STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	**3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002**

(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 #: 2599447 CENSUS: 146 SAMPLE SIZE: 3 A complaint survey was conducted at Dwellside Care and Rehab from 9/10/2025 to 9/23/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During a survey, a finding which constituted an immediate Jeopardy (IJ) was identified under 42 CFR 483.25 (d)(2) F 689, when the facility failed to provide adequate NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to a NJ Exec Order 26. resident (Resident #2) with a known history of NJ Exec Order 26.4b1 and documented history of previous NJ Exec Order 26. to NJ Exec Ord who NJ Exec Orde from the facility on NJ Exec Order 26.4b1. A review of facility record revealed that Resident #2 NJ Exec Orde from the facility while wearing a NJ Exec Order 26.4b1 (NJ Exec) through an alarmed second floor elevator, down to the first floor, and NJ Exec Order 26.4b1 through the employee entrance door on the first floor on NJ Exec Order 26.4b1 at approximately 8:15 AM. A review of facility document revealed that the Certified Nursing Aide (CNA #3) observed the resident as they NJ Exec Order 26.4 through an employee entrance door as CNA #3 was entering the facility through the same employee door. CNA #3 confirmed during interview on 9/11/2025, that he observed the resident NJ Exec Order but he NJ Exec Order 26.4b1 the resident because he thought the resident was a NJ Exec Ord because they were NJ Exec Order 26.4b1 CNA #3 also stated the exit alarm which was supposed to sound to alert staff that a resident with a NJ Exec NJ Exec Order 26.4b1 did not sound when Resident #2 NJ Exec Order 26.4b1 CNA #3 further stated that he did not recognize Resident #2 because the resident resided on the NJ Exec Order floor and "I work on NJ Exec Orde on the NJ Exec floor." Resident #2 was NJ Exec Order in the community NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 at 1:46 PM, by the NJ Exec Order 26.4b1 and transferred the resident to the hospital for evaluation.	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

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F0000	Continued from page 1 The Administration was informed of the F 689 IJ and was provided the IJ template on 9/11/2025 at 6:00 PM. An acceptable Removal Plan (RP) was received 9/15/25 at 5:50 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include: "Immediate Jeopardy Removal Plan - Resident #2 NJ Exec Order 26.4b1 1. Immediate Corrective Actions for Resident #2 Resident sent to Hospital for evaluation and NJ Exec Order 26 . Resident #2 was returned to the facility safely on NJ Exec Order 26 . Resident placed on NJ Ex NJ Exec Order 26.4b1 immediately upon return and maintained until NJ Exec Order 26.4 Comprehensive NJ Exec and NJ Exec assessments completed for residents 2 no injury noted. Physician and family notified. NJ Exec Order NJ Exec Order 26.4b1 placement and function checks ordered and initiated for resident #2. All Residents monitored by staff stationed at elevators on 8-24-25 until system repair was completed. Which monitored all resident exiting unit and staff had elopement binders for reference. U.S. FOIA (b)(6) revised resident #2 plan of care on to review resident engagement and individualized activity planning. U.S. FOIA (b)(6) service call to facility to check system on 8-25-25 2. Identification of All Residents at Risk All residents residing in the facility have the potential to be affected by the deficient practice. This can be identified by reviewing the medical records. On 08/23/25, the facility unit managers conducted facility-wide wandering risk evaluations. All residents identified as high-risk had care plans	F0000		

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F0000	Continued from page 2 immediately updated. All other residents with NJ Exec Order 26.4b1 devices were checked for placement and function, with documentation by U.S. FOIA (b)(6) on 8-23-25. MDS Section E reviewed for all residents residing in the facility by the U.S. FOIA (b)(6) on 8-25-25 and care plans were reviewed and updated for elopement related risks. All residents for Q-shift (every shift) device placement and function checks were reviewed for Missing or incorrect orders corrected by 08/25/25. Updated resident photos posted at employee entrances and included in wandering binders on 8-25-25 3. Systemic Change NJ Exec Order 26.4b1 alarm volume increased to maximum facility-wide on 08/26/25. Elevator #2 sensor relocated and repaired on 08/27/25 to prevent interference. Service ticket completed on 09/02/25: system upgraded so NJ Exec Order 26.4b1 overrides automatic door lock. Education completed on 9/2/25 with all working receptionist detailing process with buzzing employees into building from employee entrance. Education includes new features added to door that will not allow an employee to enter if a resident wearing a NJ Exec Order 26.4b1 is near the door. Receptionists were educated to alert supervisors to check employee exit to ensure no residents are by the door if this occurs. Keypad lock box was installed on 09/10/25 at elevator entry for added control. All working staff education completed on the keypad use that was installed by the elevator on the second floor on 9/10/25 including not sharing keypad code by U.S. FOIA (b)(6) Policy updated requires staff to verify identity with badge before allowing anyone through employee entrance. All working staff educated on updated policy by U.S. FOIA (b)(6) and/ or designee on 8-25-25. The staff member responsible for not implementing MD (physician) orders for NJ Exec Order 26.4b1 was	F0000		

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F0000	Continued from page 3 immediately in-serviced on 08/23/25 by the U.S. FOIA (b)(6) on the proper procedure regarding NJ Exec Order 26.4b1 orders, placement, and documentation requirements and all nursing staff subsequently received the same education. Facility-wide education on elopement policy completed 08/23/25. Staff re-educated by U.S. FOIA (b)(6) starting on 8-23-25 on use of wandering binders and photo identification process. Elopement drills conducted beginning 08/25/25 and added to new-hire orientation and annual competencies. 4. Quality Assurance Weekly audits x 8 weeks (beginning 09/01/25) of 6 residents at risk for elopement to verify: Correct orders (placement, Q-shift checks, skin integrity, serial/expiration) or at risk for elopement to include Care plan alignment, and Documentation compliance than audits will transition to monthly reviews of 6 randomly selected residents at risk for elopement, continued for 10 months thereafter will be conducted by U.S. FOIA or designee. The U.S. FOIA (b)(6) or Designee will report all findings from the tracking form to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QA committee will review the effectiveness of the implemented corrective and determine if further action is needed or until such a time consistent substantial compliance has been met. Elopement drills will be conducted monthly for 3 months, then quarterly, then annually. As o NJ Exec Order 26.4, all immediate corrective actions for Resident #2 and all potentially affected residents were completed. Systemic corrections were implemented, monitoring systems are in place, and staff have been retrained. Completion Date 8-25-25" The surveyor went back on-site 9/18/25 to verify implementation of RP. The surveyor went to the employee entrance door at 12:45 PM to test the alarm system with the U.S. FOIA (b)(6) (U.S. FOIA As part of the test, the surveyor asked a staff member (CNA #4) to bring a resident with a NJ Exec to the employee entrance door. When the resident approached the door, the alarm did not sound. At that time, the U.S. FO opened the employee entrance	F0000		

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F0000	Continued from page 4 door and asked the staff to walk with the resident through the door. The resident who was wearing a [NJ Exec] walked out of the building but the door alarm did not sound. Both CNA#4 and the [U.S. FO] stated that the alarm was supposed to sound to alert staff that a resident with a [NJ Exec] [NJ Exec Order 26.4b1] During the interview with the [U.S. FOIA (b)] in the presence of the [U.S. FOIA] on 9/18/25 at 1:55 PM, he stated that he expected the alarm system to work consistently whenever a resident with a [NJ Exec] tries to enter the elevator or to exit through the employee door. The facility removal plan was not implemented during this on-site visit. A second RP was received on 9/19/25 at 10:56 AM, was accepted on 9/22/25, which indicated steps the facility will take to prevent serious harm from occurring or recurring. The original corrective action plan to remediate the deficient practice was updated to include: "1. Immediate Corrective Actions for Resident #2 All Residents monitored by staff stationed at employee entrance/exit on 9-18-25 until system repair is completed. Which monitored all resident exiting facility and staff had elopement binders for reference. [NJ Exec Order 26.4b1] technician service call to facility to check system on 9-18-25 and increased sensitivity of system. 2. Identification of All Residents at Risk All residents with [NJ Exec Order 26.4b1] orders Q-shift device placement and function checks were reviewed for Missing or incorrect orders corrected by 08/25/25. Updated resident photos with Wander Guards posted inside both elevators on 9-18-25. All residents with [NJ Exec Order 26.4b1] devices were checked for placement and function, with documentation by [U.S. FOIA (b)] on 9-18-25. All residents with [NJ Exec Order 26.4b1] orders for Q-shift device placement and function checks were reviewed for Missing or incorrect orders corrected by 9-18-25. Completion Date 9-18-25" The surveyor verified the implementation of the RP on-site on 9/23/2025 and determined the immediacy	F0000		

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F0000	Continued from page 5 for the F 689 was removed as of 9/23/2025.	F0000		
F0689 SS = SQC-J	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: COMPLAINT #: 2599447 Based on observation, interviews, review of medical records, and review of other pertinent facility documents on 9/10/2025, 9/11/2025, 9/18/2025, and 9/23/2025, it was determined that the facility failed to provide adequate NJ Exec Order 26.4b1 of a NJ Exec Order 26 resident (Resident #2) with a known history of NJ Exec Order 26.4b1 behaviors and documented history of previous NJ Exec Order 26 to NJ Exec Or from their unit; who NJ Exec Orde form the facility on NJ Exec Order 26.4b1 The deficient practice was identified for 1 of 3 residents reviewed (Resident #2). A review of facility record revealed that on NJ Exec Order 26.4b at approximately 8:15 AM, Resident #2 NJ Exec Orde from the facility while wearing a NJ Exec Order 2 (NJ Exec NJ Exec Order 26.4b1) through an alarmed second floor elevator, down to the first floor, and NJ Exec Order 26.4b1 through the employee entrance door on the first floor. A review of facility document revealed that the Certified Nursing Aide (CNA #3) observed the resident as they NJ Exec Order 26.4 through an employee entrance door as CNA #3 was entering the facility through the same employee door. CNA #3 confirmed during interview on 9/11/2025, that he observed the resident NJ Exec Order but he NJ Exec Order 26.4b1 the resident because he thought the resident was a NJ Exec Or because they were NJ Exec Order 26.4b1 and the exit alarm which was supposed to sound to alert staff that a resident with a NJ Exec NJ Exec Order 26.4b1 did not sound when Resident #2 NJ Exec Order 26.4b1 CNA #3 further stated that he did not recognize Resident #2 because the resident resided on the NJ Exec Order floor and "I work on -wing on the floor." Resident #2 was		Plan of Correction – F689 1. Corrective Action for Resident Affected Resident #2 was NJ Exec Order on NJ Exec Order and transported to the hospital for medical evaluation and returned the same day with U.S. FOIA (b)(6). Resident #2 was placed on one-to-one (NJ Exec NJ Exec Order 26.4b1 upon return until U.S. FOIA (b)(6) All residents monitored by staff stationed at elevators on 8-24-25 until system repair was completed on 9-10-25. Resident's #2 NJ Exec Order 26.4b1 device was checked each shift for proper placement and function starting on U.S. FOIA (b)(6). Resident's #2 care plan and NJ Exec Order 26.4b1 risk assessment were updated to reflect ongoing interventions and NJ Exec Order 26.4b1 needs on U.S. FOIA (b)(6) Resident # 2 U.S. FOIA (b)(6) completed; physician and family were notified of the incident and interventions U.S. FOIA (b)(6) 2. Corrective Action for Residents with the Potential to Be Affected All residents residing in the facility have the potential to be affected by the deficient practice. This can be identified by reviewing the medical records. On 08/23/25, the facility unit managers conducted facility-wide wandering risk evaluations; all residents identified as high-risk were addressed and care plan immediately. All residents with NJ Exec Order 26.4b1 were checked for proper placement and function; documentation verified by nursing supervisor on 8-23-25.	10/22/2025

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F0689 SS = SQC-J	Continued from page 6 NJ Exec Order in the community NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 at 1:46 PM, by the NJ Exec Order 26.4b1 and transferred the resident to the hospital for evaluation. The facility's failure to provide adequate NJ Exec Order 26.4b1 to a NJ Exec Order 26.4b1 resident who was at risk for and posed a likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Exec Order 26.4b at 8:15 AM, after Resident #2 NJ Exec Order from the facility. The facility Administration was notified of the IJ on 9/11/2025 at 6:00 PM. The facility submitted an acceptable Removal Plan (RP) on 9/19/2025 at 10:46 AM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 9/23/2025. The evidence was as follows: A review of the facility provided “Elopements and Wandering Residents” policy dated July 2024, included the facility ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents…Policy Explanation and Compliance Guidelines 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk…4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering…d. Adequate supervision will be provided to prevent accidents or elopements… A review of the Facility Reportable Event (FRE) dated NJ Exec Order 26.4b, that the facility submitted to the New Jersey Department of Health (NJDOH), revealed that on NJ Exec Order 26.4b1 at around 9:34 AM, the U.S. FOIA (b)(6) a License Practical Nurse (LPN #3), called the U.S. FOIA (b)(6) (U.S. FOIA (and informed him that she could NJ Exec Order Resident #2 in the facility. The U.S. FOIA then called the NJ Exec Order 26.4b1 and reported the resident NJ Exec Order 2 and that the NJ Exec Ord went to the facility and initiated a NJ Exec Orde for the resident. The NJ Exec Ord later NJ Exec Or Resident #2 in the community and transferred them to the hospital for	F0689	Continued from page 6 MDS section E and care plans were reviewed and updated by the Regional DON on 8/25/25. Updated photographs of all residents with NJ Exec Order 2 devices were posted in designated staff areas, elevators, and employee entrances for easy identification on 8/25/25 and again on 9/18/25. On 9-18-25 Staff were temporarily stationed at facility employee exit doors until system repair was verified on 9-24-25. 3. Systemic Changes to Prevent Recurrence All staff were educated by the Director of Nursing or designee on the facility’s 1. “Elopement and Wandering Residents” policy with emphasis on: Immediate response to alarm activation on 8/25/25 by the Regional Director of Nursing. 2. Recognizing and supervising residents at risk for elopement. Responsibility of all staff to intervene and report elopement risk behavior, regardless of assignment. 3. Responsibility of all staff to intervene and report any elevator, door alarm, or security lock failures to the department head or facility supervisor immediately, regardless of assignment. All receptionists were trained by DON/ designee on proper door monitoring, including verifying identity before buzzing individuals in or out on 8/23/25 and 9/2/25. Maintenance Director to perform and document weekly functional testing of all NJ Exec Order 26.4b1 devices, door alarms, and elevator sensors, with immediate repair for any malfunction. The administrator will review the NJ Exec Order 26.4b1 audit logs weekly to verify compliance.	10/22/2025

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F0689 SS = SQC-J	Continued from page 7 evaluation. According to the NJ Exec Ord report dated NJ Exec Order 26.4b, facility staff notified the NJ Exec Ord of the resident on NJ Exec Order 26.4b1 at approximately 9:49 AM. The report included that the NJ Exec Ord arrived at facility and conducted interviews with facility staff, and the staff informed the NJ Exec Ord that Resident #2 was a "NJ Exec Order 26.4b1" and that Resident #2 NJ Exec Order 26.4b1 which were "supposed to disable the use of elevators" and sound alarms to detect if a resident left the building. The report further indicated that their review of the facility's camera footage showed Resident #2 "NJ Exec Order 26.4b1 at 8:15 AM, NJ Exec Order 26.4b1]." The report indicated that then "NJ Exec Order 26.4 the building several times with negative results." The family member responded back to the facility about the NJ Exec Order 26.4b1 of Resident #2 and mentioned that the resident "NJ Exec Order 26.4b1." The family member provided the with NJ Exec Order 26.4b1 and emphasized that the NJ Exec Ord check one of the NJ Exec Order 26.4b because Resident #2 had previously NJ Exec Order 26.4b1 The NJ Exec Ord report included that at approximately 1:46 PM, the family member informed the NJ Exec Ord that Resident #2 "NJ Exec Order 26.4b1 The resident was then taken to the hospital for an evaluation. According to an undated Investigation Summary document provided by the facility, Resident #2 returned back to the facility from the hospital at approximately 6:30 PM on NJ Exec Order 2 and that the facility assessed the resident for NJ Exec Order 26.4b1, and none was noted and placed Resident #2 on NJ Exec Order 26.4b1 (NJ Exec NJ Exec Order 26.4b1 to monitor behavior and prevent further A review of CNA #3's statement revealed that he observed Resident #2 as they NJ Exec Order 26.4b1 through an employee entrance door at the same time he was entering the building. CNA #3 indicated that he NJ Exec Order 26.4b1 the resident because he thought the resident was a NJ Exec Ord because they were "NJ Exec was dressed in a "NJ Exec Order 26.4b1 ." During interview with the U.S. FOIA (b)(6) on 9/10/2025 at 9:50 AM, he stated that the employee entrance was a locked door and that a code needed to be entered on the pin pad for an employee to NJ Exec Order 26.4b1 through that door. The U.S. FOIA (b also stated that when a resident who was wearing a NJ Exec approached the door, the door was supposed to sound an alarm and remain	F0689	Continued from page 7 Elopement drills to be conducted quarterly and reviewed during QAPI meetings. The NJ Exec Order 26.4b1 system was serviced and recalibrated by the vendor on 8/25/2025 to ensure full operational sensitivity with volume increase and elevator sensor relocation on 8/27/25. System upgraded on 9/2/25 to override automatic door lock when NJ Exec Order 26.4b1 detected. Keypad lock box installed 9/10/25 for elevator access control; education completed by DON/ Designee facility wide initiated on 9/10/25. Policy updated to require staff badge verification before entry at employee door. Elopement drills initiated 8/25/25 and incorporated into new- hire orientation and annual competencies. 4. Quality Assurance The Director of Nursing (DON) or designee will conduct Weekly audits x 8 weeks (beginning 09/01/25) of 6 residents at risk for elopement to verify: Correct orders (placement, Q-shift checks, skin integrity, serial/expiration) or at risk for elopement to include Care plan alignment, and Documentation compliance than audits will transition to monthly reviews of 6 randomly selected residents at risk for elopement, continued for 10 months thereafter will be conducted by DON or Designee. The administrator will review the NJ Exec Order 26.4b1 audit logs weekly to verify compliance. The Director of Nursing or designee will report all findings from the tracking form to the Quality Assurance and Performance Improvement (QAPI) Committee monthly. The QA committee will review the effectiveness of the implemented corrective and determine if further action is needed or until such a time consistent substantial compliance has been met. Completion Date: All corrective actions completed on 9/18/25; immediate jeopardy removed on	10/22/2025

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DWELLSIDE CARE AND REHAB	3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002

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F0689 SS = SQC-J	Continued from page 8 locked. The surveyor reviewed the medical record for Resident #2. According to the Admission Record (AR) face sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 . According to the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's cognition was NJ Exec Order 26.4b1. The surveyor reviewed Resident #2's Admit/Readmit Screener (admission assessment) with an effective date of NJ Exec Order 26.4b1 at 4:55 PM, which revealed that Resident #2 needed NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 [redacted] " A review of Resident #2's Care Plan (CP) with an initiated date of NJ Exec Order 26.4b, revealed that Resident #2 was an NJ Exec Order 26.4b risk/NJ Exec Order 26.4b as evidenced by NJ Exec Order 26.4b1 The CP also indicated that Resident #2 had a [redacted] placed on their NJ Exec Order 26.4b1 and that the resident should be NJ Exec Order 26.4b1 [redacted] A review of the Progress Note (PN) dated NJ Exec Order 26.4b1 25 at 12:03 AM, written by LPN #4, included that Resident #2 was NJ Exec Order 26.4b for NJ Exec Order 26.4b1 on to the elevator. A review of the PN dated NJ Exec Order 26.4b1 at 11:45 AM, written by LPN #5, included that the resident was NJ Exec Order 26.4b NJ Exec Order 26.4b1 , "Management made aware that the resident had a functioning NJ Exec Order 26.4b1 that has been checked multiple times, however, the elevator isn't working properly to NJ Exec Order 26.4b1 ." A review of the PN dated late entry NJ Exec Order 26.4b at 6:00 PM, written by the U.S. FOIA (b)(6) (U.S. FOIA (b)(6)) included that the U.S. FOIA (b)(6) alerted the U.S. FOIA of potential [redacted] that morning as resident NJ Exec Order 26.4b NJ Exec Order 26.4b NJ Exec Order 26.4b in the bedroom or on unit. The [redacted] arrived at facility with the NJ Exec Order 26.4b1 they reviewed the camera, and the resident was confirmed to have NJ Exec Order 26.4b from the facility at 8:15 AM. The NJ Exec Order 26.4b then went into active NJ Exec Order 26.4b and NJ Exec Order 26.4b and were able to NJ Exec Order 26.4b the resident and transported them to the hospital for evaluation.	F0689	Continued from page 8 9/22/25.	10/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002

(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
F0689 SS = SQC-J	Continued from page 9 A review of the PN dated NJ Exec Order 26.4b at 6:00 PM, written by LPN #5, included that the resident returned from the Emergency Department (ED) on a NJ Exec Order 26 with NJ Exec Order 26.4b1 and a functioning NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. The resident was placed on NJ Exec Order 26.4b1 as well as NJ Exec Ord On 9/10/2025 at 11:25 AM, the surveyor conducted an interview with Resident #2's assigned CNA (CNA #2), who stated that she last saw the resident on NJ Exec Order 26.4b1 at around 7:20 AM, in the dining room. CNA #2 was later alerted by CNA #1 that she NJ Exec O the resident after she went to give resident their breakfast. CNA #2 further stated that Resident #2 had gone down on the elevator "two to three days after admission" and had also gone and "stood by employee door hanging around" and that they went and got the resident by the employee door on that day and reported it to the nurse. CNA #2 stated that she could not remember the nurse's name because the nurse was from an NJ Exec Order 2 CNA #2 stated that usually if a resident who had a NJ Exec went on the elevator, the elevator door would probably close, but would not move up or down, it would beep and if it kept beeping long enough, the elevator would go down. When asked about staff responsibility and how staff supervised residents that NJ Exec Order 26.4b1 she stated: "the mentality is if they are not their Aide, they are not responsible... they are not going to NJ Exec Order 26.4b1 with resident to get off the elevator." On 9/10/2025 at 12:43 PM, the surveyor conducted a telephone interview with Resident #2's assigned nurse (LPN #1), who stated that for a resident at risk for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the resident should be NJ Exec Order 26.4b1 to the dining room for activities; they should NJ Exec Order the resident; make sure NJ Exec was working; and NJ Exec Order them NJ Ex to ensure the resident NJ Exec Order 26.4b1 the unit. LPN #1 stated that on NJ Exec Order 26.4b1 Resident #2 stopped at her medication cart, and that she told the resident that breakfast would be there shortly and encouraged the resident to go to the dining room, which the resident did. LPN #1 stated that 10 minutes later, around 8:15 AM, CNA #1 told her that she NJ Exec Order 26.4b1 Resident #2, and that she then informed Resident #2's CNA, and they all started to NJ Exec Orde for the resident. LPN #1 further stated that she informed the U.S. FOIA (b)(6) U.S. FOIA (b)(6) (LPN #3), who was supervising the 7:00 AM-3:00 PM shift. LPN #1 stated that LPN #3 and herself went up to the NJ Exec Order floor, and checked the unit. LPN #3 stated that she called NJ Exec contacted the U.S. FOIA (and initiated a NJ Exec Order 26.4b1 around 8:50 AM, because that was when they did a	F0689		10/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	**3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002**

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F0689 SS = SQC-J	Continued from page 10 complete [redacted]) including outside. On 9/10/2025 at 2:08 PM, the surveyor conducted an interview with CNA #1, who stated that Resident #2 had been [redacted] of admission to the facility. CNA#1 stated that on [redacted] she saw Resident #2 with another resident on the unit, and when the breakfast tray cart arrived on the floor, (she did not remember the time), she took Resident #2's tray to the dining room but the resident was not there. CNA #1 stated she then went to Resident #2's room, but they were not in the room either, and she went immediately to LPN #1and informed her, and they all [redacted] for Resident #2. CNA #1 stated that she had previously witnessed Resident #2 [redacted] prior to the [redacted] on [redacted]. CNA #1 stated that "the [redacted]" and that no one with a [redacted] should get into the elevator because if they did, the elevator closed and would go down to another floor. CNA #1 stated she reported the elevator issue to the [redacted] nurse, and that she remembered reporting it to the nurse because she was agitated on that day. CNA #1 stated that two other people were at the nurse's station waiting for her to finish care with another resident and they then sent her downstairs to get Resident #2 instead of going downstairs to get the resident themselves. CNA #1 further stated that the other aides and herself had previously informed the [redacted] that they were "tired of [redacted] Resident #2 [redacted]," and the [redacted] usually replied that she would report to the "higher ups." CNA #1 stated that when the [redacted] would come to the [redacted] floor to check on the unit, the aides had previously reported to him about the [redacted] issues with multiple residents including Resident #2, and that Resident #2 [redacted] in [redacted] the [redacted] CNA #2 further stated that a day or two before Resident #2's [redacted] she informed the [redacted] about the [redacted] issue and that he asked her to inform the [redacted]. On 9/10/2025 at 2:59 PM, the surveyor conducted an interview with LPN #2, who stated that the pin pad outside of the elevator door was newly placed that morning and required a code to be entered for the elevator to open. LPN #2 stated that the pin pad inside the elevator was previously in place and required a code for the elevator to operate when a resident with a [redacted] entered the elevator because it was a "locked unit." LPN #2 stated that the elevator alarm had been an issue and "not effective in sensing [redacted] and that after a few minutes of	F0689		10/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	**3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002**

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F0689 SS = SQC-J	Continued from page 11 opening the elevator, the elevator would close even without the code being entered, and that Resident #2 on more than one occasion went down the elevator to another floor. LPN #2 stated that it was NJ Exec Orde that Resident #2 NJ Exec Orde to NJ Exec Order 26.4b1, and that Management was aware and had even brought Resident #2 up to the NJ Exec Order floor unit on NJ Exec Order 26.4b1. LPN #2 stated that she had witnessed Resident #2 NJ Exec Order 26.4b1 by Management who stated, "we need to do a better job NJ Exec Order 26.4b1." LPN #2 further stated that they previously explained to Management that staff do NJ Exec Or the resident, "but the elevator system is not effective." LPN #2 did not provide the name of the person she informed of the elevator alarm issues. On 9/10/2025 at 4:20 PM, the surveyor conducted an interview with the U.S. FOIA (b) who stated that Resident #2 should not be able to NJ Exec Order 26.4b1 because they had a sensor in the elevator that would shut off the elevator if someone with NJ Exec enter the elevator. The U.S. FOIA (b stated that he was not sure that Resident #2 ever came off the unit with the NJ Exec The U.S. FOIA (b stated that staff were trained and supposed to recognize residents with NJ Exec C because they had binders on the nursing units with list of residents wearing NJ Exec C including pictures of those residents. The U.S. FO did not offer an explanation for why staff did not recognize and prevent Resident #2 from NJ Exec Order NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 At that time, the surveyor asked about the PN from NJ Exec Order 26.4 that indicated Resident #2 NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 floor from the NJ Exec floor, and the stated that he could not remember now. When asked if the facility completed an investigation for the incident, he stated that the facility administration team was not made aware of the incident. The U.S. FOIA (b also stated that he was not aware of any reports regarding the elevator alarm issues, and that the U.S. FOIA (b)(6) (U.S. FOI usually checked the alarm system weekly for function. On 9/10/2025 at 4:56 PM, the surveyor attempted to reach LPN #5 who wrote the PN NJ Exec Order 26, via telephone and got no response. On 9/10/2025 at 5:19 PM, the surveyor reviewed the camera footage with the U.S. FOIA (b). The security camera revealed that on NJ Exec Order 26.4b1 the U.S. FOIA (b)(6) responded to the sound of the door at the employee entrance to allow CNA #3 into the facility. At that same time, Resident #2 was NJ Exec Order out that same entrance at 7:21:46 AM. The explained that	F0689		10/22/2025

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DWELLSIDE CARE AND REHAB	3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002

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F0689 SS = SQC-J	Continued from page 12 the camera had a time lag on the clock timer, so the actual time was 8:15 AM, and not 7:21 AM. On 9/11/2025 at 10:52 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that there was a "glitch in the system and the system was not connecting to the sensor in the ceiling." The stated that she was not aware of the PN from about Resident #2 he stated that after Resident #2 on the facility recognized "gaps in the system and they started addressing them." On 9/11/2025 at 12:14 PM, the surveyor interviewed CNA #2 who stated; if a staff member was at the end of the hallway, they would not be able to see the resident NJ Exec Order 26.4b1 or hear an alarm sound from the CNA #2 stated that she did not recall hearing an alarm sound when Resident #2 NJ Exec Order 26.4b1 on and According to the U.S. FOIA (b)(6) during interview on 9/11/2025 at 12:46 PM, Resident #2 was at their " NJ Exec Order 26.4b1 " which was approximately a NJ Exec Order 26.4b1 or a NJ Exec Order 26.4b1 from the facility. On 9/11/2025 at 12:55 PM, the surveyor conducted an interview with the U.S. FOIA (b)(6) who stated that he was familiar with the system and did weekly checks by taking the sensor to the elevator and to employee entrance door to see if the alarm sounded up to three to five feet away from the exit. The stated that the setup was to not allow the resident with the to go down on the elevator unaccompanied and that when he checked the door alarms, they worked. The stated "maybe the signal on the ankle did not connect." The also stated that the technicians moved the antenna box from the top when they were called to check the elevator alarms after incident. On 9/11/2025 at 1:27 PM, the surveyor interviewed U.S. FOIA (b)(6)), who stated that she was aware that Resident #2 had behavior and that the "entire staff was aware that resident had behavior and the and resident's behavior is on the resident's care plan." On 9/11/2025 at 1:40 PM, the survey conducted an interview with CNA #3, who stated that on he was already at work and had to get something from the car. When he opened the door to re-enter the building, the resident and	F0689		10/22/2025

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F0689 SS = SQC-J	Continued from page 13 that CNA #3 was a "NJ Exec Order 26.4b1" because of the way the resident [redacted]. CNA #3 further stated that Resident #2 looked like a "[redacted]" and that he did not hear an alarm or else it would have triggered him to check. CNA #3 also stated that he did not recognize the resident because the resident resided on the [redacted] floor and he worked on the [redacted] floor. On 9/11/2025 at 2:15 PM, the surveyor re-interviewed the [redacted] in the presence of the [redacted] and [redacted] who stated that it was expected of all facility staff to know who the residents were at risk for [redacted] and who had [redacted] for the alarm system to work consistently. During interview with the [redacted] on 9/18/2025 at 10:05 AM, the surveyor asked about the facility's protocol for how staff communicated and reported any system issues including [redacted] alarm related issues. The [redacted] stated that staff were supposed to verbally inform the U.S. FOIA (b)(6) or any other administrative member. The [redacted] also stated that he was not made aware of any issues with the elevator alarming system. On 9/18/25 at 12:45 PM, during the survey team's verification of the Removal Plan (RP), the surveyor went to the employee entrance door with the [redacted] to test the alarm system. As part of the test, the surveyor asked CNA #4 to bring a resident with a [redacted] to the employee entrance door, and when the resident approached the door, the alarm did not sound. At that time, the [redacted] opened the employee entrance door and asked the staff to walk with the resident through the door. The resident, who was wearing a [redacted] walked out of the building and the door alarm did not sound. Both CNA #4 and the [redacted] stated that the alarm was supposed to sound to alert staff that a resident with a [redacted] NJ Exec Order 26.4b1 On 9/18/2025 at 1:00 PM, the surveyor went to the [redacted] floor and requested CNA #5 to walk a resident with a [redacted] through the elevator to test the functioning of the alarm system. CNA #5 then accompanied Resident #2 to Elevator #[redacted] and when Resident #2 entered Elevator #[redacted] the alarm did not sound. The surveyor entered the same elevator and joined CNA #5 and the resident. Without entering the alarm code, CNA #5 pushed the elevator down button; the elevator door closed and went down to the first floor without the code being entered and the alarm did not sound. CNA #5 stated that the elevator alarm was supposed to sound; the door was not supposed to close; and the elevator was not supposed to go down if a resident was in the elevator with a [redacted] and the code was not entered.	F0689		10/22/2025

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F0689 SS = SQC-J	Continued from page 14 CNA #5 then checked the resident's ankle to make sure the resident was wearing their [NJ Exec] and confirmed the presence of the [NJ Exec] on the resident's ankle. The surveyor then requested that the [NJ Exec] alarm be tested on Elevator #2, and CNA #5 accompanied the resident into Elevator #2, and the alarm did not sound. During interview with the [U.S. FOIA (b)] in the presence of the [U.S. FOIA] on 9/18/2025 at 1:55 PM, he stated that he expected the alarm systems to work consistently whenever a resident with a [NJ Exec] tried to enter the elevator or to exit through the employee door. The implementation of the Removal Plan was not verified, and the immediacy continued. An acceptable Removal Plan (RP) was received on 9/19/2025 at 10:56 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include Resident #2 was [NJ Exec Order] on [NJ Exec Order 26.4b1] sent to the hospital for evaluation, returned to the facility the same day, and immediately placed on [NJ Ex] [NJ Exec Order 26.4b1] that was maintained until [NJ Exec Order 26.4b1] Resident #2 had a [NJ Exec] [redacted]; the physician and family were notified; and the resident's [NJ Exec] was checked every shift for placement and function. On 8/25/2025, the facility's vendor serviced the [NJ Exec] system, and staff were stationed at employee entrance/exit until 9/18/2025, when the system was repaired when the [NJ Exec] vendor increased the system's sensitivity. All residents with [NJ Exec] were checked; updated resident photos for residents with [NJ Exec C] were posted in both elevators and employee entrance. All receptionists were educated on the process of buzzing employees in and out of the facility, and all staff were educated on the facility's elopement policy, wandering binders and identification process, and elopement drills were conducted. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 9/23/2025. NJAC 8:39-27.1(a)	F0689		10/22/2025

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F0000	INITIAL COMMENTS An on-site revisit for the facility's Plan of Correction was conducted on 10/22/2025 in relation to the 09/23/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		09/18/2025

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060402	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	**3025 CHAPEL AVENUE WEST , CHERRY HILL, New Jersey, 08002**

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S0000	Initial Comments An on-site revisit for the facility's Plan of Correction was conducted on 10/22/2025 in relation to the 10/22/2025 State of New Jersey Complaint 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		09/18/2025

Office of Primary Care and Health Systems Management

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