STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CareOne At Moorestown	**895 WESTFIELD ROAD , MOORESTOWN, New Jersey, 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
F0000	INITIAL COMMENTS Complaint #: 3015763 Census: 58 Sample size: 3 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		07/30/2026

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: 106100	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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S0000	Initial Comments Complaint #: 3015763 Census: 58 Sample size: 3 The facility was not in compliance with the standards in the New Jersey Administrative code, 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		07/30/2026
S0009	Licensure Procedure CFR(s): 8:39-2.1(c) The facility shall implement all conditions imposed by the Commissioner as specified in the certificate of need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H-1 et seq., and amendments thereto. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 3015763 Based on interviews and review of pertinent facility documentation it was determined that the facility failed, as a Medicaid certified provider, to demonstrate that subacute residents that convert to Medicaid or have Medicaid as their primary insurance were able to remain in the facility when their subacute stay had ended. This deficient practice was evidenced by the following:	S0009	On 6/19/26, the facility administrator conducted an audit of the facility's current census records to identify any resident who: (a) had Medicaid as a primary payer; (b) had a Medicaid application pending; (c) converted or was expected to convert from Medicare, private pay, managed care, or another payer source to Medicaid during the stay; or (d) was discharged, transferred, or referred for transfer based solely on Medicaid payer-source status. Based on the review conducted to date, the facility has not identified any current resident who was discharged or denied continued stay solely because of Medicaid payer-source status. All residents and applicants with the potential to be affected include: (a) current residents with Medicaid as their primary payer; (b) current residents with Medicaid applications pending; (c) current residents who may convert from Medicare, private pay, managed care, or another payer source to Medicaid during their stay; (d) residents discharged or transferred within the review period where Medicaid payer-source status was discussed; and (e) admission applicants or referrals where Medicaid, Medicaid-pending status, or anticipated long-term-care placement. The Director of Social Work and Director of Admissions received in-service education on 6/26/26 regarding the facility's	08/20/2026

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S0009	Continued from page 1 0n 6/04/2026 at 9:45 AM, the surveyor conducted an entrance conference with the Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON). The LNHA indicated that the facility was composed of 65 sub-acute rehabilitation (SAR) beds and no long-term care (LTC) beds. An interview was conducted with the Director of Social Work (DSW) on 06/04/2026 at 11:09 AM. The DSW stated that when residents were admitted to the facility, they were made aware that the facility did not accept Medicaid. The DSW stated that, if necessary, she would assist residents with Medicaid applications, discuss other facilities with the residents and their families, and send those residents' information to other facilities. The DSW stated that there were several residents in the facility who had Medicaid applications pending or who were awaiting placement at other facilities. The DSW further stated that the facility had not ever accepted Medicaid. An interview was conducted with the LNHA on 06/04/2026 at 11:44AM. The LNHA stated that the facility has never accepted Medicaid. An interview was conducted with the Director of Admissions (DOA) on 06/04/2026 at 12:38 PM. The DOA stated that the facility was a SAR and did not accept Medicaid. The DOA stated that if a resident required LTC they would have to transfer to another facility and residents and families were informed of that verbally on admission and it was included in the facility's admission agreement. A follow-up interview was conducted with the LNHA on 06/04/2026 at 2:34 PM. The LNHA stated that he was awaiting documentation from Corporate regarding the facility's authorization not to accept Medicaid. No documentation was provided. The facility license provided to the surveyor by the LHNA was reviewed. The license was issued by the NJDOH, Division of Certificate of Need & Licensing with an effective date of 08/01/2025, and an expiration date of 07/31/2026. The facility license revealed that the facility was licensed to operate as an LTC facility that consisted of 65 LTC beds. A review of the undated facility "Admission Agreement" document was conducted. Under "ARTICLE II FACILITY DUTIES" page one of the document revealed "1. Services. [...] If a Resident is	S0009	Continued from page 1 Medicaid participation obligations and the requirement that Medicaid payer-source status not be used as the sole basis for denying continued stay, discharge, transfer, or referral for alternate placement. On 6/26/26, the Administrator instructed the Director of Admissions, Director of Social Work, and Director of Nursing to suspend any verbal representation to prospective residents or families that the facility does not accept Medicaid. Staff acknowledged this instruction. Documentation is maintained in the facility's records. On 6/26/26, the Senior Vice President of Operations provided education to the facility's Administrator (LNHA), the Director of Nursing (DON), Director of Admissions, Director of Social Work, and other admissions/social-services personnel working the 7-3p and 3-11p shifts, regarding: (a) the facility's Medicaid participation and the obligation to accept and retain residents regardless of payer-source conversion to Medicaid; and (b) the requirement that Medicaid, Medicaid-pending status, or payer-source conversion not be used as the sole basis for discharge, transfer, denial of continued stay, or referral for alternate placement. The staff verbalized understanding of this education. On 6/26/26, The facility Administrator left a message for personnel at the New Jersey Division of Medical Assistance and Health Services and requested the facility's Medicaid provider number, applicable rate, and billing/enrollment requirements; revise the Admission Agreement and admissions policies to accurately reflect the facility's Medicaid participation and remove any language inconsistent with Medicaid acceptance; and provide additional staff education regarding Medicaid participation. The revised Admission Agreement replaces the current Admission Agreement. The Administrator or designee will conduct a weekly review of the Medicaid/payer-source tracking log weekly for four weeks, then monthly for three months, to confirm that residents and applicants with Medicaid, Medicaid-pending status, or anticipated payer-source conversion are addressed consistently with this Plan of Correction. The weekly and monthly review will include: (a) current residents with Medicaid or Medicaid-pending status; (b) residents who converted or may convert payer sources during their stay; (c) discharges or transfers where payer-source status was discussed; and (d) admission referrals where Medicaid, Medicaid-pending status, or long-term-care	08/20/2026

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S0009	Continued from page 2 a Medicaid and/or Medicare beneficiary, Facility will provide the services set forth in Exhibit A so long as they remain covered by those programs."	S0009	Continued from page 2 placement was discussed. Audit findings will be reported to the Administrator and the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will evaluate whether additional education, policy revision, or continued auditing is necessary.	08/20/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 08/20/2026 in relation to the 06/04/26 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		08/20/2026

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.

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New Jersey Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 08/20/2026 in relation to the 06/04/2026 State of New Jersey Complaint 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		08/20/2026

Office of Primary Care and Health Systems Management

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