New Jersey Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					С	
		030305	B. WING		11/16	6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAMBRID	GE REHABILITATION A	ND HEALTHCARE CI		E-7		
	CUIMMA DV CT		OWN, NJ 080			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint #: NJ1437 NJ146197 Census: 132 Sample Size: 8	783, NJ145736, and				
	TYPE OF SURVEY:	Complaint Survey				
The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities.						
	The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.					
S 560	8:39-5.1(a) Mandator	ry Access to Care	S 560			12/14/21
	(a) The facility shall of Federal, State, and lo regulations.	comply with applicable ocal laws, rules, and				
	by:	Γ is not met as evidenced J145736 and #NJ143783		S560 Mandatory Access to Care		
	New Jersey Departm memo, dated 01/28/2			No residents were affected by no meeting the State of NJ minimum staf requirements All residents could be affected by area of concern. Recruitment efforts continue to include: Job fairs	ffing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

12/15/21

PRINTED: 09/16/2022 FORM APPROVED

New Jersey Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		030305	B. WING		11/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
CAMBRID	GE REHABILITATION AN	ID HEALTHCARE CI 255 EAST MOORES	MAIN ST FOWN, NJ 080	57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S 560	Continued From page	: 1	S 560			
S 560	Reference: New Jerse (NJDOH) memo, date with N.J.S.A. (New Je 30:13-18, new minimum nursing homes." Indice Governor signed into at N.J.S.A. 30:13-18 (minimum staffing requestion of the following ratio(s) 02/01/2021: One certified nurse aifor the day shift. One direct care staff residents for the even fewer than half of all secretified nurse aides, member shall be sign nurse aide and perfor duties; and One direct care staff residents for the night direct care staff members aide and perfor duties. 1. A review of the "Nucompleted by the faci 05/16/2021 - 05/30/20 staff-to-resident ratios minimum requirement 05/16/2021 had 12 Cl day shift, required 13	ey Department of Health and 01/28/2021, "Compliance ersey Statutes Annotated) current staffing requirements for atted the New Jersey law P.L.2020 c 112, codified the Act), which established uirements in nursing homes. were effective on the determinant of the effective on the effective of the ef	S 560	b. Daily staffing meetings c. Sponsored orientees for 45 days toward retention of new hires d. Care Champion mentor program support retention e. Culture committee to improve and maintain staff morale f. Recruitment bonus and sign-on bonuses offered. 4. To monitor and maintain ongoing compliance the DON or designee will monitor staffing daily for 1 week, weel for 3 weeks and monthly for 2 months Results will be presented to the QAPI team monthly for continued review an recommendations.	kly	
	day shift, required 13 05/18/2021 had 10 Cl	CNAs. NAs for 94 residents on the				

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New Jersey Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		, ,	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
							<u>}</u>	
		030305		B. WING		1	6/2021	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CAMBRID	GE REHABILITATION AN	ID HEALTHCARE C	255 EAST N	_				
			MOOREST	OWN, NJ 0808	57			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
S 560	Continued From page	2		S 560				
S 560	day shift, required 12 05/19/2021 had 10 Cl day shift, required 12 05/23/2021 had 12 Cl day shift, required 13 05/25/2021 had 11 Cl day shift, required 13 05/26/2021 had 9 CN day shift, required 13 05/28/2021 had 10 Cl day shift, required 13 05/28/2021 had 10 Cl day shift, required 13 05/29/2021 had 10.5 the day shift, required A review of the "Nurse completed by the faci 09/26/2021 - 10/09/20 staff-to-resident ratios minimum requirement 09/26/2021 had 12 Cl day shift, required 15 09/27/2021 had 8 CN day shift, required 15 09/28/2021 had 7 CN day shift, required 15 09/29/2021 had 8 CN day shift, required 15 09/29/2021 had 8 CN day shift, required 15 09/29/2021 had 8 CN	CNAs. NAs for 94 residents or CNAs. NAs for 99 residents or CNAs. NAs for 104 residents or CNAs. As for 104 residents or CNAs. As for 104 residents or CNAs. NAs for 104 residents or CNAs. CNAs for 109 residents or CNAs. CNAs for 109 residents or 14 CNAs. e Staffing Report," lity for the weeks of 021, revealed as that did not meet the translated below: NAs for 117 residents or CNAs. As for 117 residents or CNAs.	on the one of the one	\$ 560				
		NAs for 117 residents of	on the					
	day shift, required 15 10/01/2021 had 10 Cl	CNAs. NAs for 116 residents o	on the					
	day shift, required 15 10/02/2021 had 12 Cl	CNAs. NAs for 116 residents o	on the					
	day shift, required 15	NAs for 115 residents of						
	day shift, required 15	CNAs. NAs for 115 residents o						

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New Jersey Department of Health

STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
							С	
		030305		B. WING			11/16/2021	
NAME OF PROVIDER	OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
CAMBRIDGE REH	ABILITATION A	ND HEALTHCARE C	255 EAST MOOREST	MAIN ST OWN, NJ 080	57			
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD B O THE APPROPRIA		
10/06/2 day sh 10/07/2 day sh 10/08/2 day sh 10/09/2 day sh During (DON) she wa regard adverti staff. It and otl retain s also im not abl facility	ft, required 15 2021 had 13 C ft, required 15 2021 had 10 C ft, required 15 2021 had 13 C ft, required 15 an interview won 11/16/2021 s aware of the ng staffing rational been a refer medical official ft during the pacted the state to call somewas trying all to	NAs for 115 residents of CNAs. NAs for 117 residents of CNAs. NAs for 116 residents of CNAs. CNAs. NAs for 113 residents of CNAs.	on the on the on the sing d that nore ity and uts ere e	S 560				

PRINTED: 09/16/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		315201	B. WING		44	C	
NAME OF DE	ROVIDER OR SUPPLIER	010201	_	STREET ADDRESS, CITY, STATE, ZIP CODE	11	/16/2021	
NAME OF F	NOVIDER OR SUFFLIER						
CAMBRID	GE REHABILITATION AN	ND HEALTHCARE CENTER		255 EAST MAIN ST			
				MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	;	FC	000			
	Complaint #: NJ1437 NJ146197 Census: 132 Sample Size: 8	783, NJ145736, and					
	Long Term Care Faci complaint survey.	FR Part 483, Subpart B, for lities based on this					
F 557 SS=D		nt to have Prsnl Property	F 5	57		12/14/21	
	§483.10(e) Respect a The resident has a rig and dignity, including	ght to be treated with respect					
	possessions, including as space permits, unl	tht to retain and use personal ig furnishings, and clothing, less to do so would infringe alth and safety of other					
	This REQUIREMENT by:	is not met as evidenced					
	residents' rights to re- upheld by ensuring were not left undress			Preparation and/or execution of to forcerction does not constitute a admission or agreement by Provide the truth or facts alleged or conclusion forth in the Statement of Deficience This plan of correction is prepared executed because the provisions Federal and State laws require it.	n der of usion set sies. d and/or		
	Findings included:			F557 Respect/Dignity/Right to personal property	have		
		ent's medical record admitted the resident with		Resident was assisted by aide with dressing since he had re			
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	l .	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed 12/15/2021

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315201	B. WING _				C / 16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION AN	ND HEALTHCARE CENTER		25	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST MAIN ST DORESTOWN, NJ 08057	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 557	dated , ind activities of daily living due to . The resident needed staff increase abilities in expersonal hygiene. A review of Resident , indicated a medic to monitor/record occ symptoms, which included a medic to monitor/record occ symptoms, which included a medic to monitor/record occ symptoms, which included to monitor/record occ symptoms, which included to make the resident and five start Resident had not provide the resident had only a bunched-up shresident's torso. The the resident, looked a continued to walk. The around to lead the su walked past Resident continued to walk tow was asked to return to the return to the return to the suit of the resident to walk tow was asked to return to the suit of the return to the return to the suit of the return to the suit of the return to the suit of the return to the resident to walk tow was asked to return to the resident to the return to the resident to walk tow was asked to return to the resident to walk tow was asked to return to the resident to the resident to walk tow was asked to return to the resident to the resident to walk tow was asked to return to the resident to the	's baseline care plan, licated the resident had an g (ADLs) performance deficit care plan indicated the interventions to be able to ating, dressing, and s care plan, dated Resident used ation. Interventions included urrences for target behavior uded disrobing in public and Unit on 11/16/2021 was observed sitting in a niddle of the dining room nurse's station. Ten other ff members were present. It ident's gown was on the led chair. Resident sthe right side of the chair no shirt on; the resident had leet covering a portion of the Administrator walked past at the resident, and the Administrator then turned reveyors off the unit and the again. The Administrator wards the exit of the unit and the again. The Administrator wards the exit of the unit and the again.	F	5557	his garment and to restore respect and dignity. 2. All residents have the potential to affected by issues of dignity. 3. All staff educated to monitor and address resident dignity issues. 4. To monitor and maintain ongoing compliance the Unit Manager or design will observe common areas weekly for weeks and then monthly for 2 months resident dignity. Results will be present to the QAPI team monthly for continuer review and recommendations.	nee 4 for nted	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		315201	B. WING_			C 11/16/2021	
NAME OF PR	ROVIDER OR SUPPLIER	1 0.020		STREET ADDRESS, CITY, STATE, ZIP C	ODE	11/16/2021	
CAMBRID	GE REHABILITATION AN	ND HEALTHCARE CENTER		255 EAST MAIN ST MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 557	Resident was four Administrator stated to respect and dignity wand asked an unident change Resident residents' right to dignize regardless of what un regardless of their constated all staff members ensuring resident right ensuring an interview of Certified Nursing Assidents who were to should be fully dressed residents out undressed violation of their rights times, due to the staff were taken out in govenough time to clean for breakfast. CNA #1 care the residents defeat. A review of the facility "Resident Rights," include the residents with dignityFederal and basic rights to all residents include the resident and dignity;h. be sexercising his or her in New Jersey Administration.	the detailed the condition in which and was not acceptable. The other esident's rights to be reen not being maintained tified staff member to. The Administrator stated the nity needed to be maintained in the resident was on and gnition. The Administrator bers were responsible for ints were maintained. In 11/16/2021 at 12:35 PM, istant (CNA) #1 stated taking and common areas and common areas and common areas areas. CNA #1 stated that at fing limitations, residents and dress everyone in time and dress everyone in time at stated that was not the served, but they needed to be a common area and dress everyone in time and dress everyone in time and dress everyone in the served, but they needed to be a controlled to the state and state laws guarantee certain dents of this facility. These adent's right to: a. a dignified and with respect, kindness, supported by the facility in	F	557			
F 584 SS=E	(12) Safe/Clean/Comforta	ble/Homelike Environment	F 5	584		12/14/21	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315201	B. WING		C 11/16/2021	
	ROVIDER OR SUPPLIER GE REHABILITATION A	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 584	but not limited to rec supports for daily livid. The facility must prof §483.10(i)(1) A safe, homelike environme use his or her person possible. (i) This includes ensureceive care and ser physical layout of the independence and dii) The facility shall end the protection of the or theft. §483.10(i)(2) Housel services necessary that comfortable interesident room, as sponsor §483.10(i)(4) Private resident room, as sponsor §483.10(i)(5) Adequate levels in all areas;	ronment. ght to a safe, clean, nelike environment, including eiving treatment and ng safely. vide- clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can vices safely and that the e facility maximizes resident oes not pose a safety risk. exercise reasonable care for resident's property from loss keeping and maintenance o maintain a sanitary, orderly,	F 584	4		
	levels. Facilities initia	ally certified after October 1, a temperature range of 71 to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		315201	B. WING			C 11/16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	11/16/2021	_
				255 EAST MAIN ST			
CAMBRID	GE REHABILITATION	AND HEALTHCARE CENTER		MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	N
F 584	Continued From pa	age 4	F 5	84			
	sound levels.	ne maintenance of comfortable					
	Based on observareviews, and facility determined the fact (Resident , Resifive resident's personal inventoried. Findings included: A review of the fact "Personal Property permitted to retain and appropriate cleThe resident's personal be inventoried admission and as replenishedThe fany complaints of mistreatment of resonal indicate who we documenting the interest of Resindicated the facility.	tions, interviews, record y policy review, it was idity failed to ensure three dent, and Resident) of conal property was safeguarded tion by failing to ensure I belongings were labeled and idity's undated policy, titled, y," indicated, "Residents are and use personal possessions othing, (as space permits) ersonal belongings and clothing d and documented upon such items are facility will promptly investigate misappropriation or sident property." The policy did as responsible for		Preparation and/or execution of correction does not constituations admission or agreement by the truth or facts alleged or offorth in the Statement of Def This plan of correction is presexecuted because the provisive Federal and State laws required. F584 Safe/Clean/Comfortable Environment (inventory procedure) Resident and and sheets were reviewed for according to the paffected. All residents have the paffected have and inventory sheets and designee oversees the procedure of	itute an Provider of conclusion se ficiencies. epared and/or sions of aire it. e/Homelike cess) inventory ccuracy and cotential to be arts were ets validated. ated to rate s Director or ess to ensure from ceptionists, staff. Those ation on the nt belongings n ongoing er or designer and concierge and personal		
	A review of Reside Data Set (MDS), d	ent 's admission Minimum ated , indicated the		monthly for 2 months. Resu presented to the QAPI team	ılts will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	315201	B. WING _	B. WING		C I1/16/2021	
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL		11/10/2021	
CAMPBIDGE BEHADII ITATION ANI	D HEALTHCARE CENTER		255 EAST MAIN ST			
CAMBRIDGE REHABILITATION ANI	D HEALIHCARE CENTER		MOORESTOWN, NJ 08057			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
quarterly Minimum Data , indicated score of , in . The reside independent/supervision bed mobility, and translimited assistance with hygiene and required edressing and personal. A review of a handwrith "Inventory Sheets," dan Resident an inventory of clothing was taken. The document resident representative During an observation AM, Resident was unable confusion. Clothing was resident was unable confusion. Clothing was resident's closet, and a wheelchair in the corne was not observed to have brought in the faci member, the items we laundry. RN #1 stated, items would be inventored.	terview for Mental Status, indicating A review of Resident ta Set (MDS), dated the resident had a BIMS dicating and personal to toileting, and personal extensive assistance with hygiene. Iten document, titled, ted 01/11/2021 with andwritten on it, indicated g and non-clothing items tent did not have a staff or exignature. In 11/16/2021 at 10:00 observed sitting on the esident was dressed in a sand light-colored pants. The interviewed due to the interviewed due to the awhite sweater was on a ter, unlabeled. Resident are any jewelry on. 11/16/2021 at 2:23 PM, 1/2 stated when clothing lifty by a resident or family re put in a bag and sent to "in a perfect world" all oried, but at the facility RN lothing in the inventory list. Tesident arrived at the	F	continued review and recomi	nendations.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315201	B. WING_			C	
NAME OF D	ROVIDER OR SUPPLIER	313201	B: Willo	STREET ADDRESS, CITY, STATE, ZIP COD		11/16/2021	
TWANE OF TH	TOVIDER OR GOLT EIER			255 EAST MAIN ST	_		
CAMBRID	GE REHABILITATION AN	ND HEALTHCARE CENTER		MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 584	Attorney (POA). RN # procedure indicating documenting resident #1 did not know what #1 stated there were on in the facility, such the inventory list was the purpose of the inventory of the purpose	a a bag and call the Power of the stated there was no set who was responsible for the facility policy stated. RN so many other things going as caring for residents, that not a priority. RN #1 stated ventory sheet would be to so. In 11/16/2021 at 4:50 PM, ent had been at the time and had issues with NA #2 did not recall what laundry was responsible for A #2 stated that Resident unlabeled. The clothing was the swheelchair, but the day hadry. CNA #2 admitted to beled due to not having a verbally tell the next CNA, rol who that CNA told the watch and two necklaces	F5	584			
		e family member stated a the administrator when the on the family					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3	O DATE SURVEY COMPLETED
		315201	B. WING _			C 11/16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION A	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057		11/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 584	member stated the a family an investigation family member would member stated the a called. The family menecklaces was an 18 crucifix that Resident in A further review of the titled, "Inventory She Resident so name watch and two neckled document. During an interview of the Social Worker (Social Worker (S	dministrator informed the on would be done and the done and the done alled back. The family dministrator had not yet ember stated one of the 3-carat gold necklace with a purchased at the purchased at the purchased at the with handwritten document had been done in the detail of the	F 5.	84		
	the Administrator star for labeling clothing a nurses would place in during admission. The purpose of the invention personal property. The not remember any is Resident The administration of the located. Then "Actually, I do recall	ted laundry was responsible and "would assume" the tems on the inventory sheet the Administrator stated the tory list was to avoid loss of the Administrator initially did sue with missing items for ministrator stated a "s missing jewelry could the Administrator stated, an incident with jewelry." The med an inventory list was not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315201	B. WING _			C 1/16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		1/10/2021	
CAMBRID	GE REHABILITATIO	N AND HEALTHCARE CENTER		255 EAST MAIN ST MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 584	created when the Administrator rem of Resident in with a crucifix on necklace was at the Administrator state summary available not recall the outer the family was to buring an interviet the Director of Number of the DON's clothing were not a resident or famic clothing, the facility often compensate items other than oneed to have a greated the grievar SW or Administration anything about longuisting about longuisting and the inventory list was belongings and to was stolen or truly with of the director of the provided the facility of the director of the provided the facility with of the stolenging of the provided the facility of the provided the provided the facility of the provided the	resident was admitted, but the sembered being shown a picture the facility wearing a necklace it and could "attest" that the he facility with the resident. The ed there was no investigation e, and the Administrator could come. The Administrator stated be compensated. Iw on 11/16/2021 at 9:04 PM, rrsing (DON) stated the facility who worked daily from 9:00 AM DON stated the concierge was bing through the bags of the eal belongings and logging the stated any items other than inventoried. The DON stated if ly member reported missing the would just believe them and enthe resident. The DON stated belothing reported missing would invence form filed. The DON composes were then handled by the tor. The DON denied knowing statems or grievances for DON stated the purpose of the to keep an accurate account of a avoid conflict by knowing what a winssing. Sident is medical record ity admitted the resident on liagnoses that included is a quarterly Minimum Data in the facility was a pictured with a purpose of the to keep an accurate account of a province of the to keep an accurate account of a province of the to keep an accurate account of a province of the to keep an accurate account of a province of the to keep an accurate account of a province of the to keep an accurate account of a province of the to keep an accurate account of a province of the to keep an accurate account of a province of the tother of the purpose of t	F	584			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		315201	B. WING _			C 11/16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION AI	ID HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 255 EAST MAIN ST MOORESTOWN, NJ 08057	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT	
F 584	(BIMS) score of resident was inventory list created through During an observation 11/16/2021 at 10:00 / observed sitting at the blue shirt and blue shresident's bed was are and two blue plastices box. Resident stated the facility did personal belongings were in the made it harder to have stated the facility did personal belongings stated the facility of procedures for resident stated the social was taken and a resident's room due to stated the SW was provide a receipt for the facility of	nterview for Mental Status at of , which indicated the . There was no or updated from and interview on AM, Resident was e edge of the bed wearing a	F	584		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		315201	B. WING _			C 11/16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION A	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 255 EAST MAIN ST MOORESTOWN, NJ 08057	<u>I</u>	11/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	DATE
F 584	nobody knew where of actions taken indi Resident 's grill w The summary indica price and inform the the resident. During an interview the Social Worker (S Resident was told grill. The SW stated the grill would be conot know when. The had the water heatin handle the issue. During an interview the Administrator state for labeling clothing nurses would place during admission. The purpose of the inverpersonal property. T SW was dealing with	partments about the grill and the grill was. The summary cated the original box for as in the SW's possession. ted the SW would look up the Administrator to reimburse on 11/16/2021 at 6:00 PM, SW) admitted to having ut stated it was a water affee pot. The SW stated to put in a grievance for the the resident was informed appensated, but the SW did SW stated the Administrator g pot and was going to on 11/16/2021 at 8:46 PM, atted laundry was responsible and "would assume" the tems on the inventory sheet the Administrator stated the atternal	F	584		
	waiting for an invoice During an interview the Director of Nursi had a concierge who to 5:00 PM. The DO responsible for going residents' personal bitems. The DON staticlothing were not invoice.	e to compensate Resident. on 11/16/2021 at 9:04 PM, ng (DON) stated the facility o worked daily from 9:00 AM N stated the concierge was g through the bags of the belongings and logging the led any items other than rentoried. The DON stated if member reported missing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315201	B. WING _			C 11/16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I	11/10/2021	
CAMBRID	GE REHABILITATION AN	ID HEALTHCARE CENTER		255 EAST MAIN ST MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	clothing, the facility w often compensate the items other than cloth need to have a grieval stated the grievances SW or Administrator. anything about lost ite Resident . The DO inventory list was to k belongings and to avo was stolen or truly mix. 3. A review of Reside indicated the facility a with diagrassistance with personassistance with personassistance with personassistance of whomas. Resident #5's 5-day Mated incomplete in the facility and incomplete in the facility staff would blate in the facility and the fa	resident. The DON stated ing reported missing would ince form filed. The DON were then handled by the The DON denied knowing ems or grievances for N stated the purpose of the eep an accurate account of oid conflict by knowing what ssing. Int is medical record dmitted the resident on noses that included need for mal care and indicated the resident had a ich indicated the resident was not completed in 11/16/2021 at 2:17 PM, we facility had lost all the indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors. Resident indicated the resident was forced is set doors.	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315201	B. WING _				C 16/2021	
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	117	10/2021	
CAMBRID	GE PEHARII ITATION A	ND HEALTHCARE CENTER		255 E	AST MAIN ST			
CAMBRID	GE REHABILITATION A	ND HEALTHCARE CENTER		МОО	RESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 584	Continued From pag	e 12	F 5	584				
	items and nothing ha	nd been resolved.						
	the Social Worker (S residents' personal be grievances and "goin" During an interview of the Administrator state for labeling clothing a nurses would place is during admission. The purpose of the invening personal property. The social property of the invening admission of the invening admission.	on 11/16/2021 at 6:00 PM, W) denied having a role in elongings other than filing ng through channels." on 11/16/2021 at 8:46 PM, ted laundry was responsible and "would assume" the tems on the inventory sheet he Administrator stated the tory list was to avoid loss of he Administrator was not here for Resident #5 but would						
	the Director of Nursin had a concierge who to 5:00 PM. The DOI responsible for going residents' personal bitems. The DON stat clothing were not invaresident or family relating, the facility woften compensate thitems other than cloth need to have a griev stated the grievance. SW or Administrator anything about lost it Resident The DOI inventory list was to belongings and to awas stolen or truly mention.	•						
	4. During a facility to	ur on 11/16/2021 at 8:35 AM,						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		315201	B. WING _			C 11/16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION A	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 255 EAST MAIN ST MOORESTOWN, NJ 08057	CODE	11/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA	DATE
F 584	electronic tablets on electronics on bedsic hanging from open of residents were not v observed. During an interview of Licensed Practical N	boms were observed to have beds, small personal de tables, and clothing closets. Labels or names of sibly written on the items on 11/16/2021 at 10:35 AM, urse (LPN) #1 stated	F 5	584		
	admission, and the L responsible for upda items were not adde brought in after adm	not always created during LPN did not know who was ting the lists. LPN #1 stated d to the inventory list if ission. on 11/16/2021 at 10:38 AM,				
	Laundry Personnel (clothing brought in d placed in a plastic be receptionist to give to bag of clothing would labeled with the resident. LND #1 wa	LND) #1 stated resident uring admission would be ag and given to the facility b LND #1. LND #1 stated the d then be washed and dent's name. LND #1 stated en be delivered to the				
	were sent to the laur would be washed an stored. LND #1 point of clothing hanging f shirt and brown pant on the rack had not lijust stay on the rack or family member coclothing, they were wacks of unlabeled of LND #1 stated all cloaccurate inventory p	sheet. LND #1 stated if items adry without a name, they d placed on a rack and sed to a rack which had bags from both ends and a green s. LND #1 stated the items been labeled and would likely. LND #1 stated if a resident implained about missing velcome to look through othing in the laundry room. Sthing should be labeled, and revented residents from ind having to wear "charity"				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		` IDENTIFICATION NI IMBED:		IPLE CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETED	
		315201	B. WING _			C 11/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	11/10/2021	
CAMBRID	GE REHABILITATION AN	ND HEALTHCARE CENTER		255 EAST MAIN ST MOORESTOWN, NJ 08057	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 584	Registered Nurse (RN was brought in the fact member, the items we laundry. RN #1 stated items would be inventiged. RN #1 stated there we indicating who was reresidents' personal be know what the facility there were so many of facility, such as caring inventory list was not purpose of the inventor all belongings. During an interview of Certified Nursing Assiciothing was placed in laundry. CNA #1 stated in the facility over who updating the inventor designated. CNA #1 stated in the facility. CNA #1 stated in the facility over who was two to three week resident clothing. CNA #1 stated in the facility over who was two to three week resident clothing. CNA #1 stated in the facility over who was two to three week resident clothing. CNA #1 stated in the facility over who was two to three week resident clothing. CNA #1 stated in the facility with two suitcases full left, forcing the CNAs "charity clothing." CNA #1 stated in the facility with two suitcases full left, forcing the CNAs "charity clothing." CNA #1 stated in the facility with two suitcases full left.	n 11/16/2021 at 2:23 PM, N) #1 stated when clothing cility by a resident or family ere put in a bag and sent to d "in a perfect world" all toried, but at the facility RN clothing in the inventory list. as no set procedure esponsible for documenting elongings. RN #1 did not policy stated. RN #1 stated other things going on in the g for residents, that the a priority. RN #1 stated the ory sheet would be to keep In 11/16/2021 at 2:44 PM, estant (CNA) #1 stated in a plastic bag and sent to ed not everyone updated the CNA felt it was important to there was a big discussion of would be responsible for y lists, and no one was ever estated reports of missing were a daily occurrence at eated the laundry department	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315201	B. WING			C 1/16/2021	
	ROVIDER OR SUPPLIER GE REHABILITATION A	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 155 EAST MAIN ST MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	Continued From pag	e 15	F 58	34			
	During an interview of the Social Worker (Stresidents' personal by grievances and "going". During an interview of the Administrator state for labeling clothing and unuses would place in during admission. The purpose of the invention personal property. During an interview of the Director of Nursing had a concierge who to 5:00 PM. The DOI responsible for going residents' personal by items. The DON state clothing were not involved a resident or family reclothing, the facility woften compensate the items other than clothed to have a griev stated the grievance SW or Administrator purpose of the inventionaccurate account of conflict by knowing with the social states. New Jersey Administrator purpose of the inventional states and the social states account of conflict by knowing with the social states and the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by Lersey Administrator purpose of the inventional states account of conflict by knowing with the social states and the social states account of conflict by knowing with the social states account of conflict by Lersey Administrator purpose of the inventional states account of conflict by knowing with the social states and the social states account of conflict by knowing with the social states and the social states account of conflict by knowing with the social states and the social states account of conflict by knowing with the social states and the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by knowing with the social states account of conflict by knowing w	on 11/16/2021 at 6:00 PM, 6W) denied having a role in belongings other than filing ing through channels." on 11/16/2021 at 8:46 PM, ated laundry was responsible and "would assume" the tems on the inventory sheet in Administrator stated the tory list was to avoid loss of on 11/16/2021 at 9:04 PM, and (DON) stated the facility of worked daily from 9:00 AM is stated the concierge was go through the bags of the belongings and logging the led any items other than rentoried. The DON stated if member reported missing would just believe them and the resident. The DON stated hing reported missing would ance form filed. The DON is were then handled by the of the tory list was to keep an belongings and to avoid what was stolen or truly) -1			
F 610 SS=D	_	Correct Alleged Violation)-(4)	F 6	10		12/14/21	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		315201	B. WING		11/16/2021	
	ROVIDER OR SUPPLIER GE REHABILITATION	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 610	neglect, exploitation must: §483.12(c)(2) Have violations are thorouse with sample of the designated representation accordance with Standard appropriate corrections are thoroused with Standard appropriate corrections are complaint intake # Based on observations and facility determined that the the misappropriation	evidence that all alleged ughly investigated. ent further potential abuse, or mistreatment while the ogress. ent the results of all eadministrator or his or her entative and to other officials in ate law, including to the State ento 5 working days of the alleged violation is verified we action must be taken. IT is not met as evidenced evidenced ento force, interviews, record policy reviews, it was facility failed to investigate ento force property for one (Resident)	F 610	Preparation and/or execution of this of correction does not constitute an admission or agreement by Provider the truth or facts alleged or conclusio forth in the Statement of Deficiencies This plan of correction is prepared ar	of n set	
	misappropriation of facility had no inves missing jewelry Findings included: 1. A review of Residential indicated the facility	residents reviewed for property. Specifically, the tigation related to Resident lent 's medical record admitted the resident on gnoses that included		executed because the provisions of Federal and State laws require it. F610 Investigate/Prevent/Correct Alleged Violation 1. Resident grievance investigat was concluded with reimbursement responsible party for missing items. 2. All residents have the potential to impacted by grievance investigations being completed and documented. A open grievances were reviewed for	tion to the o be not	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		DNSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315201	B. WING _			1	C 16/2021
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		-
CAMBRID	GE DEHARII ITATION AI	ND HEALTHCARE CENTER		255	EAST MAIN ST		
CAMBRID	GE REHABILITATION AT	ND HEALTHCARE CENTER		MO	ORESTOWN, NJ 08057		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Data Set (MDS), date resident had a Brief II (BIMS) score of quarterly Minimum Date in indicated score of out of indicated score of indicated s	's admission Minimum and indicated the interview for Mental Status indicating I. A review of Resident ata Set (MDS), dated If the resident had a BIMS indicating Indicating Indicating Indicating Indicating Indicated I	F		adherence to policy. 3. Administrator and grievance officer/social worker reviewed grievance investigation policy and procedure to ensure compliance. 4. To monitor and maintain ongoing compliance the grievance officer will review investigative steps for grievance weekly for 4 weeks and then monthly fmonths. Results will be presented to t QAPI team monthly for continued revie and recommendations.	es for 2 he	
	he could not control v	verbally tell the next CNA, but					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		315201	B. WING _			C 11/16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION AI	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 255 EAST MAIN ST MOORESTOWN, NJ 08057	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE
F 610	Resident 's family was admitted with a wand the jewelry went. The jewelry was wort member stated the jewelry stated the jewelry stated the jewelry stated the remissing as well. The facility had not done jewelry or clothes. The jicture was shown to jewelry went missing member stated the affamily an investigation family member stated the affamily member stated the accalled. The family member stated the accalled account to the second state of the second state	an 11/16/2021 at 5:15 PM, member stated Resident watch and two necklaces missing around halot of money. The family welry was not listed on the sheet, although the resident elry on admission. The family esident had clothing go family member stated the anything about the missing refamily member stated a the administrator when the on how the sheet on the stated one of the stated one of the carat gold necklace with a purchased at the mandwritten on it, indicated a reces were not listed on the shannels." The SW stated reported missing items but were really at the facility	Fé	510		
		ning else about the incident istrator was dealing with it.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		TE SURVEY MPLETED
		315201	B. WING			C I 1/16/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN				ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 610	Continued From paç	ge 19	F 61	0		
	the Administrator stated reported to state age the facility. The Administrator stated reported to state age the facility. The Adminventory list was not stated inventory list was not supported to state age the facility. The Adminventory list was not supported to state age the facility. The Adminventory list was not was admitted, but the being shown a picture facility wearing a necould "attest" that the with the resident. The was no investigation Administrator could Administrator stated compensated. During an interview the Director of Nursi had a concierge who to 5:00 PM. The DO responsible for going residents' personal litems. The DON state clothing were not invarient a resident or family clothing, the facility often compensate the items other than clother than	on 11/16/2021 at 8:46 PM, ated laundry was responsible and "would assume" the items on the inventory sheet the Administrator stated the atory list was to avoid loss of the Administrator initially did saue with missing items for the administrator stated, an incident with jewelry." The the missing jewelry was not encies by the facility because the items were ever at a sinistrator confirmed an at created when the resident and the eadministrator remembered are of Resident in the collace with a crucifix on it and the encellace was at the facility the administrator stated there is summary available, and the not recall the outcome. The the family was to be on 11/16/2021 at 9:04 PM, and (DON) stated the facility to worked daily from 9:00 AM in the stated the concierge was gotherough the bags of the pelongings and logging the ted any items other than wentoried. The DON stated if member reported missing would just believe them and the resident. The DON stated thing reported missing would wance form filed. The DON				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		X3) DATE SURVEY COMPLETED
		315201	B. WING _			C 11/16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION AN	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 255 EAST MAIN ST MOORESTOWN, NJ 08057	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 610	Continued From page 20 stated the grievances were then handled by the SW or Administrator. The DON denied knowing anything about lost items or grievances for		F 6	10		
	inventory list was to k belongings and to avo was stolen or truly mi	-				
	A review of the facility's undated policy titled "Resident Rights," indicated "Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right toc. be free from abuse, neglect, misappropriation of property, and exploitation".					
	but the policy was no	•				
F 658 SS=D	-	rative Code: §8:39 - 5.1(a) eet Professional Standards (i)	F 6	558		12/14/21
	as outlined by the commust- (i) Meet professional This REQUIREMENT by: Complaint Intake #N Based on interviews a determined that the fa and services that adh standards of quality a comprehensive care	d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced J143783 and record reviews, it was acility failed to provide care		Preparation and/or execution for correction does not considerable admission or agreement by the truth or facts alleged or forth in the Statement of Description of the provential and State laws required because the provential and State laws required for the provential and State laws	stitute an / Provider of conclusion se eficiencies. repared and/o /isions of	et

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315201	B. WING _			1	C / 16/2021
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 11/	10/2021
				25	5 EAST MAIN ST		
CAMBRID	GE REHABILITATION AN	ID HEALTHCARE CENTER		MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	÷ 21	F 6	558			
	(Resident #1) of three	e residents.					
	Findings included:				F658 Services provided meet professional standards		
	(Resident #1) of three residents.				1. Resident was discharged from facility 2. All residents have the potential to affected by not following professional standards of care. All new admissions were reviewed for assessment, orders and care plans. 3. Licensed staff received education completion of new admission process including admission chart audit, care plans and physician orders. Unit Manaor licensed designee completes weekly skin assessments, which monitors for changes in skin condition (i.e.). 4. To monitor and maintain ongoing compliance the DON or Designee will audit weekly skin assessments for completion weekly for 4 weeks and the monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendation	for ager /	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315201	B. WING _			C 1/16/2021		
	ROVIDER OR SUPPLIER GE REHABILITATION AN	ID HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 255 EAST MAIN ST MOORESTOWN, NJ 08057				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 658	A review of Resident dated nowritten to treat the development. A care was review of Resident dated now responsible party was review of Resident dated now review of Resident now review of Resident now review of Resident dated now review of Resident dated now review of Resident dated now review of Resident now review now r	's progress notes, dated dicate the physician or a called and informed about on Resident was to cks on Mondays during the shift. Is physicians' orders, dicated no orders were obtained a care plan, dicated a care plan was potential for oplan for Resident on developed. Is medical record, from indicated skin of documented as cian's order. Is care plan meeting note, time included), indicated was present for the edicated the responsible of update about Resident which did not include on the edicates on the order. Is progress notes on the one of the progress notes on the order.	F	558				
	day of discharge, no documentation reg	, revealed there was garding						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315201	B. WING _			1	C 16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION A	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057			10/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 658	During an interview of Certified Nurse Aide admitted to the facility was assigned to helped with getting the situated. CNA #2 did said the During an interview of Licensed Practical Nurse) stated the fact that would assess an Tuesdays and Wedna resident needed a was found on team was not in the first provide care and wounds. LPN #2 needed to be assess see if they were improved the fact that would assess see if they were improved they were improved to the medical record and of documentation from indicating the Resident LPN #2 discovered upon admitted. LPN #2 state necessary, so the far going on and to obtate and assess the resident. nurse should have not responsible party.	on 11/16/2021 at 4:50 PM, (CNA) #2 Resident was y with a control of the was. On 11/16/2021 at 5:30 PM, urse (LPN) #2 (a charge illity had a care team and treat residents on esdays. LPN #2 stated that if dressing changed or a new the days the wound care facility, the nurses would and assess and measure 2 stated control or needed different N #2 reviewed Resident could not locate any the care team, care team did not see a stated that if a care team, care team did not see a stated that if a care team, care team did not see a stated that if a care team be defined the notification was mily knew exactly what was in orders to treat the have the care team LPN #2 stated the admission of tified the doctor and	F	558			
		interview and record review 4 PM, the Director of Nursing ident s admission nursing at 3:25 PM, and					

NAME OF PROVIDER OR SUPPLIER CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER MORESTOWN, NJ 98057 MAG FREGEN TAG CAULATORY OR LSC DENTIFYING INFORMATION) FREGEN TAG CONTINUED THE APPROPRIATE FESSION TAG CONTINUED THE APPROPRIATE CONTINUED THE APPROPRIATE CONTINUED THE APPROPRIATE TAG FESSION THE APPROPRIATE CONTINUED THE APPROPRIAT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER MOORESTOWN, N.J. 08067	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER MOORESTOWN, N.J. 98657					2	55 EAST MAIN ST		
F658 Continued From page 24 confirmed Resident arrived at the facility with a on the on the like and the property assessed. The DON stated accurate and detailed information was important to be able to get an idea of what the wounds looked like and track if they were healing. The DON was not able to find documentation indicating the physician nortification was necessary to ensure orders to treat were received. The DON stated physician nortification was necessary to ensure orders to treat were received. The DON stated the admission and so they knew what was going on with their family member. The DON stated the admission and so confirmed to another was not implemented for the physician and responsible party. The DON then reviewed Resident should have notified the physician orders, dated and confirmed an order was written for checks weekly on Mondays. The DON confirmed no orders were written to treat the check weekly on Mondays. The DON stated the work was expensed to the staff would know how to care for the resident. The DON stated orders to treat the should have been obtained and a care plan implemented to the staff would know how to care for the resident. The DON stated the care plan implemented to the staff would know how to care for the resident. The DON stated the weekly assessments should have been dote to track the staff would know how to care for the resident. The DON stated the care plan in plemented to the staff would know how to care for the resident. The DON stated the care plan in plemented to the staff would know how to care for the resident. The DON stated the care plan in plemented to the changed. The DON stated the care plan in plemented to the changed. The DON stated the care plan in plemented to the changed. The DON stated the care plan in plemented to the changed. The DON stated the care plan in plemented to the changed. The DON stated the care plan in plemented to the changed. The DON stated the care plan in plemented to the changed. The DON stated the care plan in plemented so the staff woul	CAMBRID	GE REHABILITATION AN	ND HEALTHCARE CENTER					
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admission by the admission nurse or supervisor.			•				I	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		315201	B. WING _		C 11/16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION AN	ID HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057	11/10/2021
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F 658	The DON could not rewere discussed meeting on A review of the facility of Injuries," "Conduct a comprehe upon (or soon after) a assessment, as indicated, resident's risk factors. The Administrator did treatment of available and only proprevention. A review of the facility "Change in Resident's indicated, "Our facility resident, his or her At representative (spons resident's medical/me1. The nurse will no Physician on call whee	d during the care planning d's policy, titled, "Prevention dated 2019, indicated, assessment admission, with each risk ated according to the and prior to discharge." Into have a policy on the assessments ovided the policy for It's undated policy, titled, as Condition or Status," It's shall promptly notify the tending Physician and appropriate and condition and/or status tify the resident's Attending in there has been a(an): a. appropriate and the policy in the resident; b.	F 6	58	
F 677 SS=D	ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain gersonal and oral hygo	eative Code: §8:39 - 5.1(a) or Dependent Residents ent who is unable to carry fiving receives the necessary good nutrition, grooming, and liene; is not met as evidenced	F 6	77	12/14/21
	by: Complaint Intake #N			Preparation and/or execution of this p	lan

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		315201	B. WING				C 16/2021
NAME OF P	ROVIDER OR SUPPLIER	0.0201			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	16/2021
					255 EAST MAIN ST		
CAMBRID	GE REHABILITATION AN	ND HEALTHCARE CENTER			MOORESTOWN, NJ 08057		
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F 677			F	677	of correction does not constitute an	.	
	I .	observation, record reviews,			admission or agreement by Provider of		
		policies, it was determined			the truth or facts alleged or conclusion	set	
		to provide activities of daily			forth in the Statement of Deficiencies.	lor	
	living (ADL) care for t	residents reviewed for ADL			This plan of correction is prepared and executed because the provisions of	/OI	
	care.	esidents reviewed for ADL			Federal and State laws require it.		
	ouro.			r ederar and etate laws require it.			
	Findings included:			F677 ADL Care provided for Depen Residents	dent		
		's medical record					
	indicated the facility a	admitted Resident with			1. Resident expired in the facility	on	
	diagnoses including				DON completed an		
	and .				assessment of Resident to ensure predetermined ADL schedule is being		
	and				followed. Resident ADL status meets I	nie	
	A review of Resident	s quarterly Minimum Data			current needs and preferences.		
		, indicated that			not adversely affected by the delay in A		
		ief Interview for Mental			care.		
		of out of indicating			2. All residents have the potential to	be	
	that the resident was	. Resident			affected by not providing activities of d	aily	
	required extensive	assistance for bed mobility,			living to maintain good nutrition, groom	ing	
		f the unit, dressing, toilet			and personal and oral hygiene per		
		giene. The resident was			personal preference. All resident task		
	totally dependent on				lists were reviewed and updated to refl	ect	
	needed supervision (set up help) for eating.			their individualized preferences.		
					3. Staff received education for timeling		
	A review of Resident				and completion of activities of daily living	ng	
		that staff would try to keep ble with adjusting their			and process for notification to Unit Manager/Supervisor when unable to		
	position.	ble with adjusting their			complete ADL care.		
	position.				4. To monitor and maintain ongoing		
	Resident stated in	an interview on 11/16/2021			compliance the Unit Manager(s) or		
		fing was always a problem. It			Designee will audit the timeliness of ca	re	
		AM before staff got the			weekly for 4 weeks and then monthly for		
		The resident was observed in			months. Results will be presented to the		
	I .	ew. Due to extreme pain			QAPI team monthly for continued review		
	_	in bed, Resident stated			and recommendations.		
	that sitting in a chair I						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 255 EAST MAIN ST MOORESTOWN, NJ 08057		1/10/2021	
(X4) ID PREFIX TAG			ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 677	working, that althe aides) could not go schedule, Reside very often. Some working but staff is should have been be better for ever aides. Resident least half an hour answered. Reside to wait 30 to 60 m resident mostly had 3:00 PM shift. Registered Nurse on 11/16/2021 at long to be answered residents wait half that licensed pracefrequently had to their nursing assignare completed. If were turned about RN#1 stated that that had to wout of the bed on had worked that fresident was CNAs had been rearly when asked Certified Nursing interview on 11/16 facility reopened in number of CNAs the building. This drop even more.	de that there were too few aides ough they work hard, they (the get everything done. Due to the int was not getting out of bed days there were only two aides had told the resident there in at least four, but that it would yone if there were five or six stated that often it took at or more before call bells were ent stated it was not unusual aninutes to be changed. The lad concerns with the 7:00 AM to see (RN) #1 stated in an interview 10:29 AM that call bells took too red at times, probably making f an hour at least. RN #1 stated stical nurses (LPNs) and RNs do patient care in addition to griments just to get resident for the most part, residents at every two hours per RN #1. Resident had reported to her ait to get repositioned or to get a regular basis. When RN #1 loor, RN #1 ensured that out of bed as early as possible. eminded to get the resident up	F	577			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	, , ,	(X3) DATE SURVEY COMPLETED	
		315201	B. WING _	B. WING		C 1/16/2021	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 255 EAST MAIN ST MOORESTOWN, NJ 08057		1710/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 677	Continued From page 28 in the correct areas and be sure to keep an eye on the residents with behaviors and there were		F6	77			
	some residents who stated that they cou 100%, but maybe of shortages. Also, the not doing as much a that sometimes resineeded. Residents call bell to be answetolerance of some swith how they wanter ather than wait for resident. CNA #2 staget up early and offethe resident up due being taken care of delivered to all resident. On 11/16/2021 at 5: Nurse (LPN) #2 staff	wanted to fight. CNA #2 Id not provide quality care at hy 85% because of staff are were new staff who were as they should. CNA #2 stated dents did not get what they had to wait too long for the ered. CNA #2 stated that taff was low for new residents and to be cared for immediately the CNA to finish with another atted that Resident liked to be it was not possible to get to other residents that were and getting breakfast					
	interview on 11/16/2 her expectation that checked every two I needed and all resic with Activities of Dai provided what was I The DON stated tha time. The facility wa	ent s medical record admitted Resident with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		315201	B. WING			C 11/16/2021		
	ROVIDER OR SUPPLIER GE REHABILITATION A	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 677	Set (MDS) dated Resident #8 had a Bit Status (BIMS)score of the resident was required extensive as transfers, dressing, to hygiene. The resident for transfers, and nee help) for locomotion of eating. During an interview v 11/16/2021 at 10:10 had not gotten out of Resident was usu other day, but stated shorthanded, that did Resident stated th between 30 to 60 min Resident stated th to get to them when to it was frustrating to w Resident always t possible to ask for he Registered Nurse (Ri on 11/16/2021 at 10:1 long to be answered residents wait half an that licensed practica frequently had to do	's quarterly Minimum Data , indicated that rief Interview for Mental of , indicating that . Resident sistance for bed mobility, oilet use, and personal t required total dependence eded supervision (set up on and off the unit and with Resident on AM, the resident stated they the bed since ally gotten out of bed every with the staff being I not always happen. hat the call bell could take nutes to be answered. hat they had to wait for staff they needed assistance and rait that long to be changed. ried to wait as long as	F 67	77				
	having enough staff, get care in a timely m	#1 stated that due to not residents were not able to nanner. The staffing was not er of residents. For the most						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		315201	B. WING _			C 11/16/2021
	ROVIDER OR SUPPLIER GE REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 30	F 6	77		
	per RN #1. RN #1 s work, and the facilit very challenging. Certified Nursing As interview on 11/16/2 reopened the unit a of CNAs were then building. This had deven more. In addit must also make sur correct areas and b residents with behaves idents who want they could not provionly 85% because were new staff who they should. CNA # residents did not ge Residents had to work on the should the sh	urned about every two hours stated that no one wanted to y was understaffed, and it was esistant (CNA) #2 stated in an 2021 that when the facility bout a month ago, the number spread out more over the aused the level of care to drop ion to providing care, CNAs are that residents stayed in the e sure to keep an eye on the viors and there were some ed to fight. CNA #2 stated that de quality at 100%, but maybe of staff shortages. Also, there were not doing as much as 2 stated that sometimes at what they needed. ait too long for the call bell to #2 stated that tolerance of for new residents.				
	Nurse (LPN) #2 sta	:11 PM, Licensed Practical ted in an interview that always changed in a timely				
	interview on 11/16/2 her expectation that checked every two needed and all resis with ADLs were pro timely manner. The always have time. I	sing (DON) stated in an 2021 at 9:23 PM that it was tall incontinent residents were hours and changed when dents who needed assistance vided what was needed in a DON stated that staff did not The facility was trying to hire te not using agency staff but sted an agency.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED	
		315201	B. WING		1	C 1/16/2021	
	ROVIDER OR SUPPLIER GE REHABILITATION AI	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 677	7 Continued From page 31		F 67	7			
F 725 SS=E	New Jersey Administ Sufficient Nursing Sta CFR(s): 483.35(a)(1)		F 72	5		12/14/21	
	§483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint Intakes #NJ143783 and #NJ145736 Based on observations, resident and staff			Preparation and/or execution of of correction does not constitute admission or agreement by Protine truth or facts alleged or conditions.	an vider of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD SLIDDLIED	313201	1		TREET ADDRESS CITY STATE ZID CODE	11/	16/2021	
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
CAMBRID	GE REHABILITATION AN	ND HEALTHCARE CENTER			55 EAST MAIN ST			
				M	OORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE				
F 725	Continued From page	e 32	F 7	725				
	adequate staff to care assistance with activi care for four (Resider	acility failed to provide e for residents that required ties of daily living (ADLs) nt, Resident Resident of four residents dependent			forth in the Statement of Deficiencies. This plan of correction is prepared and executed because the provisions of Federal and State laws require it. F725 Sufficient Nursing Staff	/or		
	AM, Resident (who Brief Interview for Me stated call lights of for hours. Resident not help all the resident would has station and get ice was would not answer. Resident (who wa BIMS score of) stated if the resident would not answer. Resident (who wa BIMS score of) stated if the resident out of a problem. It was free got the resident out of observed still in bed of that was Resident stated the relieve the stated all lights of the resident stated the relieve the stated call lights of the resident stated the relieve the stated call lights of the resident stated the relieve the stated call lights of the resident stated the relieve the stated call lights of the resident stated the relieve the stated call lights of the resident stated the relieve the stated call lights of the resident stated the relieve the stated call lights of the resident stated call lights of the resident stated in the resident stated call lights of the resident stated in the resident stated call lights of the r	ental Status (BIMS) score of were frequently unanswered stated the nurses would ents in a timely manner. water or ice were needed, ave to go to the nurses atter because the nurses			1. DON assessed and interviewed Residents and and none were adversely affected by the staffing on the days observed. 2. All residents have the potential to affected by staffing inconsistencies. 3. Recruitment efforts continue to include: a. Job fairs b. Daily staffing meetings c. Licensed professionals assigned to aide in performance of ADL care. d. Sponsored orientees for 45 days toward retention of new hires e. Care Champion mentor program to support retention f. Culture committee to improve and maintain staff morale g. Recruitment bonus and increased sign-on bonuses offered. h. Contracted with outside agency 4. To monitor and maintain ongoing compliance the DON or designee will	e be o		
	hard, they (the aides) done. Due to the schogetting out of bed ver were only two aides versident there should would be better for exix aides. Resident least half an hour or resident.	o could not get everything edule, Resident was not y often. Some days there working but staff had told the be at least four, but that it veryone if there were five or stated that often it took at more before call bells were stated it was not unusual			monitor staffing daily for 1 week, week for 3 weeks and monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		315201	B. WING			C
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057		11/16/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 725	to wait 30 to 60 minuter resident mostly had of 3:00 PM shift. During an interview with 11/16/2021 at 10:10 A had not gotten out of Resident was usuated shorthanded, that did Resident stated the between 30 to 60 minuter Resident stated that oget to them when the it was frustrating to we resident always to possible to ask for her Registered Nurse (RI on 11/16/2021 at 10:2 long to be answered residents wait half and that licensed practical frequently had to do put their nursing assignments are completed. For the were turned about even RN#1 stated that Resthat had to wait the out of the bed on a reshad worked that floor Resident was out CNAs had been reminearly when asked to.	with Resident (who was BIMS score of) on AM, the resident stated they the bed since ally gotten out of bed every with the staff being not always happen. at the call bell could take outes to be answered. At they had to wait for staff they needed assistance and ait that long to be changed. The resident is a long as lp. N) #1 stated in an interview 29 AM that call bells took too at times, probably making hour at least. RN #1 stated I nurses (LPNs) and RNs postient care in addition to be the part, residents are you hours per RN #1. Sident had reported to her to get repositioned or to get regular basis. When RN #1, RN #1 ensured that of bed as early as possible. Indeed to get the resident up	F 72	25		
		alarming in the nurse's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED	
		315201	B. WING_			C 11/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	11/10/2021	
				255 EAST MAIN ST			
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER		ND HEALTHCARE CENTER		MOORESTOWN, NJ 08057			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 725	Continued From page	e 34	F 7	725			
	station as the call light alarming. At 2:20 PM sound. RN #1 and LF 2:35 PM the call light. During an interview or RN #1 stated all staff for answering the call immediately, but if oth care, then it would tall sure how long the call was not that long. RN	another call light began to PN #3 remained seated. At					
	CNA #1 stated there staffing in the facility, not safe. CNA #1 stated the CNA had reside would make it imposs timely manner, turn the hours, or change their CNA #1 stated each yout fires" and just "try 3:00 PM." CNA #1 stated each resident was midown to calculate the resident a shift. CNA seen by CNA #1, "4 reday." CNA #1 stated residents deserved, but with the limited staff.	was a big problem with and the assignments were ted that on an average day dents to care for, which sible to answer call lights in a me residents every two ir briefs in a timely manner. Work shift was spent "putting ring to keep them alive until ated the time spent with inimal, and the CNA had sat exact time with each #1 stated each resident was minutes and 15 seconds per this was not the care the but it was all they could do CNA #1 stated the care f changing a resident and					
	Certified Nursing Ass	istant (CNA) #2 stated in an					

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		315201	B. WING	B. WING		11/	16/2021	
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER		•	25	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST MAIN ST OORESTOWN, NJ 08057				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 725	facility reopened the number of CNAs were the building. This had drop even more. In a CNAs must also makin the correct areas a on the residents who stated that they could 100%, but maybe on shortages. Also, then not doing as much at that sometimes residents he call bell to be answered to all bell to be answered to a swell being taken care of a delivered to all resident. CNA #2 stated the resident up due to being taken care of a delivered to all resident. CNA #3 stanswered in a timely the average wait was hour. Resident stanswered to all ight normal response time was still unanswered.	221 at 4:39 PM that when the unit about a month ago, the re then spread out more over d caused the level of care to iddition to providing care, we sure that residents stayed and be sure to keep an eye behaviors and there were wanted to fight. CNA #2 d not provide quality care at ly 85% because of staff re were new staff who were is they should. CNA #2 stated lents did not get what they ad to wait too long for the red. CNA #2 stated that aff was low for new residents d to be cared for immediately ne CNA to finish with another sted that Resident liked to in it was not possible to get on other residents that were and getting breakfast tents on the hall. In 11/16/2021 at 6:15 PM, with atted call lights were never fashion. Resident stated is between 30 minutes to 1 atted this was the same At 6:20 PM, Resident to provide an example of the e. At 6:35 PM the call light light.	F	725				
	, ,	ed in an interview that lwavs changed in a timely						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
	315201 B. WING		1	C 1/16/2021			
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 255 EAST MAIN ST MOORESTOWN, NJ 08057			
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F 725	the DON stated evanswering call light appropriate wait tir answered was 10 tit was important to case the residents The Director of Numerick on 11/16/her expectation that checked every 2 houseded. It was also had their needs more unable to do things that staff do not alwas trying to hire magency staff but hat agency. The undated "Staff facility provides sufficiently prov	on 11/16/2021 at 9:04 PM, erybody was responsible for is. The DON stated the ne for a call light to be to 15 minutes. The DON stated answer call lights timely in needed urgent attention. The DON stated in an 2021 at 9:23 PM that it was at all incontinent residents were cours and changed when to expected that all residents at by staff when they were a for themself. The DON stated ways have time. The facility ew staff. They were not using the recently contacted an accordance for all residents in accordance for all residents based on each in."	F	725			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315201	B. WING _	B. WING		C 11/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	I		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
CAMBRID	GE REHARII ITATION AN	ND HEALTHCARE CENTER		255	EAST MAIN ST		
CAMBRID	GE REHABILHATION AT	TEACHICANE CENTER		МО	ORESTOWN, NJ 08057		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	Continued From page	e 37	F 7	760			
F 760 SS=D		f Significant Med Errors	F 7	760			12/14/21
	The facility must ensu §483.45(f)(2) Resider medication errors. This REQUIREMENT by: Complaint Intake #N Based on interviews, of facility policies and determined that the fainsulin (a significant ribe given at specific titimes) administration physician for one (Rereviewed for timely medical forms included: Reference: A review of Association's website can be seen as a series of the series of	is not met as evidenced J143783 record reviews, and review references, it was acility failed to follow the medication that is required to mes in relation to meal schedule as ordered by the sident of two residents redication administration. of the American indicated, we a serious problem if you aportant to treat as soon as a sill to treat			Preparation and/or execution of this of correction does not constitute an admission or agreement by Provider the truth or facts alleged or conclusio forth in the Statement of Deficiencies This plan of correction is prepared ar executed because the provisions of Federal and State laws require it. F760 Medication Errors 1. DON assessed and interviewed Resident and communicated finding to the Practitioner. Resident was adversely affected by late administration orders. 2. All diabetic residents have the potential to be affected. All resident orders were audited to assure that administration time was appropriate. 3. Licensed staff educated on medication administration and physic notification process when giving a medication outside of parameters.	of n set nd/or ngs not tion	
	your body car your 1. A review of Reside indicated the facility a diagnoses that includ	nt medical record admitted the resident with ed			4. To monitor and maintain ongoing compliance the DON or Designee will audit diabetic medication administrative weekly for 4 weeks and then monthly months. Results will be presented to QAPI team monthly for continued rev	l ion for 2 the	
		and			and recommendations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		315201	B. WING			C I 1/16/2021	
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 255 EAST MAIN ST MOORESTOWN, NJ 08057		11710/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Resident Set (MDS) dated resident had a Brief (BIMS) score of resident was A review of Resider plan, dated in place for The care was to indicated interventic level: included times a day. A review of Resider dated receive of resident was to rece bedtime, as of orde A review of Resider dated A review of Resider dated receive of receive of	quarterly Minimum Data , indicated the , indicated the , which indicated the , which indicated the , which indicated the , indicated a care plan was problems related to plan indicated Resident be maintained between The care plan ons to maintain Resident is in the therapeutic range three It is physicians' orders, indicated the resident was to every morning. The every morning. The every morning at ris dated In physicians' orders, indicated the resident was to every morning. The every morning at ris dated In physicians' orders, indicated the resident was to It is physicians' orders, indicated the resident was to In physicians' orde	F7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
	315201 B. WING		B. WING _			C 11/16/2021	
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COL 255 EAST MAIN ST MOORESTOWN, NJ 08057	•	11/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760	A review of Resident Administration Recor the month of On the	's Medication d (MAR) for given were: 1:00 AM dose was at 12:19 AM :00 AM dose was :00 AM dose was 1:00 AM dose was	F7	760			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
315201		B. WING			C 11/16/2021		
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER				255 E	ET ADDRESS, CITY, STATE, ZIP CODE AST MAIN ST RESTOWN, NJ 08057		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	time for nurses to parresidents. LPN #2 stated in the could vary, depending and were controlled was time. LPN #2 stated in scheduled and on were controlled dangerous. LPN #2 medication administration and administration and administration was on time to avoid levels. The DON state and administration was on time to avoid levels. The DON reviewed Flevels for the DON reviewed Resident was not and and in the resident was not and in the resident was not and in the resident was not and appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect and could lead to have appropriate to admin doing so could affect a	administration g on the resident and the N #2 stated if the should be given on t was important to give time to ensure d. LPN #2 stated levels could be eviewed Resident was given late and stated it mely due to the resident's Interview and record review A PM, the Director of Nursing dow for medication he hour before or one hour d it was important to give id N stated uld be dangerous for health. Resident and stated the resident levels and administered on time. The ent s MAR and confirmed receiving the ordered medication administration N stated it was not enterview and record review and stated the resident levels and administered on time. The ent s MAR and confirmed receiving the ordered medication administration N stated it was not ester medications late and control of	F	760			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) D/	(X3) DATE SURVEY COMPLETED		
		315201	B. WING			C 11/16/2021	
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057	.	11110/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 760	timely manner, and a are administered in a orders, including any	s prescribedMedications coordance with prescriber required time frames." rative Code § 8:39 - 29.2(d)	F 7				