STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315245	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cherry Hill	1399 Chapel Ave West Cherry Hill, NJ 08002

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. CFR9s): 483.70(h)(1)S483.70(h) Medical records.S483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized Based on interviews, medical record reviews and reviews of other pertinent facility documentation on 1/16/26, it was determined the facility failed to ensure Medication Administration Record (MAR) documentation was accurate as evidenced by a.) the Licensed Practical Nurse #1 (LPN) not obtaining and transcribing an order for a resident who required medication administration to correct low blood sugar and b.) the Director of Nursing (DON) completing medication administration entries on behalf of LPN#1. This resulted in inaccurate medical records and failure to identify potential medication errors, this deficient practice was identified for 1 of 4 residents reviewed for resident records (Resident #2), and was evidenced by the following:On 1/16/26 the surveyor Resident #2's December 2025 Medication Administration Record (MAR) and Order Summary Report (OSR) and did not find orders for glucagon that were given to Resident #2 by the LPN three times during 12/20/25 and 12/21/25 for Resident #2's hypoglycemic events.On 1/16/26 at 12:59 PM, the surveyor interviewed the DON regarding Resident #2's December 2025 MAR and questioned why the DON's signature was reflected on the MAR instead of the LPN. The DON stated she had spoken to the LPN #1 and that LPN #1 had informed her that Resident #2 had refused the insulin and since the LPN #1 was remote, she filled in the MAR for the LPN #1.According to the admission Record (AR) face sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: infective myositis (a rare inflammation of skeletal muscles caused by germs like bacteria, viruses, fungi, or parasites), sepsis (a life-threatening medical emergency where the body's extreme, overactive response to an infection triggers a chain reaction, causing the immune system to attack its own tissues and organs, leading to damage, failure, and potentially death if not treated immediately), and Type 2 Diabetes Mellitus with Hyperglycemia (the most common form of diabetes, where the body either doesn't make enough insulin or doesn't use it effectively, leading to persistently high blood sugar levels).A review of the Minimum Data Set (MDS), an assessment tool dated 08/07/25, Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15/15, which indicated Resident #2's cognition was cognitively intact.On 1/16/26 at 11:10 AM, the surveyor attempted to interview LPN#1 by phone and LPN#1 did not return the surveyor's phone call.On 1/16/26 at 12:13 PM, the surveyor interviewed LPN#2 regarding residents who are diabetic. LPN #2 told the surveyor that she follows physician orders for her residents who are diabetic regarding checking resident sugars, administering insulin, and parameters. She further stated she follows physician orders for all her medication administrations for residents.On 1/16/26 at 12:59 PM, the surveyor interviewed the DON regarding Resident #2's December 2025 MAR, OSR, and glucagon administrations by LPN#1. The DON stated that LPN #1 gave Resident #2 glucagon without a provider order as Resident #2's blood sugar was an emergent situation. She (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that ideally, LPN #1 should have reached out to the provider after Resident #2 was stable and the order for glucagon should have been transcribed and admitted that this was not done by LPN #1. When questioned why LPN #1 should have reached out to the provider for the order transcription the DON stated, signing out the order is a reflection that an intervention was implemented, utilized and that it was effective for patient safety.During this same interview, the DON stated that she had spoken to LPN#1 who reported that Resident #2 had refused their insulin on 12/16/25 and 12/17/25. When the surveyor questioned why the DON's electronic signature was on Resident #2's MAR instead of LPN#1's for those dates, the DON stated she filled it in for LPN #1 to reflect his statements as he is remote and does not have access to the MAR.On 1/16/25 at 2:02 PM, the surveyor had requested the DON to ask LPN#1 if he would return the surveyor's phone call for the investigation and the DON informed the surveyor that LPN#1 respectfully was declining to return the surveyor's call.A review of the facility's policy titled Physicians' Medication Orders that did not have a date on it, included the following information under Policy Statement: Medications shall be administered only upon the written order of a person duty licensed and authorized to prescribe such medications in this state. Under, Policy Interpretation and Implementation: 4. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order. PCC will record date and time.A review of the facility's policy titled Charting and Documentation that did not have a date on it, included the following information under Policy Statement: all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Under, Policy Interpretation and Implementation: 2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, Certified nursing assistant, etc.,) in accordance with state law and facility policy.NJAC 8:39-35.2