STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARCLAYS REHABILITATION AND HEALTHCARE CENTER	**1412 MARLTON PIKE EAST , CHERRY HILL, New Jersey, 08034**

(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 Survey Date: 8/12/25 to 8/20/25 Census: 88 Sample: 18 + 3 closed records A Recertification/LSC survey was conducted at Barclays Rehabilitation and Healthcare Center from 8/12/25 to 8/20/25, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		09/11/2025
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements	F0578	Affecting #24 & #25. The U.S. FOIA (b) (6) was re-inserviced on providing residents' and/or resident representative information on NJ Ex Order 26.4(b)(1) upon admission and documenting the resident and/or resident representative decision. Resident #24 & #25 were immediately given information on NJ Ex Order 26.4(b)(1) and proper documentation was updated in the resident's chart. The Social Services Directive conducted an audit to ensure all existing residents were properly provided information on NJ Ex Order 26.4(b)(1) and document in each resident's chart. All residents have the potential to be affected by the facility failing to provide resident's information on Advance Directives upon admission to the facility. The U.S. FOIA (b) (6) was re-inserviced by the Administrator on providing residents' and/or the resident representative information on Advanced Directives and documenting the resident and/or resident representative decision. The Social Service Director or Designee conducted an audit to ensure all existing residents were properly provided information on Advanced Directive and document in each resident's chart.	09/26/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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F0578 SS = D	Continued from page 1 of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to inform and offer educational material regarding NJ Ex Order 26.4(b)(1) [redacted]) with a resident and/or legal representative. This deficient practice was identified for 2 of 2 residents (Resident #24, and Resident #25) reviewed for [redacted] and was evidenced by the following: On 8/12/2025 at 10:31 AM, the surveyor observed Resident #25 in bed with NJ Ex Order 26.4(b)(1) [redacted]. in room [redacted] The surveyor attempted to talk to the resident, but the resident [redacted]. On 8/12/2025 at 10:31 AM the surveyor reviewed the medical record for Resident #25 which revealed the following: A review of the Admission Record (an admission summary) reflected that the resident was admitted with diagnoses which included but was not limited to; [redacted]), NJ Ex Order 26.4(b)(1) [redacted]), [redacted]), NJ Ex Order 26.4(b)(1)). The Admission Record indicated the resident was listed as a [redacted]). There was no NJ Ex Order 26.4(b)(1) [redacted] (NJ Ex Order 26.4(b)(1) [redacted]) in the medical record. There was no information that determined upon admission whether the resident had an	F0578	Continued from page 1 The Social Service Director or Designee will audit to ensure all new residents were properly provided information on Advanced Directive and document in resident's chart weekly x4, monthly x3 and quarterly thereafter. The Social Services Director/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F0578 SS = D	Continued from page 2 NJ Ex Order 26.4(b)(1), or any documentation as to whether the resident or Resident Representative wished to formulate an NJ Ex Order 26.4(b)(1). A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Ex Order 26.4(b)(the resident had a Brief Interview for Mental Status (BIMS) score of NJ /15, indicating that the resident had a NJ Ex Order 26.4(b)(1) . A physician's order (PO) dated NJ Ex Order 26, revealed Resident #25 was a NJ Ex Order 26.4(b)(", Order Type: NJ Ex Order 26.4(b) A review of the resident's individualized care plan focus area indicated [Resident #25] has an NJ Ex Order 26.4(b with a NJ Ex Or status of "NJ Ex Order 26.4(b)(1) ". On 8/12/2025 at 12:35 PM the surveyor reviewed the medical record for Resident #24. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the with diagnoses which included, but was not limited to; NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)). The Admission Record indicated the resident was listed as NJ Ex Order 26.4(b)(. There was a NJ Ex Order 2 in the medical record, that indicated NJ Ex signed by the RR on NJ Ex Order 26.4. There was no documented evident upon on admission regarding whether the resident had NJ Ex Order 26.4(b)(1), and if not, determined whether the resident was offered to formulate NJ Ex Order 26.4(b)(1). A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(b)(revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ E /15, indicating that the resident was NJ Ex Order 26.4(b)(1). A physician's order (PO) dated NJ Ex Order 26, revealed: NJ Ex O ", Order Type: NJ Ex Order 26.4(b)(1) A review of the resident's individualized care plan focus area indicated "[Resident #24] had a status of NJ Ex Order 26.4(b)(1) ." On 8/19/2025 at 9:16 AM the surveyor interviewed Resident #24 who stated that no one had spoken to them about NJ Ex Order 26.4(b)(1). The resident further stated,	F0578		

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F0578 SS = D	Continued from page 3 "I heard about it, but I don't know what it is. I would like to have information about it." On 8/13/2025 at 8:58 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated the NJ Ex Order 2 "could take the place of the NJ Ex Order 26.4(b)(1)." He further stated that typically residents do not get admitted with NJ Ex Order 26.4(b)(1) from the hospital. "We rely on the NJ Ex Order 2 if they have one." The code status orders were entered from the NJ Ex Order 2 form. He then stated that he was not aware of documentation or education that the facility provided about NJ Ex if no NJ Ex existed. He stated that NJ Ex Order 26.4(b)(1) should have met with new admissions by the next day. The U.S. FOIA that the U.S. FOIA (should have met with Resident #24 and Resident #25 to discuss the NJ Ex O On 8/14/2025 at 8:42 AM, the U.S. FOIA confirmed that there was no discussion and/or planning upon admission regarding NJ Ex with either Resident #24 or Resident #25 and/or the RP. In addition, he stated that resident #25's RP worked at the facility, and confirmed that no one had spoken with them regarding the NJ Ex (The U.S. FOIA stated that the U.S. FOIA (b) (6) was responsible for discussing NJ Ex with residents upon admission. The surveyor was informed that the U.S. FOIA (b) (6) resigned on NJ Ex Order 26.4(b)(1), and was unavailable for an interview. On 8/19/2025 at 1:41pm, the surveyor interviewed the U.S. FOIA (b) (6)), U.S. FOIA (b) (6) , and U.S. FOIA (b) (6)). The U.S. FOIA (acknowledged that Residents #24 and #25 did not have an NJ Exec Order 26.4b1 and there was no documentation that the resident/resident representative was provided education. The NJ Ex Ord added that residents should be asked if they have an NJ Ex (and if so the facility should request a copy, or if they did not have an NJ Ex (they should ask if they would like information to formulate an NJ Ex (The NJ Ex Ord further stated that residents also have the right to refuse. U.S. FOIA (b) U.S. FOIA and U.S. FOIA acknowledged that NJ Ex were not addressed with residents #24 and #25 and should have been addressed upon admission. A review of the facility's policy "Advanced Directives" revised date of 1/2025, included: Policy: it is the policy of this facility to offer every resident, or their resident representative, the opportunity to make decisions about their own health by means of preparing an Advance Directive. Procedure: Upon admission, residents and/or their responsible party are asked if	F0578		

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F0578 SS = D	Continued from page 4 an Advanced Directive or Living Will exists. If an Advanced Directive or Living Will exists, it is reviewed and will be placed in the resident's chart. 1.Upon admission, residents and/or their responsible party are asked if an Advanced Directive or Living Will exists. 2. If an Advanced Directive or Living Will exists, it is reviewed and will be placed in the resident's chart. 3. If the resident is mentally competent, and an Advanced Directive/Living Will does not exist, he/she will be asked if he/she wishes to complete an Advanced Directive. Information pertaining to his/her rights regarding Advanced Directive/Living Will will also be given to the resident... NJAC 8:39-9.6 (a)(b)	F0578		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident	F0584	Affecting Resident #44. The Housekeeping Director immediately cleaned the residents wheelchair and maintenance replaced the right armrest and the floor molding in the bathroom. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were re-inserviced by the Administrator on the facilities policy and procedure of "Cleaning and Disinfection of Resident - Care Items and Equipment". The Director of Housekeeping / Designee conducted an audit on all resident wheelchairs and bathrooms to ensure they are clean and present in a homelike manner. All residents have the potential to be affected by the facilities failure to ensure maintain a resident's wheelchair, wheelchair armrest, and bathroom in a clean and homelike manner. The Director of Housekeeping and Director of Maintenance were re-inserviced by the Administrator on the facilities policy and procedure of "Cleaning and Disinfection of Resident - Care Items and Equipment". The Director of Housekeeping / Designee conducted an audit on all resident wheelchairs and bathrooms to ensure they are clean and present in a homelike manner. The Director of Housekeeping / Designee will audit resident wheelchairs to ensure they are clean and maintained in a homelike manner weekly x 4, monthly x3 and quarterly thereafter.	09/26/2025

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F0584 SS = D	Continued from page 5 room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and review of facility documentation, the facility failed to maintain a resident's wheelchair, wheelchair right armrest, and bathroom in a clean and homelike condition. This deficient practice was identified for 1 of 2 residents reviewed for equipment and environmental care (Resident #44), and was evidenced by the following: Based on observation, interviews, record review, and review of facility documentation, it was determined that the facility failed to maintain a resident's wheelchair, wheelchair right armrest, and bathroom in a clean and homelike manner. This deficient practice was identified for 1 of 2 residents reviewed for environment (Resident #44), and was evidenced by the following: On 8/12/2025 at 9:32 AM, during the initial tour, the surveyor interviewed Resident #44 in their room and was seated in their wheelchair. The resident stated that their wheelchair was "pretty dirty" and was unsure when it was last cleaned. The surveyor observed visible debris and food-like particles on the wheelchair and noted that the right armrest was worn through, and the padding was exposed. On 8/13/2025 at 8:50 AM, the surveyor observed the rubber-like floor molding approximately eight inches was hanging off the wall toward the floor in Resident #44's bathroom. A review of Resident #44's medical record revealed that the resident was admitted with diagnoses including NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26. and NJ Ex Order 26.4(b)(1)	F0584	Continued from page 5 The Director of Housekeeping/ Designee will audit all resident bathrooms to ensure they are clean and maintained in a homelike manner weekly x 4, monthly x3 and quarterly thereafter. The Housekeeping Director/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F0584 SS = D	Continued from page 6 NJ Ex Order 26.4(b)(1)). The Quarterly Minimum Data Set (QMDS) dated NJ Ex Order 26.4(b)(indicated a Brief Interview for Mental Status (BIMS) score of NJ E /15, reflecting that the resident was NJ Ex Order 26.4(b)(1). On 8/13/2025 at 9:35 AM, the surveyor interviewed the U.S. FOIA (b) (6)) assigned to Resident #44. The U.S. FOIA stated that wheelchairs were cleaned regularly, and that the resident's wheelchair had been cleaned a few days prior. She then stated, she did not notice any dirt or damage to the wheelchair and was unaware of the worn armrest. When inquired regarding the hanging molding in the bathroom, the U.S. FOIA stated that she did not notice it. She added that dirty wheelchairs were reported to Housekeeping and damaged wheelchairs were reported to Maintenance. On 8/13/2025 at 10:33 AM, the surveyor interviewed the U.S. FOIA (b) (6) caring for Resident #44. The U.S. FOI stated that wheelchairs were washed weekly and acknowledged that the resident's wheelchair was soiled, and the armrest needed repair. The U.S. FOI also acknowledged the hanging molding in the bathroom and submitted a maintenance request in the presence of the surveyor. On 8/13/2025 at 10:44 AM, the surveyor observed the U.S. FOIA (b) (6) stapling the hanging molding back onto the bathroom wall. Upon interview, he stated that room audits were conducted weekly however, he confirmed he was not made aware of the lifted molding. On 8/14/2025 at 8:46 AM, the surveyor interviewed the U.S. FOIA (b) (6)), he stated that she maintained a wheelchair cleaning schedule. Resident #44's wheelchair was scheduled for cleaning on NJ Ex Order 26.4(b) and the resident had previously refused cleaning on NJ Ex Order 26.4(b)(1 The U.S. F stated that refusals are verbally reported to Nursing but are not documented. She also noted that she was out for two weeks in NJ Ex Or and could not confirm whether the wheelchair was cleaned during that time. On 8/15/2025 at 8:51 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that she works closely with Housekeeping and Maintenance to coordinate wheelchairs cleaning and repairs. If a resident arrived at therapy with a dirty or broken wheelchair, a work order was submitted, or the resident was transferred to a temporary chair so their chair could be cleaned by housekeeping. If the resident refused, Housekeeping and Nursing were notified. She stated that she does not document wheelchair cleaning refusals. She noted that Resident #44 last attended	F0584		

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F0584 SS = D	Continued from page 7 NJ Ex Order 2[redacted] the previous week and she did not notice any issues with the wheelchair. On 8/19/2025 at 9:03 AM, the surveyor interviewed resident #44 who stated, NJ Ex Order 26.4(b)(1) [redacted]." On 8/19/2025 at 9:12 AM the surveyor interviewed again the U.S. FOI[redacted] who cared for Resident #44. The U.S. FOI[redacted] stated that resident #44 never refused to have NJ Ex[redacted] wheelchair washed to me, if NJ Ex Order[redacted], I would document it. Review of the Maintenance logs for NJ Ex Order 26.4(b)([redacted] indicated the following: Checklist-Room #NJ Ex O[redacted] Item listed to be checked included Main Door, Bed, T.V./Remote, Call Bell, Telephone, Clock, Nightstand, Over the bed table, Light switches/Electric Plugs… wheelchairs and floor molding were not included on the list. Review of NJ Ex Order 26.4(b)[redacted] and NJ Ex Order 26.4(b)(1)[redacted] wheelchair cleaning schedule indicated the following: Room NJ Ex O[redacted] was scheduled to have NJ Ex[redacted] wheelchair cleaned on NJ Ex Order 26.4(b[redacted], and NJ Ex Order 26.4(b)(1). On 8/19/2022 at 10:43 AM, the U.S. FOIA (b) (6) provided the policy titled, "Cleaning and Disinfection of Resident- Care Items and Equipment" reviewed 12/2024 The policy Statement indicated the following: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The policy did not address wheelchair armrest replacement. NJAC 8: 39 -31.4 (c)	F0584		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F0609	Affecting Resident #11. The Administrator immediately notified the Department of Health and NJ Ex Order[redacted] of the resident's concern of NJ Ex Order 26.4(b)(1). The Administrator / designee investigated the concern and reimbursed the resident / NJ Ex Order 26.4(b)(1) that were NJ Ex Order 26.4[redacted]	09/26/2025

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F0609 SS = D	Continued from page 8 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to immediately report an NJ Ex Order 26.4(b)(1) [redacted] for 1 of 1 residents (Resident #11) reviewed for NJ Ex Order 26.4(b)(1) to the New Jersey Department of Health (NJDOH). This deficient practice was evidenced by the following: A review of the Admission Record (admission summary) indicated that Resident #11 was admitted to the facility with the diagnoses which included but was not limited to NJ Ex Order 26.4(b)(1) [redacted]) and NJ Ex Order 26.4(b)(1) [redacted]). A review of the quarterly Minimum Date Set (MDS) and assessment that facilitates a resident's care dated NJ Ex Order [redacted], reflected that Resident #11 scored a NJ E [redacted] of 15 on the basic interview for mental status (BIMS) which indicated that the resident had NJ Ex Order 26.4(b)(1) [redacted] and exhibited behaviors such as NJ Ex Order 26.4([redacted]. A review of the Care Plan (CP) did not reflect that the resident had NJ Exec Order 26.4b1 or NJ Exec Order 26.4([redacted]. On 8/13/2025 at 8:45 AM, the surveyor interviewed Resident #11 who stated that agency Certified Nursing Assistances (CNAs) were NJ Ex Order 26.4(b)(1) the resident's	F0609	Continued from page 8 All residents have the potential for the facility's failure to immediately report an allegation of misappropriation of resident property. The U.S. FOIA (b) (6) was re-inserviced by the Director of Operations on the requirements of reporting NJ Ex Order 26.4(b)([redacted] The Administrator / designee will audit all grievances pertaining to misappropriation of funds to ensure they were called into the Department of Health within the appropriate amount of time monthly x3, quarterly thereafter. The Administrator /designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 9 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) such as NJ Ex Order 26.4 and NJ Ex Orde The resident stated that the administration and nurses were aware, but no one was doing anything about it. The surveyor observed the NJ Ex O that was hanging on the NJ Ex Order 2 and it was NJ Ex Order 26 The resident stated that they reported the NJ Ex Order 26.4(b)(1) the other morning (did not specify a date) to the nurse and the CNAs but did not know their last names. The resident stated that the NJ Ex Orde were NJ Ex Order 26.4(b)(1 and the NJ Ex Ord that were 'NJ Ex Order 2 were NJ Ex Order 26.4(b)(1). The resident stated that the NJ Ex Order 26.4(b)(1) happened a NJ Ex Order 26.4(b)(1) ago, and the NJ Ex Order 26.4 was not NJ Ex Order 26.4 by the administration at the facility. Stated that the family was aware of the NJ Ex Order 26.4(b)(1). On 8/13/2025 at 9:29 AM, the surveyor interviewed Resident #11's Resident Representative (RP) and asked the RP if they were aware of any issues that Resident #11 was having in the facility and the RP stated, "What, the NJ Ex Order 26 that's going on". The RP stated that Resident #11 told her that an agency staff member was getting into the resident's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). She stated that the 'NJ Ex Order 26.4 started in NJ Ex Order 26.4(b)(1) and was reported to the U.S. FOIA (b) (6)) in NJ Ex Or The RP stated that she bought Resident #11 a NJ Ex Order 26 and the NJ Ex Order 26.4 went missing. The RP stated that she had reported the NJ Ex Order 26.4(b)(1) to the U.S. FOIA (b) (6) and to administration. She stated that the facility was supposed to replace NJ Ex Order 26.4(b)(1) but did not. The RP stated that the Administration did not have Resident #11 or RP fill out any paperwork or statements regarding the NJ Ex Order 26.4(b)(1). She stated that the NJ Ex Orde were not notified and that no one from the facility followed up with the RP with any conclusion of an investigation. She stated that Resident #11 was provided with NJ Ex Order 26.4(b)(1) after the NJ Ex Order 26.4(b)(1) but was not notified that the NJ Ex Order 26.4(b)(1) was currently NJ Ex Order 26 She stated the on NJ Ex Order 26.4(b)(1), Resident #11 told the RP that NJ Ex Ord was NJ Ex Order 26 from the NJ Ex Order 2 in the resident's room. On 8/13/2025 at 10:05 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that Resident #11 was NJ Ex O and NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) their needs and wants. The CNA revealed that the resident did not report that someone was NJ Ex Order 26.4(b)(1) to her however that "the day before yesterday" another CNA (CNA #2) was looking for the resident's NJ Ex Order 26.4(b)(1). CNA #1 stated that she was not aware of any other complaints from the resident regarding NJ Ex Order 26.4(b)(1).	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0609 SS = D	Continued from page 10 On 08/13/2025 at 10:12 AM, the surveyor interviewed Resident #11's primary care NJ Ex Order 26.4(b)(1)) who stated that Resident #11 reported to her this morning that NJ Ex Order 26.4(b)(1) and that someone NJ Ex Order 26.4 The U.S. F stated that the U.S. FOIA (was in this morning to see the resident about the complaint. The U.S. F revealed that in the past, the resident reported that perfume was stolen. The U.S. F stated that the U.S. FOIA (b) (6)) and the U.S. FOIA (were handling the issue. She stated that she was not sure if NJ Ex Orde were notified however the U.S. FOIA (gave the resident NJ Ex Order 26.4(b)(1) after the resident reported that the NJ Ex Order 26.4(b)(1). The U.S. F stated that the resident was not consistently using the NJ Ex Order 26.4(b)(1) because it was not convenient. She continued to add that if the resident complained of NJ Ex Order 26.4(b)(1) to her, she would report it to the administration, and they would handle the investigation. On 8/13/2025 at 10:24 AM, the surveyor interviewed the residents primary care CNA #2 who stated that Resident #11 reported that NJ Ex Order 26.4 was NJ Ex Order 26 from the resident's NJ Ex Order 2 a couple months ago and she thought there was an investigation was being done by the U.S. FOIA (b) (6) She stated that the U.S. FOIA (was supposed to replace the NJ Ex Order 26. but was not replaced as far as she knew. She stated that after the resident reported that the NJ Ex Order 26.4(b)(1), the administration put NJ Ex Orde on the resident's NJ Ex Order 2 She confirmed that the resident did not consistently use NJ Ex Order 26 on the NJ Ex Order 2 and always needed someone to NJ Ex Order 26. . She stated that she was not aware that the NJ Ex Order 26.4(b)(1) at this time. She added that the resident reported to her on NJ Ex Order 26 that NJ Ex Orde was now NJ Ex Order 26. CNA #2 stated that she reported the NJ Ex Order 26.4(b)(1) to an agency nurse and was not sure if the nurse told the administration. She stated Resident #11 called their RP and reported that their NJ Ex Order 26.4(b)(1) . On 8/13/2025 at 11:23 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that he was not aware and was not notified that the resident had complaints of NJ Ex Order 26.4(b)(1). He then added that he was made aware that Resident #11 stated that they had NJ Ex Order 26.4(b)(1) their room. He stated that the U.S. FOIA (was investigating the complaint of NJ Ex Order 26.4(b)(that was reported this morning (8/13/25). The surveyor asked the U.S. FOIA if he was made aware about NJ Ex Order 26 a NJ Exec Order 26.4b1. The U.S. FOIA stated that the NJ Ex Order 26.4(b)(1) was not reported to him however was reported to the U.S. FOIA (and that the U.S. FOIA (was handling that investigation. The surveyor asked the U.S. FOIA what the process was for reporting NJ Ex Order 26.4(b)(1) and he stated that an investigation would be	F0609		

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F0609 SS = D	Continued from page 11 conducted which included completing an incident report, interviewing staff, obtaining written statements from resident and staff or any other witnesses. He stated that the staff were to contact family members and report the incident to the Department of Health (DOH) within 2 hours. On 8/13/2025 at 11:36 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that the U.S. FOIA (usually instructed the U.S. FOIA to put the NJ Ex Ord on the resident's NJ Ex Order 26. if the resident requested. The U.S. FOIA stated that the U.S. FOIA (instructed the U.S. FOIA to put the NJ Ex O on Resident #11's NJ Ex Order 2 a NJ Exec Order 26.4b1. The U.S. FOIA spoke with the resident and the resident told him that the NJ Ex O had to be put on because "something about NJ Ex Order 26.4(b The U.S. FOIA did not remember the date the NJ Ex O was installed on NJ Ex Order 26.4(b)(. On 8/13/2025 at 11:54 AM, the U.S. FOIA (stated that he did not investigate and did not report the NJ Ex Order 26.4(b of NJ Ex Order 26.4(b)(1) because he did not have a time frame. He stated that he should have reported the NJ Ex Order 26.4(b to the NJDOH within two hours and called the NJ Ex Order He continued to admit that he should have obtained statements from the staff, resident and other NJ Ex O and NJ Ex Order 26. residents in the area. He stated that he did not recall if the resident was NJ Ex Order 26.4(b)(1 for the NJ Ex Order 26.4(b)(1). He stated that it would that been important to follow the process for investigating and reporting NJ Ex Order 26.4(b)(1) to protect the resident and other residents. The U.S. FOIA (stated that he was the NJ Ex Order officer for the facility and was aware that he should have reported and investigated the residents compliant of NJ Ex Order 26 The facility policy dated 9/2024 and titled, "Abuse, Neglect, and Mistreatment of Residents Policy" indicated that each resident had the right to be free from mistreatment, neglect and misappropriation of property. The policy indicated that misappropriation of property was defined as deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The policy indicated that the facility would ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown origin source and misappropriation of a resident's property would be reported immediately to the Administrator/designee or the facility and to other officials in accordance with state law including the state survey and certification agency. NJAC 8:39-4.1(a)5	F0609		

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F0609 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their [redacted] policy and thoroughly and timely investigate an [redacted] by 1 of 1 resident (Resident #11) who reported [redacted] to the [redacted]). This deficient practice was evidenced by the following: A review of the Admission Record (admission summary) indicated that Resident #11 was admitted to the facility with the diagnoses which included but was not limited to [redacted]) and [redacted]). A review of the quarterly Minimum Date Set (MDS) and assessment that facilitates a resident's care dated [redacted], reflected that Resident #11 scored a [redacted] of 15 on the basic interview for mental status (BIMS) which indicated that the resident had [redacted] and exhibited [redacted] such as [redacted] A review of the Care Plan (CP) did not reflect that the resident had [redacted] or [redacted] On 8/13/2025 at 8:45 AM, the surveyor interviewed	F0609 F0610	Affecting Resident #11. The Administrator / designee immediately investigated Resident #11's concern of [redacted]. The [redacted] was re-inserviced by the Director of Operations on implementing the facilities policy and procedure for abuse and investigating allegation of misappropriation of property. All residents have the ability to be affected by the facilities failure to implement the facilities abuse policy, as well as thoroughly and timely investigate an allegation of misappropriation of property. The [redacted] was re-inserviced by the Director of Operations on implementing the facilities policy and procedure for abuse and investigating allegation of misappropriation of property. The Administrator/designee will audit all grievances to ensure the facility properly follows the abuse policy and procedure, and any missing items are properly investigated for allegation of misappropriation of property monthly x3 and quarterly thereafter. The Administrator /designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	09/26/2025

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F0610 SS = D	Continued from page 13 Resident #11 who stated that agency Certified Nursing Assistances (CNAs) were NJ Ex Order 26.4(b)(1) the resident's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) such as NJ Ex Order 26.4(b)(1). The resident stated that the administration and nurses were aware, but no one was doing anything about it. The surveyor observed NJ Ex Order 26 that was hanging on NJ Ex Order 26.4(b)(, and it was NJ Ex Order 26 The resident stated that they reported the NJ Ex Order 26.4(b)(1) the other morning (did not specify a date) to the nurse and the CNAs but did not know their last names. The resident stated that the NJ Ex Orde were not notified and the NJ Ex Ord that were 'NJ Ex Order 2 were NJ Ex Order 26.4(b)(1). The resident stated that the NJ Ex Order 26.4(b)(1) happened a NJ Ex Order 26.4(b)(1) ago, and the NJ Ex Order 26.4 was not NJ Ex Order 26.4 by the administration at the facility. Stated that the family was aware of the missing items. On 8/13/2025 at 9:29 AM, the surveyor interviewed Resident #11's Resident Representative (RP) and asked the RP if they were aware of any issues that Resident #11 was having in the facility and the RP stated, "What, the NJ Ex Order 26 that's going on". The RP stated that Resident #11 told her that an agency staff member was getting into the resident's NJ Ex Order 26.4(b)(1) and 'NJ Ex Order 26.4(b)(1) . She stated that the NJ Ex Order 26.4 started in NJ Ex Order 26.4(b)(1) and was reported to the U.S. FOIA (b) (6)) in May. The RP stated that she bought Resident #11 NJ Ex Order 26.4(b) and the NJ Ex Order 26.4 went NJ Ex Order 26.4 The RP stated that she had reported the NJ Ex Order 26.4(b)(1) to the U.S. FOIA (b) (6) and to administration. She stated that the facility was supposed to replace NJ Ex Order 26.4(b)(1) but did not. The RP stated that the Administration did not have Resident #11 or RP fill out any paperwork or statements regarding the NJ Ex Order 26.4(b)(1). She stated that the police were not notified and that no one from the facility followed up with the RP with any conclusion of an investigation. She stated that Resident #11 was provided with a NJ Ex Order 26.4(b)(1) after the NJ Ex Order 26.4 went NJ Ex Order 26 but was not notified that the NJ Ex Order 26.4(b)(1) was currently NJ Ex Order 26 She stated the on Monday NJ Ex Order 26 , Resident #11 told the RP that NJ Ex Ord was missing from the NJ Ex Order 2 in the resident's room. On 8/13/2025 at 10:05 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that Resident #11 was NJ Ex Or and NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) their NJ Exec Ord and NJ Exec Ord The CNA revealed that the resident did not report that someone was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 to her however that "the day before yesterday" another CNA (CNA #2) was looking for the resident's NJ Ex Order 26.4(b)(1). CNA #1 stated that she was not aware of any other complaints from the resident	F0610		

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F0610 SS = D	Continued from page 14 regarding missing items. On 08/13/2025 at 10:12 AM, the surveyor interviewed Resident #11's primary care U.S. FOIA (b) (6)) who stated that Resident #11 reported to her this morning that NJ Ex Order 26.4(b)(1) and that someone ' NJ Ex Order 26 The U.S. F stated that the U.S. FOIA (was in this morning to see the resident about the NJ Ex Order 26.4(b)(The U.S. F revealed that in the past, the resident reported that NJ Ex Order 26.4 was NJ Ex Order 2 The U.S. F stated that the U.S. FOIA (b) (6)) and the U.S. FOIA (were handling the issue. She stated that she was not sure if NJ Ex Orde were notified however the U.S. FOIA (gave the resident NJ Ex Order 26.4(b)(1) after the resident reported that the NJ Ex Order 26.4 was NJ Ex Order 26.4 The U.S. F stated that the resident was not consistently using the NJ Ex O on the NJ Ex Order 2 because it was not NJ Ex Order 26.4(b)(1) She continued to add that if the resident complained of NJ Ex O or NJ Ex Order 26.4(b)(1) to her, she would report it to the administration, and they would handle the investigation. On 8/13/2025 at 10:24 AM, the surveyor interviewed the residents primary care CNA #2 who stated that Resident #11 reported that NJ Ex Order 26.4 was NJ Ex Order 26 from the resident's NJ Ex Order 2 a NJ Exec Order 26.4b1 and she thought there was an investigation was being done by the U.S. FOIA (b) (6) She stated that the U.S. FOIA (was supposed to replace the NJ Ex Order 26.4 but was not replaced as far as she knew. She stated that after the resident reported that the NJ Ex Order 26.4(b)(1), the administration put NJ Ex Orde on the resident's NJ Ex Order 2 She confirmed that the resident did not consistently use NJ Ex Order 26 on the NJ Ex Order 2 and always needed someone to NJ Ex Order 26.4 . She stated that she was not aware that the NJ Ex O was NJ Ex Order 2 at this time. She added that the resident reported to her on NJ Ex Order 26 that NJ Ex Ord was now NJ Ex Order 26.4 CNA #2 stated that she reported the NJ Ex Order 26.4(b)(1) to an agency nurse and was not sure if the nurse told the administration. She stated Resident #11 called their RP and reported that their NJ Ex Order 26.4(b)(1) . On 8/13/2025 at 11:23 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that he was not aware and was not notified that the resident had complaints of NJ Ex Order 26.4(b)(1) . He then added that he was made aware that Resident #11 stated that they had NJ Ex Order 26.4(b)(1) He stated that the U.S. FOIA (was investigating the complaint of NJ Ex Order 26.4(b)(that was reported this morning NJ Exec Order 2). The surveyor asked the U.S. FOIA if he was made aware about NJ Ex Order 26 a NJ Exec Order 26.4b1 . The U.S. FOIA stated that the NJ Ex Order 26.4(b)(1) was not reported to him however was reported to the U.S. FOIA (and that the U.S. FOIA (was handling that investigation. The surveyor asked the U.S. FOIA what the	F0610		

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F0610 SS = D	Continued from page 15 process was for reporting NJ Ex Order 26.4(b)(1) and he stated that an investigation would be conducted which included completing an incident report, interviewing staff, obtaining written statements from resident and staff or any other witnesses. He stated that the staff were to contact family members and report the incident to the Department of Health (DOH) within 2 hours. On 8/13/2025 at 11:36 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that the usually instructed the to put the on the resident's if the resident requested. The stated that the instructed the to put the on Resident #11's a NJ Exec Order 26.4b1. The spoke with the resident and the resident told him that the had to be put on because "something about The did not remember the date the was installed on . On 8/13/2025 at 11:54 AM, the stated that he did not investigate and did not report the of NJ Ex Order 26.4(b)(1) because he did not have a time frame. He stated that he should have reported the to the NJDOH within two hours and called the He continued to admit that he should have obtained statements from the staff, resident and other and residents in the area. He stated that he did not recall if the resident was for the NJ Ex Order 26.4(b)(1). He stated that it would that been important to follow the process for investigating and reporting NJ Ex Order 26.4(b)(1) to protect the resident and other residents. The stated that he was the officer for the facility and was aware that he should have reported and investigated the residents compliant of The facility policy dated 9/2024 and titled, "Abuse, Neglect, and Mistreatment of Residents Policy" indicated that the facility was to ensure timely and thorough investigation of abuse, neglect or mistreatment of residents. Observances, complaints or evidence of alleged abuse, neglect and or mistreatment are thoroughly investigated and reported to the appropriate parties. The policy describes misappropriation of property the deliberate misplacement, exploitation or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. The policy indicated that an accident incident report form would be used for residents, witnesses if any would be documented on the report and an investigation would be conducted including but not limited to statements form staff in	F0610		

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F0610 SS = D	Continued from page 16 the area where alleged incident occurred, the resident and any other individual that may have information regarding the incident. NJAC 8:39-4.1(a)(5)	F0610		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide necessary treatment services consistent with professional standards of practice by not ensuring a resident received NJ Ex Order 26.4(b)(1) and NJ Ex Order [redacted] according to a physician's order for 1 of 5 residents (Resident #24) reviewed for unnecessary medications. The deficient practice was evidenced by the following. On 8/15/2025 at 11:45 AM, the surveyor observed Resident #24 NJ Exec Order 26.4b1 in the hallway, was NJ Ex Order 26.4(b)(1), and appeared NJ Ex Order 26.4(b) The surveyor attempted to interview Resident #24, but they NJ Exec Order 26.4b1. A review of the medical record revealed the following: A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) and NJ Ex Order [redacted]. A review of the most recent comprehensive Minimum Data Set (MDS), (an assessment tool used to facilitate the management of care), dated NJ Ex Order 26.4(b)(1), reflected that the Brief Interview for Mental Status score was NJ /15, which indicated that the resident's NJ Ex Order 26.4(was NJ Ex Order 26.4(b)(1). A further review of the MDS revealed the resident was receiving a NJ Ex Order 26.4(b)(1) [redacted]) during	F0684	Affecting Resident #24. The Director of Nursing immediately contacted the resident's primary care physician to correct the NJ Ex Order order in point click care. There were no ill effects due to the NJ Ex Order order transcription error. The Director of Nursing / designee conducted an audit of all residents on insulin scale to ensure proper timing. All Nurses re-inserviced by Director of Nursing on order transcription of insulin orders into point click care. All residents having an order for insulin sliding scale have the potential to be affected by the facilities failure to monitor resident's blood sugar and insulin according to a physician's order. All Nurses re-inserviced by Director of Nursing on order transcription of sliding scale insulin orders into point click care. The Director of Nursing / Designee will audit all insulin orders to ensure proper transcription of sliding scale weekly x4, monthly x3 and quarterly thereafter. The Director of Nursing /designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	09/26/2025

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F0684 SS = E	Continued from page 17 the last seven days or since admission. A review of the Order Summary Report (OSR) (physician's order sheet) dated NJ Ex Order 26.4(b)(1) included the following Physician's orders (PO): -NJ Ex Order 26.4(b)(1)), NJ Ex Ord as per sliding scale: if NJ Ex Order 26.4(b)(1)) before meals for NJ Ex (call MD if NJ Ex Order 26. dated NJ Ex Order 26 -NJ Ex Order 26.4(b)(1) at bedtime for NJ Ex O dated NJ Ex Order 26. -NJ Ex Order 26.4(b)(1) for NJ Ex Ord Dated NJ Ex Order 26.4 A review of the NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1) electronic medication administration record (eMAR) revealed an order dated NJ Ex Order 2 for NJ Ex Order 26.4(b)(1) with the above referenced scale. The eMAR was plotted to record the NJ Ex Order 26.4(b)(1) and the corresponding NJ Ex Order 26.4(b)(1) based on that NJ Ex Order 26.4(b)(1). The times indicated were 7:30 AM, 8:00 AM and 11:00 AM. On 8/19/25 at 12:00 PM, the surveyor interviewed Resident #24's day shift Licensed Practical Nurse (LPN #1) who confirmed the resident had NJ Ex Order 26.4 and was prescribed NJ Ex Order 26.4(b)(1) . LPN #1 stated the resident would have their NJ Ex Order 26.4(b)(1) before meals, and then given their NJ Ex Order dose based on the NJ Ex Order 26.4(b)(1). When asked when mealtimes were on the unit the LPN #1 stated breakfast was between 8:00 AM and 8:15 AM, lunch was between 11:50 AM and 12:00 PM, and she was unsure when dinner was scheduled because she did not work the evening shift. At that time the surveyor and LPN #1 reviewed the resident's eMAR. LPN #1 acknowledged the eMAR administration times for NJ Ex Order 26.4(b)(1) did not coincide with the timing of the PO to be given before meals. LPN #1 further acknowledged there was no area designated to document the dinner time NJ Ex Order 26.4(b)(1) , or the corresponding dose of the NJ Ex Order 26.4(b)(1) that was provided. LPN #1 stated eMAR "needed to be changed" to reflect the appropriate times according to the PO. On 8/19/25 at 12:26 PM, the surveyor interviewed the acting U.S. FOIA (b) (6) who confirmed the resident was on a NJ Ex Order 26.4(b)(1) before	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARCLAYS REHABILITATION AND HEALTHCARE CENTER	1412 MARLTON PIKE EAST , CHERRY HILL, New Jersey, 08034

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F0684 SS = E	Continued from page 18 meals. Together the surveyor and U.S. FOIA (b) (6) reviewed the resident's order for NJ Ex Order 26.4(b)(1) and compared it to their eMAR. U.S. FOIA (b) (6) acknowledged the timing on the eMAR did not reflect mealtimes and there wasn't a area designated to document the dinner time NJ Ex Order 26.4(b)(1) or the corresponding NJ Ex Order 26.4(b)(1) dose. The U.S. FOIA (b) (6) could not locate any documentation on the eMAR that would reflect the medication being provided per the PO. On 8/19/25 at 12:50 PM the surveyor interviewed the U.S. FOIA (b) (6) who confirmed the eMAR timing for NJ Ex Order 26.4(b)(1) did not reflect the appropriate mealtime schedule according to the PO. Together the U.S. FOIA and the surveyor next reviewed the CP reports for NJ Ex Or and NJ Ex Order 26.4(b)(1). The U.S. FOIA stated the CP report was emailed monthly to the U.S. FOIA (b) (6)) the U.S. FOIA (b) (6)) and himself, and that the U.S. Fo was responsible for following up on the reports with the physicians. The U.S. FOIA acknowledged the CP reports had not been reviewed for the three months until surveyor inquiry. After further review of the NJ Ex Order 26.4(b eMAR the U.S. FOIA confirmed the resident did not receive their dinner time dose of NJ Ex Order 26.4(b)(1), and confirmed after review of the NJ Ex Order 26.4(b)(1) eMAR the resident did not receive their dinner time NJ Ex Order 26.4(b)(1) days. The U.S. FOIA added there was no way to know if the resident had received a 4:00 PM (dinner time) dose of NJ Ex Order 26.4(b)(1), because there was no 4:00 PM plotting area to document the NJ Ex or the administration of the insulin. The eMAR should have a block [an area designated] to record the NJ Ex and another to document the amount of NJ Ex Order given. The U.S. FOIA added the nurse on the night shift was supposed to do a chart check, which was a review of the orders that were entered for that day, this included medications or lab orders, etc. The U.S. FOIA was unable to provide a copy of the chart check for the time period indicated, and acknowledged he was unable to confirm the chart check had been performed. On 8/19/25 at 1:44 PM, the survey team met with the facility Administration and the U.S. FOIA (b) (6) for the facility. The U.S. FOIA acknowledged the plotting for the NJ Ex Order 26.4(b)(1) on the eMAR was incorrect. The U.S. FOIA and the U.S. FOIA acknowledged the way the order was plotted made it difficult to tell if the resident had been receiving a dose at dinner. On 8/19/25 at 3:08 PM, the surveyor interviewed the resident's evening Licensed Practical Nurse (LNP #2) who confirmed the resident had PO for NJ Ex Order 26.4(b)(1) at bedtime and NJ Ex Order 26.4(b)(1) for before meals. LPN #2	F0684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0684 SS = E	Continued from page 19 stated the NJ Ex Order 26.4(b)(1) dose at 4:00 PM was just started back up again, she stated she believed for the last month they were only monitoring the resident's NJ Ex Order 26.4(b)(1) levels, and she had not been administering a dinnertime dose of NJ Ex Order 26.4(b)(1). LPN #2 stated she had on the eMAR to only check NJ Ex Order 26.4(b)(1) at 4:00 PM and confirmed she was only monitoring the resident's NJ Ex Order 26.4(b)(1) and not giving a dose of NJ Ex Order 26.4(b)(1). On 8/20/25 at 9:05 AM, the surveyor interviewed the U.S. FOIA (b) (6) via telephone. The U.S. F confirmed she had made recommendations to give NJ Ex Order 26.4(b)(1) within 15 minutes of meals in her NJ Ex Order 26.4(b) report. The U.S. F stated the typical timing should be 7:30 AM, 11:30 AM and 4:30 PM. The U.S. F stated it was important to follow that schedule, especially NJ Ex Order 26.4(b)(1), because you didn't want the resident's NJ Ex Order 26.4(b)(1) to 'NJ Ex Order 2 [redacted]). The U.S. F stated it looked like to her that they had plotted the incorrect times for that NJ Ex Order 26.4(b)(1) order. They needed to make it for breakfast, lunch and dinner. The U.S. F confirmed it did not look like the nurse was giving the dinner time dose. On 8/20/25 at 10:30 AM the surveyor attempted to interview via telephone the resident's physician and left a message with the service, the physician could not be contacted. On 8/20/25 at 12:32 PM the surveyor interviewed the facility 's U.S. FOIA (b) (6)) who stated he had spoken to the U.S. FOIA that morning and was informed Resident #24 had an incorrect NJ Ex Order order. He reviewed the orders with the U.S. FOIA and admitted the order was confusing. The U.S. F stated he would call the resident's physician to discuss the NJ Ex Order dose error tomorrow. A review of the facility's "Insulin Administration" policy reviewed 10/24 included…" insulin administration must be based on a physician's order, which includes the type of insulin, dosage and administration schedule. A review of the facility's "Medication Transcription" policy dated reviewed 10/24 revealed " An accurate and current patient medication administration record (MAR) is critical for accurate medication administration and patient safety…Any apparent discrepancies between the MAR and the prescriber's orders will be communicated by nursing to the MD and clarification order sent to the pharmacy as needed.	F0684		

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F0684 SS = E	Continued from page 20 A review of the facility's "Medication Administration" policy dated reviewed 10/24 revealed …Medication ordered before a meal should be specific to manufacturer's recommendation and administered prior to the start of the meal… NJAC 8:39-27.1(a)	F0684		
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, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to provide the necessary care and services for one (1) of 1 resident (Resident #71) reviewed for NJ Ex Order 26.4(b)(1) care and was evidenced by the following: Review of the Admission Record (admission summary) reflected that Resident #71 was admitted to the facility with the diagnoses that included but was not limited to; NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) A review of the admission Minimum Data Set (MDS), an assessment that facilitates a resident's care dated NJ Ex Order 26.4(b), indicated that Resident #71 had a Brief Interview for Mental Status (BIMS) of NJ E out of 15 which indicated that the resident had NJ Ex Order 26.4(b) . The MDS also indicated Resident #71 was NJ Ex Order 26.4(b)(on staff for all NJ Ex Order 26.4(b)(1) and was not on NJ Ex Order 26.4(b)(1) treatments. On 8/13/2025 at 8:39 AM, Surveyor #1 observed Resident #71 in their room on NJ Ex Order 26.4(b)(1)) via (by way of) NJ Ex Ord	F0695	Resident #71 NJ Ex Order 26.4(b)(1) by this deficient practice. There were NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) was within normal range all days in question. All nurses were re-inserviced by the Director of Nursing on following physician orders for oxygen. The Director of Nursing / designee immediately audited all residents with oxygen orders to ensure the physician order was being followed properly. All residents on oxygen are affected by the facilities failure to provide necessary care and service for respiratory care. All nurses were re-inserviced by the Director of Nursing on following physician orders for oxygen. The Director of Nursing / designee will audit all residents with oxygen orders to ensure the physician orders are being followed properly weekly x4, monthly x3 and quarterly thereafter. The Director of Nursing /designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	09/26/2025

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F0695 SS = D	Continued from page 21 On 8/13/2025 at 8:30 AM, Surveyor #2 observed Resident #71 in their room with the head of bed up and neck cushion on. The resident was pleasant and had no NJ Ex Order [redacted] The resident's NJ Ex Order 26.4(b)(1) were NJ Ex Or [redacted] Surveyor #2 observed that the resident was on NJ Ex Order 26.4(b)(1) [redacted]. The resident stated that she was not sure how much NJ Ex should be administered. On 8/14/2025 at 10:38 AM, Surveyor #2 had a third observation that Resident #71 continued NJ Ex Order 26.4(b)(1) [redacted] A review of the physician order summary (POS) dated NJ Ex Order 2 [redacted] reflected a physician's order for NJ Ex Order 2 [redacted] every shift for NJ Ex Order 26.4(b)(1) A review of the Treatment Administration Record (TAR) dated NJ Ex Order 26 [redacted] reflected an order for NJ Ex Order 26.4(b)(1) [redacted] Review of the TAR dated NJ Ex Order 2 [redacted] until NJ Ex Order 26 [redacted] reflected that Resident #71's NJ Ex Order 26.4(b)(1) [redacted] was within NJ Ex Order 26.4(b)(1) A review of the progress notes (PN) dated NJ Ex Order 26.4(b) [redacted] at 20:09 (9:09 PM) revealed that the resident was admitted on NJ Ex Order 26.4(b)(1) [redacted], however a physician's order was not obtained until NJ Ex Order 2 [redacted] A review of the Care Plan (CP) dated NJ Ex Order 26 [redacted], reflected that the resident was NJ Ex Order 26.4(b)(1) with the settings at NJ Ex Order 26.4(b)(1). On 8/14/2025 at 10:47 AM, Surveyor #2 interviewed the U.S. FOIA (b) (6) [redacted] who read the resident's physician orders in the presence of the surveyor and confirmed that the order read to administer NJ Ex Order 26 [redacted]. The U.S. FOI [redacted] accompanied the surveyor to the resident's room and confirmed that the resident's NJ Ex Order 26.4(b)(1) was set to NJ Ex Order 26.4(b)(1). The U.S. FOI [redacted] stated that since the resident's NJ Ex Order 26.4(b) [redacted]s have been NJ Ex Order 26.4(b)(1) that he would reassess the resident and call the U.S. FO [redacted] for a possible change in NJ Ex Order 2 [redacted] orders. The U.S. FOI [redacted] did confirm that if the order indicated that the resident should have been given NJ Ex Order 26.4(b)(1) then the resident should not be on NJ Ex Order 26.4(b)(1). He stated that NJ Ex Order 26.4 [redacted] was the wrong NJ Ex Order 26.4(b)(1). He also stated that the NJ Ex Order 2 [redacted] order should have been obtained on NJ Ex Order 26 [redacted] when the resident was admitted to the facility. On 8/15/25 at 9:10 AM, the surveyor interviewed the U.S. FOIA [redacted]	F0695		

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F0695 SS = D	Continued from page 22 U.S. FOIA (b) (6)) who stated that he completed Resident #71's admission MDS dated NJ Ex Order 26. The surveyor asked the U.S. FOIA (b) (6) why the MDS did not indicate that the resident was on NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) (6) reviewed the resident's medical record in the presence of the surveyor and confirmed that the progress notes (PN) reflected that the resident was provided with NJ Ex since NJ Ex Order 26.4 however the staff did not obtain a PO until NJ Ex Order. He stated that the resident was receiving NJ Ex from NJ Ex Order 26 until NJ Ex Order without a physician's order. The facility policy titled, "Oxygen Administration" and dated 12/2024 which indicated that it was the policy and procedure to provide oxygen to residents in compliance with their physician orders and upon receiving an order for oxygen from the resident's physician the nurse will place the order in (electronic medical record) to be carried out. NJAC 8:39-19.4(a)	F0695		
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F0756	Affecting Resident #24. The pharmacy consultant report was immediately corrected. There were NJ Exec Order 26.4b1 related to the resident getting NJ Ex Order 26.4(b)(1) prior to meals, NJ Ex Order 26.4(b)(1) were within NJ Ex Order 26.4(b)(1) on days in question. All nurses were re-inserviced by the Director of Nursing on responding in a timely manner to the Consultant Pharmcist's monthly recommendations. The Director of Nursing / designee audited all pharmacy consultant monthly recommendations to ensure they were responded to. All residents with blood sugar orders have the potential to be affected by the facilities failure to respond in a timely manner to the Consultant Pharmacist's monthly recommendations. All nurses were re-inserviced by the Director of Nursing on responding in a timely manner to the Consultant Pharmcist's monthly recommendations. The Unit Managers / designee will audit all monthly Consultant Pharmacy recommendations to ensure they are responded to in a timely manner, monthly x3 and quarterly thereafter.	09/26/2025

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F0756 SS = E	Continued from page 23 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to respond in a timely manner to the U.S. FOIA (b) (6)) monthly recommendations from NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b) for 1 of 5 residents (Resident #24) reviewed for unnecessary medications. The deficient practice was evidenced by the following: On 8/15/2025 at 11:45 AM, the surveyor observed Resident #24 seated in a wheelchair NJ Exec Order 26.4b1 with their feet down the hallway. The resident was NJ Ex Order 26.4(b)(1) and appeared NJ Ex Order 26.4(b The surveyor attempted to interview the Resident #24, but they did not respond. A review of the medical record revealed the following information: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1), NJ Ex Orde and NJ Ex Order 26.4(b)(1)). A review of the Order Summary Report (OSR) (physician's order sheet) dated NJ Ex Order 26.4(b)(1) revealed a Physician's order (PO) dated NJ Ex Order 2 for NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) before meals for NJ Ex call MD if NJ Ex Order 26.4(b)(1). A review of the NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1) electronic medication administration record (eMAR) revealed an order dated NJ Ex Order 2 for NJ Ex Order 26.4(b)(1) with the above referenced scale. The eMAR was plotted	F0756	Continued from page 23 The Unit Manager /designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F0756 SS = E	Continued from page 24 to record the NJ Ex Order 26.4(b)(1) and the corresponding NJ Ex Order dose based on that NJ Ex Order 26.4(b)(1). The times indicated were 7:30 AM, 8:00 AM and 11:00 AM. A review of the U.S. FOIA (b) (6))- "Nursing Summary Reports" dated NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 recommended NJ Ex Order 26.4(b)(1)) should be administered within NJ Exec Order 26.4b1 a meal or immediately after a meal." On 8/19/25 at 12:00 PM, the surveyor interviewed Resident #24's day shift Licensed Practical Nurse (LPN #1) who confirmed the resident had NJ Ex Order 26.4 and was prescribed NJ Ex Order 26.4(b)(1) . LPN #1 stated the resident would get their NJ Ex Order 26.4(b)(1) checked before meals and then given their NJ Ex Order 26.4(b)(1) based on the NJ Ex Order 26.4(b)(1) . When asked when mealtimes were on the unit the LPN #1 stated breakfast was between 8:00 AM and 8:15 AM, lunch was between 11:50 AM and 12:00 PM, and she was unsure when dinner was scheduled because she did not work the evening shift. At that time the surveyor and LPN #1 reviewed the resident's eMAR. LPN #1 acknowledged the eMAR administration times for NJ Ex Order 26.4(b)(1) did not coincide with the timing of the PO to be given before meals. LPN #1 further acknowledged there was no spot to document the dinnertime NJ Ex Order 26.4(b)(1) or the dose of the NJ Ex Order and the eMAR should be changed to reflect the appropriate times according to the PO. On 8/19/25 at 12:50 PM, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed the eMAR timing for NJ Ex Order 26.4(b)(1) did not reflect the appropriate mealtime schedule according to the PO. Together the U.S. FOIA and the surveyor reviewed the U.S. F reports for NJ Exec Order 26.4(. The U.S. FOIA stated the U.S. F report was emailed monthly to the U.S. FOIA (b) (6)) the U.S. FOIA (b) (6) and himself, and that the U.S. F was responsible for following up on the U.S. F reports with the physicians. The U.S. FOIA acknowledged the U.S. F reports had not been reviewed for the three months until surveyor inquiry. On 8/20/25 at 12:32 PM, the surveyor interviewed the facility's U.S. FOIA (b) (6) who stated he had spoken to the U.S. FOIA that morning and was informed Resident #24 had an incorrect NJ Ex Order order. He reviewed the orders with the U.S. FOIA and admitted the order was confusing. The U.S. F stated he would call the resident's physician to discuss the incorrect NJ Ex Order order tomorrow. A review of the facility policy titled "Consultant Pharmacist during regular monthly visits" reviewed	F0756		

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F0756 SS = E	Continued from page 25 1/2025 included…"The consultant pharmacist shall review and perform a drug regimen review for all residents monthly…The nursing and attending physician (or licensed designee) shall respond to the recommendations in a timely manner, per facility policy for non- urgent recommendations…Clinically significant irregularities… will be brought to the attention of nursing and addressed while the consultant is in the facility, as well as included in the monthly report. Nurses should promptly communicate with the prescriber to facilitate obtaining an answer by midnight of the next day… NJAC 8:39-29.3	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060403	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARCLAYS REHABILITATION AND HEALTHCARE CENTER	1412 MARLTON PIKE EAST , CHERRY HILL, New Jersey, 08034

(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 Survey Date: 8/12/25 to 8/20/25 Census: 88 Sample: 18 + 3 closed records 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 deficieny 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		09/11/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 7 of 14 day shifts reviewed. This deficient practice was evidenced by the following: a) Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 2/01/21:	S0560	Affecting all residents. The Administrator immediately contacted the recruiter to ensure all ads are optimized to the fullest. The Staffing Coordinator and team, have weekly staffing phone calls ongoing in an effort to improve recruitment and retention. All Residents have the ability to be affected by the facility not meeting the requirements to maintain the required minimum direct care staff to resident ratios, as mandated by the State of New Jersey. Staffing coordinator was rein-serviced by the Administrator on the direct care staff to resident ratios. Agency contracts were reviewed to ensure the facility had outside resources in times of staffing shortages. Implemented a refer a friend incentive program as well as a sign on bonus.	09/26/2025

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: 060403	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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S0560	Continued from page 1 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 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. For the 2 weeks of staffing prior to survey from 7/27/2025 to 8/09/2024, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: 7/27/25 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. 7/28/25 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. 7/29/25 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. 8/02/25 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. 8/03/25 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. 8/08/25 had 9 CNAs for 85 residents on the day shift, required at least 11 CNAs. 8/09/25 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. On 8/20/2025 at 11:29 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding staffing. The LNHA stated we could fill all shifts using permanent and agency staff. We have one staffing agency we use. We have used mostly agency CNAs and occasionally a nurse from the agency. LNHA stated the CNA to resident ratios were 1-8, 1-10 and 1-14. A review of the facility policy "Staffing" dated as reviewed 12/2025 provided by the Licensed Nursing Home Administrator (LNHA) revealed, it is the policy and procedure of this facility to adequately staff the facility in accordance with the NJ State guidelines.	S0560	Continued from page 1 The staffing coordinator/designee will audit direct care staffing ratios to ensure it is within the requirements as mandated by the State of New Jersey, weekly x4, monthly x3 months, quarterly thereafter. The Staffing coordinator/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARCLAYS REHABILITATION AND HEALTHCARE CENTER	**1412 MARLTON PIKE EAST , CHERRY HILL, New Jersey, 08034**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/10/2025 in relation to the 8/20/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060403	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/10/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/10/2025 in relation to the 8/20/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARCLAYS REHABILITATION AND HEALTHCARE CENTER	1412 MARLTON PIKE EAST , CHERRY HILL, New Jersey, 08034

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 08/13/25 and 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 Occupancies. Barclays Rehabilitation & Healthcare Center is a one-story building built in the 1960's. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator powers 100% of the building per the U.S. FOIA (b) (6) . The current occupied beds are 88 of 108.	K0000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 08/13/25. The facility was found to be in compliance with 42 CFR 483.73	E0000		

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