STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD , MOORESTOWN, New Jersey, 08057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Standard Survey: 8/28/2025 to 9/3/2025 Census: 10 Sample Size: 8 + 2 closed records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F0000		09/09/2025
F0812 SS = F	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, 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:	F0812	The Team of Willowbrooke Court understands the potential risk to all our resident and to our community due to these identified issues and the importance of resolving them timely. The U. S. FOIA (b) (2) immediately certified that all food was labeled and dated appropriately, no wet stacking pans/sheets occured, and that hair nets and beard guards were being used appropriately and in required areas. The Culinary Director, Executive Chef, Nutrition Services and/or designees are responsible for DAILY audit for 1 MONTH of each respective issue to include labeling and dating, wet stacking, and use of hairnet and beard guards and then WEEKLY for 2 more months. The Culinary Director will report audit results and findings to the QAPI Committee at each quarterly meeting.	10/15/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0812 SS = F	Continued from page 1 Repeat Deficiency Based on observations, interviews, and review of facility documents, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was observed during the tour of two kitchens and was evidenced by the following: On 08/28/2025 9:30 AM, the surveyor toured the "[redacted]" which served the second-floor residents with the [redacted] in the presence of a second surveyor. The surveyor observed a [redacted]) coming out of the rear kitchen area without a hair restraint for a [redacted]. The [redacted] stated he did not think a "[redacted] net" was required unless food production or food handling was being performed. The front area of the [redacted]" had two plate warmer drawers which held clean plates. The top drawer had a sticky brownish debris on the handle as well as on the top trim inside the drawer front. The [redacted] acknowledged it needed to be cleaned. There was a square opening in the ceiling above the [name redacted] toaster oven like unit. The [redacted] stated there was a leak and maintenance had not fixed the ceiling yet. There was an open plastic 64-ounce (oz) tub of peanut butter that had a received date of 8/25/25 but had no opened date. The [redacted] acknowledged this and stated there should have been an opened date, "that is their process." In the rear kitchen area, there was a top single door reach in refrigerator which had a one quart opened container of almond milk with a received date of 8/25/25 but had no opened date. The [redacted] acknowledged this and stated there should have been an opened date. On 8/28/2025 at 10:00 AM, the [redacted]) joined the tour. Prior to joining the tour, the [redacted] walked through the rear kitchen to the front kitchen area without a hair restraint. On 8/28/2025 at 10:18 AM, the tour continued to the main kitchen.	F0812		

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F0812 SS = F	Continued from page 2 The walk-in freezer had a large build-up of ice on the floor towards the left back corner under the metal shelving and extended towards the center. The [redacted] stated that maintenance was aware and stated, they were "working on it, we chip it off to clean it." There was an opened half gallon of whole milk with no opened date in the produce walk-in refrigerator. The [redacted] acknowledged this and stated, "they should have put an opened date on the milk." The surveyor observed a woman seated in a chair near the pot wash area without a hair restraint. The [redacted] acknowledged that she should have been wearing a hair restraint. There was as rack which held inverted stacked metal pans. The [redacted] separated two pans which revealed water in between them (Wet Nesting - poses an increased risk of bacterial growth. When pans are not completely dried, moisture becomes trapped between them, creating an ideal environment for bacteria to thrive. This can lead to foodborne illnesses). The [redacted] acknowledged that the pans were not properly air dried before stacking. There were double stack convection ovens in use which had a large build-up of debris. The [redacted] acknowledged this and stated, the ovens should be cleaned once a week and "this needs to be looked at." In the storeroom there were two boxes of vinyl gloves, and one box of thickener stored less than 18 inches from the ceiling / sprinkler heads. The [redacted] acknowledged they were stored too high and should not have been less than 18 inches. The surveyor observed multiple dry storage items that were opened without opened dates as follows: - A one-gallon bottle of maple syrup. - A 61 oz bottle of sesame oil. - A one-gallon bottle of vanilla. - A 10-pound (lb.) bag of dry pasta, which was unsealed and open to the air. - A small bag of powdered sugar loosely wrapped with clear plastic. - Two small one lb. boxes of corn starch, one of which was unsealed and open to the air.	F0812		

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F0812 SS = F	Continued from page 3 - A 20 lb. bag of dry split peas. The U. S. FOIA acknowledged the above and stated, it was the responsibility of the dietary staff (chef, cooks, servers, etc.) as well as himself to ensure that an opened date was written on any opened product, and it was properly resealed. He added that "this was their system." There was a white ceiling tile in the middle of the room over a dry storage rack which was bowed, with a brown reddish discoloration and appeared cracked. The U. S. FOIA stated there was a leak about a week ago and "maintenance has not changed it yet." On 09/02/2025 at 12:49 PM, the survey team met with the U. S. FOIA (b) (2) to present the concerns during the kitchen tours. A review of the facility provided policy "Personal Appearance Standards" with a revised date of 2/2025, reflected that staff with facial hair "must wear a beard guard while in the production kitchen." It also included, hair restraints should be worn when in the production area where food was prepared or plated from a hot to cold workstation." A review of the facility provided form "Receiver Daily Tasks," reflected that the inside of the convection ovens should be cleaned weekly on Sundays. A review of the facility provided policy "Guide to Proper Food Storage Techniques" dated 8/2010, reflected the following: - Proper food handling and storage techniques must be followed to prevent contamination and pathogen growth. - The best way to control pathogen growth is to control time and temperature. - Milk and dairy products need time and temperature control for safety. - Rotate food to use the oldest first. - Identify items by the date on the label or expiration date. - Once equipment has been cleaned and sanitized, it must be stored in a way to prevent contamination.	F0812		

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F0812 SS = F	Continued from page 4 A review of the facility provided policy “Date Marking Ready- To-Eat Foods” with revised date of 7/2025, reflected that foods should be labeled to include the date the product was prepared or opened and the date the product should be used by. NJAC 8:39-17.1(a);17.2(g)	F0812		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030303	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD , MOORESTOWN, New Jersey, 08057

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S0000	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.	S0000		09/09/2025
S2120	Mandatory Physical Environment CFR(s): 8:39-31.1(c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, PO Box 809, Trenton, New Jersey 08625-0809. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on a record review and interview on 8/28/25 in the presence of the Plant Operations Director (POD), it was determined that the facility failed to ensure that quarterly Uniform Fire Code inspections were conducted in accordance with N.J.A.C 5:70. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that the New Jersey Uniform Fire Code Certificate of Inspection that was provided was conducted on 1/31/25. Documentation of quarterly inspections for the 3rd and 4th quarter of 2024 and 2nd quarter of 2025 were not provided.	S2120	We, the staff of Willowbrooke Court, recognize the potential negative impact on all our Willowbrooke Court residents, due to quarterly Uniform Fire Code inspections not conducted timely and reports not provided by our local vendor (NJ Ex Order 26.4(b)(1) upon completion of those inspections. The team of Willowbrooke Court recognizes the potential negative impact due to Quarterly Uniform Fire Code inspections' reports not provided to the facility. Director of Plant Management has immediately reached out to local vendor, Moorestown Fire Department, to secure the physical reports of inspections completed. As these inspections are scheduled by Moorestown Fire Department, Director of Plant Operations or designee will contact Moorestown Fire Department at each quarter to stress the importance of scheduling their inspections and providing physical report timely to maintain compliance. Director of Plant Operations will communicate status of inspections and problematic issues to the community Executive Director and Administrator. Status and content of inspections will be reported to	11/19/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030303	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

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S2120	Continued from page 1 In an interview at the time, the POD confirmed the record review and stated that only 1 inspection in 2025 was conducted as of date: 8/29/25 The Administrator was informed of the deficient practice at the Life Safety Code exit conference on 8/29/25 at 12:30 PM.	S2120	Continued from page 1 the quarterly QAPI Committee meeting by the Dir of Plant Management.	

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/19/2025 in relation to the 9/3/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		11/19/2025

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New Jersey State Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/19/2025 in relation to the 9/3/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		11/19/2025

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315077	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **02 - NEW SKILLED NUR...** B. WING	**09/03/2025**

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/28/25 and 8/29/25. Willowbrooke Court Skilled Care at Evergreens was found to be in non-compliance 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 Occupancies. Willowbrooke Court Skilled Care at Evergreens is a two-story building with 2-wings on floor #2 identified as East-214-226 and West 201-213 with a partial lower-level utilities area, that was built in 2012. It is composed of Type II (111) protected construction. The facility is divided into three smoke zones. The exterior diesel/natural gas (750 KW) generator powers 75% of the building per the Director of Physical Plant Services. The current occupied beds are 23 of 34 licensed beds. The building utilizes an electric fire pump and has 2-elevators currently in-service.	K0000		09/09/2025
K0222 SS = E	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	K0222	The egress door (stairwell 4) was repaired on September 4, 2025 by the Dir of Building Services and the door is operating as designed (work order #484) The repairment, upon completion, will be documented by the Director of Property Management. The Dir of Property Management of his designee will ensure that the exit / egress door are operating as designed by daily checks for two weeks and then weekly for 2 months to ensure the facility is in compliance. All findings will be reported to the monthly Safety Committee and the quarterly QAPI Committee to review and discuss.	09/26/2025

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		A. BUILDING 02 - NEW SKILLED NUR.. B. WING	09/03/2025

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K0222 SS = E	Continued from page 1 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 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 STANDARD is NOT MET as evidenced by: Based on observation and interviews on 8/28/25 in the presence of the U. S. FOIA (b) (2) , it was determined that the facility failed to ensure that the 15-second delayed egress feature on 1 of 4 exit discharge doors (with this feature), would activate when tested in accordance with NFPA 101 Life Safety	K0222		

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		A. BUILDING 02 - NEW SKILLED NUR.. B. WING	09/03/2025

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K0222 SS = E	Continued from page 2 Code (2012 Edition) Section 7.2.1.6.1. This deficient practice was identified for 1 of 4 exit/egress discharge doors observed, had the potential to affect all residents who resided on the second floor at the facility and was evidenced by the following: An observation at 10:21 AM with the [redacted] revealed that the stair 4-East exit/egress door was provided with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." The [redacted] tried to activate the doors delayed device as indicated on the sign, but the door opened immediately with no delay. An interview was conducted with the [redacted] during the observations. The [redacted] indicated he was not sure why the delayed device was not working. The [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 8/29/25 at 12:30 PM. NJAC 8:39-31.2(e)	K0222		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K0353	The Willowbrooke Court team recognizes the importance of identifying and correcting missing lights and its potential impact on community safety. The missing ceiling spotlights located in the conference room and corridor were installed and repaired by the maintenance staff on September 3, 2025 and are now working as designed (work order #487). The missing ceiling tiles located in the copy room were installed by the maintenance staff on September 2, 2025 (work order #490) The repairment, upon completion, will be documented by the Director of Property Management. The Director of Property Management, Administrator, and/or designee will facilitate educational inservice specific to the importance of identifying missing lights, its importance to fire safety, and responsibility to report it. The Dir of Property Management or his designee will perform monthly audit of lights and ceiling tiles to ensure there are no openings or penetrations for 3 consecutive months to ensure the facility is in compliance. All findings will be reported to the monthly Safety	09/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315077	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 02 - NEW SKILLED NUR.. B. WING	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD , MOORESTOWN, New Jersey, 08057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353 SS = F	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/29/25 in the U. S. FOIA (b) (2) it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101: 2012 Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13: 2010 Edition, Section 6.2.7.1 and NFPA 25: 2011 Edition, Section 5.1, 5.2.2.1. These deficient practices were identified for 3 of 15 areas observed, had the potential to affect all residents, and was evidenced by the following: 1) An observation at 11:47 AM with the U. S. FOIA in the floor-2 Conference room, revealed that 1 of 4 drop ceiling light fixtures were missing. The missing light fixture revealed an approximately 5-inch hole into the ceiling above approximately 18-inches to the above roof deck. 2) An observation at 11:51 AM with the U. S. FOIA in the floor-2 copy room, revealed that two drop ceiling tiles were not in place. The missing ceiling tiles revealed approximately 18-inches to the above roof deck. 3) An observation at 11:55 AM, with the U. S. FOIA in the floor-2 exit/egress corridor, revealed that 1 of 10 drop ceiling light fixtures were missing by the occupied day/TV open area, The missing light fixture revealed an approximately 5-inch hole into the ceiling above approximately 18-inches to the above roof deck. In an interview, the U. S. FOIA confirmed the findings above during the observations. The U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 8/29/25 at 12:30 PM. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K0353	Continued from page 3 Committee and the quarterly QAPI Committee to review and discuss.	
K0363 SS = F Bldg. 02	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K0363	1. The team of Willowbrooke Court recognizes the risk to our residents as a result of a resident room door that does not properly close and latch. 2. The Director of Property Management, Administrator,	11/26/2025

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K0363 SS = F Bldg. 02	Continued from page 4 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 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 STANDARD is not MET as evidenced by: Based on observations and interviews on 8/29/25 in the U. S. FOIA (b) (2) it was determined that the facility failed to ensure that corridor doors had no impediment to the closing of the doors and were capable of resisting the passage of smoke in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3, 42 CFR parts 403, 418, 460, 482, 483 and 485. This deficient practice was evidenced in 2 of 18 resident room doors observed, had the potential to affect all residents and was evidenced by the following: Observations on 8/29/25 from 9:30 AM. to 12:00 PM. revealed the following:	K0363	Continued from page 4 or designees will facilitate educational inservices to all Willowbrooke Court staff for proper closing and latching of resident doors and the importance of immediate communication of any problem. 3. The doors for room [redacted] and room [redacted] were repaired by the maintenance staff on September 3, 2025 and are closing and latching (work orders #[redacted] and #[redacted] 4. The repairment, upon completion, will be documented by the Director of Property Management. 5. The Dir of Property Management of his designee will perform a monthly check of doors to ensure they close and latch for 3 consecutive months to ensure the facility is in compliance. 6. All findings will be reported to the monthly Safety Committee and the quarterly QAPI Committee to review and discuss	

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		A. BUILDING 02 - NEW SKILLED NUR.. B. WING	09/03/2025

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K0363 SS = F Bldg. 02	Continued from page 5 1. Resident room #[NJ Ex C] door would not close and latch into its frame. The top of the door was sagging and rubbing into the top edge of the frame. 2. Resident room #[NJ Ex C] door would not close and latch into its frame. The top of the door was rubbing into the top edge of the frame. In interviews at the time, the[U. S. FOIA] confirmed the observations. The [U. S. FOIA (b) (2)] was informed of the deficient practice at the Life Safety Code exit conference on 8/29/25 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K0363		

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E0000	Initial Comments An Emergency Preparedness Survey was conducted at Willowbrooke Court Skilled Care at Evergreen by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 8/28/2025 and 8/29/2025. The facility was found to be in NON-COMPLIANCE with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		09/09/2025
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency	E0004	The Emergency Plan has been reviewed by the U. S. FOIA (b) (2) and the transfer agreements not updated within one years have been removed for follow-up and correction. 3 Transfer Agreements will be written and sent by the Administrator to 3 providers for the purpose of entering into updated transfer agreements with other providers. The Emergency Plan will be reviewed by the Director of Property Management and the community Safety Committee Team quarterly to ensure compliance. The Director of Property Management will immediately report any problematic issue to the Administrator. The administrator and/or the Director of Property Management will report findings to the quarterly QAPI Committee Meeting.	11/26/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

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E0004 SS = F	Continued from page 1 preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documents on 8/28/25, it was determined the facility failed to establish and maintain the facility transfer contracts and agreements at least annually in accordance with Appendix Z, §483.73(a): Emergency Plan. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility documents at 11:00 AM, revealed that the following facility contracts and transfer agreements were not updated at least annually: 1. Disaster Transfer Agreement between: Evergreens and Lima Estates Dated: 3/1/21. 2. Policy and Procedure for disaster or emergency that damages the facility Dated: 7/21/21. 3. Disaster/Transfer Agreement between Evergreens and Cambridge R&H Dated: 3/15/21 (noted a different Administrator had signed the agreement). 4. Mutual Agreement between Premier Cadbury at Cherry Hill and The Evergreens Dated: 2/10/22. 5. Disaster/Transfer Agreement between Lions Gate and The Evergreens Dated:7/24/19. 6. Disaster Plan Agreement between The Evergreens and Lutheran Crossings at Moorestown Dated: 10/24/19. In an interview at the time of document review, the U. S. FOIA (b) (2) and the U. S. FOIA (b) (2) both indicated the above documents in the provided EP manual were not updated as of this survey.	E0004		

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E0004 SS = F	Continued from page 2 The U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 8/29/25 at 12:45 PM. NJAC 8:39-31.2(e), 31.6(i)	E0004		

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K0000 Bldg. 02	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/11/2025 in relation to the 9/3/2025 Life Safety Code survey. The facility was found to be in compliance 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.	K0000		12/11/2025

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

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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/11/2025 in relation to the 9/3/2025 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		12/11/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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