from discrimination.-Resistive/noncompliant with treatment/care related to cognitive impairment. Interventions included: If resisting care, leave (if safe to do so) and return later. A review of the Progress Notes (PN), dated 1/20/26 through 2/3/26, did not include any allegations of abuse. On 2/3/26 at 10:00 AM, the surveyor conducted staff interviews on the 100 unit related to the facility's abuse prevention policy. On 2/3/26 at 10:11 AM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated she was in-serviced on abuse monthly and that if she heard about a resident being abused, she would immediately report it to the Supervisor, the Director of Nursing (DON), and the Licensed Nursing Home Administrator (LNHA). The CNA then stated that about a week ago, Resident #123 reported to her that a nightshift CNA punched the resident in the ribs. The CNA stated she immediately notified Licensed Practical Nurse (LPN #1), but that he told her he didn't want to get involved. When the surveyor asked CNA #1 if she reported the allegation of abuse to anyone else after receiving that response from LPN #1, the CNA stated, no. CNA #1 then stated she believed the perpetrator was CNA #2 who worked overnight shifts and had gotten in trouble in the past related to resident care. The CNA explained it was important to report allegations of abuse to keep residents safe. On 2/3/26 at 10:45 AM, the surveyor observed and interviewed Resident #123 who at first stated they were unable to recall the incident. The resident then stated, I can't honestly say, too much time has gone by, but I did get a couple punches from her. The resident then stated that CNA #1 probably knew who the perpetrator was and that the incident happened less than a month ago. On 2/3/26 at 10:50 AM, the surveyor interviewed CNA #6, who stated Resident #123 was confused, but had never made any false accusations towards staff. On 2/3/26 at 10:55 AM, the surveyor interviewed LPN #2, who stated Resident #123 was alert and oriented, but confused and forgetful at times. The LPN further stated the resident did not make false accusations towards staff. On 2/3/26 at 11:23 AM, the surveyor, in the presence of the survey team, interviewed the DON and the LNHA who stated that staff were supposed to report any allegations of abuse immediately to their supervisor so that an investigation could be started. The DON and the LNHA added that any staff accused of abuse should be suspended to protect the residents. At that time, the surveyor notified the DON and the LNHA of Resident #123's allegation of abuse. The DON and the LNHA stated they were unaware of the allegation and verified that CNA #1 should have (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	reported the allegation of abuse to a supervisor. On 2/3/26 at 12:18 PM, the surveyor, accompanied by the Director of Social Services (DSS), conducted a follow-up interview with Resident #123 who stated an employee punched him/her in the side/back. The resident further stated that CNA #1 was aware, but all this time went by and nothing came of it, and, if it had been reported earlier, it would have been better. On 2/3/26 at 12:34 PM, the surveyor attempted to call LPN #1 and left a voicemail for him to call the surveyor back. On 2/3/26 at 12:35 PM, the surveyor attempted to call CNA #2 and left a voicemail for her to call the surveyor back. On 2/3/26 at 12:40 PM, the surveyor conducted a phone interview with the Licensed Practical Nurse/Supervisor (LPN/S) who stated she supervised the overnight shift. The LPN/S stated that if staff received an allegation of abuse, they should immediately report it to the DON and the LNHA to protect the resident and initiate an investigation. The LPN/S then stated she was not familiar with Resident #123, but that she had not received any allegations of abuse. On 2/3/26 at 1:00 PM, the surveyor conducted a follow-up interview with the DON and the LNHA who stated that after becoming aware of Resident #123's allegation of abuse, they immediately reported it to the New Jersey Department of Health (NJDOH) and started an investigation. A review of CNA #1's written statement, signed 2/3/26, revealed Resident #123 reported the allegation to the CNA on 1/23/26 at 9:15 AM. Further review of the statement included CNA #1 reported the allegation to LPN #1 who didn't want to get involved and she did not report the allegation to anyone else. A review of the 100 Unit Daily Assignment Sheet revealed CNA #2 worked the night of 1/22/26 into the morning of 1/23/26. A review of CNA #2's personnel file revealed a written warning, dated 11/13/25, for poor customer service, ineffective communication, providing care to resident without verbalizing what she was doing, which CNA #2 refused to sign, but signed that she received education related to the write up. On 2/4/26 at 9:00 AM, LPN #1 returned the surveyor's phone call and stated that if he received an allegation of abuse, he would report it to the supervisor to protect the residents. He further stated that reporting allegations of abuse included following the chain of command to ensure the allegation was investigated. LPN #1 denied receiving any allegations related to Resident #123 and stated Resident #123 could be difficult for the overnight staff, but had never had any behaviors of false accusations towards staff. A review of the facility's Abuse Prevention Program policy, revised January 2025, included that the residents had the right to be from abuse, neglect, misappropriation of resident property, and exploitation. The policy further included, as part of the resident abuse prevention, that the administration would do the following:1. Protect residents from abuse by anyone, including facility staff.2. Conduct employee background checks.3. Develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of residents.4. Require staff training/orientation programs that include topics such as abuse prevention and identification and reporting of abuse.5. Implement measures to address factors that may lead to abusive situations.6. Identify and assess all possible incidents of abuse.7. Investigate and report any allegations of abuse within timeframes required by federal requirements.8. Protect residents during abuse investigations.9. Establish and implement a QAPI (Quality Assurance and Performance Improvement) review and analysis of abuse incidents and implement changes to prevent future occurrences of abuse.10. Involve the resident council in monitoring and evaluating the facility's abuse prevention program. NJAC 8:39-4.1(a)(5)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to report within two hours to the New Jersey Department of Health (NJDOH) an allegation of abuse after a cognitively impaired resident made an allegation of staff-to-resident physical abuse. This deficient practice was identified for 1 of 2 residents (Resident #123) reviewed for abuse and was evidenced by the following:Refer to F600 and F610 The surveyor reviewed the medical record for Resident #123. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, insomnia, major depressive disorder, generalized anxiety disorder, and other symptoms and signs involving cognitive functions and awareness. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/15/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident did not experience hallucinations or delusions and did not have any physical or verbal behaviors directed towards others. A review of the Individual Comprehensive Care Plan (ICCP), included the following focus areas:-Cognitive loss related to a BIMS of 8 upon admission. Interventions included: Allow adequate time to respond, do not rush or supply words, approach/speak in a calm, positive/reassuring manner, and identify self when speaking with the resident.-Right to a safe, home-like environment and to be treated with dignity and respect and to be free from neglect, abuse, and discrimination. Interventions included: Staff will encourage and inform the resident of the right to be free from discrimination.-Resistive/noncompliant with treatment/care related to cognitive impairment. Interventions included: If resisting care, leave (if safe to do so) and return later. A review of the Progress Notes (PN), dated 1/20/26 through 2/3/26, did not include any allegations of abuse. On 2/3/26 at 10:00 AM, the surveyor conducted staff interviews on the 100 unit related to the facility's abuse investigation and reporting policy. On 2/3/26 at 10:11 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated she was in-serviced on abuse monthly and that if she heard about a resident being abused, she would immediately report it to the Supervisor, Director of Nursing (DON), and the Licensed Nursing Home Administrator (LNHA). The CNA then stated that about a week ago, Resident #123 reported to her that a nightshift CNA punched the resident in the ribs. The CNA stated she immediately notified Licensed Practical Nurse (LPN) #1, but that he told her he didn't want to get involved. When the surveyor asked CNA #1 if she reported the allegation of abuse to anyone else after receiving that response from LPN #1, the CNA stated, no. CNA #1 then stated she believed the perpetrator was CNA #2 who worked overnight shifts and had gotten in trouble in the past related to resident care. The CNA explained it was important to report allegations of abuse to keep residents safe. On 2/3/26 at 10:45 AM, the surveyor interviewed Resident #123 who at first stated she was unable to recall the incident. The resident then stated, I can't honestly say, too much time has gone by, but I did get a couple punches from her. The resident then stated that CNA #1 probably knew who the perpetrator was and that the incident happened less than a month ago. On 2/3/26 at 10:50 AM, the surveyor interviewed CNA #6 who stated if she received an allegation of abuse, she would report it to the Unit Manager (UM) to prevent further abuse. The CNA also stated Resident #123 was confused but had never made any false accusations towards staff. On 2/3/26 at 10:55 AM, the surveyor interviewed LPN #2 who stated if she received an allegation of abuse, she would go through the chain of command and report it to the UM. The LPN then stated Resident #123 was alert and oriented, but confused and forgetful at times. The LPN further stated the resident did not make false accusations towards staff. On 2/3/26 at 11:23 AM, the surveyor, in the presence of the survey team, interviewed the DON and the LNHA who stated that staff were supposed to report any allegations of abuse immediately to their supervisor so that an investigation could be started. At that time, the surveyor notified the DON and LNHA of Resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#123's allegation of abuse. The DON and the LNHA stated they were unaware of the allegation and verified that CNA #1 should have reported the allegation of abuse to a supervisor. On 2/3/26 at 12:18 PM, the surveyor, accompanied by the Director of Social Services (DSS), conducted a follow-up interview with Resident #123 who stated an employee punched him/her in the side/back. The resident further stated that CNA #1 was aware, but all this time went by and nothing came of it, and, if it had been reported earlier, it would have been better. On 2/3/26 at 12:34 PM, the surveyor attempted to call LPN #1 and left a voicemail for him to call the surveyor back. On 2/3/26 at 12:35 PM, the surveyor attempted to call CNA #2 and left a voicemail for her to call the surveyor back. On 2/3/26 at 12:40 PM, the surveyor conducted a phone interview with the Licensed Practical Nurse/Supervisor (LPN/S) who stated she supervised the overnight shift. The LPN/S stated that if staff received an allegation of abuse, they should immediately report it to the DON and LNHA to protect the resident and initiate an investigation. The LPN/S then stated she was not familiar with Resident #123 but that she had not received any allegations of abuse. On 2/3/26 at 1:00 PM, the surveyor conducted a follow-up interview with the DON and the LNHA who stated after becoming aware of Resident #123's allegation of abuse, they immediately reported it to the New Jersey Department of Health (NJDOH). A review of CNA #1's written statement, signed 2/3/26, revealed Resident #123 reported the allegation to the CNA on 1/23/26 at 9:15 AM. Further review of the statement included she reported the allegation to LPN #1 who didn't want to get involved and she did not report the allegation to anyone else. On 2/3/26 at 3:16 PM, during a follow-up interview with the DON and the LNHA, the DON stated the abuse investigation process was overseen by the DON and LNHA and included reporting the allegation to the NJDOH within two hours. The LNHA further stated that staff should report allegations higher up if they felt they were not being taken seriously because everyone was responsible for safeguarding the residents. On 2/4/26 at 9:00 AM, LPN #1 returned the surveyor's phone call and stated if he received an allegation of abuse, he would report it to the supervisor to protect the residents. He further stated that reporting allegations of abuse included following the chain of command to ensure the allegation was investigated. LPN #1 denied receiving any allegations related to Resident #123 and stated Resident #123 could be difficult for the overnight staff but had never had any behaviors of false accusations towards staff. On 2/4/26 at 12:14 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated if she received an allegation of abuse, she would report it immediately to the DON so that the DON and LNHA could investigate the allegation and ensure the resident was safe. A review of the facility's Abuse Investigation and Reporting policy, revised 2/2026, included, Allegations of abuse/neglect will be reported to local, state, and federal agencies (as defined by current regulations). Further review of the policy included: All alleged violations involving abuse, neglect, exploitation, or mistreatment will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility . An alleged violation of abuse, neglect, exploitation, or mistreatment will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse. NJAC 8:39-9.4(f)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop and implement a care plan that was comprehensive and individualized for 1 of 30 residents (Resident #3) reviewed for care plans. This deficient practice was evidenced by the following:On 1/29/26 at 12:19 PM, the surveyor observed Resident #3 sitting in his/her room. The resident stated he/she was on a long-term use antibiotic and had no concerns. 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, fusion of spine, bacterial pneumonia, and osteomyelitis of vertebra (bone infection of the spine). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/16/25, included the resident had a Brief Interview for Mental Status score of 11 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS revealed the resident was taking an antibiotic medication. A review of the individualized comprehensive care plan (ICCP), included an incomplete focus, dated 11/10/25, of, Infection of, which did not specify the type of infection the resident had. In addition, the only intervention listed for the incomplete focus was, Administer medication per physician's order. It did not include any other interventions to assess, monitor, or treat the resident's infection. Further review of the ICCP revealed the following additional incomplete focuses and/or interventions: Need for feeding tube/potential for complication of feeding tube use related to dated 11/10/25. Nursing Nutritional Care Plan and the only intervention included, Diet type: (specify diet type, texture, and fluid consistency) dated 11/10/25. Impaired vision related to dated 11/10/25. At risk for alteration in hydration related to dated 11/10/25. Requires assistance/Potential to restore functioning (specify) for toileting related with an intervention of Toileting: total dependence (specify # of staff) dated 11/10/25. ADL Self care deficit related to with interventions that included: Assist of (specify # of staff) with ADL's [activities of daily living] and, Bed Mobility: Extensive assist of (specify # of staff assist) dated 11/10/25. At risk for falls due to initiated 11/10/25. Pain (specify location) related to and the only intervention included, Administered pain medication per physician orders, dated 11/10/25. Anticoagulant therapy to treat: dated 11/10/25. Anticonvulsant therapy to treat: dated 11/10/25. Endocrine system related to dated 11/10/25. Diuretic therapy to treat: dated 11/10/25 On 2/6/26 at 10:13 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #5 who stated the ICCP was initiated by the admitting nurse during the resident's admission assessment and updated by the nurses or supervisors. The LPN further stated the facility ensured the ICCP was resident specific by updating the ICCP according to the resident's care and creating interventions specific to the resident. The LPN then explained the importance of the ICCP was to make sure the staff were caring for and addressing any issues with the resident. On 2/6/26 at 10:17 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated the admitting nurse was responsible for initiating the ICCP at the time of the resident's admission. The LPN/UM was unsure how often the ICCP was updated or how the facility ensured the ICCP was resident specific. The LPN/UM stated the importance of the ICCP was because it was specific to the resident's diagnoses, medications, and care. On 2/6/26 at 11:54 AM, the surveyor interviewed the Director of Nursing (DON) who stated all supervisors, including the DON, were responsible for initiating the ICCP upon the resident's admission. The DON explained that the ICCP was updated through a team approach any time there was a change in the resident that required an update. The DON then stated the facility ensured the ICCP was resident specific by including interventions that were specific to the resident and that the importance of the ICCP was to coordinate and document the resident's care and needs. At that time, the surveyor notified the DON of the incomplete ICCP for Resident #3 and the DON stated the ICCP should have been completed in its entirety and should be resident specific. A review of the facility's Care Plans, Comprehensive, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Person-Centered, policy, revised 8/2025, included, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Further review of the policy included, 8. The comprehensive, person-centered care plan will:.g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems. and, 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. NJAC 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to adjust medication administration times to accommodate for scheduled dialysis times for 1 of 2 residents (Resident #116) reviewed for dialysis. This deficient practice was evidenced by the following:On 1/29/26 at 12:15 PM, the surveyor observed Resident #116 sitting in his/her room. The resident stated he/she went to dialysis on Mondays, Wednesdays, and Fridays. The surveyor reviewed the medical record for Resident #116. According to the admission Record, an admission summary, the resident had diagnoses which included, but were not limited to, end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/29/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident's cognition was intact. Further review of the MDS included the resident received dialysis treatments. A review of the individualized comprehensive care plan (ICCP) included a focus The resident needs dialysis r/t [related to] renal failure dated 12/28/25. Interventions did not include the resident's medication schedule to accommodate dialysis times. A review of the Order Summary Report, as of 2/5/26, included the following physician's orders (PO):-Hemodialysis via wheelchair Monday, Wednesday, Friday pickup 7:15 AM, dated 12/24/25.-Insulin Lispro 100 unit/milliliter (unit/ml) Inject 3 units subcutaneously with meals for diabetes mellitus type 2, dated 12/25/25.-Sevelamer 800 milligrams (mg) Give two tablets by mouth with meals for end stage renal disease, dated 12/23/25.-Timolol Maleate Ophthalmic Solution 0.5% Instill one drop in both eyes two times a day for glaucoma, dated 12/23/25. A review of the January and February 2026 Medication Administration Records (MAR) included the above PO were documented as not administered during the resident's dialysis dates and times as follows: Timolol Maleate Ophthalmic Solution 0.5% on:1/2/26 at 8:00 AM1/5/26 at 8:00 AM1/7/26 at 8:00 AM1/9/26 at 8:00 AM1/12/26 at 8:00 AM1/14/26 at 8:00 AM1/16/26 at 8:00 AM1/21/26 at 8:00 AM1/23/26 at 8:00 AM1/28/26 at 8:00 AM1/30/26 at 8:00 AM2/2/26 at 8:00 AM2/4/26 at 8:00 AM Insulin Lispro 100 unit/ml 3 units on:1/2/26 at 8:00 AM and 12:00 PM1/5/26 at 8:00 AM and 12:00 PM1/7/26 at 8:00 AM and 12:00 PM1/9/26 at 8:00 AM and 12:00 PM1/12/26 at 8:00 AM and 12:00 PM1/14/26 at 8:00 AM and 12:00 PM1/16/26 at 8:00 AM and 12:00 PM1/21/26 at 8:00 AM and 12:00 PM1/23/26 at 8:00 AM and 12:00 PM1/26/26 at 12:00 PM1/28/26 at 8:00 AM and 12:00 PM1/30/26 at 12:00 PM2/2/26 at 8:00 AM and 12:00 PM2/4/26 at 8:00 AM and 12:00 PM Sevelamer 800 mg on:1/2/26 at 8:00 AM and 12:00 PM1/5/26 at 8:00 AM and 12:00 PM1/7/26 at 8:00 AM and 12:00 PM1/9/26 at 8:00 AM and 12:00 PM1/12/26 at 8:00 AM and 12:00 PM1/14/26 at 8:00 AM and 12:00 PM1/16/26 at 8:00 AM and 12:00 PM1/19/26 at 8:00 AM1/21/26 at 8:00 AM and 12:00 PM1/23/26 at 8:00 AM and 12:00 PM1/26/26 at 12:00 PM1/28/26 at 8:00 AM and 12:00 PM1/30/26 at 8:00 AM and 12:00 PM2/2/26 at 8:00 AM and 12:00 PM2/4/26 at 8:00 AM and 12:00 PM On 2/6/26 at 10:13 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #5 who stated dialysis residents' medications were scheduled depending on their dialysis days/times. The LPN further explained that medications were scheduled either before or after dialysis so that doses weren't missed. The LPN stated that if a medication was scheduled during a resident's dialysis time, she would report it to the supervisor or physician to review the medications for the appropriate schedule. On 2/6/26 at 10:17 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated dialysis residents' medications were scheduled according to their dialysis days/times to ensure the resident received the necessary medications. The LPN/UM further stated that if a medication was scheduled during the resident's dialysis time, the nurse should speak with the Assistant Director of Nursing (ADON) or the physician to have the medication time adjusted according to the resident's dialysis schedule. On 2/6/26 at 11:54 AM, the surveyor interviewed the Director of Nursing (DON) who stated dialysis residents' medications were scheduled according to their dialysis times to prevent missed (continued on next page)

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	315231	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center for Rehab & Nursing Washington Township	535 Egg Harbor Road Sewell, NJ 08080

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doses of medications. The DON stated that if a medication was scheduled during a resident's dialysis time, the nurse should notify the physician to see if the medication time could be changed to a more appropriate time. At that time, the surveyor notified the DON of Resident #116's medications that were being documented as not administered during the resident's dialysis days and the DON stated that the medications should be sequenced to when the resident was in the facility with the physician's approval. A review of the facility's Administering Medications policy, revised 2/2025, included, Medications must be administered in accordance with the orders, including any required time frame, and, Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified. NJAC: 8:39-11.2(b), 27.1(a), 29.2(d)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and review of facility documents, it was determined that the facility failed to provide pharmaceutical services (services for the safe management of medications in a healthcare setting) in accordance with professional standards to ensure that a rationale was documented when a medication was not administered for 1 of 5 residents (Resident #149) reviewed for unnecessary medications. The 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 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 1/29/26 at 10:46 AM, the surveyor observed Resident #149 sitting in a wheelchair in the unit lounge.The surveyor reviewed the medical record for Resident #149.According to the admission Record, an admission summary, the resident had diagnoses which included but were not limited to atrial fibrillation (irregular, rapid heartbeat), hypertension (high blood pressure), and disorientation.A review of the admission Minimum Data Set (MDS), an assessment tool, dated 1/14/26, included the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated the resident's cognition was moderately impaired.A review of the Individual Comprehensive Care Plan (ICCP), dated 1/8/26, indicated the resident had cardiac disease (heart condition) related to hypertension, atrial fibrillation, and congestive heart failure (heart's reduced pumping ability). Interventions included administering medications per physician orders.A review of the Order Summary Report, as of 2/6/26, included the following physician's orders with an order date of 1/8/26:Cardizem CD extended Release 24 hour 120 milligrams (mg) Give one tablet by mouth one time a day for Hypertension (HTN).Metoprolol Succinate ER tablet Extended release 24-hour 50 mg Give one tablet by mouth one time a day for HTN.A review of the Medication Administration Record (MAR) for 1/26 included the above Cardizem and Metoprolol orders were documented with a Code 9 on the following dates:On 1/9/26 at 9:00 [NAME] 1/12/26 at 9:00 [NAME] 1/13/26 at 9:00 [NAME] 1/16/26 at 9:00 AMThe Metoprolol order was also documented with a Code 9 on the following dates:On 1/22/26 at 9:00 [NAME] 1/23/26 at 9:00 [NAME] 1/24/26 at 9:00 AMFurther review of the January MAR revealed a list of chart codes indicating a Code 9 = Other/ See Progress notes.A review of the progress notes for the corresponding dates above did not include a rationale of why the medication was not administered.On 1/30/26 at 12:00 PM, the surveyor interviewed Licensed Practical Nurse (LPN #8) who stated that if a code of 9 was used during medication administration, it could mean that the medication was not available or maybe the blood pressure was too low. LPN #8 further stated that when Code 9 was used, the nurse should write a progress note of why the medication was not administered.On 2/6/26 at 10:57 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #3 who stated that Code 9 would be used if the medication was not available or of a refusal and the nurses should write a progress note of why the medication was not administered.On 2/6/26 at 11:54 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Assistant Director of Nursing (ADON) who stated when a Code 9 was used during medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration, the nurse should write a progress note of why the medication was not administered. The DON further stated that it was important to write a progress note of why the medication was not administered to keep an accurate record and documentation.On 2/9/26 at 12:27 PM, the surveyor interviewed the DON, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, who acknowledged that a progress note should have been written when a Code 9 was used in the MAR. The DON further stated that the facility did not have a policy reflecting the specific codes used during medication administration.A review of the facility's Administering Medications policy, revised 2/2025, included, if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall indicate such on the MAR.NJAC 8:39-29.2(d)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interviews, record review and review of pertinent facility documents, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure staff, as well as himself, implemented the facility's abuse policies and procedures to ensure resident safety and well-being by ensuring an allegation of physical abuse was reported, and a thorough investigation was initiated after a cognitively impaired resident made an allegation of staff-to-resident physical abuse. This deficient practice was identified for 1 of 2 residents reviewed for abuse (Resident #123). The evidence is as follows:Refer to F600 and F610A review of the Administrator's Job Description included; Summary: Lead and direct the overall operations of the facility in accordance with government regulations and company policies. Essential Duties and Responsibilities: Monitor each departments activities, communicate policies, evaluate performance provide feedback and assist, observe, coach, and discipline as needed; Oversee regular rounds to monitor delivery of nursing care.and ensure resident needs are being addressed A review of the Director of Nursing's (DON) Job Description included, In the absence of the Administrator and Assistant Administrator, assume the responsibility of the facility. On 2/3/26 at 10:11 AM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated she was in-serviced on abuse monthly and that if she heard about a resident being abused, she would immediately report it to the Supervisor, the Director of Nursing (DON), and the Licensed Nursing Home Administrator (LNHA). The CNA then stated that about a week ago, Resident #123 reported to her that a nightshift CNA punched the resident in the ribs. The CNA stated she immediately notified Licensed Practical Nurse (LPN #1), but that he told her he didn't want to get involved. When the surveyor asked CNA #1 if she reported the allegation of abuse to anyone else after receiving that response from LPN #1, the CNA stated, no. CNA #1 then stated she believed the perpetrator was CNA #2, who worked overnight and had gotten in trouble in the past related to resident care. The CNA explained it was important to report allegations of abuse to keep residents safe. On 2/3/26 at 10:45 AM, the surveyor interviewed Resident #123, who at first stated they were unable to recall the incident. The resident then stated, I can't honestly say, too much time has gone by, but I did get a couple punches from her. The resident then stated that CNA #1 probably knew who the perpetrator was and that the incident happened less than a month ago. On 2/3/26 at 11:23 AM, the surveyor, in the presence of the survey team, interviewed the DON and the LNHA, who stated that staff were supposed to report any allegations of abuse immediately to their supervisor so that an investigation could be started. The DON and the LNHA added that any staff accused of abuse should be suspended to protect the residents. At that time, the surveyor notified the DON and the LNHA of Resident #123's allegation of physical abuse. The DON and the LNHA stated they were unaware of the allegation and verified that CNA #1 should have reported the allegation of abuse to a supervisor. On 2/3/26 at 12:40 PM, the surveyor conducted a phone interview with the Licensed Practical Nurse/Supervisor (LPN/S), who stated she supervised the overnight shift. The LPN/S stated that if staff received an allegation of abuse, they should immediately report it to the DON and the LNHA to protect the resident and initiate an investigation. The LPN/S then stated she was not familiar with Resident #123, but that she had not received any allegations of abuse. A review of CNA #1's written statement signed 2/3/26, revealed Resident #123 reported the allegation to the CNA on 1/23/26 at 9:15 AM. Further review of the statement included she reported the allegation to LPN #1, who didn't want to get involved and she did not report the allegation to anyone else. On 2/3/26 at 3:16 PM, the surveyor, in the presence of the survey team, interviewed DON and the LNHA. The LNHA explained that his job included: managing the operations of the building, ensuring a homelike environment, managing the employees, ensuring staff education was completed, and ensuring the policies and procedures were being followed. The DON explained that her job included overseeing the following: the clinical side of the facility, medications, incidents and accidents, admissions and discharges, that staff were following policies and procedures, and that staff were completing education and (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	competencies. At that time, the surveyor, in the presence of the survey team, continued to interview the DON and the LNHA. The DON stated staff were educated to report abuse allegations to their supervisors who would then report it to the New Jersey Department of Health (NJDOH) and start the investigation. She further stated that all staff were educated to go to the next higher supervisor if they felt the allegations were not being handled properly. The LNHA stated that all staff were mandatory reporters of any incident and ensured the policy was followed to keep the residents safe. He acknowledged he was responsible for the overall management of the facility and to ensure staff followed the policies. A review of the facility's Abuse Prevention Program policy, revised January 2025, included that the residents had the right to be from abuse, neglect, misappropriation of resident property, and exploitation. The policy further included, as part of the resident abuse prevention, that the administration would do the following:6. Identify and assess all possible incidents of abuse.7. Investigate and report any allegations of abuse within timeframes required by federal requirements.8. Protect residents during abuse investigations. A review of the facility's Abuse Investigation and Reporting policy, revised February 2026, included that all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be thoroughly investigated by facility management. The policy further included, Any allegation, regardless of how mild or severe it may seem, should be reported to administration so that an investigation can be initiated.NJAC 8:39-9.2(a)NJAC 8:39-9.3(a)NJAC 8:39-27.1(a)