STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03009	A. BUILDING: _____ B. WING _____	C 12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (MOORESTOWN)	212 MARTER AVENUE 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) COMPLETE DATE
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: C#: NJ142054, NJ142662, NJ144197, NJ149476 Based on facility document review on 12/1/2021 and 12/3/2021, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 22 of 28 shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (N.J.D.O.H.) 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	S 560	1. QA&A committee was notified of the State Deficiency on December 16, 2021. 2. Staffing levels are reviewed daily with the Leadership Team and facility scheduler for the [CNA] minimum staffing requirements for nursing 112 under N.J.S.A. 30:13-18 effective as of 2/1/2021. 3. Staffing Coordinator educated by Administrator regarding staffing ratios per the NJDOH Memo Dated 1/28/2021 and on 12/22/2021 “Compliance with N.J.S.A. 30:13-18, new minimum staffing requirements for nursing 112”. 4. Daily staffing meetings will continue, on-line help-wanted advertising on various	1/21/22

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

Electronically Signed | 12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03009	A. BUILDING: _____ B. WING _____	C 12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (MOORESTOWN)	212 MARTER AVENUE 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) COMPLETE DATE
S 560	Continued From page 1 New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (C.N.A.) to every eight residents for the day shift. One direct care staff member to every ten residents for the evening shift provided that no fewer of all staff members shall be C.N.A.s and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a C.N.A. and perform C.N.A. duties. 1. For the week from 10/10/2021 to 10/16/2021, the facility was deficient in C.N.A. staffing for residents on 7 of 7-day shifts and deficient in C.N.A.s to total staff on 5 of 7 evening shifts as follows: On 10/10/21, had 5 C.N.A.s for 87 residents on the day shift, required 11 C.N.A.s. On 10/10/21, had 5.5 CNAs to 15 total staff on the evening shift, required 8 C.N.A.s. On 10/11/21, had 8 C.N.A.s for 83 residents on the day shift, required 11 C.N.A.s. On 10/12/21, had 8 C.N.A.s for 83 residents on the day shift, required 11 C.N.A.s. On 10/12/21, had 7 C.N.A.s to 15.5 total staff on the evening shift, required 8 C.N.A.s. On 10/13/21, had 7 C.N.A.s for 83 residents on the day shift, required 11 C.N.A.s. On 10/13/21, had 6 C.N.A.s to 14.5 total staff on the evening shift, required 8 C.N.A.s. On 10/14/21, had 7 C.N.A.s for 83 residents on the day shift, required 11 C.N.A.s.	S 560	sites ongoing, shift bonuses are offered every day for every shift, sign-on bonuses increased for CNAs on the 3-11 shift, referral bonuses to existing staff increased and posted, CNA starting salaries increased earlier in the year and shift differentials increased for 3-11 shift in October/2021, job fair will be scheduled at the facility during January/2022, flexible scheduling, shift bonuses and all open shifts posted weekly in an effort to meet the requirements of the NJDOH Memo Dated 1/28/2021 “Compliance with N.J.S.A. 30:13-18, new minimum staffing requirements for nursing 112”. Issues identified will be reviewed with the QA&A monthly for the next 2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03009	A. BUILDING: _____ B. WING _____	C 12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (MOORESTOWN)	212 MARTER AVENUE 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) COMPLETE DATE
S 560	Continued From page 2 On 10/14/21, had 7 C.N.A.s to 15 total staff on the evening shift, required 8 C.N.A.s. On 10/15/21, had 8 C.N.A.s for 92 residents on the day shift, required 12 C.N.A.s. On 10/16/21, had 7 C.N.A.s for 92 residents on the day shift, required 12 C.N.A.s. On 10/16/21, had 6 C.N.A.s to 15.25 total staff on the evening shift, required 8 C.N.A.s. 2. For the weeks from 11/14/2021 to 11/27/2021, the facility was deficient in C.N.A. staffing for residents on 10 of 14-day shifts and deficient in C.N.A.s to total staff on 10 of 14 evening shifts as follows: On 11/14/21, had 7 C.N.A.s to 16.5 total staff on the evening shift, required 9 C.N.A.s. On 11/15/21, had 9 C.N.A.s for 81 residents on the day shift, required 11 C.N.A.s. On 11/17/21, had 8 C.N.A.s to 17 total staff on the evening shift, required 9 C.N.A.s. On 11/18/21, had 8 C.N.A.s to 17 total staff on the evening shift, required 9 C.N.A.s. On 11/19/21, had 9 C.N.A.s for 75 residents on the day shift, required 10 C.N.A.s. On 11/19/21, had 6 C.N.A.s to 14.5 total staff on the evening shift, required 8 C.N.A.s. On 11/20/21, had 8 C.N.A.s for 75 residents on the day shift, required 10 C.N.A.s. On 11/20/21, had 8 C.N.A.s to 17.5 total staff on the evening shift, required 9 C.N.A.s. On 11/21/21, had 7 C.N.A.s for 77 residents on the day shift, required 10 C.N.A.s. On 11/21/21, had 8 C.N.A.s to 17 total staff on the evening shift, required 9 C.N.A.s. On 11/23/21, had 8 C.N.A.s for 69 residents on the day shift, required 9 C.N.A.s. On 11/24/21, had 7 C.N.A.s for 69 residents on the day shift, required 9 C.N.A.s. On 11/24/21, had 6 C.N.A.s to 13.5 total staff on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03009	A. BUILDING: _____ B. WING _____	C 12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (MOORESTOWN)	212 MARTER AVENUE 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) COMPLETE DATE
S 560	Continued From page 3 the evening shift, required 7 C.N.A.s. On 11/25/21, had 8 C.N.A.s for 69 residents on the day shift, required 9 C.N.A.s. On 11/25/21, had 7 C.N.A.s to 15.5 total staff on the evening shift, required 8 C.N.A.s. On 11/26/21, had 8 C.N.A.s for 69 residents on the day shift, required 9 C.N.A.s. On 11/26/21, had 7 C.N.A.s to 14.5 total staff on the evening shift, required 8 C.N.A.s. On 11/27/21, had 8 C.N.A.s for 72 residents on the day shift, required 9 C.N.A.s. On 11/27/21, had 7 C.N.A.s to 15 total staff on the evening shift, required 8 C.N.A.s.	S 560		
S1015	8:39-11.1 Mandatory Resident Assessment and Care Plans A registered professional nurse (RN) shall assess the nursing needs of each resident, coordinate the written interdisciplinary care plan, sign and date the assessment to certify that it is complete, and ensure the timeliness of all services. This REQUIREMENT is not met as evidenced by: C#: NJ142054 Based on interviews, medical record (MR) review, and review of other pertinent facility documents on 12/1/2021 and 12/3/2021, it was determined that the facility nursing staff failed to have a Registered Nurse (RN) complete a timely assessment for a resident (Resident [redacted]) after a [redacted]. This deficient practice was for 1 of 5 residents reviewed and was evidenced by the following: According to the Admission Record (AR),	S1015	1. R 5 had no injury related to the [redacted]. R 5 no longer resides in the facility. 2. All current residents with actual falls will be reviewed by the DON/designee to ensure appropriate RN assessment upon each event. 3. Licensed nursing staff will be educated by the DON/designee on the facility [redacted] Guidance: [redacted] Evaluation" on or before the date of compliance.	1/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03009	A. BUILDING: _____ B. WING _____	C 12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (MOORESTOWN)	212 MARTER AVENUE 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) COMPLETE DATE
S1015	Continued From page 4 Resident [redacted] was admitted to the facility on [redacted] and readmitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident [redacted] had [redacted] and [redacted]. The MDS also indicated that Resident [redacted] required extensive two persons assistance with most Activities of Daily Living (ADLs). Review of Resident [redacted]s Change in Condition Evaluation form dated [redacted] at 01:08 a.m., completed by Licensed Practical Nurse (LPN), revealed that the resident had a[redacted] the night of [redacted] and was assessed by the LPN. A review of Resident [redacted] Progress Notes (PNs) dated [redacted] at 1:08 a.m., written by the LPN, revealed the resident "was observed on the floor beside the bed..." Further review of the PNs showed no documentation indicating the resident was assessed by an RN after the [redacted]. Further review of the PN dated [redacted] at 2:54 p.m. revealed Resident [redacted] was assessed by the Nurse Practioner (NP) "this afternoon status [redacted] last night, and per NP (the resident was) noted with some increased [redacted] from baseline. During an interview on 12/3/2021 at 11:14 a.m., when the Surveyor asked the Quality Assurance Consultant (QAC) about the Admission Assessment Policy, she stated there was no specific policy, just a checklist. During the same interview with the QAC, when the Surveyor asked	S1015	4. Utilizing the [redacted] Guidance: [redacted] Evaluation", each resident fall occurrence will be reviewed and audited daily X 4 weeks by the DON/designee to ensure RN assessment is properly documented. After 4 weeks, all f[redacted] will be audited weekly for 3 months. Results of audits will be reviewed monthly X 3 months with the QA&A committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03009	A. BUILDING: _____ B. WING _____	C 12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (MOORESTOWN)	212 MARTER AVENUE 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) COMPLETE DATE
S1015	Continued From page 5 who assessed residents after a [redacted] she stated a nurse does the assessment, either the LPN or the RN. During an interview on 12/3/2021 at 12:40 p.m., when the Surveyor asked the Assistant Director of Nursing (ADON) who assessed the resident after a [redacted], she replied that the LPN signed the assessment. The RN does the follow-up, but there was no documentation. During a post-survey phone interview on 12/6/2021 at 4:26 p.m., the LPN stated when a resident falls; the LPN makes sure the resident is safe and gets an RN/ Clinical Care Manager to assess the resident. However, when the Surveyor asked the LPN if she notified the RN or the RN assessed the resident, she stated she did not remember.	S1015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315517	A. BUILDING _____ B. WING _____	C 12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (MOORESTOWN)	**212 MARTER AVENUE 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 COMPLAINT#: NJ142054, NJ142662, NJ144197, NJ149476 CENSUS: 81 SAMPLE SIZE: 5 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR, PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		

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

Electronically Signed | 12/22/2021

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.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
03009 Y1	A. Building B. Wing Y2	1/24/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (MOORESTOWN)	212 MARTER AVENUE 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 01/21/2022	ID Prefix S1015 Reg. # 8:39-11.1 LSC	Correction Completed 01/21/2022	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	
12/3/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO