

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315060		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/30/2026	
NAME OF PROVIDER OR SUPPLIER ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 220 ST MARY'S DRIVE , CHERRY HILL, New Jersey, 08003			
(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 NJ Complaint # 2595944, 2600066, 2621311, 2678692, 2733795 Survey date:4/23/26-4/30/26 Census:204 Sample size: 35+ 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			05/27/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable			F0657	Plan of Correction F0657 Completion Date: 5/27/2026 Corrective Action: Hospital Discharge Summary, Physician Orders, and Care Plan reviewed for Resident # 232. No order for NJ Ex Order 26, 4B1 was identified. Care Plan for NJ Ex Order 26, 4B1 identified. Confirmed with U.S. FOIA (b) (2) for Resident #232 that NJ Ex Order 26, 4B1 is no longer needed. Care Plan for NJ Ex Order 26, 4B1 resolved. ID Other Residents: Potential to affect any resident who is admitted or re-admitted within last 30 days were reviewed by U.S. FOIA. If any concerns were identified, the concern was addressed with provider.		05/27/2026

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
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F0657 SS = D	Continued from page 1 for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to revise a care plan when there was a change in the physician's orders for NJ Ex Order 26, 4B1 for 1 of 3 residents sampled for NJ Ex Order 26, 4B1, (Resident #232). This deficient practice was evidenced by the following: During the initial tour on 04/23/2026 at 11:47 AM, the surveyor observed Resident #232 resting in bed. A review of the Admission Record revealed Resident #232 was admitted to the facility with diagnoses including, but not limited to, NJ Ex Order 26, 4B1. A review of Resident #232's electronic medical record (EMR) revealed the resident was on NJ Ex Order 26, 4B1. Resident #232 was readmitted on NJ Ex Order 26, 4B1, and per the discharge summary, there were no NJ Ex Order 26, 4B1. A review of Resident #232's care plan revealed a focus for NJ Ex Order 26, 4B1 related to NJ Ex Order 26, 4B1 initiated on NJ Ex Order 26, 4B1. No revision was made to the care plan when Resident #232 was readmitted. During an interview on 04/29/2026 at 09:58 AM with the surveyor, the U. S. FOIA (b) (2) on the NJ Ex Order 26, 4B1 unit said that care plans are reviewed every three months and as needed if changes occur. When asked if Resident #232's care plan should have been updated, the U. S. FOIA (b) (2) replied, "Yes." During an interview on 04/29/2026 at 1:18 PM with the surveyor, the U. S. FOIA (b) (2) said care plans are updated quarterly or during audits, and	F0657	Continued from page 1 Systemic Change: Hospital Discharge Summary reviews post admission and re-admission and compared to physician orders to ensure accuracy. Care plan reviews post admission and re-admission and compared to physician orders to ensure they are accurate and comprehensive. The Nurse Educator or Designee will In-service to Licensed Nurses on "Confirming Admission and Re-admission Orders with Attending Physicians" The Nurse Educator will In-service to Licensed Nurse Managers on "Creating and Reviewing Comprehensive Care Plans for Admissions and Re-Admissions" The Nurse Educator will In-service to Licensed Nurse Managers on "Revising Care Plans When There is a Change in Physician Orders" Monitoring: Audits- "Post Admission/Re-admission Physician Order and Care Plan Review" will be conducted (every admission, re-admission) by the DON x 2 weeks then (10) monthly x 2 months. Results of the audits will be brought to QA/QAPI on a quarterly basis x 2 quarters.	05/27/2026

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F0657 SS = D	Continued from page 2 should be updated upon readmission as orders and care can change. A review of a facility-provided policy titled "Resident Evaluation/Assessment" revealed, under "Monitoring results and adjusting interventions," the following requirement: "Periodically reviewing progress and adjusting treatments based on provider orders/guidance." NJAC 8:39-11.2(i)	F0657		05/27/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure an environment was free from accident hazards by failing to place assistive devices, specifically [REDACTED] NJ Ex Order 26, 4B1, to prevent avoidable accidents for 2 or 2 residents (Resident #43 and #147) investigated for Accidents. The deficient practice was evidenced by the following: 1) On 04/23/2026 at 10:28 AM, during the initial tour of the facility, the surveyor observed Resident # 147 in their room in bed. The surveyor observed one [REDACTED] NJ Ex Order 26, 4B1 on its side leaning against the wall on the far side of the room. On 04/24/2026 at 09:42 AM, the surveyor observed Resident #147 sleeping on his/her left side in bed. The surveyor observed one [REDACTED] NJ Ex Order 26, 4B1 on its side leaning against the wall on the far side of the room. A review of Resident # 147's Electronic Medical Record (EMR) revealed diagnosis of but not limited to [REDACTED] NJ Ex Order 26, 4B1	F0689	Plan of Correction S689 Completion Date: 5/27/2026 Corrective Action: [REDACTED] or designee assured that Resident #147 – [REDACTED] NJ Ex Order 26, 4B1 placed on both sides of bed. [REDACTED] UM or designee assured that Resident #43 – [REDACTED] NJ Ex Order 26, 4B1 placed on both sides of bed. ID Other Residents: Any resident who utilizes an Accident Assistive Device is potentially at risk. Systemic Change: In-service will be given to Licensed Nursing Staff and Certified Nursing Assistants on "Accident Assistive Devices and Their Importance" by the Nurse Educator. Rounding by Charge Nurses/Supervisors to assist with compliance of floor mats. Monitoring: Audits – "Accident Assistive Device Audit" will be conducted (5) weekly x's 2 weeks then (5) monthly x's 2 months by Nursing Administration.	05/27/2026

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F0689 SS = D	Continued from page 3 NJ Ex Order 26, 4B1 A review of Resident # 147's EMR revealed a physician's order for NJ Ex Order 26, 4B1 every shift with a start date of NJ Ex Order 26, 4B1 A review of Resident # 147's EMR revealed under "Care Plan" a focus for NJ Ex Order 26, 4B1 related to medication side effects, NJ Ex Order 26, 4B1. The focus revealed an initiated date of NJ Ex Order 26, 4B1. The care plan revealed an intervention for NJ Ex Order 26, 4B1 at bedside. The intervention revealed an initiated date of NJ Ex Order 26, 4B1 2) On 04/23/2026 at 10:42 AM Resident #43 was observed in bed with visitors. At that time the family member of Resident #43 stated that the resident #43's NJ Ex Order 26, 4B1 in the past, had been found behind the resident's bed while they were in bed. On 04/24/2026 at 09:40 AM Resident #43 was observed sleeping in bed. At that time the surveyor observed one floor mat on the side of the bed between the resident and the roommate, no NJ Ex Order 26, 4B1 was observed on the other side of the bed. On 04/28/2026 at 09:43 AM Resident #43 was observed sleeping in bed. At that time the surveyor observed NJ Ex Order 26, 4B1 on the side of the bed between the resident and the roommate, NJ Ex Order 26, 4B1 was observed on the other side of the bed. A review of Resident # 43's EMR revealed diagnosis of but not limited to, NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 A review of Resident #43's most recent Minimum Data Set (MDS) (an assessment tool), dated NJ Ex Order 26, 4B1 revealed under section NJ Ex Order 26, 4B1 that Resident #43 had a NJ Ex Order 26, 4B1 since prior assessment. A review of Resident # 43's EMR revealed a physician's order for NJ Ex Order 26, 4B1 every shift with a start date of NJ Ex Order 26, 4B1 A review of Resident # 43's EMR revealed under "Care Plan" a focus for NJ Ex Order 26, 4B1 due to history of NJ Ex Order 26, 4B1. The focus revealed an initiated date of NJ Ex Order 26, 4B1. The care plan revealed an intervention for NJ Ex Order 26, 4B1 at bedside. The intervention revealed an initiated date of NJ Ex Order 26, 4B1	F0689	Continued from page 3 Results of the audits will be brought to QA/QAPI on a quarterly basis x's 2 quarters.	05/27/2026

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F0689 SS = D	Continued from page 4 On 04/28/2026 at 12:59 PM during an interview with the surveyor, the U. S. FOIA (b) (2) stated that the NJ Ex Order 26, 4B1 should be on both sides of the bed while the resident is in bed. The U. S. FOIA further stated that this was necessary to NJ Ex Order 26, 4B1 in the event of NJ Ex Order 26, 4B1 On 04/29/2026 1:18 PM during an interview with the surveyor, the U. S. FOIA (b) (2) stated that residents NJ Ex Order 26, 4B1 should not be on their sides against the wall. The U. S. FOIA further stated that when ordered NJ Ex Order 26, 4B1 should be on floor to both sides of the resident's bed while they are in bed. The U. S. FOIA further stated this was necessary for resident safety. A review of the facility provided policy titled " Fall and Fall Risk Management" revealed under "Resident-Centered Approaches to Managing Falls and Fall Risk", number 4, "...staff will identify and implement relevant interventions to try to minimize serious consequences of falling." NJAC 8:39-27.1(a)	F0689		05/27/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide specialized care needs for the provision of NJ Ex Order 26, 4B1 in accordance with professional standards of practice specifically by not having a physician's order for NJ Ex Order 26, 4B1. The deficient practice was identified for 1 of 6 (Resident # 5) residents reviewed for NJ Ex Order 26, 4B1 The deficient practice was evidenced by the following:	F0695	Plan of Correction F0695 Completion Date: 5/27/2026 Corrective Action: Physician Orders and Care Plan reviewed for Resident # 5 and NJ Ex Order 26, 4B1 was identified. NJ Ex Order 26 order for Resident # 5 obtained from physician and placed in the chart by U. S. FOIA (b) (2) The U. S. FOIA (b) (2) checked all residents on oxygen to assure that orders and care plans were accurate. ID Other Residents: Potential to affect any resident who receives NJ Ex Order 26 Systemic Change:	05/27/2026

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F0695 SS = D	Continued from page 5 On 04/23/2026 at 9:58 AM, during the initial tour, the surveyor observed Resident #5 in their room lying in bed. At that time, the surveyor observed a [REDACTED] NJ Ex Order 26, 4B1 [REDACTED] applied to Resident #5. At that time the surveyor observed the [REDACTED] NJ Ex Order 26, 4B1 to be on and the resident was receiving [REDACTED] NJ Ex Order 26, 4B1 through the [REDACTED] NJ Ex Order 26, 4B1 A review of Resident #5's admission record revealed that Resident #5 had a diagnosis of but not limited to, [REDACTED] NJ Ex Order 26, 4B1 [REDACTED] A review of Resident #5's Electronic Medical Record (EMR) revealed an order for and comfort care (care focused on [REDACTED] NJ Ex Order 26, 4B1 and did not reveal a physician's order for [REDACTED] NJ Ex Order 26, 4B1 During an interview on 04/28/2026 at 1:04 PM, with the surveyor, Unit Manager (UM) #1 stated that [REDACTED] NJ Ex Order 26, 4B1 must be administered under a physician's order. UM #1 further stated that resident #5 had been receiving [REDACTED] NJ Ex Order 26, 4B1 for [REDACTED] NJ Ex Order 26, 4B1 and acknowledged that Resident did not have a physician's order. During an interview on 04/29/2026 1:18 PM, the [REDACTED] U. S. FOIA (b) (2) stated "yes" when asked if there should be a physician's order for [REDACTED] NJ Ex Order 26, 4B1 if a resident is being administered [REDACTED] NJ Ex Order 26, 4B1. A review of the facility-provided policy titled "Oxygen Administration - Resident" with a revision date of 12/2024, failed to mention the need for a physician's order. A review of the facility provided policy titled "Medication and Treatment Orders" with an effective date 3/2020, revealed a policy statement, "Orders for medications and treatments will be consistent with principles of safe and effective order writing." N.J.A.C. § 8:39-27.1	F0695	Continued from page 5 Walking rounds by [REDACTED] U. S. FOIA (b) (2) to identify residents receiving [REDACTED] NJ Ex Order 26, 4B1. The IP or designee will make routine rounds to assure all residents on oxygen have appropriate care plans and orders. In-service to Licensed Nurses on "Medication and Treatment Orders" given by Nurse Educator to all nursing staff. Monitoring: Audits- "Oxygen Orders for Residents Receiving Oxygen Therapy" will be conducted (10) weekly x 2 weeks then (10) monthly x 2 months by Nursing Administration. Results of the audits will be brought to QA/QAPI on a quarterly basis x 2 quarters.	05/27/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to	F0880	Plan of Correction F0880 Completion Date: 5/29/26 Corrective Action: The [REDACTED] NJ Ex Order 26, 4B1 for Resident #86 and Resident	05/27/2026

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F0880 SS = D	Continued from page 6 help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Continued from page 6 #5 were thrown away and new ones were issued by the U. S. FOIA (b) (2). The NJ Ex Order 26, 4B1 for Resident # 79 was thrown away and a new one was issued by the U. S. FOIA (b) (2). ID Other Residents: Facility audit was conducted by U. S. FOIA (b) (2) on all residents utilizing respiratory equipment. If any identified concerns were noted, they were corrected by the U. S. FOIA (b) (2). Systemic Change: In-service "Storage of Respiratory Equipment When Not In Use" given by Nurse Educator to the nursing staff. In-service "What Improper Storage of Respiratory Equipment Means for Infection Control" given by Infection Prevention Nurse to nursing staff. U. S. FOIA (b) (2) completed rounds to ensure all NJ Ex Order 26, 4B1 masks are stored properly when not in use. Monitoring: Audits- "Proper Storage of Nebulizer and CPAP masks When Not in Use" will be conducted (10) weekly x 2 weeks then (10) monthly x 2 months by the Infection Preventionist. Results of the audits will be brought to QA/QAPI on a quarterly basis x 2 quarters.	05/27/2026

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F0880 SS = D	Continued from page 7 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility staff failed to ensure that respiratory equipment was stored in a manner that prevented contamination, in accordance with infection prevention and control standards, for 3 of 6 residents reviewed for NJ Ex Order 26, 4B1 (Resident #5, Resident #79, and Resident #86). The deficient practice was evidenced by the following: On 04/23/2026 at 10:22 AM, during the initial tour, surveyor #1 observed Resident #86' NJ Ex Order 26, 4B1 lying in the nightstand drawer, open to air. A review of Resident #86's Admission Record revealed the resident was admitted to the facility with, but not limited to, NJ Ex Order 26, 4B1 A review of Resident #86's Electronic Medical Record (EMR) revealed a physician's order for NJ Ex Order 26, 4B1 every NJ Ex Order 26, 4B1 for NJ Ex Order 26, 4B1 with a start date of NJ Ex Order 26, 4B1 During an interview on 04/28/2026 at 10:49 AM with surveyor #1, the U. S. FOIA (b) (2) said that the NJ Ex Order 26, 4B1 should be stored in a plastic bag when not in use. During an interview on 04/29/2026 at 1:18 PM with surveyor #1, the U. S. FOIA (b) (2) said that	F0880		05/27/2026

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F0880 SS = D	Continued from page 8 after the NJ Ex Order 26, 4B1 is cleaned and dried, it should be stored in a bag for infection control purposes. A review of the facility-provided policy titled "Respiratory Equipment" failed to mention how respiratory equipment should be stored when not in use. NJAC 8:39-19.4 (k) On 4/23/2026 at 9:58 AM during initial tour, Surveyor #2 observed Resident #5's NJ Ex Order 26, 4B1 (NJ Ex Order 26, 4B1) with the NJ Ex Order 26, 4B1 beside it on top of the bedside table open to air. A review of Resident #5's admission record revealed that Resident #5 had a diagnosis of but not limited to, NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 A review of Resident #5's Electronic Medical Record (EMR) revealed a physician's order for NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 every NJ Ex Order 26, 4B1 as needed for NJ Ex Order 26, 4B1 (care NJ Ex Order 26, 4B1 focused on NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 A review of Resident #5's Care Plan in the EMR revealed a nursing focus of "Comfort Care due to NJ Ex Order 26, 4B1" initiated on NJ Ex Order 26, 4B1. On 04/23/2026 at 10:50 AM during initial tour, Surveyor #2 observed Resident #79 NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 A review of Resident 79's admission record revealed that Resident #79 was admitted with but not limited to NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 A review of Resident #79's Electronic Medical Record (EMR) revealed a physician's order, "Apply NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 A review of Resident #79's Care Plan in the EMR revealed a nursing focus of NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 with NJ Ex Order 26, 4B1	F0880		05/27/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 220 ST MARY'S DRIVE , CHERRY HILL, New Jersey, 08003	
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F0880 SS = D	Continued from page 9 intervention that included the use of residents [REDACTED] During an interview on 04/29/2026 at 1:18 PM, the [REDACTED] U. S. FOIA (b) (2) stated when not in use, [REDACTED] are cleaned and dried and stored in a labeled bag, for infection control purposes. A review of the facility-provided policy titled "Respiratory Equipment" failed to mention how respiratory equipment should be stored when not in use. NJAC 8:39-19.4 (k)	F0880		05/27/2026
F0908 SS = D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and review of documentation provided by the facility, it was determined that the facility failed to maintain acceptable standards of essential kitchen equipment in a safe and operable condition. This deficient practice was evidenced by the following: During initial tour of the kitchen on 04/23/2026 at 10:05 AM, the surveyor observed the following in the kitchen with the [REDACTED] U. S. FOIA (b) (2) The stove had no knobs. The [REDACTED] U. S. FOIA (b) (2) stated that the knobs had been broken for 1 month and ordered more [REDACTED] U. S. FOIA (b) (2) stated we are supposed to be getting a new stove. On the portable holding temperature box, the gaskets (rubber seal) were falling off. The [REDACTED] U. S. FOIA (b) (2) stated the box is new, but this can happen because of the high heat. During an interview with the surveyor on 04/23/2026 at 11:48 AM, [REDACTED] U. S. FOIA (b) (2) acknowledged that there should be knobs on the stove top. He also stated that the gaskets on the portable temperature box should be replaced. A review of the facility provided policy titled, "Facility Equipment", reflected that if an equipment	F0908	Plan of Correction F 908 Completion Date: 5/27/2026 Level D Corrective Action: Knobs placed on stovetop by the [REDACTED] U. S. FOIA (b) (2) 5/8/26. New stovetop replaced on 5/8/26. Gasket was replaced on Portable Temperature Holding Box by [REDACTED] U. S. FOIA (b) (2) on 5/8/26. ID Other Residents: [REDACTED] U. S. FOIA (b) (2) or designee assured any kitchen equipment that utilizes a knob was in working condition. In addition, [REDACTED] U. S. FOIA (b) (2) /designee assured that any equipment with a gasket was in working condition. Any item not in working condition was repaired by the department. Systemic Change: In-service to dietary employees on "Maintaining Equipment and Reporting" by the Food Service Director.	05/27/2026

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NAME OF PROVIDER OR SUPPLIER ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 220 ST MARY'S DRIVE , CHERRY HILL, New Jersey, 08003			
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F0908 SS = D	Continued from page 10 in the facility is not functioning as designed, the maintenance department will work with the department head to correct the concern of that piece of equipment. Maintenance Department will orchestrate the overall maintenance of facility equipment. NJAC 8:39 31.7(d)			F0908	Continued from page 10 Mechanical Rounds to be completed by [REDACTED] on a Monthly basis. Monitoring: Audits – "Mechanical Equipment" will be conducted by Dietary Director or Designee weekly x's 2 weeks then monthly x's 2 months. Results of the audits will be brought to QA/QAPI on a quarterly basis x's 2 quarters.		05/27/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30402		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/30/2026	
NAME OF PROVIDER OR SUPPLIER ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 220 ST MARY'S DRIVE , CHERRY HILL, New Jersey, 08003			
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S0000	Initial Comments NJ Complaint # 259544 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 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			05/27/2026	
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: Based on interview, and review of pertinent facility documentation, 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. This deficient practice was evidenced by the following: Findings include: A.) 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	Plan of Correction S560 Completion Date: 5/27/2026 Corrective Action: No residents were identified. Staffing levels were reviewed for all deficient dates listed. Additional staff were recruited to meet the minimum staffing standards moving forward. ID Other Residents: Potential to affect all residents residing within the facility. Systemic Change: Bonuses are offered for double shifts, extra shifts and weekends.		05/27/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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New Jersey Department of Health

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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 08/17/2025 to 08/23/2025, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -08/17/25 had 22 CNAs for 210 residents on the day shift, required at least 26 CNAs. -08/18/25 had 21 CNAs for 209 residents on the day shift, required at least 26 CNAs. -08/19/25 had 20 CNAs for 208 residents on the day shift, required at least 26 CNAs. -08/20/25 had 25 CNAs for 208 residents on the day shift, required at least 26 CNAs. -08/21/25 had 24 CNAs for 208 residents on the day shift, required at least 26 CNAs. -08/23/25 had 24 CNAs for 212 residents on the day shift, required at least 26 CNAs. 2. For the 2 weeks of staffing prior to survey from 04/05/2026 to 04/18/2026, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -04/05/26 had 18 CNAs for 196 residents on the day shift, required at least 24 CNAs. -04/06/26 had 23 CNAs for 196 residents on the day shift, required at least 24 CNAs. -04/08/26 had 23 CNAs for 196 residents on the day shift, required at least 24 CNAs. -04/11/26 had 21 CNAs for 199 residents on the day shift, required at least 25 CNAs.			S0560	Continued from page 1 Perfect attendance bonuses are offered on a weekly basis. In-service on lateness and attendance policy Usage of Staffing agencies to supplement staffing needs. Referral Program promoted for staff Sign on bonuses to assist with staff recruitment Employee Appreciation parties. In-services on State Mandated Staffing Levels to the nursing Department by Nurse Educator by 5/27/26. Additional shifts will be made available to meet staffing levels for Certified Nursing Assistants. Licensed staff will supplement Certified Nursing Assistant positions if the need arises that staffing levels go below the state required minimum. Monitoring: Audits – weekly staffing schedule audits by Nursing Administration. Nursing Administration will bring results to the Administrator Results of the audits will be brought to QA/QAPI on a quarterly basis x's 2 quarters.		05/27/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30402		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/30/2026	
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S0560	Continued from page 2 -04/12/26 had 18 CNAs for 199 residents on the day shift, required at least 25 CNAs. -04/13/26 had 22 CNAs for 199 residents on the day shift, required at least 25 CNAs. -04/16/26 had 24 CNAs for 198 residents on the day shift, required at least 25 CNAs. -04/17/26 had 24 CNAs for 198 residents on the day shift, required at least 25 CNAs. -04/18/26 had 24 CNAs for 198 residents on the day shift, required at least 25 CNAs. During an interview on 04/29/2026 at 12:48 PM with the surveyor, the staffing coordinator said she feels that are mostly meeting staffing requirements.			S0560			05/27/2026

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NAME OF PROVIDER OR SUPPLIER ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 220 ST MARY'S DRIVE , CHERRY HILL, New Jersey, 08003			
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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/22/2026 in relation to the 04/30/2026 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.

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New Jersey Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 07/22/2026 in relation to the 04/30/2026 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315060		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/30/2026	
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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/28/2026, 04/29/2026 and 04/30/2026. St Mary's Center for Rehabilitation and Healthcare 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.			K0000			05/28/2026
K0324 SS = F Bldg. 01	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 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:			K0324	It is the practice of the facility to have proper inspection of suppression system all residents had the potential to be affected by this deficiency. The owners tag on the kitchen suppression system has been added to the monthly rounds of the maintenance team to be signed off. Every month after proper inspection of the system and has been signed off for this month as of 05/15/2026. All owner tags and hood required equipment have been inspected and comply with the design and are properly signed off as of 5/15/2026. The U. S. FOIA (b) (2) has completed education with the maintenance staff on how to inspect owner tags, procedures, and signoffs. Maintenance will complete rounds and review the owner tags on a monthly basis. The results will be presented by the Maintenance Director to QAPI on a quarterly basis x's 2 quarters.		05/27/2026

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.

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K0324 SS = F Bldg. 01	Continued from page 1 Based on observation, record review and interview on 04/28/2026 in the presence of the [REDACTED] NJ Ex Order 26, 481 [REDACTED] it was determined the facility failed to ensure the kitchen range hood fire suppression system's monthly owners inspection was performed in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6. This deficient practice had the potential to affect 204 residents and was evidenced by the following: Observations at 12:10 PM of the kitchen revealed, the kitchen line consisted of: a fryer, tilt skillet, 6 burner range, and a flat top grill protected by a 9 nozzle wet chemical suppression system. Record review of the semiannual suppression system inspection tag dated November 2025 revealed, the monthly inspection rows on back of the tag were blank indicating the monthly owners inspections had not been performed for the last 5 months. In an interview at the time, the [REDACTED] U. S. FOIA (b) (2) confirmed the observation and record review. The facility's [REDACTED] U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference on 04/30/2026 at 3:18 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 17A	K0324		05/27/2026
K0345 SS = F Bldg. 01	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 observation, record review and interview on 04/28/2026 and 04/29/2026 in the presence of the [REDACTED] U. S. FOIA (b) (2), it was determined	K0345	It is the practice of the facility to have proper testing and reporting of Fire Alarm System all residents had the potential to be affected by this deficiency. The facility created and completed a new log detailing proper weekly testing of the battery-operated single station smoke detectors in the resident's room as per the manufacturer's guidelines. This test has been completed and documented on new log on a weekly basis as of 5/15/2026. All testing and maintenance paperwork has been checked and adjustments made to staff to perform all necessary testing. The [REDACTED] U. S. FOIA (b) (2) has completed education and training with [REDACTED] U. S. FOIA (b) (2) staff to	05/27/2026

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K0345 SS = F Bldg. 01	Continued from page 2 the facility failed to ensure battery operated single station smoke alarms in resident rooms were tested in accordance with NFPA 72: 2010 Edition, Section 14.4.5, 14.4.6, 14.4.2.2, table 14.4.2.2(14)(g)(4) and Manufacturers published instructions. This deficient practice had the potential to affect 204 residents and was evidenced by the following: Observations on 04/28/2026 during a facility tour revealed the resident rooms were equipped with battery operated single station smoke alarms. Record review on 04/29/2026 of the facility based battery operated single station smoke alarms test reports revealed the alarm devices were tested monthly. Further review of the manufacturers SMOKE ALARM USERS GUIDE revealed the TESTING section stated: NOTE: WEEKLY TESTING IS REQUIRED. Additionally, the guide stated: TEST THE ALARM WEEKLY TO ENSURE PROPER OPERATION. In an interview at the time, [REDACTED] confirmed the observations and record review. The facility's [REDACTED] were informed of the deficient practice at the Life Safety Code exit conference on 04/30/2026 at 3:18 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 72	K0345	Continued from page 2 confirm proper testing and reporting on paperwork for weekly smoke detectors is completed timely. Maintenance Director will review log weekly. Maintenance Director will review information provided on log. This information will be presented by the director to the QAPI quarterly x's 2 quarters.	05/27/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system.	K0914	It is the practice of the facility to ensure annual testing of all resident room electrical receptacles; all residents had the potential to be affected by this deficiency. All Resident Rooms electrical receptacles have been inspected according to electrical code for Integrity, polarity, tension, and function. A log has been created to maintain records of this test to avoid future tests not being completed timely. A local electrician has completed a facility wide electrical inspection of all outlets, panels, and breakers. The [REDACTED] has completed education with [REDACTED] regarding the importance of electrical inspection testing and timely reporting of these tests on logs and documentation	05/27/2026

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NAME OF PROVIDER OR SUPPLIER ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 220 ST MARY'S DRIVE , CHERRY HILL, New Jersey, 08003			
(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			
K0914 SS = F Bldg. 01	Continued from page 3 Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview on 04/28/2026, 04/29/2026 and 4/30/2026 in the presence of the U. S. FOIA (b) (2) it was determined the facility failed to ensure electrical receptacles at patient bed locations that are not hospital-grade receptacles are tested at intervals not exceeding 12 months in accordance with NFPA 99: 2012 Edition, Sections 6.3.3, 6.3.3.2, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect 204 residents and was evidenced by the following: Observations during a facility tour on 04/28/2026 revealed the resident room electrical receptacles at the resident beds were not hospital-grade. Record review on 04/29/2026 and 04/30/2026 of the facility's Life Safety Code inspection, test and maintenance reports revealed, there was no report documenting the electrical receptacles at the resident bed locations were tested for physical integrity, grounding continuity, correct polarity and blade retention in the last 12 months. In an interview on 04/30/2026 at 2:08 PM the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference on 04/30/2026 at 3:18 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 99	K0914	Continued from page 3 of issues. Maintenance Director or designee will check electrical receptacles for the key tests on a monthly basis. This information will then be entered on a log and will be presented by the director to QAPI quarterly x's 2 quarters.	05/27/2026			
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall	K0918	It is the practice of the facility to ensure proper testing of the facilities emergency backup generator; all residents had the potential to be affected by this deficiency. The facilities generator company performed the three-year 4-hour load test on 5/15/2026 and the generator passed its test, and company has provided the facility with proper documentation.	05/27/2026			

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K0918 SS = F Bldg. 01	Continued from page 4 be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review and interview on 04/29/2026 and 04/30/2026 in the presence of th U. S. FOIA (b) (2) U. S. FOIA (b) (2) it was determined the facility failed to ensure the 250 Kilowatt Emergency Power Diesel Generator Set was exercised under the required loading for 4 continuous hours once every 36 months in accordance with NFPA 110: 2010 Edition, Section 8.4.9, 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect 204 residents and was evidenced by the following: Record review on 04/29/2026 of the 250 Kilowatt Emergency Power Diesel Generator Set's inspection, test and maintenance reports revealed, there was no document of the 3 year 4 hour full load or load bank test provided. In an interview on 04/30/2026 the U. S. FOIA (b) (2) confirmed the record review. The facility's U. S. FOIA (b) (2) were informed of the deficient practice at the Life Safety Code exit conference on 04/30/2026 at 3:18 PM.	K0918	Continued from page 4 The facility will has set a calendar reminder for schedule with generator company in 2 years to ensure testing in the future is conducted timely without the need to schedule. The U. S. FOIA (b) (2) has completed education with U. S. FOIA (b) (2) regarding the importance of timely reporting and testing of generator requirements and proper documentation. Maintenance Director or designee will check generator logs for proper testing on a monthly basis. This information will then be presented by the director to QAPI quarterly x's 2 quarters.	05/27/2026

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K0918 SS = F Bldg. 01	Continued from page 5 N.J.A.C. 8:39 - 31.2 (e) NFPA 110	K0918		05/27/2026
K0271 SS = E Bldg. 01	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 04/28/2026 in the presence of the U. S. FOIA (b) (2) [REDACTED] it was determined the facility failed to ensure in means of egress walking surfaces abrupt changes in elevation do not exceed 1/4 inch in accordance with NFPA 101: 2012 Edition, Section 7.1.6, 7.1.6.2. This deficient practice had the potential to affect 24 of 204 residents and was evidenced by the following: Observations at 12:55 PM of the U. S. FOIA (b) (2) [REDACTED] end hall stairway exit discharge sidewalk to public way revealed, where the second to last concrete pad met the last concrete pad there was a 1-7/8 inch high lip on the right that ran at an angle across the 4 foot wide path to 0 inches high on the left where the last concrete pad was raised above the prior pad. This posed a trip hazard in the path of egress. In an interview at the time, the U. S. FOIA (b) (2) [REDACTED] confirmed the observation. The facility's U. S. FOIA (b) (2) [REDACTED] were informed of the deficient practice at the Life Safety Code exit conference on 04/30/2026 at 3:18 PM. N.J.A.C. 8:39 - 31.2 (e)	K0271	It is the practice of the facility to ensure exit discharge paths are level walking surfaces, and all residents had the potential to be affected by this deficiency. The U. S. FOIA (b) (2) [REDACTED] stairway exit discharge path to the public way has had the concrete path replaced with a new concrete path. This new path is the same level as the remaining concrete discharge path. The trip hazard has been corrected. Any person utilizing this discharge path has the potential to be affected. All exit discharge paths from the facility have been inspected on 5/18/2026. A few other minor corrections have been made and currently all exit discharge paths are now level surfaces leading to the public way. The U. S. FOIA (b) (2) [REDACTED] has completed education with U. S. FOIA (b) (2) [REDACTED] to confirm proper inspection of exit discharge path Inspection of discharge paths will be completed on a monthly basis and documented by the Maintenance Director or designee. These results will be brought to QAPI on a quarterly basis x's 2 quarters.	05/27/2026
K0374 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrier CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K0374	It is the practice of the facility to ensure smoke barrier door is free to close to resist smoke passage all residents had the potential to be affected by this deficiency.	05/27/2026

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K0374 SS = E Bldg. 01	Continued from page 6 Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 04/28/2026 in the presence of the U. S. FOIA (b) (2) [REDACTED] it was determined the facility failed to ensure doors in smoke barriers shall be self closing or automatic closing in accordance with NFPA 101: 2012 Edition, Section 19.3.7.8. This deficient practice had the potential to affect 30 of 204 residents and was evidenced by the following: Observations at 11:15 AM of the double smoke doors at the end of [REDACTED] Unit by room [REDACTED] revealed, the doors did not close all the way when tested by releasing them from their hold open devices. The left door leaf had an astragal that hit the right door leaf holding them open several inches. In an interview at the time, the U. S. FOIA (b) (2) [REDACTED] confirmed the observation and the U. S. FOIA (b) (2) [REDACTED] stated the doors need a coordinator. The facility's U. S. FOIA (b) (2) [REDACTED] were informed of the deficient practice at the Life Safety Code exit conference on 04/30/2026 at 3:18 PM. N.J.A.C. 8:39 - 31.2 (e)	K0374	Continued from page 6 The double smoke door by [REDACTED] unit room [REDACTED] has had a coordinator installed and now closes properly after release from hold open devices providing a smoke tight seal. And functions as designed as smoke doors. All other Doors throughout the facility were checked to sealing smoke tight on 05/15/2026. The U. S. FOIA (b) (2) [REDACTED] has completed education with U. S. FOIA (b) (2) [REDACTED] regarding monitoring doors to remain smoke tight when closed. Monthly, the Maintenance Director or designee will check smoke and fire doors throughout the facility to ensure the doors are closing smoke tight into each other. This information will then be entered on a log and will be presented by the director to QAPI quarterly x's 2 quarters.	05/27/2026
K0321 SS = D Bldg. 01	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	K0321	It is the practice of the facility to ensure hazardous storage areas self-close, and all residents had the potential to be affected by this deficiency. The basement storage room door has been fixed and now self closes and latches. A self-closure has been installed the rehab storage room door.	05/27/2026

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K0321 SS = D Bldg. 01	Continued from page 7 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 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 04/28/2026 in the presence of the U. S. FOIA (b) (2) [REDACTED] [REDACTED] it was determined the facility failed to ensure hazardous area doors are self closing or automatic closing and latching in accordance with NFPA 101: 2012 Edition, Section 19.3.2, 19.3.2.1.3. This deficient practice had the potential to affect 10 of 204 residents and was evidenced by the following: Observations at 10:41 AM of the basement housekeeping storage room revealed, the room was greater than 50 square feet and contained combustible storage. The corridor door to the room did not positive latch when tested because the strike	K0321	Continued from page 7 All hazardous storage rooms have been inspected for self-closing devices on 5/15/2026. The U. S. FOIA (b) (2) [REDACTED] has completed education with U. S. FOIA (b) (2) [REDACTED] to confirm proper installation of door equipment based on rooms designation and use and to ensure positive self-closing and latching. Storage room doors log will be completed monthly by the Maintenance Director or designee to ensure closure is in working order. Results will be brought to QAPI quarterly x's 2 quarters.	05/27/2026			

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K0321 SS = D Bldg. 01	Continued from page 8 was stuck in the door leaf. In an interview at the time, the [U. S. FOIA (b) (2)] confirmed the observation. Observations at 12:44 PM of the rehab storage room revealed, the room was greater than 50 square feet and contained combustible storage. The door to the room was not equipped with a self closing or automatic closing device. In an interview at the time, the [U. S. FOIA (b) (2)] confirmed the observation. The facility's [U. S. FOIA (b) (2)] were informed of the deficient practice at the Life Safety Code exit conference on 04/30/2026 at 3:18 PM. N.J.A.C. 8:39 - 31.2 (e)			K0321			05/27/2026

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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 04/30/2026. ST Mary's Center for Rehabilitation and Healthcare was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.			E0000			05/28/2026

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
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NAME OF PROVIDER OR SUPPLIER ST MARY'S CENTER FOR REHABILITATION & HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 220 ST MARY'S DRIVE , CHERRY HILL, New Jersey, 08003			
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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/22/2026 in relation to the 04/30/2026 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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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 07/22/2026 in relation to the 04/30/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.			E0000			

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.

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