STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315396	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE , BRIDGETON, New Jersey, 08302**

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F0000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Complaint #: NJ188009, NJ186402, NJ185958, NJ185691, NJ184527, NJ177323, NJ176670, and NJ2563671. Survey Dates: 08/04/25 to 08/07/25 Survey Census: 132 Sample Size: 32 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F0000		08/28/2025
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a	F0640	Element 1: The MDS discharge assessment for R13 was completed and transmitted on [redacted]. The[redacted] was provided with a re-education regarding timely submission of MDS in accordance with the RAI guidelines and on the transmittal process through the 3rd party vendor Simple LTC. Education was given on 8/22/25 Element 2: All residents who have an MDS that are due for electronic submission have the potential to be affected by the cited practice. Element 3: MDS Coordinator will transmit MDS that are due for electronic submission on a weekly basis and will cross reconcile PCC transmission compared to Simple LTC transmission to ensure that it is transmitted to CMS repository in accordance with the RAI requirements. Any negative findings will be corrected by the MDS coordinator.	09/20/2025

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: 315396	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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F0640 SS = D	Continued from page 1 facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that one (Resident (R) 13) out of four residents reviewed for Minimum Data Set (MDS) assessments was transmitted in a timely manner, out of a sample of 32 residents. This had the potential for the resident's progress not to be monitored and potential for decline. Findings include: Review of the "RAI" manual version 1.191 dated 10/24	F0640	Continued from page 1 Element 4: The Regional MDS Coordinator will conduct a weekly audit x 4 weeks and then monthly x 3 months for MDS assessments that are due for submission to ensure that the MDS are electronically transmitted in a timely manner in accordance with the RAI guidelines. Any negative findings will be corrected by the MDS coordinator. The results of the audits will be submitted to the QAPI committee who meets quarterly, to review and determine the frequency and necessity of future audits.	

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F0640 SS = D	Continued from page 2 revealed . . . "Chapter 2: Assessments for the Resident Assessment Instrument, 2.6: Required OBRA Assessments for the MDS…RAI OBRA-required assessment summary for admission…MDS completion date (Z0500B) no later than 14th calendar day of the resident's admission (admission date + 13 calendar days) …Transmission date no later than care plan completion date + 14 calendar days". Along with, " Discharge Assessment…MDS completion date (Item Z0500B) no later than discharge date + 14 calendar days…Transmission date no later than MDS completion date +14 days." Review of R13's "Face Sheet" provided by the facility revealed R13 was re-admitted to the facility on NJ Exec Order 26. Review of the resident's "Census Data" located in the electronic medical record (EMR) under the "Census" tab revealed R13 discharged to the hospital on NJ Exec Order 26. The EMR also revealed a discharge return not anticipated "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ Exec Order 26 was started, however the status did not indicate that it had been completed or accepted. During an interview on 08/07/25 at 1:58 PM with the US FOIA (b)(6)) she confirmed that the "MDS" team submitted the assessment late on NJ Exec Order 26 (five months after the MDS was started). When asked why the assessment was not submitted timely, she stated that it was "overlooked." NJAC 8:39-11.2	F0640		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F0655	Element 1: Resident # 161 was NJ Exec Order 26.4b1 by this cited practice. Resident # 161 care plan was reviewed by the Director of Nursing. The resident has since been discharged therefore no update to the care plan was conducted. The admitting nurse was provided with one-on-one re-education on 8/22/25 by the nurse educator regarding the development of a baseline person-centered care plan upon admission to reflect their comorbidities and the utilization of BiPAP. Element 2: All residents that require BiPAP have the potential to be affected by this cited practice. All resident medical records were reviewed and for those residents	09/20/2025

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F0655 SS = D	Continued from page 3 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure the baseline care plan included sufficient information to provide person-centered care for one of three sampled residents (Resident (R) 161) reviewed for new admission in a total sample of 32 residents. This failure had the potential for the resident to have unmet care needs.	F0655	Continued from page 3 requiring BiPAP a comprehensive medical record and care plan review was conducted to ensure that measures were taken by the licensed nurse to maintain compliance with the baseline person-centered care planning process in conjunction with their co-morbidities. Element 3: The Unit Managers, Nursing Supervisors, Licensed Nurses and the Interdisciplinary team members who have responsibility in the development of the baseline person-centered care plans have been re-educated. The re-education is inclusive of capturing comorbidities and the utilization of the BiPAP in the baseline person-centered care plan. This re-education was initiated on 8/22/25.This education will be given during orientation for a newly hired licensed nurses, Interdisciplinary team members, annually and as deemed necessary. Newly admitted residents' baseline person-centered care plans will be reviewed by the Interdisciplinary team to ensure a baseline person-centered care plan is developed and address the utilization of a BiPAP and in conjunction with their comorbidities. Element 4: Unit Managers or nurse designee will audit 5 residents' care plans weekly x 4 weeks and update care plans as needed then 10 residents' care plans monthly x 3 months. Any updates to the care plan will be discussed in morning meeting with the Interdisciplinary team. The results of all audits will be submitted to the QAA committee who meets quarterly for review and will determine the necessity of future audits and recommendations.	

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F0655 SS = D	Continued from page 4 Findings include: Review of the facility policy titled, "Baseline Care Plan" created 01/2025 revealed, "…The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards. The baseline care plan will …include the minimum healthcare information to properly care for the resident …but not limited to …Physician Orders…." Review of R161's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab revealed that R161 was admitted to the facility on [redacted] with diagnoses that included NJ Exec Order 26.4b1 [redacted]. Review of the "Physician Orders" dated [redacted] located in the EMR under the "Orders" tab revealed, apply [redacted] machine at the following settings at bedtime for [redacted] and remove in the morning per schedule. Review of the "Baseline Care Plan" dated [redacted] located in the EMR under the "Care Plan" tab failed to reveal that R161's conditions of NJ Exec Order 26.4b1 [redacted] were included in the baseline plan of care. Review of the five day "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of [redacted] identified a "Brief Interview for Mental Status (BIMs)" score of [redacted] out of 15 that indicated R161 was [redacted], had [redacted] when [redacted] required [redacted], and utilized a [redacted] During an interview on 08/07/25 at 1:09 PM, the US FOIA (b)(6) reviewed R161's "Baseline Care Plan" and confirmed the resident's [redacted] conditions of NJ Exec Order 26.4b1 , [redacted] on [redacted] and order for [redacted] were not included in R161's "Baseline Care Plan."	F0655		

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F0655 SS = D	Continued from page 5 NJAC 8:39-11.2	F0655		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on record review, activity calendar review, interview, and observation the facility failed to ensure activities were provided in accordance with the resident's preferences for one of two sampled residents (Residents (R) 98) reviewed for activities in a total sample of 32 residents. This failure had the potential for the resident to have a diminished quality of life. Findings include: Review of R98's "Face Sheet" located in the Electronic Medical Record (EMR) under the "Profile" tab revealed R98 was admitted to the facility on [redacted] with diagnoses that included [redacted] and [redacted] Review of R98's admission "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of [redacted] identified a "Brief Interview for Mental Status (BIMs)" score of [redacted] out of 15 that indicated [redacted] for wheelchair [redacted] and the interview for daily and activity preferences should be conducted. The interview for daily activity preferences revealed that the resident indicated it was somewhat important while at the facility to [redacted], do things with [redacted], and [redacted]	F0679	Resident 98's activity preference was updated to specifically include preference-based [redacted] All residents that wish to participate in activities have the potential to be affected by this deficient practice. All activities staff were in-serviced on preference based activity planning. Activity Director or designee will audit activity attendance records weekly for 2 months, then monthly for 3 months, to verify preference-based activities are provided. All findings will be given to the quarterly quality assurance committee.	09/20/2025

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F0679 SS = D	Continued from page 6 Review of the "Care Plan" dated NJ Exec Order 26.4b1 and revised on NJ Exec Order 26.4b1 located in the EMR under the "Care Plan" tab revealed, "[Resident name] NJ Exec Order 26.4b1 to all NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 when weather permits, NJ Exec Order 26.4b1. [Resident name] will take part in the NJ Exec Order 26.4b1 program. Interventions included to transport to activities of interest, provide supplies/materials for leisure activities as needed/requested and NJ Exec Order 26.4b1 [redacted] Review of the 'NJ Exec Order 26.4b1' and 'NJ Exec Order 26.4b1' activity calendars revealed programs included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Review of R98's NJ Exec Order 26.4b1 "Record of One-on-One Activities" documentation provided by the Interim US FOIA (b)(6)) revealed one on one activities were provided once a day on NJ Exec Order 26.4b1 [redacted] The activities provided included NJ Exec Order 26.4b1 [redacted]. Review of R98's NJ Exec Order 26.4b1 "Record of One-on-One Activities" documentation provided by the US FOIA (b)(6) revealed one on one activities were provided once a day on NJ Exec Order 26.4b1 [redacted]. The activities provided included NJ Exec Order 26.4b1. During an observation on 08/04/25 at 10:00 AM revealed R98 was in bed sleeping and the TV was on and tuned to a talk show. At 2:01 PM R98 was in bed, and the TV was on and tuned to a soap opera drama. At 2:10 PM a music program was taking place in the main dining room/activity room. R98 was not in attendance. At 3:00 PM R98 was in a NJ Exec Order 26.4b1 chair in the hallway alcove area near the nurse's station. The area did not have any form of stimulation, and no activities were being provided. During an observation on 08/05/25 at 10:30 AM revealed R98 was in a NJ Exec Order 26.4b1 chair in the hallway alcove area near the nurse's station. The area did not have any form of stimulation, and no activities were being provided. During an observation on 08/06/25 10:27 AM revealed a	F0679		

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F0679 SS = D	Continued from page 7 music program was taking place in the main dining room/activity room and R98 did not attend. During an interview on 08/07/25 at 9:10 AM, the [US FC] stated recreation staff would bring residents to programs and if they did not go to programs they would provide one on one visits. The [US FC] stated music programs take place at least every Monday and Wednesday and sometimes more often when performers come in. The [US FC] reviewed the R98's activity attendance documentation and stated the resident had not attended any scheduled programs including the music programs in [NJ Exec] and [NJ Exec Order 26.4b1]. The [US FC] was unsure of R98's specific activity preferences and stated one to one visits were being provided. The [US FC] confirmed the one on one activities being provided were not based on the resident's activity preferences. NJAC 8:39-7.3	F0679		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on record review, "NJ Ex Order 26.4(b)(1) Program" documentation review, and interview, the facility failed to ensure recommendations for [NJ Exec Order 2] were implemented for one sampled resident (Residents (R) 98) reviewed for [NJ Exec Order 26] in	F0688	Element 1: Resident # 98 was NJ Exec Order 26.4b1 by this cited practice. The Director of Nursing reviewed the medial record of Resident # 98, and the care plan and certified nursing assistant Kardex were updated to include NJ Exec Order 26.4b1 to the [NJ Ex] with the provision of morning and evening care. Resident was on active caseload with NJ Exec Order 26.4b1, [NJ Ex] [NJ Exec Order 2] was reassessed, and it was determined that there was NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 with morning and evening care. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) involved were provided with one-on-one re-education on 8/22/25 by the nurse educator regarding the implementation NJ Exec Order 26.4b1 with correlating update to the comprehensive care plan and certified nursing assistant Kardex, Element 2: All residents that require Range of Motion have the potential to be affected by this cited practice. All residents' medical records were reviewed and for those residents requiring Range of Motion a comprehensive medical record review was conducted to ensure the implementation of the range of motion and development of a comprehensive person-centered care plan and initiation of the Kardex for the certified nursing	09/20/2025

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F0688 SS = D	Continued from page 8 NJ Exec C in a total sample of 32 residents. This failure had the potential for the resident to experience a NJ Exec Orde in NJ Exec Or Findings include: Review of R98's "Face Sheet" located in the Electronic Medical Record (EMR) under the "Profile" tab revealed R98 was admitted to the facility on NJ Exec Order 26 with diagnoses that included NJ Exec Order 26.4b1 [redacted]. Review of the admission "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of NJ Exec Order 26 identified R98 had a "Brief Interview for Mental Status (BIMs)" score of NJ Exec C out of 15 that indicated NJ Exec Orde [redacted] and NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 . Review of the 'NJ Exec Order 26.4b1 Discharge Summary" dated NJ Exec Order 26 in the EMR under the "Therapy" tab revealed, "…Discharge Recommendations and Status …NJ Exec Order 26.4b1 Program Established/ Trained = NJ Exec Order 26.4b1 Program …NJ Exec Order 26.4b1 Program Established/Trained: NJ Exec Order 26.4b1 [redacted]] on NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1]…." Review of the "Functional Maintenance Program (FMP)" document dated NJ Exec Order 26. located in the US FOIA (b)(6) [redacted] office in a FMP notebook revealed, "…Reason why resident recommended to NJ Exec Order 26.4b1 Program -maintain gains achieved in NJ Exec Order …goals for NJ Exec Order 26.4b program: maximize available NJ Exec Order 26.4b1] on NJ Exec Order 26.4b …approaches/recommendations for implementation of goals: NJ Exec Order 26.4b1 [redacted] …Modify goal: NJ Exec Order 26.4b1 as NJ Exec Order 26 during AM/PM care." Review of the "Care Plan" dated NJ Exec Order 26.4b1 located in the EMR under the "Care Plan" tab revealed the resident had a NJ Exec Order 26.4b1 [redacted] with interventions that included to monitor/document/report to physician as needed for NJ Exec Order 26.4b1 [redacted] monitor/document the residents abilities	F0688	Continued from page 8 assistant. for the Range of Motion. Element 3: All Unit Managers, Nursing Supervisors and Licensed Nurses who have responsibility for implementing Range of Motion and the development of the comprehensive person-centered care plans and the certified nursing assistant Kardex have been re-inserviced. This re-education was initiated on 8/22/25 and is inclusive of implementation and development of a comprehensive care plan and certified nursing assistant Kardex for range of motion. The education will be provided during orientation for newly hired unit managers, nursing supervisors and licensed nurses, annually and as deemed necessary. Residents care plans and certified nursing assistant Kardex will be reviewed by the ADON or designee to ensure a comprehensive person-centered care plan is developed and address their Range of Motion. Element 4: Unit Managers or nurse designee will audit 5 residents' care plans weekly x 4 weeks and update care plans as needed then10 residents' care plans monthly x 3 months. Any updates to the care plan will be discussed in morning meeting with the IDT. The results of all audits will be submitted to the QAA committee who meets quarterly for review and will determine the necessity of future audits and recommendations.	

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F0688 SS = D	Continued from page 9 for activities of daily living and assist resident as needed, encourage resident to do what he/she is capable of doing for NJ Exec and monitor for NJ Exec Order 26.4b1 The care plan did not identify that NJ Exec Orde was an intervention being implemented for NJ Exec Order 26 in NJ Exec Or [redacted]. Review of the NJ Exec Order 26.4b1 certified nurse aide (CNA) documentation (NJ Ex Order 26 with the US FOIA (b)(6) on 08/07/25 at 1:00 PM did not reveal that NJ Exec Orde was being provided to R98. During an interview on 08/06/25 at 1:00 PM, the US FOIA (b)([redacted]) in the US FC discharge made a recommendation for the resident to receive NJ Exec C to the NJ Exec Order 26.4b1 through the NJ Exec Order 26.4b1). The US FC stated referrals for NJ Exec C are made to nursing. During an interview on 08/06/25 at 2:30 PM, the US FC confirmed the resident did not receive services by the facility NJ Exec C per the US FC recommendation. During an interview on 08/07/25 at 10:00 AM, the US FOIA (b)(stated she was the US FOIA (b)(6)) that oversaw the NJ Exec C in the facility. The US FOIA (b)(stated the NJ Exec C committee includes the US FOIA (b)(6) , Rehab CNAs, and Unit Managers. The US FOIA (b)(stated at the NJ Exec [redacted] monthly NJ Exec C committee meeting, the committee discussed the NJ Ex recommendation for the resident to be picked up by the NJ Exec C to receive NJ Exec Order The US FOIA (b)(stated the NJ Exec C committee decided not to pick the resident up for services, but to refer the resident to the unit CNAs for NJ Exec Orc NJ Exec C of the NJ Exec Order 26.4b1 during morning and evening care. The US FOIA (b)(stated the US FOIA (b)(6) is responsible to include the intervention in the resident care plan and the CNA Kardex. The US FOIA (b)(reviewed the resident's care plan and CNA Kardex and was unable to find NJ Exec Orde was included as an intervention. The US FOIA (b)(stated the unit the resident resides, had changes in unit managers over the past three months and "it" must have been missed. NJAC 8:39-27.1(a)	F0688		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary	F0812	1. The stack of six pans, 12 inches by 12 inches by 6	09/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315396	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	154 SUNNY SLOPE DRIVE , BRIDGETON, New Jersey, 08302

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F0812 SS = F	Continued from page 10 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure kitchen staff thoroughly cleaned and air-dried pots and pans prior to storage. This failure had the potential to increase the risk of foodborne illness and had the potential to affect 128 of 132 residents who received dietary services. Findings include: Review of the facility's policy titled, "Cleaning and Storage of Pots/Pans in Dietary," dated 02/28/25 revealed, Policy: To ensure pots and pans are cleaned, sanitized, and stored in a sanitary manner that prevents contamination and complies with state and federal regulations. Procedure: 1. Cleaning and Drying: Cookware should be properly cleaned and dried after use using available methods approved for kitchen sanitation. Staff should ensure items are appropriately dry before putting them away…3. Stacking and Nesting: Staff should use good judgment when stacking or nesting cookware to avoid taping moisture or introducing contaminants…"	F0812	Continued from page 10 inches deep, and the three pans 8 inches by 12 inches by 6 inches deep were immediately cleaned, sanitized, and air dried. 2. The deficiency cited under F812 is related to sanitation. All residents receiving food from the kitchen have the potential to be affected by this deficient practice. 3. All dietary staff were in-serviced on proper sanitary procedures for the food pans. 4. The food service director or designee are inspecting the kitchen on a daily basis for sanitary procedures. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	

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F0812 SS = F	Continued from page 11 During an observation and interview on 08/04/25 at 9:55 AM, the US FOIA (b)(6) confirmed six pans, 12 inches by 12 inches by 6 inches deep, three pans 8 inches by 12 inches by 6 inches deep that had been cleaned and stacked for use and were still wet when they were stacked. The pans were found to have been stacked wet and not allowed to properly air dry prior to being stacked. Interview with the US FO at this time, stated, "they should be dry before being put away, they weren't dry before they were stacked. Being put away wet increases the risk of contamination." NJAC 8:39-17.2(g) NJAC 8:39-19.7	F0812		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060603	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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PREFERRED CARE AT CUMBERLAND	154 SUNNY SLOPE DRIVE , BRIDGETON, New Jersey, 08302

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S0000	Initial Comments The facility is 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.	S0000		08/28/2025
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 review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: 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 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 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift.	S0560	1. There were no care concerns reported on the shifts that were identified. 2. All residents have the potential to be affected by this deficient practice. 3. Facility Staffing Coordinator was in serviced on 08/22/2025 on the requirements for proper staffing and ratios and the need to review and address the staffing needs daily to meet the state requirements. Recruitment efforts are in place to assist the facility in hiring staff. Certified Nurses Aides (CNA)’s receive sign on bonuses. The facility also has paid advertisements to help with our recruitment effort. The Staffing Coordinator or designee also reviews staff attendance records monthly to ensure that excessive callouts are addressed. The facility also utilizes agency CNAs if needed. 4. The Facility Administrator, Director of Nursing and the Staffing Coordinator will conduct weekly meetings x4 then monthly x 6 to review staffing schedules, upcoming needs, and the efficacy of the systems in place to fill the facility needs. Results of the audits will be submitted to the Quality Assessment and Assurance (QAA) committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	09/20/2025

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: 060603	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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S0560	Continued from page 1 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 Complaint staffing from 04/20/2025 to 05/03/2025, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -05/03/25 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs.	S0560		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	**154 SUNNY SLOPE DRIVE , BRIDGETON, New Jersey, 08302**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/15/2025 in relation to the 8/7/2025 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: 060603	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/15/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/15/2025 in relation to the 8/7/2025 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: 315396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/05/25 and this facility was found to be in non-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. Preferred Care at Cumberland is a three-story building built in 1977. It is composed of Type II protected construction. The facility is divided into 11 - smoke zones. The generator powers 100% of the building per the Maintenance Director. The current occupied beds are 132 of 196.	K0000		08/28/2025
K0311 SS = F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure stairway fire doors	K0311	#1 Temporary signage and monitoring were put in place until corrective work is completed. Vendor was contacted to replace panic hardware with compliant fire exit hardware on all affected stairway doors. #2 All residents have the potential to be affected by this deficient practice. #3 All maintenance staff were re-in-serviced on life safety and the importance of all fire doors having proper fire exit hardware. #4 The maintenance director/designee will audit the fire doors for any issues weekly times four weeks and then monthly times three months and ensure proper functioning. All findings will be reported to the quarterly QAPI committee.	09/20/2025

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

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K0311 SS = F	Continued from page 1 were equipped with fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) section 7.2.1.7.2 for eight of 12 stairway doors. This deficient practice had the potential to affect all 132 residents and was evidenced by the following: Observations on 08/05/25 from 1:00 PM to 4:30 PM revealed panic hardware was installed on eight of 12 stairway fire doors and not the required fire exit hardware. The eight doors with panic hardware were the stairway doors adjacent to the old generator room, the stairway doors across from the storage room on the first floor annex building, the stairway doors across from the business office second floor annex building, the stairway doors adjacent to the loading dock, the stairway doors adjacent to the employee breakroom in main building first floor, the stairway doors adjacent to the Human Resource room, the stairway doors adjacent to kitchen in main building second floor and the stairway doors across from maintenance office in main building third floor. During an interview at the time of observations, the U.S. FOIA (b) (6) confirmed panic hardware was on the fire doors. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K0311		
K0341 SS = F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is NOT MET as evidenced by:	K0341	#1 The maintenance director immediately re-secured the smoke detector boxes in rooms 150, 251, 258, and 260. #2 All residents have the potential to be affected by this deficient practice. #3 All maintenance staff were re-in-serviced on life safety and the importance of properly securing the smoke detector boxes. #4 The maintenance director/designee will audit the smoke detectors for any issues weekly times four weeks and	09/20/2025

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K0341 SS = F	Continued from page 2 Based on observation and interview, it was determined that the facility failed to ensure smoke detectors were installed securely in the acoustical ceilings in accordance with NFPA 70 National Electrical Code (2011 Edition) section 300.11 (A). This deficient practice had the potential to affect all 132 residents and was evidenced by the following: Observations on 08/05/25 from 1:00 PM until 4:30 PM revealed the smoke detector electrical boxes in rooms 150, 251, 258 and 260 were loose in the Acoustical ceilings. During an interview at the time of observations, the US FOIA (b)(6) confirmed the smoke detector electrical boxes were not secured properly in the Acoustical ceilings. NJAC 8:39-31.1(c), 31.2(e) NFPA 70	K0341	Continued from page 2 then monthly times three months and ensure proper functioning. All findings will be reported to the quarterly QAPI committee	
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by:	K0353	1. The fire department connection caps were replaced. 2. All residents have the potential to be affected by this deficient practice. 3. All maintenance staff were re-in-serviced on life safety and the importance of maintaining fire department connection caps. 4. The maintenance director/designee will audit the fire department connection caps weekly times four weeks and then monthly times three months. All findings will be reported to the quarterly QAPI committee.	09/20/2025

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K0353 SS = F	Continued from page 3 Based on observation and interview, it was determined that the facility failed to ensure the fire department connection (FDC) caps were in place in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) section 13.7.1 (3). This deficient practice had the potential to affect all 133 residents and was evidenced by the following: An observation on 08/05/25 at 2:20 PM revealed that the caps for the FDC were not in place in the annex building near the emergency generator. During an interview at the time of observation, the US FOIA (b)(6) confirmed that fire department connection caps were missing. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K0353		
K0741 SS = F Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.	K0741	1. A compliant self-closing metal ashtray disposal container was purchased and placed in the smoking area. 2. All residents who use the smoking area have the potential to be affected by this deficient practice. 3. All maintenance staff were re-in-serviced on life safety and the importance of having a compliant ashtray disposal container. 4. The maintenance director/designee will audit the smoking area compliance weekly times four weeks and then monthly times three months. All findings will be reported to the quarterly QAPI committee.	09/20/2025

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K0741 SS = F Bldg. 01	Continued from page 4 (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure a metal trash container with a self-closing cover for ashtrays to be emptied in was provided available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.4. (6). This deficient practice had the potential to affect all 133 residents and was evidenced by the following: An observation on 08/05/25 at 4:30 PM of the facility's smoking area revealed no self-closing fire rated container was in the smoking area where ashtrays could be emptied into. During an interview at the time of the observation, the US FOIA (b)(6) confirmed that a self-closing fire rated metal trash can was not present. NJAC 8:39-31.2(e)	K0741		

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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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/05/25. The facility was found to be in compliance with 42 CFR 483.73.	E0000		08/28/2025

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: 315396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT CUMBERLAND	154 SUNNY SLOPE DRIVE , BRIDGETON, New Jersey, 08302

(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
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/30/2025 in relation to the 8/7/2025 Life Safety Code survey. The facility 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 Occupancy.	K0000		

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