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 01/06/2026

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 #: 2595311, 2601489 Survey Dates: 1/6/26 Census: 144 Sample Size: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F0842	Corrective action for the resident affected A comprehensive review of Resident #1's medical record was completed to ensure all available documentation related to medication procurement, pharmacy communication, and provider notifications were present. Resident #1's NJ Ex Order 26.4(b)(1) plan was reviewed and confirmed to be current, complete, and accurately documented. Identification of other residents with the potential to be affected The facility determined that all residents have the potential to be affected by this deficient practice; this can be indicated by reviewing the resident's medical record. Systemic change to Prevent Recurrence An in-service was conducted by the Director of Nursing beginning 2/5/26 for all nursing staff. Education included nursing guidance requiring a corresponding progress note for every MAR chart code, including Medication unavailable Held doses	02/13/2026

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

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 01/06/2026

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
F0842 SS = D	Continued from page 1 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations	F0842	Continued from page 1 Education also covered: Documentation of provider contact Pharmacy communication Accuracy and completeness of medical records Staff were educated that any action taken but not documented is considered not completed. Monitoring and Quality Assurance To monitor ongoing compliance, five (5) random resident audits of controlled-substance MARs and corresponding progress notes will be conducted by DON/designee weekly for four (4) weeks, then monthly for three (3) months, and quarterly thereafter. Audits will review MAR chart codes, including medication unavailable and held doses Documentation of provider contact Pharmacy communication The Director of Nursing will report controlled-substance MARS and progress notes audit findings to the Administrator and the QAA Committee monthly and quarterly for the next four (4) quarters, or until consistent substantial compliance is achieved. Additional corrective action will be implemented as needed.	

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 01/06/2026

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
F0842 SS = D	Continued from page 2 conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT #259311 Based on interview, review of medical records and other pertinent facility documentation on 1/6/26, it was determined that the facility failed to maintain an accurate and complete medical record in accordance with acceptable professional standards of practice. This deficient practice was identified for 1 of 4 residents reviewed (Resident #1) and was evidenced by the following: During an interview on 1/6/26, at 12:24 PM, Resident #1 stated that there was a time in August when they ran out of NJ Ex Order 26.4(b and that the facility did not refill the medication timely. The resident further stated that they received NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4 as substitute during the period when the NJ Ex Order 26.4(b was not available. A review of the Admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Orde , and NJ Ex Order 26 The comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26.4 , revealed a Brief Interview of Mental Status (BIMS) of NJ E out of 15, which indicated that the resident was NJ Ex Order 26.4(b)(1) . Further review of the MDS indicated that Resident #1 had NJ Ex Order 26.4(b)(1) . A review of Resident #1's Order Summary Report indicated that the resident had an active order for NJ Ex Order 26.4(b)(1) Tablet Extended Release. A review of Resident #1's Medication Administration Record (MAR) for NJ Ex Order 26.4(b)(1) indicated that the resident was prescribed: NJ Ex Order 26.4(b)(1) Oral Tablet NJ Ex Order 26.4(b)(1) – Give 1 tablet by mouth every 12 hours for NJ Ex Order 26.4(b)(1) . The following was also	F0842		

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 01/06/2026

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
F0842 SS = D	Continued from page 3 noted on the specified dates/times: [redacted] at 9 AM: #9 [redacted] at 9 PM: #9 [redacted] at 9 AM: #9 [redacted] at 9 PM: #9 [redacted] at 9 AM: #9 [redacted] at 9 PM: #5 [redacted] at 9 AM: #9 [redacted] at 9 PM: #9 [redacted] at 9 AM: #9 [redacted] at 9 PM: #5 [redacted] at 9 AM: #9 Further review of MAR revealed a "Chart Codes" section which indicated the following: #5 = Hold/See Nurse Notes #9 = Other/See Nurse Notes A review of Resident #1's Progress Notes (PN) for the corresponding dates revealed the following: [redacted] Physician Note (3:30 PM) Resident was seen after a report of [redacted] that was '[redacted] A [redacted] was ordered. [redacted] EMAR Note (11:54 PM) Awaiting pharmacy delivery [redacted] APN Note (2:41 PM) Resident was seen for a medication refill. The resident was noted as '[redacted] and stated that the prescribed [redacted] had not been received. Nurse reported that they were waiting for the pharmacy delivery. APN provided a script for the [redacted] the nurse. [redacted] EMAR Note (9:35 PM) Awaiting pharmacy delivery. [redacted] EMAR Note (9:49 PM) Waiting on pharmacy	F0842		

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 01/06/2026

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
F0842 SS = D	Continued from page 4 delivery. -[redacted] EMAR Note (8:00 PM) Med [Out of stock] awaiting order A review of the medical record did not reveal documented evidence that the facility made an attempt to contact Resident #1's medical provider to request a refill for the [redacted] Oral Tablet [redacted] from [redacted] until [redacted]. A review of a grievance dated [redacted], revealed that the [redacted] interviewed the resident regarding this concern and that it was resolved as of [redacted]. On 1/6/26 at 3:35 PM the surveyor attempted to contact Licensed Practical Nurse (LPN #1) via telephone, without success. During an interview with the facility's contracted pharmacy on 1/6/26, at 2:20 PM, the pharmacist provided the following timeline regarding the [redacted] prescribed to Resident #1: [redacted] -Electronic request from facility received by pharm to refill [redacted] -Pharm sent fax to MD, stating a script was needed -Pharm received script w/missing info [redacted] -Pharm spoke w/[staff] at facility advised of clarification needed [redacted] -Pharm received correct script [redacted] -Pharm delivered medication During an interview with the Registered Nurse (RN #1) on 1/6/26 at 3:39 PM, RN #1 stated that nurses were to monitor medication counts to ensure that there was no gap in between deliveries. RN #1 further stated that [redacted] cannot be re-ordered electronically, a script is needed. RN #1 stated that this made monitoring the counts even more important because the doctor needs to be contacted and that, "All of this takes time." RN #1 further stated that all of this should be documented. In the presence of the surveyor RN #1 reviewed Resident #1's [redacted] MAR and confirmed that she entered #9	F0842		

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 01/06/2026

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
F0842 SS = D	Continued from page 5 in the [NJ Ex Order 26.] box at 9 PM. RN #1 also confirmed that there was no corresponding PN for that date explaining any further details. RN #1 stated that she could not recall calling the doctor but that she should have and that she also should have documented it so that everyone was aware that it was done. During an interview with the [U.S. FOIA (b) (6)] on 1/6/26 at 4:20 PM, the [U.S. FOIA] stated that as part of the investigation into grievance, the [U.S. FOIA] interviewed Licensed Practical Nurse (LPN #1) who was assigned to Resident #1 on [NJ Ex Order 26.4] The [U.S. FOIA] stated that LPN #1 informed the [U.S. FOIA] that an attempt to reach the physician was made during the [NJ Ex Order 26] day shift and multiple times after that. The [U.S. FOIA] stated that he was unsure why nurses were not documenting their efforts to obtain a script but that they should have. The [U.S. FOIA] further stated documentation in the medical record was important to ensure that the record accurately reflects the care being provided to each resident. A review of the facility's undated "Charting and Documentation" policy revealed that all services provided to residents should be documented and that documentation would be complete and accurate. A review of the facility's "Medication Procurement Policy" dated January 2025, revealed that all communication with physicians and supervisory staff must be documented in a resident's medical record. N.J.A.C. 8:39-27.1(a)	F0842		

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 01/06/2026

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
S0000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S0000		
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 review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 3 day shifts and 2 evening shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as 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. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a	S0560	No residents were affected by this deficient practice. Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. All residents have the potential to be affected by the deficient practice. Corrective measures to prevent recurrence: On 2/6/2026, the facility Administrator provided an in-service to the Staffing Coordinator on the required staffing ratios and the importance of consistently meeting the required staffing ratios. The facility Administrator has put in place a bonus structure to help increase the levels of staffing accordance to census. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials, and referral bonuses are being utilized to become more competitive in the marketplace. In addition, the Director of Nursing or designee will meet with the Staffing Coordinator to ensure appropriate staffing. The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. Findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI committee quarterly until compliance is met.	02/13/2026

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: 060402	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026

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
S0560	Continued from page 1 certified nurse aide 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. For the 2 weeks of staffing from 12/21/25-1/3/26 the facility was deficient in CNA staffing for residents on 1 of 14 day shifts and 2 of 14 evening shifts as follows: -12/27/25 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. -1/2/26 had 13 CNAs for 145 residents on the evening shift , required at least 14.CNAs. -1/3/26 had 15 CNAs for 144 residents on the evening shift , required at least 18 CNAs. For the week of staffing from 8/24/25-8/30/25 the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -8/24/2025 had 17 CNAs for 150 residents on the day shift , required at least 19 CNAs. -8/24/2025 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs.	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315068	A. BUILDING B. WING	**02/18/2026**

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 An offsite/desk review of the facility's Plan of Correction was conducted on 2/18/26 in relation to the 1/6/26 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		02/13/2026

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

New Jersey State 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 02/18/2026

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
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 2/18/26 in relation to the 1/6/26 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		02/13/2026

Office of Primary Care and Health Systems Management

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