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 04/22/2024

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
F 000	INITIAL COMMENTS Complaint #: NJ173002 Census: 54 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.	F 000		

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

Electronically Signed | 05/04/2024

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
	106100	A. BUILDING: _____ B. WING _____	C 04/22/2024

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 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.	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: Complaint #: NJ173002 Based on interviews and review of facility documents on 4/22/2024, it was determined that the facility failed to ensure staffing ratios were met for 4 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. 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 as N.J.S.A. 30:13-18 (the Act), which	S 560	1. The facility leadership team has met on ongoing basis and continued to identify minor staffing challenges and areas of improvement for certified nursing assistants needs. The facility hired nurses and certified nursing assistants since completion of the facility visit. 2. All residents have he potential t be affected by this practice. 3. The DON conducted an audit of staffing schedules with the current facility census to ensure fulfillment of staffing requirements per shift. The facility has implemented an	5/4/24

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

Electronically Signed | 05/04/24

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 04/22/2024

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 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. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs 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 CNA and perform CNA duties. The facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: On 04/09/24 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. On 04/11/24 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. On 04/14/24 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs. On 04/16/24 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs.	S 560	incentive program including tuition reimbursement, referral bonus for employees referring staff where appropriate to strengthen hiring program. The facility continues to post job vacancy internally and externally, and hiring initiatives on social media. Immediate interviews, contingency offers and onboarding process in place for new hires. 4. The DON and or designee meets with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. DON and director of rehab will collaborate as needed if rehab staff assistance are needed to compliment 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 forwarded to the facility Administrator and QAPI Committee for further review and recommendations as needed.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
106100 (Y1)	A. Building B. Wing (Y2)	5/6/2024 (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 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 05/04/2024	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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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	
4/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO