STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING ______ B. WING ______	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

(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	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/19/23-09/22/23 Survey Census: 49 Sample Size: 27 Supplemental Residents: 0 Complaint #: NJ157753, NJ163728, NJ164320, NJ167210	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		9/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/21/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING ______ B. WING ______	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

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F 880	Continued From page 1	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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	315482	A. BUILDING ______ B. WING ______	C 09/22/2023

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CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

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F 880	Continued From page 2 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure an effective infection control program was followed. Specifically, the facility failed to ensure staff properly removed (doffed) a contaminated gown and gloves for two of 21 sampled residents, (Resident (R) 200 and R202), diagnosed with Ex Order 26. 4B1. This failure increased the risk of spreading the Ex Order 26. 4B1. Findings include: Observation on 09/19/23 at 3:20 PM, revealed Certified Nursing Assistant (CNA#1) was assisting R200 and R202 in their room. CNA#1 had entered the shared room with full PPE in place, including eye protection, gown, gloves, and N95 mask. After completing tasks with both residents, CNA#1 exited the room into the common hallway, with soiled gown and gloves still in place. Review of R200's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed R200 was re-admitted to the facility on Ex Order 26. 4B1, with a primary diagnosis of Ex Order 26. 4B1. Review of R200's revised "Care Plan" located in the EMR under the "Care Plan" tab, dated Ex.Order 26.4(b)(1) included Ex Order 26. 4B1 Ex.Order 26.4(b)(1) and maintaining contact and droplet	F 880	F880 (D) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice a.) Staff were educated on Ex Order 26. 4B1 □ Using PPE. b.) Clinical practice referral was made to the IPRN for CNA #1. c.) CNA #1 was educated on Ex Order 26. 4B1 □ Using PPE. d.) CNA #1 completed competency for using PPE, donning and doffing and was validated by the IPRN. No residents were negatively affected. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the center receiving nursing care had the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur a) Staff were educated on Coronavirus Disease □ Using PPE. b) Random staff competencies and observations with return demonstration for using PPE for IC purposes will be completed and validated by the IPRN.	

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F 880	Continued From page 3 Ex Order 26. 4B1 . Review of R200's "Order Summary Report" located in the EMR under the "Orders" tab included Ex Order 26. 4B1 precautions starting Ex.Order 26.4(b)(1), with no end date. Review of R200's untitled document, dated Ex.Order 26.4(b)(1)3, provided by the Infection Prevention nurse confirmed that R200 tested Ex Order 26. 4B1 for Ex Order 26. 4B1 on Ex.Order 26.4(b)(1). Review of R202's "Admission Record" located in the EMR under the "Profile" tab, revealed R202 was admitted to the facility on Ex Order 26. 4B1 with a primary diagnosis of Ex Order 26. 4B1 . Review of R202's "Care Plan" located in the EMR under the "Care Plan" tab, dated Ex.Order 26.4(b)(1) included Ex Order 26. 4B1 , and maintaining contact and droplet Ex Order 26. 4B1 . Review of R202's "Order Summary Report" located in the EMR under the "Orders" tab included Ex Order 26. 4B1 precautions starting Ex.Order 26.4(b)(1) with no end date. Review of R202's untitled document, dated Ex.Order 26.4(b)(1), provided by the Infection Prevention nurse, confirmed that R202 tested Ex Order 26. 4B1 for Ex Order 26. 4B1 on Ex.Order 26.4(b)(1) During an interview on 09/19/23 at 3:20 PM, CNA#1 confirmed he was aware that R200 and R202 were on Ex Order 26 for Ex Order 26. 4B1. CNA#1 confirmed full PPE (personal protective equpment) was required to enter the room, and	F 880	How the facility will monitor its corrective action to ensure that the deficient practice will not recur a) The IPRN or Designee will complete ten (10) observations for staff weekly x4 weeks and monthly x2 months for adherence to COVID-19 use of PPE. The audit results will be presented to the QAA Committee monthly and ongoing. The QAA Committee will determine the need for further performance improvement. Completion Date: 09/27/2023	

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F 880	Continued From page 4	F 880		

that the gown and gloves should have been doffed prior to exiting the room per facility policy. CNA#1 stated he forgot to remove the gown and gloves prior to exiting the room but should have. CNA#1 stated he had recently received PPE training.

During an interview on 09/21/23 at 11:48 AM, the Director of Nursing (DON) stated it was her expectation that staff should remove gown and gloves prior to exiting a Ex Order 26. 4B1 room.

During an interview on 09/22/23 at 4:29 PM, the Infection Prevention Nurse stated it was her expectation that staff remove gown and gloves prior to exiting a Ex Order 26. 4B1 room. Staff may continue to wear their N95 mask and eye protection while on the Ex Order 26. 4B1 unit. If staff need to exit the unit, they should don a new N95 mask, and sanitize eye protection. The Infection Prevention Nurse confirmed that CNA#1 had PPE competency training in March and September 2023.

Review of the facility policy titled, "Coronavirus Disease (COVID-19)- Using Personal Protective Equipment," dated 09/2022, revealed staff should put on (don) personal protective equipment (PPE) to include ". . . NIOSH-approved [National Institute for Occupational Safety and Health] N95 or equivalent or higher-level respirator, gown, gloves, and eye protection . . . Gloves are removed and discarded before leaving the resident room or care area, and hand hygiene performed immediately . . . The gown is removed and discarded in a dedicated container for waste or linen before leaving the resident room . . . "

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F 880	Continued From page 5 NJAC 8:39-19.4(a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106100	A. BUILDING: ______ B. WING ______	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

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S 000	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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. 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:	S 560	What corrective action will be accomplished for those residents affected by the deficient practice? The facility leadership team has met on an ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified staffing needs. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents residing in the center have the potential to be affected.	9/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106100	A. BUILDING: ______ B. WING ______	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	**895 WESTFIELD ROAD MOORESTOWN, NJ 08057**

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S 560	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 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. The facility was deficient in CNA staffing for residents day shifts as follows: 1. For the week of Complaint staffing from 08/28/2022 to 09/03/2022, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -08/28/22 had 4.5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -09/03/22 had 4 CNAs for 48 residents on the day shift, required at least 6 CNAs. 2. For the 2 weeks of Complaint staffing from 08/20/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -08/20/23 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs. -08/21/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs. -08/22/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs. -08/23/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs. -08/24/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs.	S 560	What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? A market analysis conducted and demonstrated the center has implemented rates conducive for certified nursing staff. The facility has implemented an incentive program including sign-on bonuses for new hires, and referral bonuses for employees referring staff where appropriate. The facility continues to conduct ongoing job fairs, internally and externally with immediate interviews and contingency offers. The facility implemented an expedited and robust onboarding process to new hires. The facility will use agency staff as needed to meet staffing needs as available. The facility will continue to partner with Rowan College Burlington County for certified clinical rotations and schooling. The facility will continue to offer free attendance at their CNA training program offered throughout the year. The facility will continue to utilize social media, employment sites and recruitment efforts to hire new staff members. How will the facility monitor its corrective actions to ensure that the deficient	

New Jersey Department of Health

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S 560	Continued From page 2 -08/25/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs. -09/02/23 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. 3. For the 2 weeks of staffing prior to survey from 09/03/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -09/03/23 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs. -09/05/23 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs -09/15/23 had 4 CNAs for 43 residents on the day shift, required at least 5 CNAs. -09/16/23 had 4.5 CNAs for 43 residents on the day shift, required at least 5 CNAs.	S 560	practice is being corrected and will not recur? The DON and/or Designee meets with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. The DON and/or Designee will monitor call outs and staffing ratios weekly until the requirement is met. The results of the audits will be presented mothly at the QAPI meeting for further review and recommendations as needed.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315482 Y1	A. Building B. Wing Y2	11/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 09/27/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
106100	A. Building B. Wing	11/1/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/23/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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
9/22/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING 01 B. WING	09/22/2023

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/19/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Health Care Management Solutions LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/19/23 and was found not to be in compliance with 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. CareOne at Moorestown was constructed in 2003. The facility has a lower level that houses mechanicals and laundry. The facility has two stories above ground. The first floor is occupied by assisted living residents and the second floor is skilled nursing. CareOne at Moorestown is a type II protected construction a complete sprinkler system and smoke detection in all bedrooms, at smoke doors and common areas. The facility has a 100 KW (kilowatt) diesel generator with an onsite fuel tank. The facility does not have load test information available, however, a load bank test was completed. The facility has 49 occupied beds. The facility has two smoke zones.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/21/2023

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.

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	315482	A. BUILDING 01 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

(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
K 000	Continued From page 1 .	K 000		
K 311 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that unprotected vertical openings of less than one hour were not present between floors in accordance with NFPA 101 (2012 edition) section 19.3.1. and 8.6. This can affect all 49 the residents in the facility. On 09/19/23 at 9:15 AM observation with the Maintenance Director revealed that one of three smoke compartments for the two long term care units on the second floor passed through a stairway between the first and second floors at the elevator landing (by stairwell 5) to the assisted living. Interview with the Maintenance Director at the time of the observation verified the opening between floors.	K 311	K 311 (F) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice There were no residents identified who were affected by the condition. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur An FSES was conducted at the facility and the facility achieved a passing FSES to demonstrate equivalency.	11/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING 01 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

(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
K 311	Continued From page 2 NJAC 8:39-31.2(e) NFPA 101, 2012 Edition: 19.3.1 Protection of Vertical Openings. Any vertical opening shall be enclosed or protected in accordance with Section 8.6, unless otherwise modified by 19.3.1.1 through 19.3.1.8. 19.3.1.1 Where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. 19.3.1.2 Unprotected vertical openings in accordance with 8.6.9.1 shall be permitted. 8.6.9 Convenience Openings. 8.6.9.1 Where permitted by Chapters 11 through 43, unenclosed vertical openings not concealed within the building construction shall be permitted as follows: (1) Such openings shall connect not more than two adjacent stories (one floor pierced only). (2) Such openings shall be separated from unprotected vertical openings serving other floors by a barrier complying with 8.6.5. (3) Such openings shall be separated from corridors. (6)*Such openings shall not serve as a required means of egress.	K 311	How the facility will monitor its corrective action to ensure that the deficient practice will not recur The facility will continue to rely on the FSES evaluation which demonstrates compliance via equivalent alternate. Completion Date: 11/03/23	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be	K 321		9/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING **01** B. WING	**09/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	**895 WESTFIELD ROAD** **MOORESTOWN, NJ 08057**

(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
K 321	Continued From page 3 separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure hazardous area doors required to be closed were not secured in the open position at any time and were self-closing or automatic closing in accordance with NFPA 101 (2012 edition) Sections 7.2.1.8.2 and 8.4.3.5. This deficient practice had the potential to affect 14 residents in the Hamilton Wing. Findings include: An observation on 09/19/23 at 9:45 AM revealed the corridor door labeled "soiled linen room" hazardous area, located on the second floor	K 321	K321 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice There were no residents identified who were affected by the condition. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the center have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING 01 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

(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
K 321	Continued From page 4 Hamilton Wing, would not fully self-close and latch into the frame. The door was closed by the Maintenance Director three times and each time the door remained ajar. The room contained one 100-gallon trash container with one bag of trash inside and a layer of cardboard boxes on the bottom of the container. During an interview at the time of the observation, the Maintenance Director confirmed the door was ajar and did not close after three attempts were made and the room was used for trash storage. NJAC 8:39-31.2(e) .	K 321	What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur Maintenance staff were educated on the requirement to ensure hazardous area doors are self-closing or automatic closing in accordance with the NFPA 101 guidelines. The soiled linen room located on the Hamilton Wing, self-closure and door handle were adjusted to ensure self-closure and latching. This adjustment and repair were performed prior to the surveyor exiting for the day. The Maintenance Director or Designee will identify hazardous areas located throughout the center and map the area for monitoring to ensure automatic closing, self-closing, and latching. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The facility Director of Maintenance or Designee will audit hazardous areas for automatic, self-closure and latching weekly x4 weeks and then monthly x2 months. The findings will be presented monthly to the QAPI committee. The QAPI committee will determine the need for further performance improvement at the monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING 01 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

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K 341	Continued From page 5	K 341		
K 341 SS=E	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 REQUIREMENT is not met as evidenced by: . Based on record review, observation, and interview, the facility failed to ensure one of 97 photo electric smoke detector was greater than 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 29.8.3.4.(6). This deficient practice had the potential to affect 30 residents in two units (Hamilton and Maple Shade). Findings include: A review of the annual inspection and semiannual Fire Alarm reports dated 04/13/23 and 04/27/23 titled "Fire Alarm v2-Annual with Sensitivity and	K 341	K341 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice There were no residents identified who were affected by the condition. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the center have the potential to be affected.	9/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING 01 B. WING ______	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

(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
K 341	Continued From page 6 Fire Alarm v2 Semiannual" respectively revealed no reference to a smoke detector too close to an air diffuser. Both documents were provided by the Maintenance Director from the Red Binder titled "Physical Plant and Life Safety-2019 to present". An observation on 09/10/23 at 10:00 AM revealed a smoke detector, located in the corridor common area near bedroom 222, was installed 20 inches from a heating and cooling air diffuser as measured by the Maintenance Director on 09/19/23 at 1:30 PM. During an interview on 09/19/23 at 1:30 PM, the Maintenance Director confirmed the smoke detector was installed 20 inches from a heating and cooling air diffuser. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 341	What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur Maintenance staff were educated on the requirement to ensure smoke detectors are located greater than 36 inches from ceiling air diffusers in accordance with the NFPA 72 guidelines. The photo electric smoke detector was re-located to a position greater than 36 inches from the air diffuser and in accordance with the NFPA 72 guidelines. This adjustment was performed prior to the surveyor exiting for the day. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Maintenance Director or Designee will identify photo electric smoke detectors located throughout the center and map them for monitoring to ensure they are greater then 36 inches from the air diffusers. The facility Director of Maintenance or Designee will randomly audit weekly x4 weeks and then monthly x2 months to ensure no changes to the location of the smoke detectors lessening the distance required. The findings will be presented monthly to the QAPI committee. The QAPI committee will determine the need for further performance improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING 01 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

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PRINTED: 03/06/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. BUILDING 01 B. WING ______	R 02/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

(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
{E 000}	Initial Comments	{E 000}		
{K 000}	INITIAL COMMENTS A desk/paper review was conducted and the facility is not in compliance with 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, specifically K311. The facility conducted a Fire Safety Evaulation System (FSES) survey and demonstrated equivalency with the LSC. CareOne at Moorestown was constructed in 2003. The facility has a lower level that houses mechanicals and laundry. The facility has two stories above ground. The first floor is occupied by assisted living residents and the second floor is skilled nursing. CareOne at Moorestown is a type II protected construction a complete sprinkler system and smoke detection in all bedrooms, at smoke doors and common areas. The facility has a 100 KW (kilowatt) diesel generator with an onsite fuel tank. The facility does not have load test information available, however, a load bank test was completed. The facility has 65 certified beds. The facility has two smoke zones. .	{K 000}		

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

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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315482	A. Building 01 - CARE ONE AT MOORESTOWN B. Wing	2/24/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 Reg. # NFPA 101 LSC K0311	Correction Completed 11/03/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 09/23/2023	ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 09/23/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 9/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315482 Y1	A. Building 01 - CARE ONE AT MOORESTOWN B. Wing Y2	1/5/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 09/23/2023	ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 09/23/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO