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	06/05/2026

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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. COMPLAINT #2801510Based on interviews, review of medical records and other pertinent facility documentation on 6/4/26 and 6/5/26, it was determined that the facility failed to maintain an accurate and complete medical record in accordance with acceptable professional standards of practice, when staff failed to consistently document that wound care was provided on the Treatment Administration Record (TAR). This deficient practice was identified for 2 of 3 residents reviewed for wound care (Resident #3 & Resident #6) and was evidenced by the following:a). A review of the admission Record revealed that Resident #3 was admitted to the facility with diagnoses that included but were not limited to: paraplegia, injury of the thoracic spinal cord at the T7-T10 level, and chronic pain syndrome. Review of Resident #3's care plan (CP) indicated that Resident #3 had a focus related to the resident having skin impairment. Interventions for this focus area included to provide treatments per facility protocol. A review of Resident #3's Treatment Administration Record (TAR) for March 2026 revealed two treatments as follows:- Change wound dressing to left ischium [left hip area] . every Mon, Wed, Fri, for wound care- Cleanse left ischial wound. every day shift for wound care.Blank boxes (indicating the wound treatment as not done) for the above treatments on 3/2/26 and 3/26/26. A review of Resident #3' progress notes (PN), did not include documentation that the above treatments were provided. b). A review of the admission Record revealed that Resident #6 was admitted to the facility with diagnoses that included but were not limited to: frostbite with tissue necrosis of the left and right foot, acquired absence of the left and right foot, and unspecified disorder of muscle. Review of Resident #6's care plan (CP) indicated that Resident #3 had a focus related to the resident having skin impairment. Interventions for this focus included that treatments were to be provided per facility protocol. A review of Resident #6's Treatment Administration Record (TAR) for May 2026 revealed two treatments as follows:-Betadine Solution was to be applied to the left heel for wound care on the evening shift. Area was to be cleansed and gauze was to be applied.-Betadine Solution was to be applied to the right heel for wound care on the evening shift. Area was to be cleansed and gauze was to be applied.Blank boxes noted, (indicating wound care not provided) as ordered for the above treatments on 5/18/26 and 5/21/26.A review of Resident #6' progress notes (PN), did not include documentation that the above treatments were provided. An interview was conducted on 6/4/26 at 3:36 PM with the Licensed Practical Nurse (LPN #1) who stated that documentation was important to show that care was provided. LPN #1 recalled being assigned to Resident #3. She stated that Resident #3 was always compliant with care during her assignments and that she must have forgotten to document that treatment was provided. She further stated that she was familiar with Resident #6 also and that she must have either forgotten to document that the wound treatments was provided, or she forgot to document that the resident refused. A joint interview was conducted on 6/4/26 at 4:19 PM with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). During the interview the DON stated that after staff completed wound treatments, she expected that nurse document that that care was provided in the resident's electronic medical record. She further stated that documentation confirmed that care was provided. No additional documentation was provided related to the above treatments. A review of the facility's (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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(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 - Few	undated Charting and Documentation policy revealed that services provided to residents would be documented. The policy further described the minimum care-specific details that would be included when documenting treatments including, but not limited to, the name of the person providing the treatment along with the date and time it was provided. N.J.A.C. 8:39-27.1(a)