DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		315060	B. WING			C 3/15/2024
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		5/15/2024
			220	ST MARY'S DRIVE		
SIMARY	S CENTER FOR REHAB	ILITATION & HEALTHCARE	СН	ERRY HILL, NJ 08003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	Complaint #: NJ1762	288				
	Census: 186					
	Sample Size: 3					
	42 CFR PART 483, S	THE REQUIREMENTS OF UBPART B, FOR LONG TIES BASED ON THIS				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE	TITLE		(X6) DATE
	cally Signed					09/09/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Joho Initial Comments S 000 S 000 Initial Comments Complaint#: NJ176288 Census: 186 Sample: 3 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 deficience and plan to in accordance with the provisions of 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 deficience and plan 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 of formation.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLI A. BUILDING:	(X3) DATE SURVEY COMPLETED		
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MARY'S CENTER FOR REHABILITATION & HEALT CHERRY HILL, NJ 08003 (M) ID PRETEX TAS SUMMARY STATEMENT OF DEFICIENCIES UP PROVIDER'S PLAN OF CORRECTION RESULTION ON LSC DENTIFYING WFORMATION) ID PRETEX TAS PROVIDER'S PLAN OF CORRECTION (EACH COMMECTIVE ACTION SHOLD BE CORSER REFERENCIENCY) DO (EACH COMMETTIVE ACTION DEFICIENCY) DO (EACH COM	AME OF PF	ROVIDER OR SUPPLIER			ATE, ZIP CODE		
Image Image <th< th=""><th>T MARY'</th><th>S CENTER FOR REHAB</th><th>ILITATION & HEALTI</th><th></th><th>3</th><th></th><th></th></th<>	T MARY'	S CENTER FOR REHAB	ILITATION & HEALTI		3		
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		documents on 08/15/ the facility failed to er met for 11 of 14-day s deficient practice had residents.	2024, it was determined that nsure staffing ratios were shifts reviewed. This		Date: 9/10/24 Corrective Action: • No residents were identified		
		rinaings include:					

STATE FORM

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If continuation sheet 1 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30402						(X3) DATE SURVEY COMPLETED	
			A. BUILDING.	с			
		B. WING			5/2024		
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE			
T MARY	S CENTER FOR REHAB	BILITATION & HEALTI	MARY'S DRIVE Y HILL, NJ 0800	3			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLET DATE	
S 560	Continued From pag	e 1	S 560				
	Reference: New Jer (NJDOH) memo, dat with N.J.S.A. (New J 30:13-18, new minim nursing homes," indie Governor signed into codified as N.J.S.A. established minimum nursing homes. The effective on 02/01/20 One Certified Nurse A residents for the day member to every 10 shift, provided that ne shall be CNAs and e be signed into work a shall perform nurse a care staff member to night shift, provided the member shall sign in perform CNA duties. For the 2 weeks of st survey from 07/28/20 was deficient in CNA of 14-day shift, require On 07/30/24 had 22 the day shift, require On 07/31/24 had 22 the day shift, require On 08/01/24 had 20 the day shift, require	sey Department of Health ed 01/28/2021, "Compliance ersey Statutes Annotated) hum staffing requirements for cated the New Jersey o law P.L. 2020 c 112, 30:13-18 (the Act), which is staffing requirements in following ratio (s) were 021: Aide (CNA) to every eight shift. One direct care staff residents for the evening o fewer of all staff members ach direct staff member shall as a certified nurse aide and aide duties: and One direct every 14 residents for the that each direct care staff to work as a CNA and taffing prior to complaint 024 to 08/10/2024, the facility a staffing for residents on 11 llows: CNAs for 181 residents on d at least 23 CNAs. CNAs for 181 residents on d at least 23 CNAs. CNAs for 181 residents on d at least 23 CNAs. CNAs for 187 residents on		 Potential to affect all resident rewithin the facility Systemic Change: Bonuses are offered for double extra shifts and weekends Perfect attendance bonuses are offered on a weekly basis In-service – Lateness and Atter Policy Usage of Staffing Agencies to supplement staffing needs Offering of Certified Nursing Ast Courses within the facility Referral Program promoted for Sign on bonuses to assist with a recruitment Employee Appreciation parties Monitoring: Nursing Administration will condweekly CNA staffing schedule audits Nursing Administrator Results of the audits will be bro QA/QAPI on a quarter basis 	shifts, e idance sistant staff staff duct s		

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If continuation sheet 2 of 3

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			С
		30402	B. WING		08	/15/2024
ME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, 2	ZIP CODE		
MARY'	S CENTER FOR REHAB	BILITATION & HEALTI	MARY'S DRIVE Y HILL, NJ 08003			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN C	F CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	COMPLE
S 560	Continued From pag	e 2	S 560			
		CNAs for 181 residents on				
	the day shift, require					
	the day shift, require	CNAs for 181 residents on				
		CNAs for 183 residents on				
	the day shift, require					
		CNAs for 183 residents on				
	the day shift, require On 08/08/24 had 22	d at least 23 CNAs. CNAs for 181 residents on				
	the day shift, require					
	On 08/09/24 had 22	CNAs for 181 residents on				
	the day shift, require	d at least 23 CNAs.				

8EY911

STATE FORM: REVISIT REPORT

	1						
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	•			
IDENTIFICATION NUMBER	A. Building						
30402 _{Y1}	B. Wing	Y2	9/11/2024	Y3			
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE					
ST MARY'S CENTER FOR REHA	BILITATION & HEALTHCARE	220 ST MARY'S DRIVE					
		CHERRY HILL, NJ 08003					

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM DATE		ITEM		DATE	ITEM		DATE	
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	S0560	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:39-5.1(a)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		09/10/2024	LSC					
ID Prefix		Correction	ID Prefix		Correction	ID Prefix _		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		_	LSC _		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		_	LSC _		
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC _		
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF S	URVEYOR		DATE	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/15/2024				K FOR ANY UNCORRECTI RRECTED DEFICIENCIES				5 🗌 NO