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 _____	07/08/2022

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 Survey Date: 07/08/22 Census: 51 Sample: 13 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, medical record review and review of other pertinent facility documentation, it was determined that the facility failed to adequately monitor a resident that was identified as a high risk for [redacted] and implement [redacted] prevention interventions to prevent frequent [redacted] in accordance with facility policy for 1 of 2 residents reviewed for [redacted] Resident #34. This deficient practice was evidenced by the following: On 06/23/22 at 11:05 AM, during the initial tour of	F 689	F689 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #34 discharged from the center. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the center with risk of falls have the potential to be affected. Risk management incidents were	8/15/22

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

Electronically Signed | 08/10/2022

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F 689	Continued From page 1 the facility, the surveyor observed Resident #34 lying in bed awake. The resident did not respond to the surveyor when spoken to. The surveyor observed a NJ Exec Order 26.4b1 on the resident's EX Order 26.4B1 and there was a NJ Exec O on the floor on the EX Order 26.4B1 of the resident's bed. The surveyor reviewed the Admission Record of Resident #34 which indicated that the resident was admitted to the facility in EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1 Review of the admission Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, reflected that Resident #34 had a Brief Intermittent Mental Status (BIMS) score of EX Orde which indicated that the resident was EX Order 26.4B1 EX Order 26.4B1. Further review of the document identified that the resident required extensive assistance of one person for both NJ Exec O and NJ Exec Order 26.4b1 and required assistance of one person for EX Order 26.4B1 and utilized a Ex Order 26.4B1 and or wheelchair. Further review of the MDS revealed that the resident had EX Order 26.4B1 NJ Exec Order 26 and EX Order 26.4B1 (except major) since admission. On 06/27/22 at 10:45 AM, the surveyor observed Resident #34 seated in the hallway outside of the EX Order 26.4B1. The resident's EX Order 26.4B1 was wrapped in EX Order 26.4B1 and had a EX Order 26.4B1	F 689	reviewed for implemented interventions. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur Fall risk evaluations and plans of care for all residents at risk for falls will be reviewed to ensure that the interventions are resident centered, appropriate and in place. Interdisciplinary Team will identify interventions related to the residents□ specific risks and/or cause to try and prevent the resident from falling and/or minimize complications from the fall. Falls will be reviewed by Interdisciplinary Team for effectiveness of interventions and modifications made as needed. Staff will be educated on fall prevention, care planning measures and implementation. How the facility will monitor its corrective action to ensure that the deficient practice will not recur The Director of Nursing or Designee will check 5 residents weekly deemed high risk for falls to ensure the appropriate measures are in place per the care plan and Kardex. The Director of Nursing or Designee will audit weekly x4 weeks, then monthly x2 months. The results of the audit will be presented to the QAA Committee quarterly for 2 quarters. The QAA Committee will determine the need for further performance improvement. Completion Date: 08/15/2020	

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of EX Order 26.4B1 that seeped through the NJ Exec Order 26.4b1 in the region of the EX Order 26.4B1 EX Order 26.4B1. The EX Order 26.4B1 was dated EX Order 26.4B1. The resident stated, NJ Exec Order 26.4b1 At 2:30 PM, the surveyor requested to view all investigations related to Resident #34.

Review of the Progress Notes (PN) contained within the Electronic Health Record (EHR), revealed that on NJ Exec Order 26.4b1 at 12:38 PM, the Registered Nurse/Unit Manager (RN/UM) documented that she was called to Resident #34's room by the resident's roommate and found Resident #34 EX Order 26.4B1. The resident's roommate reported that the resident got up from the chair and walked to the wardrobe, knocked on the door of it and took a EX Order 26.4B1.

Further review of the PN revealed that on EX Order 26.4B1 at 11:27 PM, the Registered Nurse (RN) #1 documented that at approximately 07:40 PM, Resident #34 was noted EX Order 26.4B1 in the room in the EX Order 26.4B1. The resident reported that he/she Ex Order trying to go to the bathroom. The resident was observed to have been EX Order 26.4B1 EX Order 26.4B1 The resident was sent to the Emergency Room (ER) for evaluation. On NJ Exec Order 26.4b1 at 08:48 AM, RN #2 documented that Resident #34 returned to the facility with EX Order 26.4 EX Order 26.4B1

On NJ Exec Order 26.4b1 at 06:51 PM, the Assistant Director of Nursing (ADON) documented that the Resident #34 was EX Order 26.4B1 in the doorway of the bedroom Ex Order 26.4B1

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side. The resident sustained a EX Order 26.4B1 to the EX Order 26.4B1

On NJ Exec Order 26.4b1 at 07:33 PM, RN #3 documented that Resident #34 was EX Order 26.4B1 and was unable to explain what happened.

On NJ Exec Order 26.4b1 at 07:54 PM, RN #1 documented that at approximately 07:45 PM, the Resident #34 called for help and the resident's primary nurse indicated the resident EX Order 26.4B1. The resident was noted to be EX Order 26.4B1 . The resident stated that he/she attempted to walk to a family member's home.

On NJ Exec Order 26.4b1 at 08:26 AM, RN #2 documented that the Certified Nursing Assistant (CNA) reported to the nurse that Resident #34 EX Order 26.4B1 EX Order 26.4B1 in his/her room. The Supervisor assessed the resident and noted that an EX Order 26.4B1 .

On NJ Exec Order 26.4b1 at 02:11 PM, the RN/UM documented that she heard a EX Order 2 from down the hall and Resident #34 EX Order 26.4B1 When she approached the room, the resident was observed EX Order 26.4B1. She documented that the resident appeared to have been coming from the Ex Order 26.4B1 and the resident was unable to state where he/she was going or tried to do at that time.

On NJ Exec Order 26.4b1 at 2:27 AM, RN #2 documented that at 08:45 PM on 06/26/22, Resident #34 was

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EX Order 26.4B1 in another resident's room. The resident had EX Order 26.4B1 a EX Order 26.4B1 and EX Order 26.4B1

Review of a EX Order 2 Risk Assessment dated EX Order 26.4B1, revealed that Resident #34 scored EX Orde on the assessment which indicated that the resident was a EX Order 26.4B1 (total score of EX Orde or greater).

On 06/28/22 at 10:25 AM, the surveyor observed Resident #34 seated in a wheelchair outside of the EX Order 26.4B1 NJ Exec Ord with a tray table placed in front of the wheelchair. The resident stood without assistance and held onto the table. The Registered Dietician (RD) heard the surveyor speaking with the resident and came out of a nearby office and redirected the resident to sit down.

On 06/28/22 at 11:30 AM, the Director of Nursing (DON) presented the surveyor with EX Order 26.4B1 investigations that pertained to Resident #34 which were completed between EX Order 26.4B1 and EX Order 26.4B1

The surveyor reviewed Resident #34's Care Plan which included the following entry: At risk for EX Order 2 due to history of EX Order 26. EX Order 26.4B1. The Care Plan was reviewed on EX Order 26.4B1, EX Order 26.4B1 The interventions included but were not limited to the following: On EX Order 26.4B1 Seat resident in common area for close supervision, on NJ Exec Order 26.4B1 Offer NJ Exec Order 26.4 to patient upon rising (6 AM), before and after meals, before bed, and as needed throughout the day. On NJ Exec Order 26.4B1 Medications reviewed and EX Order 26.4B (EX Order 26.4B1)

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F 689	Continued From page 5 discontinued due to EX Order 26.4B1 [redacted] On EX Order 26.4B1 A EX Order 26.4B1 was to be worn at all times except for hygiene to prevent EX Order 26.4 and NJ Exec Order 26.4b1 to the EX Order 26.4B1 of the bed. On 06/28/22 at 02:31 PM, the surveyor interviewed the Infection Preventionist (IP) and former DON, who stated that the facility did not use any type of EX Order 26.4B1 to prevent EX Order 26 She stated that I should speak with the current DON to obtain further information. The surveyor reviewed Resident #34's PN contained within the EHR which revealed that on NJ Exec Order 26.4 at 08:42 PM, RN #1 documented that at approximately 08:30 PM, she responded to a EX Order 26.4B1." Resident #34 was observed in the room near the doorway leaning against the wall/chair. The Primary Nurse and CNA responded at the same time. The resident was observed to have had on "EX Order 26.4B1" EX Order 26.4B1). The call bell was on and the resident's room mate reported that he/she pushed it when the resident EX Orde and only observed the EX Order The surveyor requested to review the investigation related to this EX Orde and was later provided with the investigation for review on 7/1/22 at 11 AM. On 06/30/22 at 10:11 AM, the surveyor observed Resident #34 lying in bed awake. The EX Order NJ Exec O was not observed on the EX Order 26.4B1 of the floor beside the resident's bed but instead was placed against the wall behind a chair. The resident did not respond to the surveyor when spoken to. The surveyor attempted to locate the resident's assigned CNA or Nurse but was unable to do so as both staff members were providing care to	F 689		

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F 689	Continued From page 6 other residents at that time. On 06/30/22 at 10:15 AM, the surveyor interviewed the Lead EX Order 26.4B1 who stated that she was not assigned to Resident #34, but was working with the resident on prevention and She stated that she knew the resident had been "EX Order 26.4B1." She stated that the resident was very and was not She stated that the resident's medications were changed and the resident's NJ Exec Order 26.4b1. She stated that we trialed a to , but the first trial was as the resident took it off on both EX Order 26.4B1 of this week. She stated that they needed to ensure that the resident was able to remove it independently before it were issued to the resident. She stated that when the resident was seated in the common area, outside of the the , the staff were not watching the resident because we worked with other residents. She stated that the area had high visibility and the charge nurse should have been responsible. She further stated that the aides sat with the resident sometimes and activities gave the resident things to do to keep busy. At that time, the further stated that the should have been beside the resident when the resident was in bed. She stated that the aides removed the from the floor once the resident was up and dressed and in the wheelchair. She stated that the purpose of the was to cushion if the resident tried to get up. She stated she was unaware of any other safety mechanism employed to prevent resident	F 689		

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EX Order 2 other than the EX Orde NJ Exec O and the trial of the EX Order 26.4B1. She demonstrated the Ex Order 26.4B1 and stated that the longest the resident was able to tolerate it was for ten seconds and then the resident took it off. She stated the resident would not even permit us to secure the strap. She further stated that the resident always needed assistance and NJ Exec Order 26 as he/she does not have the EX Order 26.4B1 NJ Exec Order 26.4b1. She stated the resident was able to walk for 15 to 25 feet with a Ex Order 26.4B1 and minimal staff assistance with wheelchair following behind. She stated that the resident's discharge date was not yet set as the resident required 24/7 supervision, was at a EX Order 26.4B1, and needed standby assistance for NJ Exec Order 26.4b1

On 06/30/22 at 10:37 AM, the surveyor interviewed Resident #34's CNA #1 at Resident 334's bedside and both the surveyor and CNA #1 observed that the resident laid in bed and that there was no Ex Orde NJ Exec O next to the bed as required. She stated that the EX Orde NJ Exec O should have been in place when the resident was in bed. She stated she got the resident up this AM and placed the Ex Orde NJ Exec O against the wall. She stated she did not know who put the resident back in bed but they should have put the EX Orde NJ Exec O to the left side of the bed in case the resident tried to get up. She stated the resident was not good with using the call bell. She stated that she had eight residents today and the staffing was the same in the evening. She stated that this resident required NJ Exec Order 26.4b and we do not do NJ Exec Order 26.4b here, only rarely. She stated that sometimes the families provided NJ Exec Order 26.4b1. She stated that she needed to place the NJ Exec O on the floor. She

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asked the surveyor to remain with the resident for a minute until she left the room to get soap to wash her hands so she could help her resident. She returned and donned gloves and placed the [redacted] to the left of the resident's bed.

On 06/30/22 at 11:08 AM, the surveyor interviewed the Assistant Director of Social Services (ADSS) who stated that Resident #34 had both EX Order 26.4B1 with [redacted] She stated that the resident was brought out to the common area for observation and a [redacted] was placed next to the resident's bed in case the resident [redacted] so he/she would [redacted] on the [redacted] instead of on the floor. She stated the bed was kept in the lowest position. She sated that we really do not do [redacted] here, but family could provide it for "peace of mind." She stated we recommend private duty agencies for reference. She stated that we have not offered the resident's family the option of NJ Exec Order 26.4b1 to privately pay for NJ Exec Order 26.4b1 services, as the resident seemed to manage well during the day. She stated a [redacted] was not explored at night when the resident [redacted]. She stated NJ Exec Order 26.4b1 [redacted]. She further stated the resident was EX Order 26.4B1 [redacted]

On 06/30/22 at 01:45 PM, the surveyor interviewed Resident #34's room mate, an unsampled resident whose BIMS score was [redacted] which indicated that the resident was [redacted] EX Order 26.4B1. The room mate stated that he/she witnessed Resident #34 EX Order 26.4B1 in all. Once as the resident walked toward the door, once near the bathroom and once out in the hall.

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F 689	Continued From page 9 The room mate stated that he/she called for nursing each time via the call bell and the nurses responded right away. He/She further stated that the [redacted] was down at night when the resident [redacted] On 06/30/22 at 01:47 PM, the surveyor observed Resident #34 lying in bed awake. The resident had a [redacted] on his/her night stand and asked the surveyor to pass it to him/her. The surveyor attempted to locate the resident's nurse to accommodate the resident's request to wear the [redacted] and the nurse passed medications at the time. Except for when performing hygiene, the facility failed to ensure that the [redacted] was always worn to [redacted] as specified in the resident's Care Plan entry dated [redacted] On 06/30/22 at 01:56 PM, the surveyor interviewed the RN/UM who stated that she would have expected the aides and nurses to ensure that Resident #34 had his/her [redacted] on at night. She stated that a [redacted] was implemented and should have been part of the care plan when it was implemented. She stated that the facility was not staffed to provided [redacted]. She stated that Social Services could offer a list to families for privately paid private duty aides. She further stated, "You do what you need to do on an hourly basis and should round every two hours." On 06/30/22 at 02:38 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #2 who stated that Resident #34 was [redacted] and was a [redacted] She stated that we round more frequently, every 45 minutes to an hour to observe the resident. She stated that the resident	F 689		

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was placed in the hall for observation at times. She stated that the CNA's put on the resident's socks and [redacted] wear. She stated that it was rare that the facility did [redacted] and the responsibility to provide such coverage was left up to the family. She stated if the family could not afford it, we do not provide [redacted]. She stated that the resident was [redacted] She further stated that she knew that the resident [redacted] his/her [redacted] in the past, but to her knowledge the [redacted]

On 07/1/22 at 11:05 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, who stated that Resident #34 may have put himself/herself back to bed independently when the resident was observed by the surveyor lying in bed without a [redacted] beside the bed. She stated the resident could have self-propelled the wheelchair from the hallway and gotten back into the bed independently as he/she did sometimes. She stated that the Care Plan and [redacted] Policy should have been followed to ensure resident safety. She stated if a staff member placed the resident back in bed, then they should have placed the [redacted] next the bed at that time.

At 12:21 PM, in a later interview with the DON, she stated that after the surveyor brought it to her attention, she spoke with [redacted] Social Worker who provided the Resident #34's family with a list of [redacted] private duty agencies for which the family had the option to pay for privately if they wished due to repeated [redacted] She also provided the surveyor with a [redacted] Care Visit Report dated [redacted] which pertained to Resident #34 and detailed that the resident had the following [redacted]

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EX Order 26.4B1

#8 EX Order 26.4B1

On 07/1/22 at 11 AM, the surveyor received and reviewed a EX Order 2 Investigation from the DON dated Ex Order 26.4B1 The surveyor reviewed the investigation and noted that the facility did not include a PN written by RN #1 which detailed the Ex Order and noted that the resident wore EX Order 26.4B1 Ex Order 26.4B1 instead of NJ Exec Order 26.4b1 as required. Further review of the Investigation revealed a PN written by RN #2, which did not specify that the resident wore EX Order 26.4B1." On 07/11/22 at 10:56 AM, during a post-survey telephone interview, when the surveyor asked the DON why the PN that specified the resident wore 'EX Order 26.4B1" was not included in the investigation? She stated that at the time of the Ex Order RN #2 was on her medication pass and RN #1, the Desk Nurse, responded to the resident. She stated that the PN was not included in the investigation as the way the resident Ex Orde was a 'NJ Exec Order 26.4b1" and was not a EX Order 26.4B1 thing." She stated that the resident required supervision for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 She stated the resident should not have been walking alone. She stated that the Ex Orde NJ Exec O was not placed on the resident's Care Plan prior to EX Order 26.4B1 because we felt it would have been more of a hazard to the resident after the resident was

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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 689	Continued From page 12 observed trying to pick it up from the floor. She stated that the Care Plan was reviewed and if it was determined that an intervention did not work, we revise the Care Plan and try something else to prevent [redacted] Review of the facility policy titled, "Falls and Fall Risk, Managing (Revised March 2018) revealed the following: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling to try to minimize complications from falling. Fall Risk Factors: Environmental factors that contribute to the risk of falls include: ...footwear that is unsafe or absent Resident-Centered Approaches to Managing Falls and Fall Risk: ...Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.	F 689		
F 761 SS=D	NJAC 8:29-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		8/15/22

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F 761	Continued From page 13 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to secure medications in a locked compartment by leaving unattended medication in a plastic cup on top of a medication cart. The deficient practice was identified for 1 out 4 medication carts observed and was evidenced by the following: On 07/07/22 at 9:56 AM while touring the second floor, the surveyor observed medication tablets in a plastic cup on top of a medication cart outside of room [redacted]. The medication tablets were unattended.	F 761	F761 (D) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice The medications found in the plastic cup were discarded. The nurse also received a clinical practice referral. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility who receive medications have the potential to	

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F 761	Continued From page 14 On the same date at 9:58 AM, the Licensed Practice Nurse #1 (LPN) was observed around the corner in room [EX Order 26.4B1]. At this time, during an interview with the surveyor, LPN #1 stated that she should not have left the medication on top of the medication cart. LPN #1 stated, "Its just [EX Order 26.4B1]." LPN #1 then confirmed that [EX Order 26.4B1] was also in the plastic cup. On 07/07/22 at 1:53 PM, during an interview with the surveyor, the Director of Nursing confirmed that unattended medication should not be left on top of a medication cart. She further confirmed that medication should be stored in a locked cart. Review of the facility policy titled "Storage of Medications" with a reviewed date of November 2020, under subheading, "Policy Interpretation and Implementation" number 1. revealed, "Drugs and biologicals used in the facility are stored in locked compartments..." The policy further revealed under number 3. that, "The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner."	F 761	be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur Licensed staff will be educated on maintaining medication storage and preparation areas in a clean, safe and sanitary manner. How the facility will monitor its corrective action to ensure that the deficient practice will not recur The Director of Nursing or Designee will inspect medication carts weekly x 4 weeks, then monthly x2 months. The results of the audit will be presented to the QAA Committee quarterly. The QAA Committee will determine the need for further performance improvement. Completion Date: 8/15/22	
F 812 SS=E	NJAC 8:39-29.4(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		8/8/22

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F 812	Continued From page 15 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of foodborne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross-contamination and c.) maintain sanitation in a safe and consistent manner to prevent foodborne illness. This deficient practice was observed and evidenced by the following: On 06/23/22 from 10:09 AM until 11:29 AM, the surveyor toured the kitchen in the presence of the Director of Culinary Services (DCS) and observed the following: 1. On a metal shelf in the walk-in freezer, there was one knotted clear plastic bag that contained	F 812	F 812 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were found to have been affected by the deficient practice. Foods items identified as not dated, not labeled were discarded. Plastic lidded food containers identified as stored improperly were discarded. Dented cans identified were discarded. Cutting boards with slice marks and smudges were discarded and replaced with new boards. The contents in the sanitizing bucket were discarded, refilled, and tested. Vendor inspected and corrected dispensing system. How the facility will identify other	

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F 812	Continued From page 16 four pieces of frozen oval shaped dough, that the DCS identified as flat bread, that had no label and no dates. The DCS acknowledged that the bag should have been dated and that he did not know when it was opened. The DCS further stated it was important to date food correctly, so you knew how old it was. 2. On a metal pan on a shelf in the prep refrigerator, there was a lunchmeat sandwich on a plate wrapped in clear plastic wrap with no label and no dates. The DCS acknowledged there was no label or date and stated that the sandwich should have had a snack sticker that would include the resident's name, room number and date. The DCS further acknowledged it was important to label and date food items to prevent illness. 3. In the dry storage room, there was: one large opened clear plastic bag in an opened box that contained plastic lidded food containers that were exposed to air. The DCS stated they were "to go containers" and that the bag and box should be closed to keep the containers free from dust, dirt and contaminants; one large metal shelf which contained one dented 6 pound 8 ounce can of sliced apples, and one dented 108 ounce can of cannellini beans. The DCS acknowledged the cans were dented and stated they should not be used because they could contain botulism which could cause illness. The DCS removed the cans and placed them in the dumpster. 4. In a wire rack on the bottom shelf of a metal prep table there was one yellow cutting board, one green cutting board, and one red cutting board with black smudges and slice marks. The	F 812	residents having the potential to be affected by the same deficient practice Residents residing in the facility, who eat by mouth, receiving food from the kitchen, 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 The Director of Culinary Services or Designee will re-educate the Culinary Services employees on Food Receiving and Storage, Sanitation and Prevention of Food Borne Illnesses and Sanitary Practices. How the facility will monitor its corrective action to ensure that the deficient practice will not recur The Culinary Services Director or Designee will monitor and audit kitchen service operations, storage, and food preparation weekly x4 weeks and monthly x3 months. The results of the audit will be presented to the QAA Committee monthly. The QAA Committee will determine the need for further performance improvement. The Culinary Services Director or Designee will monitor and audit kitchen cleaning and sanitation weekly x4 weeks and monthly x3 months. The results of the audit will be presented to the QAA Committee monthly. The QAA Committee will determine the need for further performance improvement. Completion Date: 08/08/2022	

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F 812	Continued From page 17	F 812		

DCS stated the cutting boards got cleaned and sanitized then were stored in the wire rack. The DCS acknowledged the smudges and slices should not be there and that it was important to keep them clean and sanitized.

5. On the bottom shelf under the prep sink area was one liquid filled green bucket that the DCS identified as soap and one liquid filled red bucket that the DCS identified as sanitizer. The DCS stated the area gets wiped down with soap then sanitized before and after use. The DCS tested the sanitizer bucket with a testing strip which read an orange color which was less than zero parts per million (ppm). The DCS stated that the amount of sanitizer in the bucket was nonexistent and that it should be between 150-200 ppm QUAT (quaternary ammonium compound) to have the right concentration to kill the germs. The DCS refilled the sanitizer bucket.

On 07/07/22 at 1:47 PM, the Licensed Nursing Home Administrator, the Director of Nursing, and the Infection Preventionist were made aware of the surveyor's concerns.

The surveyor reviewed the facility's policy, "Food Receiving and Storage", edited 12/4/2018, which revealed Policy Interpretation and Implementation, 5. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated "dry storage" unit which is temperature and humidity controlled, free of insects and rodents and kept clean. 8. Foods stored in the refrigerator or freezer will be stored using food service standards.

The surveyor reviewed the facility's policy,

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F 812	Continued From page 18 "Sanitation", edited 05/02/2018, which revealed Policy Interpretation and Implementation, 2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning ...3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. 4. Sanitizing of environmental surfaces must be performed with one of the following solutions: b. 150-200 ppm quaternary ammonium compound ... The surveyor reviewed the facility's undated policy, "Dented Can Policy," which revealed Policy Statement: All cans must be inspected, placed in the Culinary Directors office for a credit and then disposed of. We will not store any dented, bulging, or damaged cans in any other space. Policy Interpretation and Implementation: 1. During delivery inspect cans for dents, bulges, and dings by visually inspecting and placing hand around the can while rotating all the way around. Discard into Culinary Directors office. 2. Inspect all cans before use for dents, bulges, and dings by visually inspecting and placing hand around the can while rotating all the way around. Discard into Culinary Directors office. No policies on kitchen dating and labeling were provided. NJAC 8:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/15/22

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F 880	Continued From page 19 §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 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;	F 880		

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F 880	Continued From page 20 (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 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 document review it was determined the facility failed to ensure: a.) the facility completed thorough NJ Exec Order 26.4b1 upon the identification of a resident who tested NJ Exec Order 26.4b1 to ensure all potential contacts are identified and tested for NJ Exec Order 26.4b1 per the facility's outbreak response plan and per federal guidance for	F 880	F880 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice a.) Staffing assignments were reviewed to ensure that staff contacts were identified and tested for those members	

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F 880	Continued From page 21 infection control, b.) ensure contracted staff (NJ Exec Order 26.4b1) wore appropriate personal protective equipment (PPE) when NJ Exec Order 26.4b1 from a NJ Exec Order 26.4b1 resident, c.) staff wore appropriate PPE during the handling of a NJ Exec Order 26.4b1 specimen, d.) minimize the potential spread of infection to residents during medication administration for 2 of 2 nurses observed during the medication pass on 2 of 3 units, (NJ Exec Order 26.4b1), and e.) maintain infection control standards and procedures to address the risk of infection transmission by failing to: a) perform proper hand hygiene and perform a Ex Order 26.4B1 treatment in a safe and sanitary manner for 1 of 1 nurse observed providing a Ex Order 26.4B1 care treatment, to 1 of 1 resident, (Resident #103); References: Centers for Clinical Standards and Quality/Survey & Certification Group, Ref: QSO-20-38-NJ, REVISED 03/10/2022 Centers for Disease Control (CDC), Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing Updated May 18, 2022 CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, Nursing Homes & Long-Term Care Facilities, Updated Feb. 2, 2022 a. On 06/23/22 at 10:00 AM during the entrance conference conducted with the facility Administrator (LHNA) and Director of Nursing (DON), the LHNA informed the survey team that	F 880	who worked with NJ Exec Order 26.4b1 patients. b.) Phlebotomist was educated on PPE, cohorts and workflow then escorted out of the building. Phlebotomist□s supervisor was notified, and a replacement was provided. c.) AD was educated on proper PPE to be worn during the handling of a NJ Exec Order 26.4b1 specimen and/or testing. d.) Ex Order 26.4B1 and Ex Order 26.4B1 were properly discarded. Clinical practice referrals were made for LPN #3 and LPN #4 to the IPRN for hand hygiene and infection control practices while administering medications. e.) Clinical practice referral was made to the IPRN for hand hygiene and clean NJ Exec Order 26.4b1 for LPN #5. LPN #5 completed competency for NJ Exec Order 26.4b1 change was validated by 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) Contact tracing will be completed and reviewed to include staffing assignments to ensure all staff in contact with the COVID-19 positive patient are identified and tested. Staff will be in-serviced on	

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F 880	Continued From page 22 the facility was currently experiencing an outbreak of [redacted] which began on [redacted]. The LHNA stated staff and residents were tested for [redacted] on Monday, Wednesday and Friday with a [redacted] rapid test. On 06/29/22 at 9:32 AM, the Infection Preventionist Registered Nurse (IPRN) stated there was a new [redacted] case yesterday on [redacted]. The unsampled resident (UR #1) was admitted on [redacted] and had tested [redacted] at that time and was placed in a [redacted] room due to being [redacted] for [redacted] and having had [redacted] for [redacted]. The IPRN stated the UR #1, became [redacted] for [redacted] and had an elevated [redacted] and then tested [redacted] on the same day. The IPRN stated the DON was responsible to update the local department of health, and the facility line listing. The IPRN stated the [redacted] was initiated yesterday on [redacted] The surveyor reviewed the UR #1's medical record. A Progress Note, dated [redacted] revealed the resident displayed symptoms of [redacted], had a temperature of [redacted] degrees Fahrenheit, and was moved to the [redacted] and was placed on [redacted] for [redacted]. The Admission Record (AR) revealed the resident diagnoses included but were not limited to, [redacted] The Certified Nurse Aide [redacted] revealed the resident required the assistance of one person for activities of daily living [redacted],	F 880	testing protocols during an outbreak. b) COVID-19 education and training provided to both facility-based staff and consultants. c) Staff will be educated on proper PPE to be worn while administering COVID-19 tests and handling COVID-19 specimens. d) Licensed staff will be in-serviced on hand hygiene and infection control practices during medication pass. Competencies and return demonstration for hand hygiene and IC practices during medication pass will be completed and validated by the IPRN. e) Licensed staff were in-serviced on hand hygiene and infection control practices during treatment pass. Competencies and return demonstration for hand hygiene and IC practices during treatment pass will be completed and validated by the IPRN. f) An in-depth root cause analysis was performed by the leadership team and found that: The CNA was not working on the day that the patient tested positive or the next day. When the DON performed the initial contact tracing, she did not review the assignment sheet. The phlebotomist confirmed that she was informed of the PPE needs of the facility by the receptionist when she entered the facility. She also saw the signage at the door of the room, the available PPE in the bin which she can use, however she	

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F 880	Continued From page 23 NJ Exec Order 26.4b1). On 06/30/22 at 9:35 AM, the surveyor interviewed the facility IPRN regarding who was responsible for conducting NJ Exec Order 26.4b1 to determine the contacts of the newly diagnosed EX Order 26.4B1 . The IPRN stated the DON completed the NJ Exec Order 26.4b1 for UR #1, and the facility would provide a copy to the surveyor. On 06/30/22 at 9:48 AM, the DON provided the surveyor with the facility NJ Exec Order 26.4b1 completed for UR #1. The NJ Exec O revealed that UR #1 had symptoms that included an EX Order 26.4B1 [redacted] Seven (7) nursing staff were listed as contacts on the NJ Exec Order 26.4b1 form. On 06/30/22 at 10:34 AM, the surveyor observed UR #1 in a NJ Exec Order 26.4b1 resident room. On 06/30/22 at 2:30 PM the surveyor reviewed the daily Certified Nurse Aide (CNA) Daily Assignment Sheet for for NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . A CNA, CNA #1 had UR #1 listed on her assignment on NJ Exec Order 26.4b1 . CNA #1 was not listed on the NJ Exec Order 26.4b1 document as identified staff. On 06/30/22 at 2:44 PM, the surveyor interviewed CNA #1 regarding providing care for the unsampled resident. CNA #1 stated she had been informed today about UR #1 who had testedEx Order 26.4B1 and stated she had been off on Tuesday NJ Exec Order 26.4b1	F 880	states she chose to follow the practices of non-CareOne facilities. The activity staff did not think she needed to wear a gown, as she had not preformed the collection of the specimen but was wearing gloves, N-95 and face shield when she received the swabbed specimen and placed it in the card. She assumed that she did not need to don a gown as she was not the one performing the test. After an interview with the employees related to the process of hand hygiene and their individual scenarios, each employee was able to identify when hand hygiene is needed or appropriate as well as the correct steps of handwashing. LPNs #3, LPN #4, and LPN #5 confirmed they know when to practice hand hygiene as they had been previously educated on it. LPNs #3, LPN #4, and LPN #5 stated they became nervous during medication pass, treatment pass and hand hygiene observation as they were not used to being observed by a state surveyor. The employees were receptive to the additional training, and each had a separate coaching with nursing leadership. The competencies were validated by the infection preventionist registered nurse. After an interview with LPN #5 related to the process of cleaning the surface before treatment pass the employee was able to identify the appropriate steps in the	

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F 880	Continued From page 24 and Wednesday [NJ Exec Order 26.4b1] and no one had contacted her. She stated she had provided care for UR #1, and had not yet taken a [Ex Order 26.4B1] test. On 06/30/22 at 3:18 PM, the DON provided the [NJ Exec Order 26.4b1] policy to the surveyor. The surveyor inquired to the DON as to the [NJ Exec Order 26] process. The DON stated that the facility reviewed the staff that were assigned to the [NJ Exec Order 26.4b1] residents and stated that they typically had the same staff for the same resident rooms. The DON stated that she would look back 48 hours to see if there was possible exposure and that the facility relied on the staff for screening and we would test the staff if they had symptoms. The DON confirmed that even if the staff was on vacation that they would be contacted and she confirmed that she had completed the [NJ Exec Order 26.4b1]. The surveyor inquired to the DON if the [NJ Exec Order 26.4b1] for the unsampled resident was completed and the DON stated everyone has been tested by now and the one that was off was contacted, "I am confident I got everybody." The surveyor inquired to the DON regarding if CNA #1 was listed a contact for the UR #1. The DON stated that she was unaware that CNA #1 provided care for UR #1 because she did not review the CNA assignment sheet for [NJ Exec Order 26.4b], and that UR #1 was not on CNA #1's usual assignment. The surveyor reviewed the time in and out information for CNA #1 which revealed CNA #1 worked 7.5 hours on [NJ Exec Order 26.4b1] (7:06 AM to 3:01 PM) and [NJ Exec Order 26.4b1] (7:05 AM to 3:02 PM) and did not work on [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1].	F 880	process and the corrected actions related to the scenario. LPN #5 stated she became nervous during the treatment pass as she was not used to being observed by a state surveyor. The employee was receptive to the additional training and had a separate coaching with nursing leadership. The competencies were validated by the infection preventionist registered nurse. Directed In-Servicing Training: To be completed by August 15, 2022. Employees who are on vacation or leave will complete the trainings and/or modules upon their first day returning to work. Nursing Home Infection Preventionist Training Course Module 1 -Infection Prevention and Control Program https://www.train.org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID -19 Out! https://youtu.be/7srwrF9MGdw Provide the training to: Frontline Staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces https://youtu.be/t7QH8RQr5Ig Provide the training to: Frontline staff	

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F 880	Continued From page 25 b. On 06/30/22 at 10:34 AM, the surveyor observed the NJ Exec Order 26.4b1 enter an Unsampled Resident's (UR #2) room on the Ex Order 26.4B1 designated resident area . The NJ Exec Order 26.4b1 was observed donning (put on) a disposable gown, and was wearing a surgical mask and eye-glasses upon entering UR #2's room. The surveyor observed that there were bins of PPE, which included N95 Respirators, gowns and face shields outside of UR #2's room. The side of the door was clearly labeled with two signs. One sign revealed: NJ Exec Order 26.4b1 Everyone Must: including visitors, doctors, and staff, Clean hands: when entering and exiting, Gown, N95 Respirator, KN95 Respirator, Eye Protection (face shield or goggles) and gloves. The second sign revealed: Personal Protective Equipment: Put on this order: 1. Wash or Gel Hands (even if gloves used), 2. Gown-extended use permitted, 3. Mask and eye cover, 4. Gloves, Take off in this order: 1. Gloves, 2. Gown, 3. Wash or Gel Hands, 4. Mask and eye cover. Remove from earpiece or ties to discard-do not grab from front of mask, 5. Wash or Gel hands (even if gloves worn). On 06/30/22 at 10:44 AM, a second surveyor joined the observation and also observed the NJ Exec Order 26.4b1 exit the UR #2's room without a gown, and was wearing a surgical mask below her mouth. The NJ Exec Order 26.4b1 then used her bare hand to move the surgical mask over her nose. The Phlebotomist was wearing eye-glasses, no face shield or goggles and held NJ Exec Order 26.4b1 in her left hand, there was no hand hygiene observed. At that time the surveyor interviewed the NJ Exec Order 26.4b1 regarding what had occurred while she was in the UR #2's room. The	F 880	CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtu.be/xmYMUly7qiE Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents https://youtu.be/lbT1Njv6xA Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTATw9yav4 Provide the training to: Frontline staff Nursing Home Infection Preventionist Training Course Model 5 □ Outbreaks https://www.train.org/cdctrain/course/1081803/ Provide the training to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Model 11B □ Environmental Cleaning and Disinfection https://www.train.org/main/course/1081815/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 4 □ Infection Surveillance	

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F 880	Continued From page 26 NJ Exec Order 26.4b1 stated that she NJ Exec Order 26.4b1 from UR #2's and pointed to the closed door of UR #2's room. The surveyor asked the NJ Exec Order 26.4b1 what kind of mask she wore inside the room, and then acknowledged that she was presently wearing a surgical mask. The NJ Exec Order 26.4b1 stated, "just this mask" (referenced the surgical mask) and "I had a gown and gloves on". The surveyor inquired to the NJ Exec Order 26.4b1 why she had exited the UR #2's room wearing the surgical mask below her nose, and then adjusted the surgical mask to cover her nose. The Phlebotomist stated that her nose was running, and she had blown her nose in the UR #2's bathroom. The surveyor inquired to the NJ Exec Order 26.4b1 if she had observed the signs affixed to the door of the UR #2's room. The NJ Exec Order 26.4b1 stated "yes" and that was why she had put a gown on. The Surveyor reviewed the sign with the NJ Exec Order 26.4b1 and asked the NJ Exec Order 26.4b1 to read the sign and at that time, she read the sign and the surveyor asked if she was wearing an N95 mask, she stated "no, it is not" and the NJ Exec Order 26.4b1 confirmed she wore her eye-glasses inside the UR #2's room and inquired to the surveyors, "where would I get eye protection from?", and then the surveyor inquired if the NJ Exec Order 26.4b1 had asked anyone for the required PPE. The NJ Exec Order 26.4b1 responded "no, from now on when I come in, I will ask". At that time, the surveyor inquired to the NJ Exec Order 26.4b1 if she had other residents to NJ Exec Order 26.4b1 from, and she stated "yes" on the other unit (NJ Exec Order 26.4b1 resident unit). The surveyor asked the NJ Exec Order 26.4b1 if there was usually an order that she would NJ Exec Order 26.4b1 from the residents in? The NJ Exec Order 26.4b1 stated, "I do NJ Exec Order 26.4b1, then ", and stated "I didn't know they had NJ Exec Order here until I got here". The surveyors	F 880	https://www.training.org/cectrain/course/1081802/ Provide the training to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 7 □ Hand Hygiene https://www.train.org/main/course/1081806/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6A □ Principles of Standard Precautions https://www.train.org/main/course/1081804/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6B □ Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Provide the training to: All staff including topline staff and infection preventionist. How the facility will monitor its corrective action to ensure that the deficient practice will not recur a) The IPRN or Designee will audit the contact tracings of any new cases of	

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F 880	Continued From page 27 accompanied the NJ Exec Order 26.4b1 toward the other unit, and encountered the Director of Nursing (DON). The NJ Exec Order 26.4b1 continued to wear the same surgical mask that was worn inside UR #2's room. The surveyor informed the DON of the observations that had occurred with the NJ Exec Order 26.4b1, and the DON then inquired to the NJ Exec Order 26.4b1 about what had occurred. The NJ Exec Order 26.4b1 stated to the DON that she had entered a NJ Exec Order 26.4b1 resident room without wearing the appropriate eye protection or an N95 respirator. The surveyor asked the DON if what the NJ Exec Order 26.4b1 stated was okay, and the DON stated to the NJ Exec Order 26.4b1 and surveyors that what had occurred, "was not going to be okay", and the NJ Exec Order 26.4b1 could not see any other residents because the NJ Exec Order 26.4b1 was now "exposed" to NJ Exec Order 26.4b1. On 06/30/22 at 1:12 PM, the surveyor interviewed the facility IPRN regarding the observation that had occurred with the NJ Exec Order 26.4b1 t who entered the NJ Exec Order 26.4b1 resident's room without wearing the appropriate PPE. The IPRN stated, she "obviously" should have known what to wear, and the facility was awaiting the NJ Exec Order 26.4b1 s competencies from the company she was employed with, since the company was responsible to educate their own staff regarding infection control practices. The surveyor had inquired if what the NJ Exec Order 26.4b1 had worn into the room was acceptable, and the IPRN stated "no", "absolutely not". The surveyor inquired if removing your mask in a NJ Exec Order 26.4b1 NJ Exec Order 26.4 resident's room to blow your nose was acceptable and she stated "no, obviously not" because a person could become infected if they pull their mask down, and she should have	F 880	COVID-19 positive patients and staff for thoroughness to ensure that all potential contacts are identified and tested per facility outbreak response plan and federal guidance. The audit results will be presented to the QAA Committee monthly and ongoing. The QAA Committee will determine the need for further performance improvement. b) The IPRN or Designee will complete ten (10) observations for staff and contracted employees weekly x4 weeks and monthly x2 months for adherence to workflow, cohorts and 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. c) The IPRN or Designee will complete ten (10) observations weekly x4 weeks and monthly x2 months for staff adherence to wearing the proper PPE while administering COVID-19 tests and handline COVID-19 specimens. The results of the audit will be presented to the QAA Committee quarterly x 2 quarters. The QAA Committee will determine the need for further performance improvement. d) Director of Nursing or Designee will complete three (3) medication administration observations weekly x4 weeks and monthly x2 months to ensure proper hand hygiene and infection control practices during medication pass. Medication pass competency will be validated by the DON or Designee. The results of the audit will be presented to	

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F 880	Continued From page 28 discarded the mask, and should have worn an N95 mask. The surveyor asked the IPRN if the NJ Exec Order 26.4b1 should have went into the NJ Exec Order 26 resident's room first. The IPRN stated that the NJ Exec Order 26.4b1 should have provided care from NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 and that the signage was very clear in that area and she should have had everything in place including a face shield or goggles. c. On 06/29/22 at 8:54 AM, the surveyor observed staff NJ Exec Order 26.4b1 in the presence of the Corporate Staff Educator (CSE). On 06/29/22 at 8:59 AM , the surveyor, in the presence of the CSE, watched staff self perform a NJ Exec Order 26.4b1 and at 9:00 AM, the staff proceeded to hand the sample off to the Activity Director (AD). The AD was wearing and N95, a face shield and wore gloves. The AD took the NJ Exec Orde with her gloved hand and placed it inside a card to complete the NJ Exec Order 26.4b1 Upon exiting the room, the surveyor interviewed the AD about what PPE she was wearing and if she should have worn a isolation gown. The AD stated "I don't wear a gown" and stated usually the staff would do the NJ Exec Order 26.4b1 testing themselves. On 06/30/22 at 1:27 PM, the surveyor interviewed the IPRN regarding what PPE should be worn if you are accepting a NJ Exec Order 26.4b1 She stated "I would wear a gown". d. On 06/27/22 at 08:52 AM, the surveyor observed Licensed Practical Nurse (LPN) #3 as he prepared medications for one resident. LPN #3 opened the top drawer of the medication cart and stated that there was no Ex Order 26.4B1	F 880	the QAA Committee monthly. The QAA Committee will determine the need for further performance improvement. e) Director of Nursing or Designee will complete three (3) medication administration observations weekly x4 weeks and monthly x2 months to ensure proper hand hygiene and infection control practices during medication pass. The results of the audit will be presented to the QAA Committee monthly. The QAA Committee will determine the need for further performance improvement. Completion Date: 08/15/2022	

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F 880	Continued From page 29 Ex Order 26.4B1 NJ Exec Order 26.4b1) available for administration. He stated that he needed to go to the medication storage room to obtain the medications. The surveyor accompanied LPN #3 into the locked medication room and observed him as he obtained the medications. On 06/27/22 at 08:59 AM, the surveyor and LPN #3 returned to the medication cart from the medication room with both EX Order 26.4B1 and EX Order 26.4B1 The surveyor observed that LPN #3 did not perform hand hygiene before he opened the bottle of EX Order 26.4B1, broke the seal with the tip of a pen, and pulled out a piece of cotton that was contained within the bottle with his bare hands and discarded it before he poured the required dosage of medication into a medication cup and repeated the same process with theEX Order 26.4B1. LPN #3 then dated both medication bottles and placed them in the top drawer of the medication cart. LPN #3 accessed the computer that was on top of the medication cart and reviewed the medications that were to be administered and prepared one additional scheduled medication and one supplement. On 06/27/22 at 09:06 AM, the surveyor accompanied LPN #3 into the resident's room and observed that he had not performed hand hygiene before he handed the resident a Styrofoam cup of water that was on the resident's over bed table and a plastic medication cup that contained the resident's medications. After LPN #3 administered the medications, he went into the resident's bathroom and washed his hands for 20 seconds.	F 880		

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F 880	Continued From page 30 On 06/27/22 at 09:14 AM, the surveyor interviewed LPN #3 who stated that he washed his hands before he left the last room that he was in prior to the medication pass observation. He stated that he should have washed his hands after he returned from the medication room and before he resumed medication preparation. He stated that by failing to do so, it could have been an infection control issue. On 06/27/22 at 09:40 AM, the surveyor observed LPN #4 as she prepared medications for two residents. At 10:06 AM, the surveyor observed LPN #4 as she prepared medications for the second resident. She opened the top drawer of the medication cart and obtained a bottle of EX Order 26.4B1. She stated that the bottle of EX Order 26.4B1 failed to contain an expiration date and would be discarded. She stated that she needed to obtain a replacement bottle from the medication storage room. The surveyor accompanied LPN #4 to the locked medication room where she obtained a bottle of EX Order 26.4B1. As LPN #4 and the surveyor walked onto the nursing unit, LPN #4 noted that Resident #34 was seated in a wheelchair in front of the [redacted]. The resident wore a surgical mask that was pulled down beneath his/her chin, which left the resident's mouth and nose exposed. LPN #4 stopped and told the resident to pull the mask up so that it covered his/her nose. When the resident did not respond, LPN #4 transferred the bottle of [redacted] out of her right hand and into her left and pulled up the resident's surgical mask to cover his/her mouth and nose with her right hand. She then transferred the bottle of [redacted]	F 880		

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from her left hand into her right hand and carried it back to the medication cart and placed the bottle of [redacted] on top of the medication cart. LPN #4 did not perform hand hygiene or sanitize the outside of the bottle of EX Order 26.4B1 She then proceeded to open the bottom drawer of the medication cart and obtained a bottle of drug buster (solvent used for medication destruction) and proceeded to discard the contents of the bottle of EX Order 26.4B1 which did not bear an expiration date. She dated the newly obtained Ex Order 26.4B1. After, she utilized alcohol based hand rub and performed hand hygiene before she resumed medication preparation.

On 06/27/22 at 10:27 AM, the surveyor observed LPN #4 as she washed her hands after she obtained a resident's vital signs (EX Order 26.4B1 [redacted] and administered medications. She washed her hands for ten second out of the stream of running water and continued to rub her hands together under the stream of running water for 12 additional seconds.

On 06/27/22 at 10:36 AM, the surveyor interviewed LPN #4 who stated that she was required to scrub her hands for 20-30 seconds out of the stream of running water in accordance with the facility policy. She stated that she sang row, row, row your boat to determine the length of time that she washed her hands. She stated that after she pulled up Resident #34's mask and then proceeded to carry the bottle of [redacted] EX Order 26.4B1 back to the medication cart without

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first performing hand hygiene, she risked contamination. She stated that she should have returned to the cart and secured the [redacted] before she assisted the resident to pull up his/her mask. She stated that the resident was unable to follow commands and that was why she pulled the resident's mask up for him/her.

On 06/27/22 at 12:26 PM, the surveyor interviewed the DON who stated that nursing should have performed hand hygiene prior to medication administration. She stated that LPN #4 should have asked someone else to assist Resident #34 to pull up his/her mask.

On 06/27/22 at 01:09 PM, in a later interview with the DON, she stated that the medications that LPN #3 touched after he left the medication room would be discarded since he left the medication room and handled the medications without first performing hand hygiene.

On 06/27/22 at 1:39 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the process for hand washing was to: Turn on the water, apply soap, lather both sides of the hands and in between the webbing of the fingers and sing happy birthday or the alphabet twice to determine the length of time to wash hands, then rinse from the wrist down, obtain a towel to dry hands, another to shut off the faucet and discard the paper towel after. She clarified that hands were required to be washed out of the stream of running water or else you would have washed the soap right off. She further stated that your hands would not be cleaned if you only washed them for 10 seconds out of the stream of running water and under the

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F 880	Continued From page 33 stream of running water for 12 seconds. She stated that once the nurses left the medication room and returned to the medication cart they should have performed hand hygiene to prevent the possible spread of infection, as this was not good infection control practice. She further stated that when LPN #4 touched Resident #34's mask, especially during a [NJ Exec Order 26] outbreak, you never knew who may [NJ Exec Order 26.4b1]. She further stated that after LPN #4 touched the resident's mask and then handled medications, she risked the chance of the spread of infection. On 6/27/22 at 01:33 PM, the DON provided the surveyor with LPN #3 and LPN #4's Clinical Practice Referrals related to handwashing and infection control practices while administering medications that were completed on 6/27/22 and their Medication Pass Observation's that were conducted by the Consultant Pharmacist (CP). Review of LPN #3's Medication Pass Observation dated [Ex Order 26.4B1], revealed that the CP made the following observation comments: "Review of infection control-cleaning equipment, handwashing before and after gloves." Review of LPN #4's Medication Pass Observation dated [Ex Order 26.4B1] revealed that the CP made the following observation comments: "Discussed medication disposal, items put directly on the tray table, discussed infection control tips to keep items clean." e. On 6/23/22 at 12:02 PM, during the initial tour of the facility, the surveyor observed Resident #103 lying in bed on an [NJ Exec Order 26.4b1]. When interviewed, the resident stated that he/she thought that a [Ex Order 26.4B] was developing on his/her [Ex Order 26.4B1].	F 880		

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F 880	Continued From page 34 The surveyor reviewed the Admission Record (an admission summary) which revealed that Resident #103 was admitted to the facility in EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1 [redacted] A review of Resident #103's Admission Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 revealed that the resident's Brief Interview for Mental Status (BIMS) score of EX Orde indicated that the resident was NJ Exec Order 26.4b1. Further review of the MDS revealed that the resident required extensive assistance of one person for NJ Exec Order 26.4b1 in room and NJ Exec Order 26.4b. A review of the NJ Exec Order 26.4b1 portion of the MDS indicated that the resident had EX Order 26.4B1 [redacted] EX Order 26.4B1 all of which were documented to have been present on admission/entry or reentry to the facility. On 6/29/22 at 11:27 AM, the surveyor observed Licensed Practical Nurse (LPN) #5 perform EX Order 26.4B1 treatment (s) on Resident #103 and observed the following: The surveyor met with LPN #5 at the treatment cart outside of Resident #103's room. LPN #5	F 880		

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donned gloves and removed the resident's personal belongings from the bedside table. She doffed her gloves and washed her hands for 42 seconds. She returned to the treatment cart and reviewed the resident's treatment orders in the computer and gathered all necessary supplies. She returned to the resident's room and placed the [EX Order 26.4B1] treatment supplies on the resident's bedside table without first cleaning it. She then donned gloves and cleaned half of the table with bleach wipes. She did not wait for the table to dry before she placed paper towels on the portion of the table that she cleaned as a barrier and moved the treatment supplies from the other end of the table onto the paper towels. She doffed her gloves and washed her hands for 39 seconds after.

LPN #5 pulled the string and turned on the light that was over Resident #103's bed. She then donned gloves, removed the blankets that covered the resident, removed the resident's sock from the [EX Order 26.4B1]. She then doffed her gloves and removed [NJ Exec Order 26.4b1] from the package and dated them. She then proceeded to don gloves without first performing hand hygiene. She donned a pair of gloves and applied [Ex Order 26.4B] to a [NJ Exec Order 26.4b1] and cleansed the [EX Order 26.4B1]. She doffed her gloves and donned a new pair without first performing hand hygiene. She patted the resident's [EX Order 26.4B1] dry with a [NJ Exec Order 26.4b1]. She doffed her gloves and donned a new pair of gloves without first performing hand hygiene. She applied a [Ex Order 26.4B1] on the [EX Order 26.4B1]. She doffed her gloves and donned a new pair without first performing hand hygiene. She applied a second [Ex Order 26.4B1] to the resident's [EX Order 26.4B1] She doffed

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her gloves and donned a new pair without first performing hand hygiene and proceeded to apply [redacted] to the resident's [redacted]. She doffed her gloves and applied a new pair without first performing hand hygiene before she proceeded to reposition the resident's [redacted] which was in a [redacted]. She doffed her gloves and washed her hands for 40 seconds.

LPN #5 donned gloves and removed a [redacted] and [redacted] from Resident #103's [redacted] before she removed a [redacted] from the resident's [redacted]. She doffed her gloves and washed her hands for 27 seconds. She then opened a [redacted] and dated it before she donned gloves and applied [redacted] to a [redacted] and [redacted] next to the resident's [redacted]. She doffed her gloves and donned a new pair without first performing hand hygiene. She then proceeded to dab the area with a dry [redacted] and applied a [redacted] over the area. She lifted the resident's [redacted] and applied [redacted] to the resident's [redacted]. She doffed her gloves and donned a new pair of gloves before she applied a [redacted].

LPN #5 doffed her gloves and washed her hands for 44 seconds. She donned a pair of gloves and applied [redacted] to the resident's [redacted]. She doffed her gloves and donned a new pair of gloves without first performing hand hygiene. She applied [redacted] to the resident's [redacted]. She doffed her gloves and washed her hands for 32 seconds.

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LPN #5 donned a pair of gloves. Resident #103 complained that his/her EX Order 26.4B1. LPN #5 assisted the resident to reposition in the bed and removed the adhesive from the resident's EX Order 26 and exposed the resident's EX Order 26.4B1 EX Order 26.4B1 She cleansed the area with a soapy wash rag and dried the area with a towel. She then doffed her gloves and donned a new pair without first performing hand hygiene. She assisted the resident to turn and utilized wipes to cleanse EX Order 26.4B1 from the resident's EX Order 26.4B1 She doffed her gloves and washed her hands for 25 seconds and donned a new pair of gloves.

LPN #5 used a wash rag to cleanse the Resident #103's EX Order 26.4B1 and then patted the area dry with a clean towel. She placed the resident's soiled linens in a trash bag. She then doffed her gloves and donned a new pair of gloves without first performing hand hygiene. She then proceeded to apply EX Order 26.4B1 to the resident's EX Order 26.4B1. She doffed her gloves and donned a new pair without first performing hand hygiene. She placed a NJ Exec Orde beneath the resident and assisted the resident to turn and position the NJ Exec Orde She then proceeded to apply EX Order 26.4B1 EX Order 26.4B1 to the resident's EX Order 26.4B1 She doffed her gloves and donned a new pair of gloves without first performing hand hygiene. She doffed her gloves and pressed the bed remote to lower the height of the bed. She donned a new pair of gloves and put the resident's package of wipes back into the drawer.

LPN #5 doffed her gloves and washed her hands x 20 seconds and donned a new pair of gloves.

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She then used a wash rag to cleanse the area under Resident #103's EX Order 26.4B1 and dried the area with a towel. She doffed her gloves and donned a new pair without first performing hand hygiene. She then proceeded to apply EX Order 26.4B1 under the resident's EX Order 26.4B1.

LPN #5 washed her hands x 24 seconds. She donned a pair of gloves and used a bleach wipe to clean her bandage scissors. She placed the resident's EX Order 26.4B1 treatment supplies back into the drawer. She discarded all waste into a trash bag and tied up the bag. She doffed her gloves and donned a new pair without first performing hand hygiene before she assisted the Certified Nursing Assistant (CNA) reposition the resident in bed.

At 12:42 PM, in a post-EX Order 26.4B1 treatment observation interview, LPN #5 stated that she should have cleaned the over bed table with bleach wipes and allowed the table to dry for three minutes (effective germ kill time per manufacturer) before she brought the resident's EX Order 26.4B1 treatment supplies into the room and placed them on the resident's over bed table. She stated that by placing the EX Order 26.4B1 treatment supplies on the table prior to cleaning it and before it dried, she risked contamination of the supplies and they would now have to be discarded. She stated that each time that she doffed her gloves she was required to wash her hands rather than donning a new pair. She stated that she should have doffed her gloves and washed her hands and donned new gloves after she cleansed the resident's EX Order 26.4B1 EX Order 26.4B1 because by failing to do so, she spread the "EX Order 26.4B1" that was in the resident's EX Order 26.4B1 that she cleansed and spread it

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F 880	Continued From page 39 back into the [EX Order 26.4B] which posed an [EX Order 26.4B1] control issue. She stated that she realized it right away after she did it. On 6/29/22 at 01:40 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that when a [EX Order 26.4B] treatment was to be performed the nurse should have cleared the resident's overbed table and cleaned it with a bleach wipe and waited three minutes for it to dry. She stated that she utilized a trash bag to cover the top of table which served as a drape for supplies. She stated that the nurse should have washed her hands for 20 seconds and donned gloves prior to the treatment and discarded the gloves once doffed and repeated that same process with each [EX Order 26.4B] treatment. She stated that the area should have been cleaned and prepped before she brought any supplies into the room. She stated that she would have expected that between every [EX Order 26.4B] treatment that you had to doff your gloves, wash your hands and don a new pair of gloves. She stated that,"a [EX Order 26.4B] opening was a portal of [NJ Exec Order 26.4b] and we had to practice hand hygiene to preven[NJ Exec Order 26.4b1]." She stated that the table surface was important because we did not know what may have been on the surface prior to the treatment or when it was last disinfected. She stated that if the table was cleaned with a bleach wipe and not permitted to dry for the proper kill time prior to use, then it was a sloppy mess, that was what that was. On 6/29/22 at 02:17 PM, the surveyor interviewed the Infection Preventionist (IP) who stated that the process for [EX Order 26.4B] treatment was to: gather products, check order first, clean	F 880		

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F 880	Continued From page 40 surface in the room with bleach wipe and allow to dry for three minutes, put down a clean paper towel after it dried per kill time, bring in supplies and place on top of paper towels, assess [NJ Exec O] level advise of procedure. She stated that you should wash your hands, don gloves, cleanse [EX Order 26.4B1] or apply necessary treatments. She stated when gloves were removed, you needed to wash your hands again. She stated she would have donned gloves and applied the new treatment. When finished, doff gloves, wash hands, gather supplies, sanitize the area and sign out the treatment. She Stated that she would not have placed supplies on the resident's table without it being cleaned first. She stated that the whole table should have been cleaned first. She stated there could have been germs on the table that could have been transferred onto the clean paper towel that she put down as a drape for supplies. She stated that every time gloves were doffed, hand hygiene should have been performed. She stated that the nurse should have doffed her gloves, washed her hands and put on a pair of gloves prior to putting a clean [NJ Exec Order 26.4b] on. She stated that it was possible to introduce germs that were on the table into open areas in the [EX Order 26.4B]. She stated that [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b1] were probably a little less likely, but [NJ Exec O] is permeable and [NJ Exec O] does absorb. On 7/1/22 at 11:20 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurse should have performed hand hygiene when she doffed her gloves and when she cleaned a [EX Order 26.4B] prior to drying and applying the treatment. She stated that the surface of the table should have been cleared prior to bringing in supplies, wiped down, wait three minutes or until	F 880		

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F 880	Continued From page 41 it dried before supplies were placed on the table. She stated that the risk with lack of hand hygiene after gloves were doffed, and if not cleaning table prior to putting supplies on the table posed a possible risk of contamination. The surveyor reviewed LPN #5's competencies which revealed she completed a [redacted] (Clean) competency on 4/10/21. Review of the facility policy titled, "Medication Administration General Guidelines For The Administration of Medications" (Revised 1/15) revealed the following: ...Nurse washes hands appropriately before and after medication administration depending on degree of resident contact. Review of the facility policy titled,"Handwashing/Hand Hygiene" (Reviewed 2/28/20) revealed the following: The facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. ...Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...Before and after direct contact with residents, Before preparing or handling medications;...After	F 880		

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F 880	Continued From page 42 contact with a resident's intact skin;...After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; Procedure Washing Hands: 1. Wet hands first with water, apply soap and vigorously rub hands together creating friction to all surfaces for a minimum of 20 seconds (or longer). 2. Rinse hands thoroughly under running water. Hold hands lower than wrist. Do not touch fingertips to inside of sink. 3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. 4. Discards towels into trash... Review of the facility policy titled, "Clean Dressing Change" (Revision Date(s): 3/22/13; 4/29/2016) revealed the following: Purpose: To promote wound healing; prevent infection; assess the healing process; and protect the wound from mechanical trauma. ...Clean the surface of the over bed table and dry thoroughly. ...Perform hand hygiene according to local requirements Don clean gloves. Clean the wound as indicated, or according to the physician order:	F 880		

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F 880	Continued From page 43 Cleanse the wound from the center outward using a circular motion, or vertical stroke Use one gauze sponge or applicator swab per stroke and discard after use ...Remove gloves, perform hand hygiene according to local requirements and don a new pair of clean gloves. Review of the facility policy titled, "Handwashing/Hand Hygiene" (Reviewed 2/28/20) revealed the following: Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...Before moving from a contaminated body site to a clean body site during resident care; ...After handling used dressings, contaminated equipment, etc.; ...After removing gloves; Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. The surveyor reviewed the following facility provided policies which revealed the following: Personal Protective Equipment, Version 2.0	F 880		

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F 880	Continued From page 44 (H5MAPL0619), Policy Statement: Personal protective equipment appropriate to specific task requirements is available at all times. Policy Interpretations and Implementation, 3. Not all tasks involve the same risk of exposure, or the same kind or extent of protection. The type of PPE required for a task is based on: a. The type of transmission-based precaution;, b. The fluid or tissue to which there is a potential exposure;, c. The likelihood of exposure;, d. The potential volume of material;, e. The probable route of exposure; and. The overall working conditions and job requirements. 6. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with personnel policies. , 7. Visitors and residents who are asked to comply with transmission-based precautions are educated on the proper use of PPE and provided with equipment at no charge. COVID-19 Preparedness and Response Key Actions Protocol SummaryRev. 12/30/2021, ...Follow CDC/state guidelines for potentially or confirmed exposed contacts, If HCP exposure conduct exposure risk assessment, Use N95 or equivalent or higher-level respirator, gloves, gown & eye protection for COVID positive, Continue to implement droplet and contact precautions for positive cases, symptomatic residents, and unvaccinated new admissions and other residents in quarantine...Cohort Plan NJ, Rev. 06/08/2022, Patient Type: Red (Covid positive), Green (Naive, negative, recovered, vaccinated). Coronavirus Disease (COVId-19) - Testing Residents, Revised September 2021, Policy Statement: Residents are tested for the	F 880		

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F 880	Continued From page 45 SARS-CoV-2 virus to detect the presence of current infections (viral testing) and to help prevent the transmission of COVID-19 in the facility. Policy Interpretations and Implementation, 7. Contact Tracing and Focused Testing: a. If there is the ability to identify close contacts of the individual with SARS-CoV-2 infection, contact tracing and focused testing are conducted. Coronavirus Disease (COVID-19)- Education and Training revised September 2021, Residents, visitors, family and staff are provided educational materials and updated information on COVID-19, including signs and symptoms, infection prevention and control and testing. 2. Staff includes both facility-based personnel and consultants (therapists, medical specialist). Education and training are also provided to volunteers. Infection Prevention and Control Program, Review 03/04/2019, Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 7. Surveillance: b. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. NJAC 8:39-19.4 (a)	F 880		

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	106100	A. BUILDING: _____ B. WING _____	07/08/2022

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) 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: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain the required minimum direct care staff-to-resident ratios for the day shift and b.) provide that no fewer than half of all staff members shall be Certified Nursing Assistants (CNA) on the evening shifts as mandated by the State of New Jersey. This was evident for 8 of 14 day shifts reviewed and for 14 of 14 evening shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	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? Any resident has the potential to be affected.	8/1/22

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

Electronically Signed | 08/10/22

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 _____	07/08/2022

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 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. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One 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 CNA 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. As per the "Nurse Staffing Report" completed by the facility for the weeks of 06/05/22-06/12/22 and 06/12/22-06/19/22, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below: -06/05/22 had 4 CNAs for 61 residents on the day shift, required 8 CNAs. -06/07/22 had 6 CNAs for 60 residents on the day shift, required 7 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 the center will implement a rate adjustment for licensed and 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. The facility will continue to partner with local College for licensed and certified clinical rotations and schooling. The facility will continue to offer free attendance at their CNA training program offered non-stop throughout the year. The facility will continue to utilize social media, employment sites and recruitment efforts to hire new staff members.	

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	106100	A. BUILDING: _____ B. WING _____	07/08/2022

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 2 -06/08/22 had 6 CNAs for 60 residents on the day shift, required 7 CNAs. -06/13/22 had 6 CNAs for 56 residents on the day shift, required 7 CNAs. -06/15/22 had 5 CNAs for 54 residents on the day shift, required 7 CNAs. -06/16/22 had 6 CNAs for 53 residents on the day shift, required 7 CNAs. -06/17/22 had 5 CNAs for 53 residents on the day shift, required 7 CNAs. -06/18/22 had 4 CNAs for 51 residents on the day shift, required 6 CNAs. As per the "Nurse Staffing Report" completed by the facility for the weeks of 06/05/22-06/12/22 and 06/12/22-06/19/22, the staffing-to-resident ratios that did not meet the minimum requirement of no fewer than half of all staff members shall be CNAs on the evening shift: -06/05/22 had 5 CNAs to 13 total staff on the evening shift, required 6 CNAs. -06/06/22 had 6 CNAs to 15 total staff on the evening shift, required 7 CNAs. -06/07/22 had 6 CNAs to 15 total staff on the evening shift, required 7 CNAs. -06/08/22 had 6 CNAs to 15 total staff on the evening shift, required 7 CNAs. -06/09/22 had 6 CNAs to 16 total staff on the evening shift, required 8 CNAs. -06/10/22 had 6 CNAs to 15 total staff on the evening shift, required 7 CNAs. -06/11/22 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs. -06/12/22 had 6 CNAs to 16 total staff on the evening shift, required 8 CNAs. -06/13/22 had 5 CNAs to 13 total staff on the evening shift, required 6 CNAs. -06/14/22 had 6 CNAs to 15 total staff on the	S 560	How will the facility monitor its corrective actions to ensure that the deficient 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, open positions and staffing ratios weekly until the requirement is met. The results of these audits will be forwarded to the facility Administrator and QAA Committee monthly for further review, revisions and recommendations as needed.	

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 _____	07/08/2022

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 3 evening shift, required 7 CNAs. -06/15/22 had 6 CNAs to 16 total staff on the evening shift, required 8 CNAs. -06/16/22 had 6 CNAs to 15 total staff on the evening shift, required 7 CNAs. -06/17/22 had 5 CNAs to 14 total staff on the evening shift, required 7 CNAs. -06/18/22 had 5 CNAs to 13 total staff on the evening shift, required 6 CNAs. On 07/07/22 at 09:14 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the Staffing Coordinator (SC) was on vacation and that she had done staffing while the SC was away. The DON stated that the staffing ratios were 1:8 for 7-3 shift, 1:10 for 3-11 shift, and 1:15 or 1:16 for 11-7 shift and that they staff up for higher acuity residents. The DON stated they were trying to build a relief pool of staff to cover vacations and call outs. On 07/07/22 at 09:23 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the required staff ratios were 1:8 on 7-3 shift, 1:10 on 3-11 shift, and 1:14 on 11-7 shift. The LNHA stated that they had better staffing than the ratios and that they tried to have the ratios as correct as possible. NJAC 8:39-5.1(a)	S 560		

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	9/23/2022 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 F0689	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	08/15/2022	LSC	08/15/2022	LSC	08/08/2022
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/15/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/8/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
106100 Y1	A. Building B. Wing Y2	9/23/2022 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 08/01/2022	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	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 7/8/2022	☐ 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 _____	**07/08/2022**

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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/07/22 and 07/08/22, was found to be in noncompliance with the 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 The facility is a 2-story building with a partial basement,that was built in 2003, It is composed of Type II protected construction.The facility is divided into 12- smoke zones. The generator does approximately 40% of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 65 certified beds. At the time of the survey the census was 42. The building is required to have an annual FSES (fire safety evaluation system) that addresses the vertical opening by an existing open stair that connects floors 1 and 2. The stair is located in	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/02/2022

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 _____	**07/08/2022**

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K 000	Continued From page 1 the center of the building.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the	K 161		8/15/22

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K 161	Continued From page 2 construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 07/07/22, in the presence of the facility's Maintenance Director, Regional Plant Operations Director and Administrator, it was determined that the facility failed to provide an acceptable construction type and fire resistance rating of a building's structural elements in accordance with the requirements of NFPA 101, 2012 Edition, Section Table 19.1.6.1, 19.1.6.2 through 19.1.6.7. The deficient practice could affect all residents. On 07/07/22 from approximately 09:00 AM, to 02:30 PM, the surveyor observed on floor 1 that when the surveyor had the Maintenance Director remove ceiling tiles to observe and confirm the construction type and protection. The verified locations observed were at the assisted living to the underside of stairs and it was determined that the wall was not fire rated (vertical opening approximately 4'x4' stud wall, no sheetrock provided). The surveyor had the Maintenance Director remove 2-areas of 2'x'2' drop ceiling tiles in the LTC exit/egress area outside 2-sets of smoke doors, for verification of protection and both observations determined that a large girder was unprotected and not enclosed in fire rated material, to the concrete decking above. GIRDER: a large iron or steel beam or compound structure used for building framework of large	K 161	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? There were no patients 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 Patients residing in the center 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 The unprotected structural steel observed on Floor 1 is consistent with the overall Type of Construction of the Building. While much of the structural steel in this section of the building is encased in gypsum, there are several sections that are not. This has been the case since the original construction and is not the result of renovation. In accordance with LSC Section 8.1.2.3(3), the least fire-resistive construction type has to be applied to the entire building which requires the Type of Construction be classified as Type II(000). This type of construction requires no fire resistance rating for structural assemblies	

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K 161	Continued From page 3 buildings. A girder is a support beam used in construction. The findings were verified by the Maintenance and Regional Plant Operations Director. Plans identifying the UL assembly and fire resistance rating for the steel beams were requested but were not provided. The Administrator was informed of the findings at the Life Safety Code exit conference on 07/08/22. NJAC 8:39-31.2(e)	K 161	and the unprotected girder and is therefore not a deficient condition. Rather, it appears there is an error in the Type of Construction as noted under K000 □ Initial Comments, that has not been noticed until now. Type II(000) is compliant for a 2-story (with a partial basement) existing health care occupancy building with complete sprinkler protection. Maintenance staff will be trained to identify the correct Construction Type for the building and to understand the requirements of this Type of Construction to avoid future confusion. Given this information we will need a Time Limited Waiver in order to reconcile where the error occurred and if necessary give the DCA time to update the record. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Maintenance Director will review staff inservice results to ensure proper knowledge of building type. The Maintenance Director will review any documentation needed to support the correct classification of building type. The results will will be presented to the monthly QAPI Committee. The QAPI Committee will determine the need for further performance improvement. Completion Date: Updated FSES passing score confirmed on 8/12/22 and	

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K 161	Continued From page 4	K 161	previously on 7/28/22.	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222		7/9/22

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CAREONE AT MOORESTOWN	**895 WESTFIELD ROAD** **MOORESTOWN, NJ 08057**

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K 222	Continued From page 5 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of Surveyor 2, Maintenance Director, Plant Operations Director and Administrator on 07/07/22, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 1 of 2 sets of exterior exit/egress doors observed. This deficient practice was evidenced as follows:	K 222	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice There were no patients 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 Patients 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 _____	**07/08/2022**

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 222	Continued From page 6 A. On 07/08/22 at 9:30 AM, the Surveyor, Surveyor 2, Maintenance Director, Regional Plant Operations Director and Administrator observed 2 sets of glass sliding doors, the outside set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. The Maintenance Director, Regional Plant Operations Director and Administrator were interviewed at the time of the observations, where they stated that the lockset (hook type deadbolt) lockset was never engaged but could be locked from the egress-side. The Administrator was notified of the findings at the Life Safety Code exit conference on 07/08/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur The lockset was removed from the sliding glass door disabling the deadbolt allowing unrestricted emergency use of the exit. Maintenance staff will be in-serviced on exit doors in the means of egress should be readily accessible and free of all obstructions or impediments for instant use in the case of fire or other emergencies. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Maintenance Director or designee will monitor and audit the exit doors weekly x4 weeks then monthly x2 months to ensure all exits are unrestricted and accessible for emergency use. The findings will be presented to the QAPI Committee monthly. The QAPI Committee will determine the need for further performance improvement. Completion Date: 07/09/22	
K 241 SS=F	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are	K 241		8/15/22

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K 241	Continued From page 7 provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/07/22, in the presence of the Surveyor 2, Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide at least 2 acceptable exits remote from each other, for each floor or fire section of Building: floor 2 (Maple shade/Hamilton). This deficient practice was evidenced for 2 of 2 egress exits by the following: 1. On 07/07/22 at 02:18 PM, the Surveyor, Surveyor 2, Maintenance Director and Regional Plant Operations Director observed that the 2nd floor Maple Shade wing, was provided with two distinct egress paths, but the second egress would now lead into an open stair in the center of the building that connects floors 1 and 2. The stairs in the convenience opening are not a required means of egress, and vertical travel up and down the convenience opening for egress is prohibited and unacceptable in accordance with LSC section 8.6.7. 2. On 07/07/22 at 02:32 PM, the Surveyor, Surveyor 2, Maintenance Director and Regional Plant Operations Director observed that the 2nd floor Hamilton wing, was provided with two distinct egress paths, but the second egress would now lead into an open stair in the center of the building that connects floors 1 and 2. The	K 241	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice There were no patients 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 Patients residing in the center 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 The facility will obtain an updated FSES with passing score demonstrating equivalency with LSC. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The facility will continue to rely on an annual FSES evaluation which demonstrates compliance via equivalent	

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K 241	Continued From page 8 stairs in the convenience opening are not a required means of egress, and vertical travel up and down the convenience opening for egress is prohibited and unacceptable in accordance with LSC section 8.6.7. An interview was conducted with the Maintenance Director and Regional Plant Operations Director, who stated that the second egress/exit would lead to the open stair from the Maple shade and Hamilton wings. The Administrator was informed of the finding at the Life Safety Code exit conference. 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	K 241	alternative. The Maintenance Director or Designee will obtain an updated FSES on an annual basis. The Maintenance Director or Designee will monitor the results of the FSES evaluation on a monthly basis. The findings will be presented to the monthly QAPI Committee. The QAPI Committee will determine the need for further performance improvement. Completion Date: Obtain updated FSES on 8/12/22 with passing score.	

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K 241	Continued From page 9 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 241		
K 251 SS=F	Dead-End Corridors and Common Path of Travel CFR(s): NFPA 101 Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/07/22 in the presence of Surveyor, Surveyor 2, Maintenance Director, Regional Plant Operations Director and Administrator, it was observed that dead-end corridors shall not exceed 30 feet. This deficient practice was evidenced for 1 of 1 basement corridors that failed to provide proper exits. and evidenced by the following: During the survey, it was observed that the facility basement was provided with 2-egress/exit stairwells. The stairwells were not designed to be remote from each other and lead to a dead-end corridor that produced approximately 44' when measured. NFPA 101-2012 edition Life Safety Code *A.19.2.5.2 Every exit or exit access should be arranged, if practical and feasible, so that no corridor has a dead end exceeding 30 ft. (9.1 m)	K 251	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice There were no patients 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 Patients residing in the center 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 The facility will obtain an updated FSES	8/15/22

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K 251	Continued From page 10 This finding was verified with the Director of Maintenance, Regional Plant Operations Director and Administrator at the time of discovery. The Administrator was informed of the finding at the Life Safety Code exit conference on 07/08/22. NJAC 8:39-31.2(e)	K 251	analysis, and the building will receive a passing score demonstrating equivalency with LSC. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The facility will continue to rely on an FSES evaluation with passing score to demonstrate compliance via equivalent alternative. The Maintenance Director or Designee will present the annual FSES findings to the monthly QAPI Committee. The Maintenance Director or Designee will monitor the findings and compliance monthly x3 months and present to the monthly QAPI Committee. The QAPI committee will establish the need for further performance improvement. Completion Date: FSES passing score confirmed on 7/28/22 Obtain updated FSES on 8/12/22	
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	K 311		8/15/22

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K 311	Continued From page 11 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, interview, and documentation review, it was determined that facility failed to protect vertical openings between floors with a one-hour fire rated enclosure. This deficient practice was evidenced by the following: On 07/07/22 at 11:00 AM, the Surveyor, Surveyor 2, Maintenance Director, Regional Plant Operations Director and Administrator observed that 1 of 3 smoke compartments, for the two Long Term Care Units on the 2nd floor, passed through an open stairway between the 1st and 2nd floors at the elevator landing (by stairwell #5) to the Assisted Living occupancy. In an interview, at the time, the Administrator stated that they had done a Fire Safety Evaluation System (FSES) survey to address a deficiency cited during a Federal Monitoring survey, dated 11/04/21. 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,	K 311	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice There were no patients 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 Patients residing in the center 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 The facility continues to rely on the annual FSES and obtained an updated FSES analysis, and the building received a passing score demonstrating equivalency with LSC. How the facility will monitor its corrective actions to ensure that the deficient	

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K 311	Continued From page 12 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	practice will not recur The facility will continue to rely on an FSES evaluation which demonstrates compliance via equivalent alternative. The Maintenance Director or Designee will present the annual FSES findings to the monthly QAPI Committee. The Maintenance Director or Designee will monitor the findings compliance monthly x3 months and present to the monthly QAPI Committee. The QAPI committee will establish the need for further performance improvement. Completion Date: FSES passing score confirmed on 7/28/22 Obtain updated FSES on 8/12/22	
K 342 SS=E	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded.	K 342		7/9/22

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K 342	Continued From page 13 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 07/07/22, in the presence of the facility Maintenance Director, Surveyor 2, Plant Operations Director and Administrator, it was determined that the facility failed to maintain fire alarm manual pull stations accessible at all times in accordance with NFPA 72. This deficient practice was evidenced for 1 of 8 manual pull stations observed by the following: At 10:02 AM., the surveyor observed that outside the front receptionist desk, in the facility sitting area, that the manual fire alarm pull station was blocked by a love seat and end table. The receptionist indicated that the love seat and end table were in that position in the sitting area since she started. The Administrator was notified of the deficiency at the exit conference on 07/08/22. NJAC 8:39-31.2(e) NFPA 72	K 342	K342 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice There were no patients identified who were affected by the deficient practice. The love seat and end table were relocated. How the facility will identify other residents having the potential to be affected by the same deficient practice Patients residing in the center 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 Staff will be inserviced on the requirement that fire alarm manual pull stations should be accessible at all times. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur Director of Maintenance or Designee with	

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K 342	Continued From page 14	K 342	randomly audit 8 pull stations weekly x4 weeks and monthly x2 months for compliance with the requirement that fire alarm manual pull stations are accessible at all times. The findings will be presented to the QAPI Committee monthly. The QAPI Committee will determine the need for further performance improvement. Completion Date: 07/09/22	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is	K 363		8/5/22

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K 363	Continued From page 15 pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/07/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close, and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in six 5 of 30 resident room doors (single door with opening sidelight- active leaf door's) observed and was evidenced by the following: The following resident room doors, when closed left a gap at the top of the room door's, approximately 1/4 to 1/2 inch, due to a	K 363	K363 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice The resident room doors identified (200, 202, 206, 207 and 224) will be repaired and/or replaced and fit properly in the door frame. How the facility will identify other residents having the potential to be affected by the same deficient practice Patients residing in the center have the potential to be affected.	

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K 363	Continued From page 16 malfunction in the door hardware installation and warping doors, causing the door to not fit properly in its frame in the following rooms: 200, 202, 206, 207 224 will not latch (hardware issue) An interview was conducted with the Maintenance Director and Regional Plant Operations Director, at the time of the observations who confirmed the above findings. The Administrator was informed of the finding at the Life Safety Code exit conference on 07/07/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.	K 363	What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur An audit of corridor doors was conducted to identify any doors that do not fit properly into the door frame. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur Director of Maintenance or Designee will inspect and audit 10 corridor doors weekly to ensure that those doors fit properly into the frame, therefore, being able to resist the passage of smoke. The audit will be conducted weekly x4 weeks and monthly x2 months. The findings will be presented to the QAPI Committee monthly. The QAPI Committee will determine the need for further performance improvement. Completion Date: 08/05/22	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.	K 511		7/15/22

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K 511	Continued From page 17 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 07/07/22 in the presence of Surveyor 2, Maintenance Director, Administrator and Regional Plant Operations Director, it was determined that the facility failed to install and maintain gas piping that complies with NFPA 54, National Electric Code. This deficient practice was evidenced for 1 of 1 observed gas line installation's by the following: At approximately 10:39 AM, the surveyor observed in the buildings partial basement, that in the exit/egress corridor an approximately 15' exposed yellow flexline gas pipe, was observed to be supported by small white zip ties to a metal unprotected truss beam frame. The Maintenance Director, Regional Plant Operations Director and Administrator confirmed the findings during the observation. The Administrator was informed of the findings at the Life Safety Code exit conference on 07/08/22. NJAC 8:39-31.2(e) NFPA 70	K 511	K511 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice The white zip ties were replaced with metal brackets securing the yellow flex line gas pipe. How the facility will identify other residents having the potential to be affected by the same deficient practice Patients residing in the center 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 The Regional Director of Plant Operations or designee will in-service the maintenance staff on the requirement that gas, or gas related piping should be properly anchored to prevent undue strains on other equipment. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur	

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 _____	**07/08/2022**

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 511	Continued From page 18	K 511	Director of Maintenance or Designee will inspect yellow flex line gas pipes to ensure they are secured properly with metal brackets. The audit will be conducted weekly x4 weeks and monthly x2 months. The findings will be presented to the QAPI Committee monthly. The QAPI Committee will determine the need for further performance improvement. Completion Date: 07/15/22	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		7/27/22

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	315482	A. BUILDING **01** B. WING _____	**07/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 19 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/08/22, in the presence of the Maintenance Director, Regional Plant Operations Director and Administrator, it was determined that the facility did not ensure a remote manual stop station for 1 of 1 generator, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 01:28 PM, the surveyor, Maintenance Director, Regional Plant Operations Director and Administrator, observed the exterior diesel generator. There was no remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed outside the enclosure housing the prime mover. An interview was conducted during the observation with the Maintenance Director, Regional Plant Operations Director and	K 918	K918 (F) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. A remote manual stop station installation date was obtained and scheduled. How the facility will identify other residents having the potential to be affected by the same deficient practice Patients residing in the center have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure	

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	315482	A. BUILDING **01** B. WING _____	**07/08/2022**

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 918	Continued From page 20 Administrator, where they stated that at the time of observation, the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located outside the enclosure housing the prime mover. The facility provided an estimate document dated: 06/15/22 indicating under description, that (1) Estop switch for generator that will be mounted remotely, no installation date was provided at this time. The Administrator was informed of the finding at the Life Safety Code exit conference on 07/08/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	that the deficient practice will not recur A remote manual stop station was installed for the generator. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur Director of Maintenance or Designee will inspect the manual stop station to ensure it there is unrestricted access. The audit will be conducted weekly x4 weeks and monthly x2 months. The findings will be presented to the QAPI Committee monthly. The QAPI Committee will determine the need for further performance improvement. Completion Date: 07/27/22	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		7/9/22

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 _____	**07/08/2022**

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 920	Continued From page 21 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/07/22, the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was idenitified in 1 of 14 offices, observed and was evidenced by the following: At 10:40 AM, the Surveyor, Surveyor 2, Maintenance Director, Regional Plant Operations Director and Administrator, observed in the basement maintenance office, that a microwave oven was plugged into a multi-outlet power strip. The power strip was then plugged into a quad electrical wall outlet.	K 920	K920 (E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. The power strip was removed, and the microwave was plugged into a wall outlet. How the facility will identify other residents having the potential to be affected by the same deficient practice Patients residing in the center 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	

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K 920	Continued From page 22 The finding was verified by the Maintenance Director and Regional Plant Operations Director at the time of the observation, where they stated and confirmed that multi-outlet power strips was not to be used for high draw appliances in the facility. The Administrator was notified of the findings at the Life Safety Code exit conference on 07/08/22. NJAC 8:39-31.2(e)	K 920	The Regional Director of Plant Operations or designee will in-service the maintenance staff on the prohibited use of extension cords and power cords. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur Director of Maintenance or Designee will audit 10 rooms weekly throughout the center to ensure there is no use of extension cords or power cords. The audit will be conducted weekly x4 weeks and monthly x2 months. The findings will be presented to the QAPI Committee monthly. The QAPI Committee will determine the need for further performance improvement. Completion Date: 07/09/22	

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	11/2/2022 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0161	08/15/2022	LSC K0222	07/09/2022	LSC K0241	08/15/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0251	08/15/2022	LSC K0311	08/15/2022	LSC K0342	07/09/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	08/05/2022	LSC K0511	07/15/2022	LSC K0918	07/27/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0920	07/09/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/8/2022	☐ YES ☐ NO