

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03A004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2025
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NAME OF PROVIDER OR SUPPLIER HARMONY VILLAGE AT CAREONE STANWICK	STREET ADDRESS, CITY, STATE, ZIP CODE 301 N STANWICK ROAD MOORESTOWN, NJ 08057
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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) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: REVISED</p> <p>TYPE OF SURVEY: Renovation/Expansion</p> <p>The facility's previous licensed capacity was 99. During the renovation, one licensed bed/apartment was eliminated and converted to a common area. Following the completion of the renovation, an addition of 36 new beds (one of the 36 new beds replaced the previously eliminated licensed bed/apartment). This addition resulted in a total facility licensed capacity of 134 Assisted Living beds.</p> <p>CENSUS: 64 (existing facility). 0 (newly renovated 36 beds). The additional 36 beds were not occupied and waiting for approval at the time of the survey.</p> <p>SAMPLE: 0</p> <p>The facility was in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this survey.</p>	A 000		

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