STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315517	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	212 MARTER AVENUE MOORESTOWN, NJ 08057

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ #: 151039, 151627, 153838, 154077, 156221, 160228, 163447, 163686 STANDARD SURVEY: 12/08/2023 CENSUS: 118 SAMPLE SIZE: 24 + 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the medical records and other facility documentation, it was determined that the facility failed to clarify a physician's order from NJ Exec Order 26.4 until NJ Exec Order 26.4 for 1 of 4 residents (Resident #94) observed during medication observation.	F 658	The attending physician for resident # 94 was contacted for order clarification to specify to which NJ Exec Ord to apply the NJ Exec Order 26.4b1 was completed on NJ Exec Order 26.4b One on one re-education was given on	1/22/24

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

Electronically Signed | 12/29/2023

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F 658	Continued From page 1 This deficient was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." Review of the Admission Record for Resident #94 reflected the resident was admitted to the facility with medical diagnoses which included, but were not limited to, NJ Exec Order 26.4b1 [redacted] The admission Minimum Data Set (MDS), an	F 658	12/7/23 to the licensed nurse who was involved with the cited deficient practice, regarding physician order clarification to assure that the physician order is complete, with the emphasis on specifying the location for lidocaine patches application. Residents with physician orders pertaining to Lidocaine patch application have the potential to be affected by the cited practice. A facility wide audit was conducted on 12/9/23 for those residents who have an order for Lidocaine patches, no negative findings was observed. Inservice Education was initiated on 12/21/23 and ongoing with licensed nurses on the importance of ensuring orders are complete upon entry and clarified when noticed incomplete upon administering. In-service education will be given during orientation for newly hired licensed nurses, annually and as deemed necessary. Night Supervisor or designee will audit 10 physician orders weekly x 4 then monthly x 3 to ensure physician orders are complete and accurate. Upon findings of incomplete orders, the Provider will immediately be contacted for clarification. Negative findings from the audit will be reported to DON or ADON and addressed through one-on-one re-education and disciplinary measures as appropriate. The results of the audits will be reported to the QAA committee who meets quarterly for review, and to determine the necessity of	

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F 658	Continued From page 2 assessment tool, dated [NJ Exec Order 26.] reflected that Resident #94 was [NJ Exec Order 26.4b1] and required limited to extensive assistance with activities of daily living. The MDS also indicated that the resident was on scheduled [NJ Exec Order 26.4b1]. On 11/30/23 at 9:14 AM, the surveyor observed the Licensed Practical Nurse (LPN) administer medications to Resident #94. The LPN asked Resident #94 if he/she wanted the [NJ Exec Order 26.4b1] that was ordered for [NJ Exec Order 26.4b1]. The resident replied, "yes" and further stated, "not on the[NJ Exec Order 26.4b1]." The LPN replied, "okay" and proceeded back to the medication cart to prepare the [NJ Exec Order 26.4b1] for the resident. During an interview with the surveyor at that time, the LPN stated, "we just ask the resident which [NJ Exec O] and [he/she] tells us." When asked how the nurses document which [NJ Exec Order 26.4b1] was applied to, the LPN responded, "we don't." On 11/30/23 at 9:14 AM, the surveyor reviewed the Physician's Order Sheet (POS), dated [NJ Exec Order 26.4] , with a physician's order for the [NJ Exec Order 26.4b1] that read: [NJ Exec Order 26.4b1] apply in the AM and remove at night and apply to [NJ Exec O] one time a day for remove at 9p." The physician's order did not specify to which [NJ Exec O] to apply the[NJ Exec Order 26.4b1]. The Treatment Administration Record (TAR) for the month of [NJ Exec Order 26.4b1] did not reflect an order to document location of [NJ Exec Order 26.4b1] after application. On 12/05/23 at 12:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the order for [NJ Exec Order 26.4b1] for Resident #94 should have been clarified and was	F 658	future audits, and recommendations. Element 5- Date of compliance: 1/16/2024	

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F 658	Continued From page 3 considered incomplete. The facility policy labeled "Nursing Medication Administration "with revised date of 01/18/2023 indicated that "Medications are administered by licenses nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." Under a subsection called "Policy Explanation and Compliance Guidelines," numbered 1 to 21, reflected under #11 that nursing should "Compare medication source (bubble pack, vial, etc.) with MAR to verify the resident name, medication name, form, dose, route and time." Under #21 of the subsection "Policy Explanation and Compliance" it further directed nursing to "Correct any discrepancies and report to nurse manager." N.J.A.C. 8:39-27.1 (c) (3i)	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		1/22/24

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F 755	Continued From page 4 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to promptly record the removal of controlled drugs from the narcotic inventory record for 1 of 3 nurses observed during medication pass observation. This deficient practice was evidenced by the following: On 11/30/23 at 9:40 AM, the surveyor asked the Licensed Practical Nurse (LPN) to complete a NJ Exec Order 26.4 count for the third-floor medication cart labeled "High Cart C." As the surveyor and the LPN proceeded to conduct the NJ Exec Order 26 count the surveyor discovered that the Controlled Drug Record (CDR) sheet for the NJ Exec Order 26 medication named NJ Exec Order 26.4b1 tablets NJ Exec Order 26.4b1) for Resident #80 indicated that there should have been 25 tablets	F 755	The license nurse immediately signed the Controlled Drug Record (CDR) for patient #80, facility's NJ Exec Order 26.4 inventory log for removal of the medication as soon as it was brought to her attention. One on one re-education of the licensed nurse who was involved with the cited deficient practice was provided on 12/7/23. All Controlled Drug Record were audited upon notification of the cited deficient practice was conducted and completed to assure that the disposition of all controlled drugs is accurately reconciled. No negative findings were observed during the audit.	

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F 755	Continued From page 5 available, however there was only 24 tablets in the pill packet. The LPN at stated she gave the medication earlier, but forgot to sign it in the CDR to indicate that she had administered the [NJ Exec Order 26] She then proceeded to search the time that she administered the medication in the Electronic Medical Record (EMR). Afterwards, she proceeded to sign the CDR in the presence of the surveyor that indicated that she administered the [NJ Exec Order 26]. When the surveyor asked the LPN why it was important to sign out [NJ Exec Order 26.4] medications on the CDR at the time the medication was given, the LPN stated to ensure the [NJ Exec Order 26] count was correct and to avoid medication errors. The surveyor reviewed Resident #80's Admission Record which indicated that the resident was admitted to the facility with a diagnosis which included, but was not limited to, [NJ Exec Order 26.4b1] [redacted]. Review of the Physician Order Report indicated that the physician had prescribed [NJ Exec Order 26.4b1] [redacted] to be given two times a day for [NJ Exec Order 2] [redacted] Review of the EMR indicated that the LPN gave the [NJ Exec Order 26] medication NJ Exec Order 26.4b1 on [NJ Exec Order 26.] at 09:17 am. The surveyor observed that the nurse did not sign the CDR until 9:40 am after surveyor inquiry. On 12/05/23 at 12:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the LPN should had signed the [NJ Exec Order 26] inventory log immediately after the [NJ Exec Order 26.] medication was administered to Resident #80. She further stated that the LPN had already brought this to her attention after it was	F 755	One on one re-education provided on 12/7/23 to the nurse involved in the med pass at the time on the policy and procedure and the importance of immediately signing out on the Controlled Drug Record when removing narcotic medication. In-service education was initiated on 12/8/23 and ongoing regarding facility's policy on Controlled Substances and Medication Administration with emphasis on signing the Controlled Drug Record when removing a narcotic medication. This in-services will be given during orientation for newly hired licensed nurses, annually and as deemed necessary. Unit Managers or nurse designee will conduct a weekly audit of Controlled Drug Record for 2 medication carts alternating other shifts x 4 weeks and monthly x 3 to ensure that the CDR/narcotic inventory countdown sheets are accurately reconciled and signed when a narcotic medication is removed. Negative findings from the audit will be reported to DON and addressed through one-on-one re-education and disciplinary measures as appropriate. The results of the audits will be reported to the QAA committee who meets quarterly for review, and to determine the necessity of future audits, and recommendations.	

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F 755	Continued From page 6 discovered by the surveyor and the LPN was in-serviced (educated) by the DON. The facility provided the surveyor with an "individual one on one in-service" untimed and dated 11/30/23, which indicated that the LPN was educated on the importance of ensuring that medications were signed out immediately after administration on the EMR and narcotic sign out sheet. Review of the facility policy titled, "Controlled Substances," dated 02/08/2023, which indicated that the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. The policy also specified that controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. Review of the facility policy titled, "Medication Administration," dated 01/18/2023, indicated that the nurse was responsible to sign the Medication Administration Record after the medication was administrated and if the medication was a controlled substance the nurse was responsible to sign the narcotic book.	F 755		
F 761 SS=D	N.J.A.C. 8:39-29.7 (c) 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 professional principles, and include the	F 761		1/22/24

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F 761	Continued From page 7 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 pertinent facility policies, it was determined that the facility failed to a.) secure a medication administration cart during the medication pass conducted on 11/30/23 and b.) maintain medications with appropriate label/dating for 2 of 8 medication administration carts inspected This deficient practice was evidenced by the following: 1.) On 11/30/23 at 9:40 AM, the surveyor observed the medication storage cart on the third floor labeled "High Cart C." During the inspection Licensed Practical Nurse (LPN #2) proceeded to walk to the medication storage room with the	F 761	Medications on the High B medication cart with short expiration dates were appropriately labeled. One on one re-education provided to the nurse involved in the med pass at the time on 12/7/23. One on One re-education provided to nurse involved on the importance of locking the medication cart whenever it is not within their view on 12/7/23. All Medication carts were audited upon receiving the cited deficient practice for dating of short expiration medication	

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F 761	Continued From page 8 surveyor and away from the medication cart without locking and securing it. The surveyor went over to the medication cart to wait for the LPN's return from the storage area. When LPN #2 returned to High Cart C, the surveyor asked LPN #2 if the medication cart should be unlocked. LPN #2 stated "probably not" and further stated she usually locked the cart, but was very nervous at this time. She then explained that it was important to lock the medication cart when out of her eyesight because if a resident was to wander through the unit, they could get in the medication cart and take the medication. She confirmed that locking the medication cart protected the residents. On 12/05/23 at 12:40 PM, in the presence of the survey team, the Director of Nursing (DON) stated that the medication cart should always be kept locked when out of the nurse's view to prevent any issues with unauthorized individuals gaining access to the medications. 2.) On 11/30/23 at 9:40 AM, the surveyor conducted a medication administration observation and inspection of the 3rd floor medication administration cart. The surveyor observed LPN #2 perform medication administration on a medication cart labeled "High Cart C." At this time during the cart inspection, the surveyor observed the following opened short expiration medications were not labeled with the date they were opened: -Budesonide 0.5 9 milligrams (mg) 2ml opened foil packet. According to the manufactures recommendations after the envelope is opened the shelf-life of the unused ampules was two weeks.	F 761	packaging, no other negative findings were observed. All medication carts were audited for proper securement and locking when out of eyesight. All medication carts were locked. Re-education with Licensed nurses was initiated on 12/7/23 and ongoing on the importance of dating when opening packages of medications with short expiration life and on the importance of locking the medication cart whenever it is not within their eyesight. These in-services education will be given during orientation for newly hired licensed nurses, annually and as deemed necessary. ADON or designee will conduct a weekly audit for 10 medications requiring dating after opening due to short expiration life covering other med carts, and DON or designee will perform weekly audits on all 8 carts to ensure each is locked when out of view of the nurse. Negative findings from the audit will be reported to DON and addressed through one-on-one re-education and disciplinary measures as appropriate. The results of the audits will be reported to the QAA committee who meets quarterly for review, and to determine the necessity of future audits, and recommendations.	

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F 761	Continued From page 9	F 761		

LPN #2 was interviewed at this time and indicated that medications should be dated when opened.

On 12/01/23 at 08:32 AM, the surveyor conducted an inspection of the medication storage cart on the second floor labeled "High Cart B." The surveyor observed that the following short expiration medications were not labled with a date when opened:

-Trilogy Elipta Inhaler 200mg/62.5 mcg/25/mcg. The surveyor observed that the foil tray containing the inhaler was not dated when opened and according to manufactures recommendation, the medication was only good for six (6) weeks after opening the foil tray.

- Fluticasone Furate Inhaler 100 mch/25 mcg. According to the insert on the box the medication was only good for 6 weeks after opening.

The surveyor interviewed LPN #3 at this time who indicated that she was not sure why the medications were not dated when opened. She stated that all medications should be opened when dated because certain medications could expire after opening and were only good for a certain amount of time.

On 12/07/23 at 11:21 AM, the surveyor interviewed the Pharmacy Consultant (PC) who stated that he had been coming to the facility for about 5 years. The PC stated that he was in the facility monthly and inspected the medication carts to assure proper labeling and dating. He stated that he focused on all medications in the medication cart however prioritized the medications with shortened expiration dates after

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F 761	Continued From page 10	F 761		

they were opened. He stated that the nurses were to monitor these types of medications to assure that they kept track of the shorter expiration date medications in between his visits. He stated that the nurses needed to check that these medications were dated when opened. He stated that the medication "Budesonide" was light sensitive and when a pouch is opened it expires 7 days after opening. He stated that some literature regarding this medication indicated that it expired 14 days after opening, but other literature indicated that it expired 7 days after opening. He further stated that the facility followed the more stringent recommendations of 7 days. He also stated that this medication was very light sensitive and that since it could not be assured that it was out in the light too long, that he educated the nurses in the facility that it expired 7 days after opening. He continued to add that it was good practice is to assure that medications were dated when opened. He confirmed that the medications Trilogy Elipta Inhaler and Fluticasone Furate Inhaler expired 6 weeks after opening.

The facility policy titled, "Security of the Medication Cart" dated April 2007, which indicated that the medication cart shall be secured during medication passes. The policy indicated that the nurse would secure the medication art during the medication pass to prevent unauthorized entry and that medication carts must be securely always locked when out of the nurse's view.

The facility policy titled, "Labeling of Medication Containers" with a revised date of 11/01/23 which indicated that all medications maintained at the facility were properly labeled in accordance with current state and federal guidelines and

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F 761	Continued From page 11 regulations. NJAC 8:39-29.2(d) NJAC 8:39-29.4(a)	F 761		
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of	F 836		1/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315517	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	212 MARTER AVENUE 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 836	Continued From page 12 non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act.	F 836	Facility Obtained approval from Department of health for transfer of ownership and submitted form 855. This has the potential to affect all residents. Reginal Administrator Reeducated Administrator, and Administrator Reeducated staff responsible for marketing on the requirement of advertising under the proper state approved name. Administrator will audit to ensure facility is advertising using state approved name monthly for 3 months and present findings at Facility quarterly Quality Assurance and Performance improvement meeting for any further recommendations.	

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	315517	A. BUILDING _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	212 MARTER AVENUE MOORESTOWN, NJ 08057

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F 836	Continued From page 13	F 836		

(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76.....
(d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.
Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:
(1) Within 30 days -
(i) A change of ownership;
(ii) Any adverse legal action; or
(iii) A change in practice location.
(2) All other changes in enrollment must be reported within 90 days."

On 11/27/23 at 10:45 AM, upon arrival of the surveyors to the facility, the surveyor observed a facility sign, "Total Rehab at Moorestown" that had a name that did not correspond with the CMS licensed, approved name and provider registered name "Promedica Total Rehab + Moorestown."

Upon entrance into the facility, the survey team observed there were displayed signs and brochures with the same name "Total Rehab at Moorestown." The facility name displayed in the entrance area, "Total Rehab at Moorestown" did not correspond with the CMS licensed and approved name of "Promedica Total Rehab + Moorestown."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	212 MARTER AVENUE 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 836	Continued From page 14	F 836		

On 11/27/23 at 11:57 AM, the survey team conducted the entrance conference with the Director of Nursing (DON), the License Nursing Home Administrator (LNHA), and the Vice President of Clinicals (VP of Clinicals). During the discussion the LNHA informed the survey team that the facility was now named "Total Rehab at Moorestown" and was under the new ownership of Preferred Care. The VP of Clinical stated that the ownership and name change occured in January of 2023. She further stated that the New Jersey Department of Health (NJDOH) state licensing was notified of the new ownership and name change.

On 11/28/23 at 09:00 AM, the survey team reviewed various pertinent facility documents - the facility's website and brochures which indicated the facility was advertising as "Total Rehab at Moorestown" rather than "Promedica Total Rehab + Moorestown." The pertinent documents provided reflected that the facility name currently in use did not match the facility's licensed name. The facility name, "Total Rehab at Moorestown" utilized was not approved by CMS.

The Surveyor reviewed the facility license which documented, "Promedica Total Rehab + (Moorestown)" as the facility name. The license issued by the New Jersey Department of Health (NJDOH) Division of Certificate of Need and Licensing was issued on 09/28/23 and expired on 10/31/24.

On 11/28/23 at 09:20 AM, the LNHA stated in the presence of the survey team that he was unsure if the CMS 855A application for the name change was completed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 836	Continued From page 15	F 836		

On 11/28/23 at 09:41 AM, the LNHA in the presence of the survey team stated that the signage outside and the documents that reflected Total Rehab at Moorestown was done prior to him starting at the facility. The LNHA stated he become the LNHA two (2) months ago, and prior to that he started as the Assistant LNHA in April of 2023.

On 11/28/23 at 12:38 PM, the LNHA provided the LSC-9 Application for a Long-Term Care Facility License that was submitted in February of 2023.

On 11/28/23 at 01:12 PM, the surveyor interviewed the Regional LNHA who stated he spoke with the corporate office and that the CMS 855A application could not be submitted until they received approval from the state licensure.

Upon further review of the documents provided by the LNHA, there was an email dated for 2/17/23 and 11/2/23 sent to NJDOH from the facility's attorney regarding the new license, reflected the following:

-After approval and closing, the new name of the facility will be Total Rehab Moorestown.
-Page 3: The Medicare provider number will be assigned to "Moorestown Operator, LLC following approval of a CMS855A application, and a new Medicaid provider number will be issued to the applicant following the review and approval.

The state surveyor met with the facility's LNHA to discuss the deficient practice of utilizing the facility name "Total Rehab at Moorestown" without NJDOH Licensure approval.

On 12/8/23 at 09:22 AM, the LNHA in the

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F 836	Continued From page 16 presence of the Regional Nurse, the Assistant LNHA, the DON and survey team, stated that the name change, and transfer of ownership was sent in February 2023 and should be getting approval this week. He further stated that the facility reached out to their lawyer who was "not aware it was an issue." The LNHA stated that the CMS 855A application could only be completed once the NJDOH gave the approval. The LNHA acknowledged they did not get official approval for the name change. No further information or documentation was provided to the survey team to refute these findings.	F 836		
F 880 SS=D	NJAC 8:39-5.1 (a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880		1/22/24

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F 880	Continued From page 17	F 880		

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;
(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.

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F 880	Continued From page 18 §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 review of other pertinent facility documentation, it was determined that the facility failed to follow appropriate infection control practices to prevent the spread of infection. This deficient practice was identified for 1 of 3 nurses observed during a medication administration observation. The deficient practice was evidenced by the following: On 11/30/23 at 9:44 AM, the surveyor observed the Licensed Practical Nurse (LPN) administer medications to Resident #419. The Department Nurse Manager (DNM), with an ungloved hand, handed the LPN three (3) packets of medication for Resident #419. The medications received by the LPN included one (1) NJ Exec Order 26.4b1 [redacted]), one (1) NJ Exec Order 26.4b1 [redacted], and one (1) NJ Exec Order 26.4b1 [redacted] tablet. The LPN received the packets of medication in her ungloved hands and then placed them in her pocket. The LPN then went to finish the NJ Exec Order 26.4 count with the surveyor in the storage room. No hand hygiene was observed at this time.	F 880	The nurse who was involved of the cited deficient practice was re-in-serviced on the importance of following infection control practices by not placing loose medication into the same medication cup with unopened packets of medication as observed with patient #419 All residents receiving medications from unopened packets of medication along with loose medication have the potential to be affected by the cited deficient practice. All nursing staff were in-serviced and re-educated on the importance of following infection control practices by not placing loose medication into the same medication cup with unopened packets of medication. This education will be given annually during nurses□ medication pass observations, during orientation medication pass observations for newly hired nurses and when deemed necessary. Facility Infection Preventionist and/or	

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F 880	Continued From page 19 On 11/30/23 at 9:59 AM, the LPN returned to the medication cart and began to prepare the medications received from the DNM for Resident #419. The LPN removed the medication with her ungloved hand from her pocket and placed the unopened packets into a medicine cup. The LPN then removed one (1) pill of NJ Exec Order 26.4b1 from a medication bottle and placed that into the same medicine cup with the unopened packets. The LPN then stated she will be giving the patient the medications now. At that time, the surveyor confirmed with LPN that she will be giving Resident #419 the medications as prepared and the LPN replied, "yes". The LPN failed to follow appropriate infection control practices by placing loose medication (NJ Exec Order 26.4b1) into the same medication cup with unopened packets of medication which included one (1) NJ Exec Order 26.4b1, one (1) NJ Exec Order 26.4b1, and one (1) NJ Exec Order 26.4b1 tablet. All medication packets had been touched by both the DNM and the LPN with ungloved hands. On 11/20/23 at 10:02 AM, the surveyor interviewed the LPN. On interview of the LPN the surveyor asked the LPN if it was acceptable to give the medications the way she had prepared them with the closed packets and the open medication in the same medicine cup, after the packets were touched by multiple staff. The LPN replied, "no because it would be contaminated." It was at that time the LPN stated she will restart her medication preparation, and proceeded to appropriately waste the loose pill of NJ Exec Order 26.4b1 that was in the medicine cup. The LPN then discarded the old medicine cup; performed	F 880	nurse designee will complete a weekly observation audit for 5 residents receiving medications covering all shifts x 4 weeks and then monthly x 3 months to ensure that loose medication is not placed into the same medication cup with unopened packets of medication. Negative results will be corrected immediately through re-education and or disciplinary action as appropriate. Results of the audits will be submitted to the QAA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	

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F 880	Continued From page 20	F 880		

hand hygiene, donned gloves, retrieved a new medicine cup, and began preparing medications again for Resident #419, which included pouring a new tab of [redacted] into a clean medicine cup from the supply bottle and then removing the medication from the pill packets before placing them into the medication administration cup.

On 12/05/23 at 11:51 AM, the surveyor interviewed the Registered Nurse Infection Preventionist (RN/IP). The RN/IP explained that the LPN should not have placed medications that were still in blister packs, in the same medicine cup as loose medications because it can cause "cross contamination."

On 12/06/23 at 1:28 PM, the surveyor reviewed the facility policy labeled "Infection Control Program and Surveillance Plan" with revised date of 02/01/2023, indicated that "Total Rehab + at Moorestown's infection control program will identify and reduce the risk of acquiring and transmitting infections among residents, staff volunteers, students, and visitors. The program incorporates a broad range of education, surveillance, prevention, and infection control practices involving all departments with oversight by the designated infection control preventionist nurse under the guidance of the Infection Control Committee". Under subsection called "Structure and Organization" it further specifies that "This manual also contains information related to specific clinical conditions, including practices to prevent or minimize the spread or occurrence of infections while caring for residents" including "General Infection control policies and procedures that mandate routine infection control practices, including personal protective measures, hand hygiene and guidelines for

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	**212 MARTER AVENUE MOORESTOWN, NJ 08057**

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F 880	Continued From page 21 Standard and Transmission-Based Precautions". NJAC 8:39-19.4(a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03009	A. BUILDING: _____ B. WING _____	C 12/08/2023

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H 000	Initials Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	H 000		

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

Electronically Signed | 12/29/23

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315517	A. Building B. Wing	2/2/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	212 MARTER AVENUE 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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 01/22/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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	
12/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315517 Y1	A. Building B. Wing Y2	2/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	212 MARTER AVENUE MOORESTOWN, NJ 08057

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658	Correction	ID Prefix F0755	Correction	ID Prefix F0761	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	01/22/2024	LSC	01/22/2024	LSC	01/22/2024
ID Prefix F0836	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.70(a)-(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	01/31/2024	LSC	01/22/2024	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	
12/8/2023	☐ 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
	315517	A. BUILDING **01** B. WING _____	**12/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	**212 MARTER AVENUE** **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
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 11/28/23 and 11/29/23 Promedica (Total Rehab), 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 Occupancies. Promedica (Total Rehab) is a three story Type II Protected building that was built in October 2014. The facility is divided into 15 smoke zones. The exterior 600 KW diesel generator does 100% of the building. The facility is certified for 124 beds and currently is at 118 occupied beds. *The facility is in ACO as Promedica, but the exterior sign, brochure, and most recent inspections indicate "Total Rehab". *It was noted that the facility currently did not have a Maintenace Director. The surveyor toured the facility with the Housekeeping Director.	K 000		
K 222 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	K 222		1/22/24

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

Electronically Signed | 12/27/2023

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K 222	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 on 11/29/23, in the presence of the Housekeeping Director (HD), 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. This deficient practice was identified for 1 of 2 sets of sliding doors and was evidenced by the following. At 11:15 AM, the surveyor and HD observed at the main entrance, that the outer set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the doors could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. The sliding doors had signs indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors as stated on the signs.	K 222	• Facility removed the existing lock on the door, ensuring that it can be easily opened from the inside without the need for a key or tool during an emergency. Facility Assessed all doors designated as means of egress in the nursing facility to ensure that they do not have locks requiring tools or keys to unlock during an emergency. • Administrator educated maintenance and housekeeping staff on the importance of maintaining accessible means of egress and the proper operation of the door. • Maintenance /designee will audit 2 Means of egress to confirm there is no key or tool needed to exit during an emergency, monthly for 3 months and present findings at Facility quarterly Quality Assurance and Performance	

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K 222	Continued From page 3 At the time of the observation, the surveyor interviewed the HD who stated that the lockset (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency. The Administrator and Regional staff were notified of the findings at the Life Safety Code Exit Conference on 11/29/23. 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	improvement meeting for any further recommendations.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		1/22/24

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K 321	Continued From page 4 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/29/23, in the presence of the Housekeeping Director (HD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified for one (1) of five (5) hazardous storage areas and was evidenced by the following: At 11:58 AM, the surveyor and HD, observed that 50 plus combustible cardboard boxes were being stored in the Rehab Transitions gym. The room was greater than 50 square feet in size and required an auto-close device installed on the door. The HD confirmed the finding, during the observations. The Administrator and Corporate staff were informed of the finding at the Life Safety Code Exit Conference on 11/29/23.	K 321	•Facility Removed all combustible cardboard boxes from the room to eliminate the fire hazard. • Conducted a facility-wide assessment to identify and remove any other combustible materials stored in areas without self-closing fire doors. • Administrator educated Maintenance, Housekeeping and Central supply staff on the importance of fire safety and proper protocol with rooms 50 SQF or larger • Maintenance /designee will audit the transition gym to ensure that rooms meet fire safety standards and that no combustible materials are stored in areas without self-closing fire doors Biweekly for 4 weeks and then monthly for 2 months and present findings at Facility Quality Assurance and Performance improvement meeting for any further recommendations.	

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K 321	Continued From page 5 NJAC 8:39-31.2(e)	K 321		
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 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	K 363		1/22/24

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K 363	Continued From page 6 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 11/29/23, in the presence of the Housekeeping Director (HD), it was determined that the facility failed to maintain 49 of 120 doors to resident rooms in exit corridors to close and provide protection from the passage of smoke to the exit corridors. This deficient practice was evidenced by the following: Throughout a tour of the facility, the Surveyor and the HD observed doors in exit corridors that would not latch into its frame and vertical door sets were observed to have gaps from 1/4" to 1/2" from missing and torn door gaskets in the following resident rooms: 306, 307, 308, 312, 321, 322, 323, 326, 328, 329, 333, 334, 336, 342, 344, & 345. 207, 208, 209, 210, 212, 214, 217, 220, 221, 223, 225, 226, 227, 228, 229, 230, 232, 234, 235, 238, 239, 246, 248, 249, 251, 254, 255, 256, 267, 258, 259, 260, & 261. An interview was conducted during the observation's with the Housekeeping Director, where she stated and confirmed that she needed to check all the doors, so they would resist the passage of smoke in each smoke compartment in the facility. The Administrator and Corporate staff were notified of the findings at the Life Safety Code exit	K 363	•Facility Implemented immediate repairs and replacement of any damaged or missing latches and gaskets to ensure all doors are properly latching and sealed. • Conducted a comprehensive assessment of all doors and door sets to identify and correct any additional latching or gasket issues. • Administrator educated Maintenance and Housekeeping staff on proper door latching and gasket maintenance. • Maintenance /designee Will audit 10-15 door latches and gaskets to ensure compliance Biweekly for 4 weeks and monthly for 3 months and present findings at facility Quality Assurance and Performance improvement meeting for any further recommendations.	

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K 363	Continued From page 7 conference on 11/29/23. NJAC 8:39-31.1(c), 31.2(e)	K 363		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 11/29/23, in the presence of the Housekeeping Director (HD), it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 6 smoke barrier door sets observed and was evidenced by the following: At 10:28 AM, the surveyor observed that the set of smoke barrier doors by resident room 212, when released from the electro-magnetic hold open device. The doors closed properly, but when the double doors met, a gap was observed on the	K 374	• Facility repaired the specific smoke barrier door ensuring there is no gap • Facility Inspected all smoke barrier doors to ensure there are no additional gaps or issues • Administrator Educated maintenance and housekeeping staff on the importance of ensuring smoke barrier doors close completely without having any gaps. • Maintenance/designee will audit 3 smoke barrier doors Biweekly Times 3 and then Monthly Times 3 to ensure all	1/22/24

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K 374	Continued From page 8 lower section of the doors from the gasket being compromised. The Housekeeping Director, confirmed the findings above during the observation. The Administrator and Corporate staff were informed of the findings during the Life Safety Code survey exit conference on 11/29/23. NJAC 8:39-31.1(c), 31.2(e)	K 374	smoke barrier doors are properly sealed and maintained. Findings will be presented at the quarterly Facility Quality Assurance and Performance improvement meeting for any further recommendations.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 11/29/23, in the presence of the Housekeeping Director (HD), it was determined that the facility failed to ensure that 1 of 10 electrical outlets located next to a water source was equipped with a Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: At 12:02 PM, the surveyor and HD observed in	K 912	• Facility Installed a GFI outlet next to the water source that did not have. • Facility Conducted an assessment to identify all electric outlets near water sources in the facility to ensure that a GFI outlet is installed next to each one. • Administrator Educated housekeeping and maintenance staff on electrical safety and the importance of utilizing GFI outlets	1/22/24

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K 912	Continued From page 9 the Physical Therapy room that a Hydrocollator was plugged into a regulator duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. The Housekeeping Director confirmed the finding at the time of observation. The Administrator and Regional staff were informed of the finding at the Life Safety Code exit conference on 11/12/23. NJAC 8:39 -31.2 (e) NFPA 99	K 912	near water sources. • Maintenance /designee will Audit 5 outlets near a water source Biweekly 3 times and then monthly times 3 to ensure GFI outlets are installed near water sources. Findings will be presented quarterly at the facility Quality Assurance and Performance improvement meeting for any further recommendations.	
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	K 918		1/22/24

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K 918	Continued From page 10 stored energy power sources (Type 3 EES) are in 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 11/28/23 and 11/29/23, in the presence of the Housekeeping Director (HD), it was determined that A). The facility failed to ensure a remote manual stop station for 1 of 1 generators. B). The facility failed to ensure the monthly load test transfer times were documented for: 12 of 12 monthly load tests observed on the provided log in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: A). On 11/29/23 at 11:42 AM, the surveyor and HD, observed that the 600 KW generator, was not provided with a remote manual stop station, observed outside the area of the generator. The generator did have an auto stop button, but it was located inside the generator cabinet only. An interview was conducted during the time of the	K 918	• Facility Immediately reviewed the generator inspection log to ensure that it includes a section for documenting the generator transfer time to ensure ongoing compliance. Facility installed ae emergency Stop button for the generator. • Conduct a review of the facility's generator documentation procedures to ensure that all required information, including generator transfer time, is being recorded accurately and consistently. •Administrator Educated maintenance and housekeeping staff on the importance of documenting the generator transfer time and proper use of the manual stop button. • Maintenance /designee will audit Monthly times 3 to ensure that the generator transfer time is being documented correctly and that the manual stop station	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 11 observation with the HD, who stated and confirmed that the exterior generator, did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current generator in service. B). On 11/29/23 at 11:48 AM, the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, for 3 of 12 monthly load tests on the following documented dates: 10/30/23 transfer time marked N/A 08/28/23 transfer time marked N/A 07/19/23 transfer time marked 0 The Administrator indicated that the document provided was current, but that he may have a another document on his computer, but at the LSC exit no further documentation was provided. The Administrator was informed of the findings at the Life Safety Code exit conference on 11/29/23. 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	is available, positioned and maintained properly. Findings will be presented quarterly at the facility Quality Assurance and Performance improvement meeting for any further recommendations.	

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
315517 Y1	A. Building 01 - POWERBACK - MOORESTOWN B. Wing Y2	2/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL REHAB MOORESTOWN	212 MARTER AVENUE 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 K0222	01/22/2024	LSC K0321	01/22/2024	LSC K0363	01/22/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	01/22/2024	LSC K0912	01/22/2024	LSC K0918	01/22/2024
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	
12/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO