

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

PRINTED: 04/16/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/19/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BARCLAYS REHABILITATION AND HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1412 MARLTON PIKE EAST</b> <b>CHERRY HILL, NJ 08034</b>		
(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
F 000	<p>INITIAL COMMENTS</p> <p>Complaint #: NJ00176489, NJ00173582, NJ 00174053</p> <p>Survey Dates: 11/18/24, 11/19/24</p> <p>Census: 96</p> <p>Sample Size: 5</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/03/2024

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>060403</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/19/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BARCLAYS REHABILITATION AND HEALTHCA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1412 MARLTON PIKE EAST</b> <b>CHERRY HILL, NJ 08034</b>		
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S 000	Initial Comments  The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care  The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.  This 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 16 day shifts and 1 night shift. 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	S 560	1) The staffing coordinator was educated on the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. The facility will continue to reach out to existing staff to see if they want to pick up overtime shifts and continue to try and staff accordingly  2) All residents have the ability to be affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New	12/13/24

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NAME OF PROVIDER OR SUPPLIER  <b>BARCLAYS REHABILITATION AND HEALTHCA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1412 MARLTON PIKE EAST CHERRY HILL, NJ 08034</b>		
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S 560	<p>Continued From page 1</p> <p>established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>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 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.</p> <p>1. For the 2 weeks of Complaint staffing from 05/05/2024 to 05/18/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows:</p> <p>-05/05/24 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. -05/06/24 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. -05/07/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/08/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/09/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -05/10/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -05/11/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs.</p> <p>-05/12/24 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -05/13/24 had 8 CNAs for 88 residents on the day</p>	S 560	<p>Jersey.</p> <p>3) The facility will continue to post job openings on job sites to promote CNA openings The facility is offering a sign on bonus The facility has contracted with agency to assist with our staffing needs The administrator/designee will review the daily staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter.</p> <p>4) The Administrator/designee will review any findings of these audits and present them quarterly to the QAPI committee to determine frequency of future audits.</p>	

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S 560	<p>Continued From page 2</p> <p>shift, required at least 11 CNAs. -05/14/24 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -05/15/24 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -05/16/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. -05/18/24 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.</p> <p>2. For the 2 weeks of Complaint staffing from 08/11/2024 to 08/24/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <p>-08/11/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -08/12/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -08/13/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -08/14/24 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -08/15/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -08/16/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -08/17/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.</p> <p>-08/18/24 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -08/19/24 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -08/20/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -08/21/24 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -08/22/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs.</p>	S 560		

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S 560	<p>Continued From page 3</p> <p>-08/23/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -08/24/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.</p> <p>3. For the 2 weeks of staffing prior to survey from 11/03/2024 to 11/16/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows:</p> <p>-11/03/24 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. -11/04/24 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. -11/05/24 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. -11/06/24 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs.</p> <p>-11/11/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -11/12/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -11/13/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -11/14/24 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -11/15/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -11/16/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs.</p>	S 560			

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060403	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/9/2024
NAME OF FACILITY BARCLAYS REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 MARLTON PIKE EAST CHERRY HILL, NJ 08034	

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/09/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 11/19/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			