STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315201	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	**255 EAST MAIN ST , MOORESTOWN, New Jersey, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint NJ #: 372517, 372532, 372566, 372602, 373614, 373616, 373628, 373632, 373640, 373650, 373655, 373662, 373663, 373667 STANDARD SURVEY: 08/05/2025 CENSUS: 144 SAMPLE SIZE: 29+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		08/25/2025
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a	F0656	F 0656 (D) Develop/Implement Comprehensive Care Plan How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. Resident #14 care plan focus area was updated to include NJ Ex Order 26.4(b)(1) and interventions for use. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents on anticoagulant therapy have the potential to be affected. An anticoagulant medication audit was completed to ensure that residents on anticoagulants had documentation of a care plan focus with interventions. Any deviations were corrected. What measures will be put into place or systemic	08/25/2025

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F0656 SS = D	Continued from page 1 facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled:Number of residents cited: This deficient practice was evidenced by the following: A review of Resident # 14's admissions record revealed that, Resident # 14 was admitted with but not limited to NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) [redacted]). A review of Resident #14's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4(b)(1) revealed under section NJ that the resident was ordered an NJ Ex Order 26.4(b)(1) [redacted]). A review of Resident #14's Electronical Medical Record revealed a physician's order with a state date of NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) [redacted] to be given every twelve hours. A review of the current Care Plan (CP) for Resident #14 did not include documentation of a CP focus area or interventions for the use of NJ Ex Order 26.4(b)(1). During an interview on 08/01/2025 at 09:58 AM with the	F0656	Continued from page 1 changes made to ensure that the deficient practice would not recur. The Director of Nursing or Designee will re-educate licensed nursing staff on completion of comprehensive care planning with focus area for residents receiving anticoagulant therapy. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Director of Nursing or Designee will audit resident's receiving anticoagulant therapy for care plan focus and interventions, daily x5 days, weekly x4 weeks and then monthly x2 months. Results of these audits will be presented to the Quality Assurance Performance Improvement team monthly for continued review for a period of 3 months and recommendations to revise as needed. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director, and infection Preventionist as well as other interdisciplinary members.	

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F0656 SS = D	Continued from page 2 surveyor the Unit Manger Registered Nurse (UMRN)# 1 said that care plan consists of focus areas for NJ Ex Or NJ Ex Order 26.4 NJ Ex Order 26.4(b) certain medications and diagnoses. When asked if Resident #14 should be care planned for NJ Ex Order 2 the UMRN replied, “Yes, but it’s not in there. I must have missed it.” During an interview on 08/01/2025 at 12:14 PM with the surveyor the U.S. FOIA (b) (6) stated, there should be a focus or an intervention on use of an anticoagulant on the resident’s care plan. A review of a facility provided policy titled “Care Plans, Comprehensive Person-Centered” revealed under section “Policy Statement” that, “A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39-27.1(a)	F0656		
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F0676	F 0676 (D) Activities Daily Living (ADLs)/Mntn Abilities 1 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. Resident #179 was discharged from the center on NJ Ex Order 26.4 Resident #152 NJ Ex Or tasks were reviewed, and the updated NJ Ex Order 2 schedule is reflected on the POC. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents requiring ADL assistance and turning and positioning have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The Director of Nursing or Designee will re-educate	08/25/2025

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F0676 SS = D	Continued from page 3 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide the necessary care and services to ensure that a resident's abilities in NJ Ex Order 26.4(b)(1), specifically by not NJ Ex Order 2 the resident in bed every two hours to prevent NJ Ex O. The deficient practice was identified for 2 of 5 residents (Resident # 179, 152) investigated for NJ Ex Order 26.4(b)(1). The deficient practice was evidenced by the following: A review of Resident # 179's Minimum Data Set (MDS; an assessment tool) dated NJ Ex Order 26.4(b) revealed under section NJ Ex O that he/she has NJ Ex Order 26.4(b)(1). Further, the MDS revealed under section, NJ E that he/she is at risk of NJ Ex Order 26.4(b)(1). A review of Resident # 179's Care Plan revealed a focus of an NJ Ex Order 26.4(b)(1) Care NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) status post NJ Ex Order 26.4(b)(1) NJ Ex Or and NJ Ex Order 26.4(b)(The Care Plan revealed an intervention for NJ Exec " that Resident # 179 requires the assistance of one staff member and a sheet for NJ Ex Order 2 and NJ Ex Order 26.4(b)(1). The intervention was dated NJ Ex Order 26.4(b)(A review of the Physician's Orders located in the Electronic Medical Record (EMR) revealed an order to, NJ Ex O every NJ hours for NJ Ex Order 2 schedule" with a start date of NJ Ex Order 26.4(b)(.	F0676	Continued from page 3 nursing staff on providing the necessary care and services appropriate to maintain or improve their ability to carry out ADLs and the importance of documentation of those ADL tasks in the electronic medical record. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Director of Nursing or Designee will select 20 residents for those residents with orders for turning and audit the Treatment Administration Record (TAR) for documentation completion daily x5 days, weekly x4 weeks and then monthly x2 months. Results of these audits will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Director of Nursing or Designee will select 20 residents and audit the Electronic Medical Record for those residents' receiving showers for documentation completion daily x5 days, weekly x4 weeks and then monthly x2 months. Results of these audits will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director, and infection Preventionist as well as other interdisciplinary members.	

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F0676 SS = D	Continued from page 4 A review of the Treatment Administration Record (TAR) located in the EMR revealed blanks in the documentation area for the order to turn every two hours. The blank areas were identified for the following dates and times: NJ Ex Order 26.4 – 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM. NJ Ex Order 26.4(b) – 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM NJ Ex Order 26.4(b) – 12:00 PM, 2:00 PM, 6:00 PM, 8:00 PM, 10:00 PM On 8/01/2025 at 12:05 during an interview with the surveyor, the U.S. FOIA (b) (6)) replied, “After investigation and following up with the nurse, I would make that determination.” After the surveyor asked if there are blanks on the Treatment Administration Record and no progress notes referring to the administrations, would you consider that completed. The U.S. FOIA said rotating residents in bed is important because it helps with skin integrity prevention or maintenance. A review of the facility policy titled, “Activities of Daily Living (ADL), Supporting” revised April of 2025 revealed that, "Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.” NJAC § 8:39-27.1 (a) A review of Resident # 152’s Minimum Data Set (MDS) an assessment tool dated NJ Ex Order 26.4(b)(1) revealed in the Brief Interview for Mental Status (BIMS) that the resident scored a NJ E indicating that the resident is NJ Ex Order 26.4(b)(. The MDS also revealed in section NJ Ex (that the resident has NJ Ex Order 26.4(b)(1) and requires NJ Ex Order 26.4(b)(1) assist with NJ Ex Order 26.4(b)(1 A review of Resident # 152's Care Plan revealed a focus for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) deficit related to NJ Ex Order 26.4(b)(1). The Care Plan revealed an intervention for “NJ Ex Order 26.4 that Resident # 152 requires the assistance of1 staff with NJ Ex Order 26. The intervention was dated NJ Ex Order 26.4(b)(1).	F0676		

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F0676 SS = D	Continued from page 5 A review of the ADL record documentation sheet located in the Electronic Medical Record (EMR) revealed blanks in the documentation area for showering evening shift. The blanks were identified for: NJ Ex Order 26.4(b)(1) 3-11 NJ Ex Order 26.4(b)(1) 3-11 NJ Ex Order 26.4(b)(1) 3-11 NJ Ex Order 26.4(b)(1) 3-11 A review of Resident # 152's grievances revealed that on NJ Ex Order 26.4(b)(1) the resident filed a grievance regarding his/her NJ Ex Order 2 schedule. The resolution was a NJ Ex Order 2 schedule hung on the residents closet door. On 07/01/25 at 9:30 A.M. during an interview with the U.S. FOIA (b) (6) regarding blanks on the NJ Ex Or record regarding NJ Ex Order 26.4 and would they be considered performed. The U.S. FOIA (b) (6) stated that the resident "may have refused it." A review of the facility policy titled, "Bathing and showering" revised February 19, 2024, revealed that "the interdisciplinary team will develop bathing/showering schedules with resident and/or representative," It further revealed that "Provision of refusal of showers and/or tub baths will be documented in the medical record by the certified nursing assistant and/or licensed nurse." A review of the facility policy titled, "Activities of Daily Living (ADL), Supporting" revised April of 2025 revealed that "Residents are provided with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out services of daily living independently received the services necessary to maintain good nutrition, grooming, and personal and oral hygiene, NJAC 8:39-27.1(a)	F0676		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F0697	F 0697 (D) Pain Management How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD.	08/25/2025

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F0697 SS = D	Continued from page 6 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and other pertinent facility documents, it was determined that facility to failed to ensure residents received the appropriate NJ Ex O management by administering NJ Ex O medications according to the physician's ordered NJ Ex O level parameters. This deficient practice was identified in 2 of 4 residents reviewed for NJ Ex O (Resident #7 and #49) and was evidenced by the following: 1.On 7/29/2025 at 10:47 AM, during the initial tour Resident #7 was in the room in bed. The resident's NJ Ex was NJ Ex Order 26.4 on pillows and the resident appeared comfortable to the surveyor. The surveyor reviewed the medical record for Resident #7. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1). A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 26, section NJ for NJ Ex Order 26.4(b)(1) revealed the resident had a Brief Interview of Mental Status of NJ Ex meaning the resident was NJ Ex Order 26.4(b)(. Section N of the MDS, health conditions indicated the resident was receiving a NJ Ex O management regime. The NJ Ex O assessment indicated NJ Ex O was present and frequently affected NJ Ex Ord and NJ Ex Order 2 activities. A review of the physician orders showed the following orders related to NJ Ex O management. NJ Ex Order 26.4(b)(1) one tablet every four hours as needed for NJ Ex Order 26.4(b)(1) Give 2 tablets by mouth every 6 hours as needed for NJ Ex Ord A review of Resident #7 individualized comprehensive care plan (ICCP) included a focus area of NJ Ex Order 26.4(b)(related to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). Interventions included administering NJ Ex O medication as ordered by the physician and evaluate the effectiveness of the NJ Ex O management.	F0697	Continued from page 6 Resident #7 physician orders were reviewed for NJ Ex O level parameters. No changes were made to physician orders and patient remains on the same NJ Ex O regimen. Resident #49 physician orders were reviewed for NJ Ex O level parameters. Physician orders were updated to reflect parameters moderate to NJ Ex Order 26.4(b)(1) of NJ Ex Ord). How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents receiving as needed pain medication with parameters have the potential to be affected. An as needed pain medication audit was completed to ensure that residents on pain medications with parameters had documentation with sequencing related to pain level. No other residents were affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Director or Nursing or Designee re-educated licensed nursing staff on pain – clinical protocols. Education included sequencing for milder, moderate and severe pai levels and medicating within the pain parameter. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Unit Manager or Designee will select 15 residents receiving opioid PRN medication and audit the Electronic Medical Record to ensure medication was administered as per parameters daily x5 days, weekly x4 weeks and then monthly x2 months. Results of these audits will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee	

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F0697 SS = D	Continued from page 7 A review of the Medication Administration Record (MAR) indicated that Resident #7 received 92 doses of NJ Ex Order 26.4(b)(1) in the month of NJ Ex O Nine of the doses were given outside of the NJ Ex O parameter as ordered by the physician. NJ Ex Order 26.4(b)(1) level NJ Ex O NJ Ex Order 26.4(b)(1) level NJ Ex NJ Ex Order 26.4(b)(1) level NJ Ex NJ Ex Order 26.4(b)(1) level NJ Ex Ord NJ Ex Order 26.4(b)(1) level NJ Ex Ord NJ Ex Order 26.4(b)(1) level NJ Ex NJ Ex Order 26.4(b)(1) level NJ Ex Ord NJ Ex Order 26.4(b)(1) level NJ Ex NJ Ex Order 26.4(b)(1) level NJ Ex On 07/30/2025 at 11:13 AM, the surveyor interviewed the resident regarding NJ Ex Ord Resident #7 told surveyor they NJ Ex Order 26.4(b)(1) and required NJ Ex Order 26 The resident stated they were receiving NJ Ex O medication with NJ Ex Ord 2. 7/31/25 at 10:15 AM, Resident #49 was in bed with eyes closed, the resident NJ Exec Order 26.4b1 at the time of the observation. The surveyor reviewed the medical record for Resident #49. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1). A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 26, section NJ for NJ Ex Order 26.4(b)(1) revealed the resident had a Brief Interview of Mental Status of NJ Ex meaning the resident was NJ Ex Order 26.4(b)(Section N of the MDS NJ Ex Order 26.4(b)(1) indicated the resident was receiving a NJ Ex O management regime. The NJ Ex O assessment indicated NJ Ex O was present and occasionally affected NJ Ex Ord and day to day activities.	F0697	Continued from page 7 will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director, and infection Preventionist as well as other interdisciplinary members.	

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F0697 SS = D	Continued from page 8 A review of the physician orders showed the following orders related to NJ Ex O management. NJ Ex Order 26.4(b)(1) one tablet every 12 hours and NJ Ex Order 26.4(b)(1) every four hours as needed for NJ Ex Order 26.4(b)(1) scale). A review of Resident #49 individualized comprehensive care plan (ICCP) included a focus area of NJ Ex O and/or potential for NJ Ex O related to NJ Ex Order 26, NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Interventions included administering NJ Ex O medication as ordered by the physician and evaluate the effectiveness of the pain management and notify physician if interventions are unsuccessful. A review of the Medication Administration Record (MAR) indicated that Resident #49 received 93 doses of NJ Ex Order 26.4(b)(1) in the month of NJ Ex O Twelve of the doses were given outside of the NJ Ex O parameter as ordered by the physician. NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) level NJ NJ Ex Order 26.4(b)(1) n level NJ NJ Ex ONJ Ex Order 26.4(b)(1) On 7/31/25 at 11:25 AM, the surveyor interviewed the NJ Ex Order 26.4(b)(1) regarding p NJ Ex medication and NJ Ex O scales. The NJ Ex O told the surveyor the numeric NJ Ex O scale was 1 to 3 for U.S. FOIA (b) (6), 4 to 7 for U.S. FOIA (b) (6), and 8 to 10 for U.S. FOIA (b) (6). The surveyor asked what if a resident had NJ Ex O outside of the parameters that a physician ordered and the U.S. FOI stated she would have to call the physician to have either a onetime dose of a medication or an order for a	F0697		

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(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0697 SS = D	Continued from page 9 medication for a [redacted]. On 8/5/25 at 9:15 AM, the surveyor reviewed the policy titled, “Pain-Clinical Protocol”. The policy had a revision date of 4/2025. Under the section Treatment and Management, the policy read that the lowest possible effective dose was prescribed for the shortest time possible with ongoing staff monitoring for effectiveness. NJAC 8:39-27.1 (a)	F0697		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 7/25/2025 from 09:49 AM to 10:14 AM the surveyor accompanied by the [redacted]),	F0812	F 812 (E) Food Procurement, Store/prepare/Serve-Sanitary How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. Food items identified as expired were immediately discarded. Dry goods removed from the original packaging and open to air were immediately discarded. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center who receive nutritional support from Dietary Services have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Dietary Director or Designee re-educated dietary staff on food and dry goods receiving, storing, dating and labeling. Director of Nursing or Designee re-educated Nursing Staff on unit pantries related to refrigerators and freezers and receiving and storage.	08/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315201	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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F0812 SS = E	Continued from page 10 observed the following in the kitchen: 1. In the walk-in freezer a frozen lasagna was wrapped in plastic wrap with a use by date of 7/25/25. When asked if lasagna should be used, the U.S. FOI replied “No, I’m going to take it out right now.” The expired food was removed by U.S. FOIA 2. In the walk-in refrigerator a container of chicken noodle soup wrapped in plastic wrap with a use by date of 7/28/25. The expired food was removed by U.S. FOIA On 7/30/2025 at 10:36 AM on the Strawbridge unit in the pantry 11 plastic cups labeled for “7/30 7-3” were seen stacked facing up and exposed to the air. Licensed Practical Nurse, (LPN) #1 accompanied surveyor to the Strawbridge unit pantry to ask about the cups. LPN #1 said she did not know what the cups were for and “they shouldn’t be out, they should be in a container” for infection control reasons. LPN #1 discarded the cups which were left open to air in unsanitary manner. On 7/31/2025 at 09:51 AM on the Laurel Creek unit in the panty a sleeve of plastic cups were seen laying on their side open to air and one cup in the cabinet facing upward open to air in an unsanitary manner. On 8/01/2025 at 12:17 PM The surveyor interviewed U.S. FOIA (b) (6)) who said “Cups should be contained in a sleeve when not in use…to prevent any food-born illness.” The surveyor asked if outdated food should be in the refrigerator or freezer and the U.S. FOIA (replied “No” and the importance is “To prevent food born illness.” A review of an undated facility policy titled “Refrigerators and Freezers”, revealed under “Policy Interpretation and Implementation” that “7. All food is appropriately dated to ensure proper rotation by expiration dates.” The policy further reveals “9. Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers, are not past “use by” or expiration dates. N.J.A.C. 8:39-17.2(g)	F0812	Continued from page 10 Bins are provided for use in pantries for storage when items are removed from original packaging, such as plastic cups. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Dietary Services Director/Designee will inspect kitchen operations daily x5 days, weekly x4 weeks, then monthly x2 months to ensure proper food receiving and storage. Results of these audits will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Unit Managers/Designee will inspect pantries daily x5 days, weekly x4 weeks, then monthly x2 months to ensure proper food receiving and storage. Results of these audits will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director, and infection Preventionist as well as other interdisciplinary members.	
F0813 SS = E	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F0813	F 0813 (E) Personal Food Policy How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD.	08/25/2025

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F0813 SS = E	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, the facility failed to ensure that food brought to residents by family and other visitors were stored, handled, and consumed in a safe and sanitary manner. This deficient practice was identified for 4 of 6 residents (Resident # 9, Resident # 13, Resident # 26 and Resident # 51) who had personal refrigerators in their bedrooms. The deficient practice was evidenced by the following: On 07/31/2025 at 10:23 AM, the surveyor observed that Resident # 26's personal refrigerator, located in room NJ Ex Order 2 temperature log had not been filled out since NJ Ex Order 26.4(b On 07/31/2025 at 10:24AM, the surveyor observed that Resident # 9's personal refrigerator, located in room NJ Ex Order 2, was missing temperature log entries for the whole month of NJ Ex Or On 07/31/2025 at 10:42 AM, the surveyor observed that Resident #51's personal refrigerator, located in room NJ Ex Order 2 had no temperature log was on the refrigerator for the month of NJ Ex Or On 07/31/2025 at 10:35 AM the surveyor observed that Resident # 13's personal refrigerator, located in room NJ Ex Order 2 temperature log had not been filled out since NJ Ex Order 26.4(b 07/31/2025 at 10:44 AM, during an interview with the surveyor, the U.S. FOIA (b) (6)) said that nursing staff was responsible for cleaning, checking and documenting the personal refrigerators in residents' rooms. The U.S. F was unsure how often the temperatures needed to be check and said the 11-7 shift was responsible to that. 07/31/2025 at 12:14 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) said personal refrigerator temperatures should be checked daily to prevent food born illnesses. A review of the facility's dated policy September 2022, titled, "Refrigerators and Freezers-Resident Personal", revealed, "Designated employees will check and record refrigerator and freezer temperatures daily." NJAC 8:39-17.2(g)	F0813	Continued from page 11 Resident #26 refrigerator temperature was obtained and recorded on the log and the log is current. Refrigerator content was inspected and unlabeled/outdated food was immediately discarded. Resident #9 refrigerator temperature log was replaced. Refrigerator temperature was obtained and recorded on the log and the log is current. Refrigerator content was inspected and unlabeled/outdated food was immediately discarded. Resident #51 refrigerator temperature log was replaced. Refrigerator temperature was obtained and recorded on the log and the log is current. Refrigerator content was inspected and unlabeled/outdated food was immediately discarded. Resident #13 refrigerator temperature was obtained and recorded on the log and the log is current. Refrigerator content was inspected and unlabeled/outdated food was immediately discarded. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center who have personal refrigerators located in their rooms have the potential to be affected. An audit was completed of all residents who have a personal refrigerator in their rooms. No other residents were affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Director of Nursing or Designee re-educated staff on safe use of personal refrigerator and freezers for resident personal use including maintenance, temperatures and sanitation. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the	

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F0813 SS = E		F0813	Continued from page 12 systemic change? The Unit Managers/Designee will inspect 5 resident rooms with resident personal refrigerators daily x5 days, weekly x4 weeks, then monthly x2 months to ensure safe refrigerator and freezer maintenance, temperatures and sanitation. Results of these audits will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director, and infection Preventionist as well as other interdisciplinary members.	
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Complaint # NJ00172812 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide access to the call system while a resident was in bed. The deficient practice was identified for 2 of 8 residents investigated under the Environment Task. (Resident # 2 and Resident # 77) On 07/29/2025 at 10:29 AM, during the initial tour of the facility, the surveyor observed Resident # 2 asleep in bed. At that time, the surveyor observed the handheld call device on the floor adjacent to the bed.	F0919	F 0919 (D) Resident Call System How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. Resident #2 call bell was placed within reach and secured by clip to provide access to call system. Resident #77 call bell was placed within reach and secured by clip to provide access to call system. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Director of Nursing or Designee re-educated staff on ensuring that residents have access to the call bell system while in bed.	08/25/2025

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F0919 SS = D	Continued from page 13 On the same date at 10:37 AM, the surveyor observed Resident # 77 awake in bed. At that time, the surveyor observed the handheld call device on the floor adjacent to the bed. On 07/30/2025 at 10:29 AM, the surveyor observed Resident # 77 wake in bed. At that time, the surveyor observed the handheld call device on the floor adjacent to the bed. On 07/31/2025 at 09:40 AM, the surveyor observed Resident # 2 asleep in bed. At that time, the surveyor observed the handheld call device on the floor adjacent to the bed. On the same date at 09:42 AM, the surveyor observed Resident # 77 wake in bed. At that time, the surveyor observed the handheld call device on the floor adjacent to the bed. On 07/31/2025 at 09:43 AM, during an interview with the surveyor, the Certified nursing assistant (CNA) # 1 said that when residents are in bed the handheld call device should be attached to their sheet within their reach. On 08/01/2025 at 09:58 AM, during an interview with the surveyor, the Registered Nurse Unit Manager (RNUM) #1 said that the handheld call system should be clipped to the resident's blanket and within reach when residents are in their bed. The RNUM #1 replied, "no" when asked if the handheld call device should be on the floor. On 08/01/2025 at 01:01 PM, during an interview with the surveyor, the U.S. FOIA (b) (6)) replied, "No" when asked if the handheld call device should be on the floor when residents are in bed. A review of the facility policy titled, "Answering the Call Light" dated April 2016 revealed under "General Guidelines" number 5., "When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident." N.J.A.C. § 8:39-31.8	F0919	Continued from page 13 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Unit Manager or Designee will audit 5 residents on each unit daily x5 days, weekly x4 weeks and then monthly x2 months for access to call bells. Results will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing and Medical Director, as well as other interdisciplinary members.	

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030305	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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S0000	Initial Comments The facility was not in compliance with 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 the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S0000		08/25/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: NJ#00172812, 00185216, Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 29 of 70 day shifts reviewed and 2 of 70 evening shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift.	S0560	S 0560 Mandatory Access to Care How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. No residents were found to be affected by the center not maintaining the required minimum direct care staff-to-resident ratios as mandated by the state of NJ. The facility leadership team has met on ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified staffing needs How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.	08/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S0560	Continued from page 1 One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 04/07/2024 to 04/13/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -04/07/24 had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs. -04/08/24 had 13 CNAs for 152 residents on the day shift, required at least 19 CNAs. -04/09/24 had 14 CNAs for 152 residents on the day shift, required at least 19 CNAs. -04/10/24 had 16 CNAs for 152 residents on the day shift, required at least 19 CNAs. -04/12/24 had 14 CNAs for 152 residents on the day shift, required at least 19 CNAs. -04/13/24 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs. 2. For the 3 weeks of Complaint staffing from 01/26/2025 to 02/15/2025, the facility was deficient in CNA staffing for residents on 10 of 21 day shifts, was deficient in CNAs to total staff on 1 of 21 evening shifts, and was deficient in total staff for residents on 1 of 21 evening shifts as follows: -01/26/25 had 15 CNAs for 156 residents on the day shift, required at least 19 CNAs. -01/27/25 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/27/25 had 7 CNAs for 16 total staff on the evening shift, required at least 8 CNAs. -01/28/25 had 18 CNAs for 155 residents on the day shift, required at least 19 CNAs. -02/01/25 had 14 CNAs for 156 residents on the day	S0560	Continued from page 1 Market rate analysis for nursing and certified nursing assistants completed. Daily center staffing meetings with leadership team. Weekly labor management reviews with regional leadership team. Reviewed and revised our mentor program to support retention and growth. Reviewed and revised incentive programs to include sign-on bonuses for new hires, referral bonuses for employees referring staff where appropriate, no call out incentives and X-Shift pick-up bonuses to fill shift vacancies/needs. Ongoing job fairs, open interview days with immediate interviews and contingency offers. Expedited and robust onboarding process for new hires. Ongoing partnership with LPN school and CNA School. Utilization of social media and employment sites to support recruitment efforts. Utilization of retention platform for employee retention purposes. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Director of Nursing or Designee will meet with staffing coordinator to review daily census, call outs and staffing needs if any.	

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S0560	Continued from page 2 shift, required at least 19 CNAs. -02/02/25 had 18 CNAs for 156 residents on the day shift, required at least 19 CNAs. -02/05/25 had 17 CNAs for 156 residents on the day shift, required at least 19 CNAs. -02/07/25 had 19 CNAs for 161 residents on the day shift, required at least 20 CNAs. -02/08/25 had 17 CNAs for 160 residents on the day shift, required at least 20 CNAs. -02/10/25 had 18 CNAs for 160 residents on the day shift, required at least 20 CNAs. -02/14/25 had 15 total staff for 162 residents on the evening shift, required at least 16 total staff. -02/15/25 had 17 CNAs for 162 residents on the day shift, required at least 20 CNAs. 3. For the week of Complaint staffing from 03/02/2025 to 03/08/2025, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -03/02/25 had 16 CNAs for 155 residents on the day shift, required at least 19 CNAs. -03/07/25 had 18 CNAs for 153 residents on the day shift, required at least 19 CNAs. -03/08/25 had 18 CNAs for 153 residents on the day shift, required at least 19 CNAs. 4. For the 2 weeks of Complaint staffing from 03/30/2025 to 04/12/2025, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -03/30/25 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs. -03/30/25 had 14 total staff for 151 residents on the evening shift, required at least 15 total staff. -03/31/25 had 18 CNAs for 151 residents on the day shift, required at least 19 CNAs. -04/05/25 had 18 CNAs for 151 residents on the day shift, required at least 19 CNAs.	S0560	Continued from page 2 The Director of Nursing or Designee will monitor census, call outs and staffing ratios weekly until the staffing ratio requirement is met. The results of the audits will be forwarded to the Administrator and presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing and Medical Director, as well as other interdisciplinary members.	

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S0560	Continued from page 3 -04/06/25 had 17 CNAs for 151 residents on the day shift, required at least 19 CNAs. -04/12/25 had 16 CNAs for 148 residents on the day shift, required at least 18 CNAs. 5. For the week of Complaint staffing from 04/27/2025 to 05/03/2025, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -04/27/25 had 17 CNAs for 156 residents on the day shift, required at least 19 CNAs. -05/02/25 had 16 CNAs for 153 residents on the day shift, required at least 19 CNAs. -05/03/25 had 15 CNAs for 153 residents on the day shift, required at least 19 CNAs. 6. For the 2 weeks of staffing prior to survey, from 07/13/2025 to 07/26/2025, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -07/21/25 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. -07/23/25 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 08/01/25 at 12:35 PM, the surveyor interviewed the facility Staffing Coordinator (SC) The SC was able to recite the state regulations to the surveyor and stated that the facility met standards "A lot of days, getting better and better". The SC said the schedule was completed monthly and if days are short, she uses a “call” list and then calls the “pier diem” staff. If still short, she would reach out to the Director of Nursing. On 08/05/25 at 10:30 AM, the surveyor reviewed the policy titled, “Staffing, Sufficient and Competent Nursing”. The policy had a revision date of 04/2025. The policy read that the facility provided sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Number 8 under the Sufficient Staffing stated that the minimum staffing requirements imposed by the state, if applicable are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing.	S0560		
S2120	Mandatory Physical Environment	S2120	S 2120 Mandatory Physical Environment	08/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030305	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	255 EAST MAIN ST , MOORESTOWN, New Jersey, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S2120	Continued from page 4 CFR(s): 8:39-31.1(c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, PO Box 809, Trenton, New Jersey 08625-0809. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview on 7/29/25 in the presence of the Director of Maintenance (DM), it was determined the facility failed to ensure carbon monoxide detection was installed in the immediate vicinity of all sources of carbon monoxide in accordance with NJAC 5:70. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:18 AM of the basement boiler room revealed 2 fuel fired hot water heaters and 2 fuel fired hot water storage tanks. The rooms and adjoining corridors were not provided with Carbon Monoxide (CO) detection. Observations at 10:54 AM of the laundry room and surrounding area revealed there were fuel fired commercial dryers and there was no CO detection. Observations at 11:25 AM of the main service area boiler room by laundry revealed 6 fuel fired hot water heaters and 2 fuel fired boilers. There was also a room within the boiler room that had the main diesel fueled generator and there was no CO detection in the rooms or adjoining corridors and other adjacent rooms. In interviews at the times the DM confirmed the observations. The facility's Administrator, DM and Regional Director of Plant Operations were made aware of the deficient practice at the Life Safety Code exit conference on 7/31/25 at 3:11 PM.	S2120	Continued from page 4 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. No residents were affected by the center not having CO detectors in the vicinity of all sources of carbon monoxide. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Sr. Maintenance Director will re-educate maintenance staff on ensuring carbon monoxide detection is installed in the immediate vicinity of all sources of carbon monoxide. CO detectors were installed at locations of gas burning equipment and in the vicinity. A CO detector was installed in the basement boiler room, laundry room and surrounding area, main service area boiler room, generator room, dryer room and kitchen vicinities. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Maintenance Director or Designee will audit weekly areas within the center for CO detection in areas where sources of CO exist. These weekly audits will continue x4 weeks and then monthly x2 months. Results will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030305	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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S2120		S2120	Continued from page 5 The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Infection Preventionist and Medical Director, as well as other interdisciplinary members.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315201	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/10/2025 in relation to the 8/5/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030305	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/10/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/10/2025 in relation to the 8/5/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315201	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 7/29/25, 7/30/25 and 7/31/25, Cambridge Rehabilitation and Healthcare Center was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Cambridge is a 2-story building that was built in 80's. It is composed of Type II unprotected construction. The facility is divided into 8-smoke zones.	K0000		08/25/2025
K0271 SS = E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 7/29/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure abrupt changes in walking surfaces in the means of egress did not exceed 1/4-inch in accordance with NFPA 101: 2012 Edition, Section 7.1, 7.1.6.2 and 7.1.10. This deficient practice had the potential to affect 22 of 144 residents and was evidenced by the following: An observation at 2:46 PM of the Laurel Creek end of corridor exterior exit discharge revealed there was a concrete ramp leading to the public way. There was a	K0271	K 0271 (E) Discharge From Exits How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. No residents were affected by the abrupt changes in walking surface in the means of egress. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing on the Laurel Creek unit have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The abrupt changes (separation) in the walking surface in the means of egress off Laurel Creek Unit was repaired and sealed to level the path of egress in	08/25/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315201	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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K0271 SS = E	Continued from page 1 crack in the concrete separating the concrete slab in half where the second side of the slab was raised 1-1/2 inches to 2-inches across the width of the slab in the path of egress. In an interview at the time the U.S. FO and the U.S. FOIA (b confirmed the observation. The facility's U.S. FOIA (b) (6) U.S. FO and U.S. FOIA (b were informed of the deficient practice at the Life Safety Code exit conference on 7/31/25 at 3:11 PM. N.J.A.C 8:39 - 31.2 (e)	K0271	Continued from page 1 accordance with NFPA 101, 7.1.7. All exits, as paths of egress, were inspected for level walking surfaces and free of obstructions. Sr. Maintenance Director will re-educate Maintenance staff on ensuring exits, as paths of egress, shall have level walking surfaces and shall be maintained free of obstructions. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Maintenance Director or Designee will audit weekly exits, paths of egress, to ensure they are level walking surfaces and free of obstructions. These weekly audits will continue x4 weeks and then monthly x2 months. Results will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director and Infection Preventionist, as well as other interdisciplinary members. Completion Date: 08/25/25	
K0321 SS = F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and	K0321	K 0321 (F) Hazardous Areas - Enclosure How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. No residents were affected by the hazardous area doors not automatically closing and/or closing fully. How the facility will identify other residents having	08/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315201	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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K0321 SS = F	Continued from page 2 permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 7/29/25 in the presence of the U.S. FOIA (b) (6)), it was determined the facility failed to ensure hazardous area doors were self-closing or automatic closing in accordance with NFPA 101: 2012 Edition, Section 19.3.2.1.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:05 AM of the basement storage room revealed there were 2 sets of corridor doors to the hazardous area, a double door and a single door. The storage area contained combustible maintenance supplies and a paint shop and was greater than 50 square feet. The double doors had a left leaf without a self-closing device that was in the open position and the right leaf that had a self-closing device was propped open. The single door did not shut all the way on its own when tested from the fully open position.	K0321	Continued from page 2 the potential to be affected by the same deficient practice. Residents residing in the center have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The basement storage room with two sets of corridor doors were repaired to include self-closing or automatic closing devices in accordance with NFPA 101. These doors now fully close when tested. The laundry room with 2 sets of doors to the exit corridor were repaired to include self-closing or automatic closing devices in accordance with NFPA 101. These doors now fully close when tested. The boiler room double doors were repaired to include self-closing or automatic closing devices in accordance with NFPA 101. These doors now fully close when tested. The Activities storage room was repaired to include a self-closing or automatic closing device in accordance with NFPA 101. This door now fully closes when tested. All hazardous area doors were inspected for self-closing or automatic closing devices. All self-closing or automatic closing doors were tested for unobstructed, full closure. Sr. Maintenance Director will re-educate Maintenance staff on ensuring that hazardous area doors have self-closing or automatic closing devices and fully close when tested. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?	

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K0321 SS = F	Continued from page 3 An observation at 10:54 AM of the laundry room area revealed the laundry had 2 sets of doors to the exit corridor. The laundry was greater than 100 square feet. The first laundry door did not close all the way into its frame when tested from the fully open position. It stopped before the door frame. The second laundry door (across from the boiler room) did not shut all the way into its frame when released from its hold open device. The door bounced off the frame and stayed open. An observation at 11:29 AM of the boiler room double doors revealed the doors did not close all the way into the door frame when tested. The left leaf hit the right leaf on its edge and stopped. An observation at 11:47 AM of the Activities storage room #1 revealed the door did not close into its frame when tested. The door hit the door frame and stopped. The room contained combustible storage. In interviews at the times, the [redacted] confirmed the observations. The facility's [redacted] and [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 7/31/25 at 3:11 PM. N.J.A.C. 8:39 - 31.2 (e)	K0321	Continued from page 3 The Maintenance Director or Designee will audit weekly hazardous area doors, to ensure self-closing or automatic closing devices are intact and doors are fully closing when tested. These weekly audits will continue x4 weeks and then monthly x2 months. Results will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director and Infection Preventionist, as well as other interdisciplinary members.	
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or	K0324	K 0324 (F) Cooking Facilities How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. No residents were affected by the delay in the inspection of the fire suppression system or recording of the same. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center have the potential to	08/13/2025

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K0324 SS = F	Continued from page 4 fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 7/29/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) , it was determined the facility failed to ensure the kitchen wet chemical fire suppression system monthly owners inspection was performed and recorded in accordance with NFPA 17A: 2009 Edition, Section 7.2, 7.2.1 through 7.2.6. This deficient practice had the potential to affect 144 residents and was evidenced by the following: An observation of the kitchen at 10:44 AM revealed the kitchen range hood was equipped with a wet chemical fire suppression system. A record review at the time revealed the suppression system had its last semi-annual inspection during December of 2024. The inspection tags on the cylinder box and on the pull station had blank rows on the back of the tag in the monthly inspection recording locations and no further documentation was provided that a monthly inspection was performed. In an interview at the time, the U.S. FO confirmed the observation and record review and stated the facility did not do a monthly owners inspection. The facility's U.S. FOIA (b) (6) U.S. FO and U.S. FOIA (b were informed of the deficient practice at the Life Safety Code exit conference on 7/31/25 at 3:11 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 96	K0324	Continued from page 4 be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The semi-annual inspection was added to the service contract to be performed by a licensed contractor as now scheduled for February 2026. The annual inspection was scheduled and conducted 08/19 – 21/2025 by a licensed contractor. The kitchen wet chemical fire suppression system was inspected and performed in accordance with NFPA 17A: 2009 Edition, Section 7.2, 7.2.1 through 7.2.6. The inspection tag on the cylinder box and on the pull station were updated with the monthly inspection performance recorded. The cylinder box and the pull station were added to the monthly fire extinguisher audit. Sr. Director of Maintenance will re-educate Maintenance staff on ensuring monthly inspections are performed and recorded on inspection tags. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Maintenance Director or Designee will audit weekly 10 inspection tags to ensure equipment was inspected and performance recorded. These weekly audits will continue x4 weeks and then monthly x2 months and monthly thereafter. Results will be presented to the Quality Assurance Performance Improvement team monthly for continued review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement	

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K0324 SS = F		K0324	Continued from page 5 committee consists of the Administrator, Director of Nursing, Medical Director and Infection Preventionist, as well as other interdisciplinary members.	
K0341 SS = F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 7/29/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure the unsupervised Fire Alarm Control Unit (FACU) was smoke detector protected in accordance with NFPA 72: 2010 Edition, Section 10.15. This deficient practice had the potential to affect 144 residents and was evidenced by the following: An observation at 1:01 PM of the main fire alarm panel room revealed that the room was not a continuously attended location and there was no smoke detector provided to protect the fire alarm panel. There was no environmental condition present at the location that would prevent or hinder a smoke detector from operating properly. In an interview at the time, the U.S. FO and the U.S. FOIA (b) confirmed the observation. The facility's U.S. FOIA (b) (6) U.S. FO and U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 7/31/25 at 3:11 PM.	K0341	"Past Noncompliance - no plan of correction required"	08/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315201	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	255 EAST MAIN ST , MOORESTOWN, New Jersey, 08057

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K0341 SS = F	Continued from page 6 N.J.A.C. 8:39 - 31.2 (e) NFPA 72	K0341		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 7/30/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure the fire alarm system was tested semi-annually in accordance with NFPA 72: 2010 Edition, Section 14.4.2, 14.3.1 and 14.4.5. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the fire alarm system inspection reports revealed there was no semi-annual inspection performed since the last annual inspection on 5/31/24 and there is no record of battery tests being performed for visual inspection, battery replacement, charger test, discharge test, and load voltage test, on the fire alarm system backup power batteries. In an interview at the time, the U.S. FO and U.S. FOIA (b confirmed the record review. The facility's U.S. FOIA (b) (6) U.S. FO and U.S. FOIA (b were informed of the deficient practice at the Life Safety Code Exit Conference on 7/31/25 and 3:11 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 72	K0345	K 0345 (F) Fire Alarm System – Testing and Maintenance How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. No residents were affected by the fire-alarm system not being tested on a semi-annually. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Monthly checks of the fire alarm panel will be conducted by the Maintenance Director. The semi-annual inspection was added to the service contract and is scheduled for February 2026 to be performed by a licensed contractor. The annual inspection and testing are scheduled for 08/19 – 21/2025 to be performed by a licensed contractor. Inspections will be scheduled annually and semi-annually. Sr. Director of Maintenance re-educated Maintenance staff on ensuring annual and semi-annual inspections are performed and documentation recorded timely.	08/25/2025

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K0345 SS = F		K0345	Continued from page 7 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Maintenance Director or Designee will review the vendor provided inspection reports to ensure equipment was inspected and performance is recorded and is operational. The Maintenance Director will ensure paperwork is recorded properly and in the Life Safety binder monthly x12 months. The results will be presented to the Quality Assurance Performance Improvement team for review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director and Infection Preventionist, as well as other interdisciplinary members.	
K0351 SS = F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by:	K0351	"Past Noncompliance - no plan of correction required"	09/19/2025

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K0351 SS = F	Continued from page 8 Based on observations and interview on 7/29/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure fire sprinkler protection was installed throughout the facility in accordance with NFPA 101: 2012 Edition, Section 19.3.5.1, 9.7 and NFPA 13: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:38 AM of the A Hall stairwell section connecting Stanwick unit to the basement, revealed there was no sprinkler coverage on the top, middle or bottom landing in the stairwell. In an interview at the time, the U.S. FO confirmed the observation. In an interview at 1:41 PM, the U.S. FOIA (b confirmed the observation. An observation at 1:41 PM of the A Hall stairwell section connecting Hartford unit with the Stanwick unit, revealed the first accessible landing (middle landing) was not provided with sprinkler coverage. The stairwell is a closed stairwell with sheetrock walls bordering both sides of the 44-inch-wide stairwell in the path of egress from landing to landing. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the observation. This deficient practice was cited at a previous standard survey on 9/15/21. The A Hall stairwell runs from the upper floor (Hartford) to the floor below (Stanwick) where it exits outside at ground level. The landing at the Stanwick level is divided by a door that proceeds to the basement level. The facility's U.S. FOIA (b) (6) U.S. FO and U.S. FOIA (b were informed of the deficient practice at the Life safety Code exit conference on 7/31/25 at 3:11 PM.	K0351		

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K0351 SS = F	Continued from page 9 N.J.A.C. 8:39-31.1(c), 31.2 (e) NFPA 13	K0351		
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on observation, record review and interviews on 7/31/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined the facility failed to ensure fire drills were conducted quarterly on each shift in accordance with NFPA 101: 2012 Edition, Section 19.7 and 19.1.1.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 1:30 PM revealed the Assisted Living (AL) occupancy building is separated from the Long-Term Care (LTC), Nursing Home occupancy building by 2-hour fire wall and 1.5-hour fire rated doors at the corridor going to AL off the main LTC lobby. A record review of the monthly fire drill records for the last 12 months revealed 6 of the last 12 drills were not conducted in the LTC facility. The drills for 7/8/24, 8/1/24, 9/14/24, 3/31/25, 5/29/25 and 6/30/25 were conducted in the AL facility. In an interview at 3:05 PM, the U.S. FO stated he alternates the drills between the AL and LTC for the different months. In an interview at 3:07 PM, the U.S. FOIA (b) (6) and the	K0712	K 0712 (F) Fire Drills How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. No residents were affected by the fire drills not being conducted quarterly on each shift in accordance with NFPA 101: 2012 Edition, Section 19.7 and 19.1.1.1. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Fire drills will be scheduled monthly and conducted quarterly, one on each shift in the SNF in accordance with the NFPA requirements. Sr. Director of Maintenance re-educated Maintenance Staff on the NFPA 101 requirements for conducting fire drills to standard. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Maintenance Director or Designee will review the fire drill documentation monthly x12 months to ensure standards are met and recorded in accordance with the standing regulations. The results will be presented to the Quality Assurance Performance Improvement team for	08/08/2025

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K0712 SS = F	Continued from page 10 U.S. FOIA (b) stated that they do the monthly drills for the entire complex at the same time. The U.S. FOIA (b) (6) U.S. FO and U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference at 3:11 PM. N.J.A.C. 8:39-31.2(e), 31.6 (b)	K0712	Continued from page 10 review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director and Infection Preventionist, as well as other interdisciplinary members.	
K0911 SS = F Bldg. 01	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 7/29/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure Emergency Power Supply (EPS) equipment locations was provided with battery power emergency lighting in accordance with NFPA 110: 2010 Edition, Section 7.3.1. This deficient practice had the potential to affect 144 residents and was evidenced by the following: An observation at 2:10 PM of the basement electric fire pump room revealed the transfer switch that controlled emergency power from generator number 2 to the electric fire pump was not provided with battery powered emergency lighting. In an interview at the time, the U.S. FO and the U.S. FOIA (b) confirmed the observation. The facility's U.S. FOIA (b) (6) U.S. FO and U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 7/31/25 at 3:11 PM.	K0911	K 0911 (F) Electrical Systems - Other How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the SOD. No residents were affected by the basement electric fire pump room not supplying battery powered emergency lighting. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents residing in the center have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Battery powered emergency lighting was installed in the basement electric fire pump room where the transfer switch that controls emergency power from generator #2 to the electric fire pump. This location will be added to the auditing of testing and performance recording of emergency powered emergency lighting. Sr. Maintenance Director re-educated Maintenance Staff on the NFPA 110: 2010 Edition, Section 7.3.1.	08/08/2025

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K0911 SS = F Bldg. 01	Continued from page 11 N.J.A.C. 8:39 - 31.2 (e) NFPA 99, 110	K0911	Continued from page 11 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Maintenance Director or Designee will audit weekly x4 weeks, then monthly thereafter the testing and performance documentation to ensure standards are met and recorded in accordance with the standing regulations. The results will be presented to the Quality Assurance Performance Improvement team for review and recommendations until compliance is maintained. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. The Quality Assurance Performance Improvement committee consists of the Administrator, Director of Nursing, Medical Director and Infection Preventionist, as well as other interdisciplinary members.	

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E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 7/29/25, 7/30/25 and 7/31/25. Cambridge Rehabilitation and Healthcare Center was found to be in substantial compliance with CFR 483.73, Requirements for Long Term Care Facilities.	E0000		08/25/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315201	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/14/2025

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K0000 Bldg. 01	INITIAL COMMENTS An onsite revisit was conducted on 11/14/2025 to verify the facility's Plan of Correction in relation to the 8/5/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE