STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: 170784, 171624, 163924, 152604, 152868, 153743, 158278, 167786, 169132, 168547 Survey Date: 04/10/2024 - 04/18/2024 Census: 102 Sample: 24 + 4 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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		5/3/24

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

Electronically Signed | 04/29/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain an orderly physical environment for 2 of 2 facility units ([redacted]) reviewed under the Environmental Task. The deficient practice is evidenced by the following: On 04/11/2024 at 10:20 AM during a tour of the [redacted] Unit communal shower room, the surveyor observed a shelf on the wall adjacent to the shower stall. On the shelf was an unpackaged NJ Exec Order 26.4b1, a hairbrush with hair entangled in the bristles, and various hygienic bottled toiletries. The room also emanated a [redacted] On the same date at 10:27 AM during a tour of	F 584	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice The NJ Exec Order 26.4b1 [redacted], hairbrush, and various hygienic bottled toiletries were immediately removed from the [redacted] unit communal shower room. The [redacted] unit communal shower room was immediately cleaned and disinfected by housekeeping to eliminate odors. The food debris was removed from the table in the common area on the 100 unit. The blue slipper was returned to the resident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 584	Continued From page 2 the NJ Exec Order 26.4b1 area across from the nurses station, the surveyor observed a table that had food debris and two partially consumed beverages left on top. On the floor under the table was a single, blue slipper. The surveyor observed Residents participating in an activities exercise in the same common area at the time of the observation. On the same date at 10:37 AM during a tour of the NJ Exec O Unit communal shower room, the surveyor observed five PVC (polyvinyl chloride) constructed mobile trash bins stored in the shower room. At least one of the trash bins still contained clear plastic bags filled with trash. The room contained a scale chair (chair fitted with a scale to measure a persons weight) that had but was not limited to NJ Exec Order 26.4b1 , disposable glove boxes, and plastic bags on top of it. On the same date at 10:52 AM, the surveyor observed Resident # 72's room. At that time, the surveyor observed a chair near the foot of the bed. The chair had an unpackaged NJ Exec Order 26.4b1 NJ Exec O, towels, a linen sheet, and a hospital gown left on the seat. At that time, during an interview with the surveyor, Resident # 72 stated, "I don't want it [items observed on chair] there because my NJ Exec O and NJ Exec Order 26.4b1 visit and I don't want them seeing a NJ Exec Order 2. I keep telling them [the facility] to not do that." On 04/16/2024 at 10:58 AM in the hallways outside of room NJ Exec O, the surveyor observed a NJ Exec Order 26.4b recliner chair. On the chair was a grey plastic container that included unpackaged NJ Exec Ord	F 584	The trash was removed from the bin in the NJ Exec O communal shower room. The various items including briefs, glove boxes and plastic bags were immediately removed from the scale in the NJ Exec O unit communal shower room. The NJ Exec Order 26.4b1 , towels, linen sheet and hospital gown were immediately removed from the chair in resident #72□s room. Resident #72 had no untoward effects related to the unpackaged items in the room. The grey container containing the NJ Exec Order 26.4b1 was immediately removed from the NJ Exec O chair outside room NJ Exec O. The linens and hospital gown were immediately removed from the chair in resident #11□s room. Resident #11 had no untoward effects related to the unpackaged items on the chair. The mixed linen and unpackaged NJ Exec Order 26.4b1 were removed from the chair in room NJ Exec Order, as well as the pillows and linen on the chair in NJ Exec Order. The residents in room NJ Exec O had no negative effects related to the open linen on the chairs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 584	Continued From page 3 NJ Exec Order 26.4b1. On the same date at 11:02 AM while in Resident # 11's room, the surveyor observed a chair near the foot of the bed. The chair had a hospital gown and white linens left on the seat. At that time during an interview with the surveyor, Resident # 11 replied , NJ Exec Order 26.4b1." when the surveyor asked if he/she wanted the hospital gown and linens on the chair. Resident # 11 further said he/she does not use hospital gowns because they are not warm enough. On 04/16/2024 at 10:58 AM during an interview with the surveyor, Housekeeper # 1 said he was not responsible for removing linens from room. He said he was responsible for mopping, sweeping, garbage, and cleaning. On 04/17/2024 at 12:29 PM during an interview with the surveyor, the U.S. FOIA (b)(6) replied, "They should be stored in the closets and if on the floor, in carts." when the surveyor asked what was her expectation for storing linens including but not limited to unpackaged NJ Exec Order 26.4b1 and linens. Lastly, she replied, "Closets in the rooms." when the surveyor asked where should they NJ Exec Order 26.4b1, linens) be stored. On 04/11/2024 at 12:04 PM during the initial tour, Surveyor # 2 entered room NJ Exec Order and observed linen mixed with NJ Exec Order 26.4b1 in the chair. Further, there were pillows and more linen observed on another chair in the corner.	F 584	The untied bags of linen located on the floor in room NJ Exec Order were immediately removed from the room. The resident in room NJ Exec Order had no negative effects related to the linen in the room. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents residing on the 100 unit have the potential to be affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Director of Nursing, Director of Housekeeping and Administrator conducted rounds on unit 100 including the communal shower room, unit 100 common area and residents□ #72, 11 rooms to ensure all items were removed. Director of Nursing conducted in-service re-education to all nursing and housekeeping staff on maintaining an orderly physical environment throughout the facility. Education included bag, glove, toiletry, linen, incontinent brief, gown, towel and pillow storage. As well as table cleaning, trash and dirty linen storage/disposal. 4) How the facility will monitor its corrective actions to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 584	Continued From page 4 On 04/16/2024 at 10:22 AM, Surveyor # 2 entered room [NJ Exec Order], and observed untied bags of linen on the floor. On 04/17/2024 at 12:38 PM, during an interview with surveyor # 2, the [U.S. FOIA (b)(6)] confirmed that resident's linen should be kept in the supply closet. Secondary, the [U.S. FOIA (b)(6)] confirmed that the nursing staff was responsible for removing linen and [NJ Exec Order 26.4b1] from resident rooms. Lastly, the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] confirmed that linen and [NJ Exec Order 26.4b1] should be kept in the resident's room closet and not on their chairs. A review of the facility policy titled, "Departmental (Environmental Services) - Laundry and Linen" with a revised date of January 2014, revealed under "Washing Linen and Other Soiled Items" but not limited to, "7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts."	F 584	deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Housekeeping Director/Designee will conduct daily rounds (audits) on the 100 unit resident rooms, hallways, common area and communal shower room to ensure an orderly physical environment. Rounds will be conducted daily x 3 weeks, then weekly x 4 weeks, then monthly x 3 months. All audit findings will be presented to the QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
F 644 SS=D	N.J.A.C. § 8:39-31.4 (a) Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 644	Continued From page 5 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to conduct a new NJ Exec Order 26.4b1 assessment after a resident was newly diagnosed with a NJ Exec Order 26.4b1. This deficient practice was identified in 1 of 1 resident reviewed for NJ Exec Order 26.4b1 (Resident #54) and was evidenced by the following: On 04/15/2024 the surveyor reviewed Resident #54's electronic medical record (EMR) which included review of the NJ Exec Order 26.4b1 completed on NJ Exec Order 26.4b1, which was NJ Exec Order 26.4b and marked NJ Exec for any diagnosis of NJ Exec Order 26.4b1. A review of the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, revealed a Brief Interview of Mental Status (BIMS) score of NJ Exec Orde, indicating NJ Exec Order 26.4b1 and review of section I did not include any NJ Exec Order 26.4b1 A review of the annual MDS dated NJ Exec Order 26.4b1 indicated diagnoses of NJ Exec Order 26.4b1,	F 644	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. A new NJ Exec Order 26.4b1 assessment was completed for Resident #54. The screening NJ Exec Order 26.4b1. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with newly diagnosed mental illness have the potential to be affected. An audit was completed of residents newly diagnosed with mental illness, no other residents were found to have been affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 644	Continued From page 6 NJ Exec Order 26.4b1 noted in Section I. A review of the quarterly MDS dated NJ Exec Order 26.4b1, indicated diagnoses of NJ Exec Order 26.4b1 noted in Section I. A review of Resident #54's care plans included but were not limited to a focus of "At risk for changes in NJ Exec Orde related to , NJ Exec Order 26.4b1 . No additional NJ Exec Order 26.4 including the diagnosis of NJ Exec Order 26.4b1 was located. On 04/15/24 at 10:50 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that if a resident presents with a new diagnosis, then a new NJ Exec Order 26.4 was done and sent to the state. When asked for new NJ Exec Order 26.4 on Resident #54, after searching the EMR, SW stated, "I don't see where that is captured." "I don't see one." "A new NJ Exec Order 26.4 should've been completed." On 04/17/24 at 12:38 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated there was no policy on reevaluating NJ Exec Order 26.4b1 She stated that audits were done, but there is no regulation that they have to be updated annually. Review of facility policy "Admission Criteria", edited 06/23/22, which addressed PASRR under number 9, does not address a resident with a NJ Exec Order 26.4b1 .	F 644	The US FOIA (b)(6) was educated by the Administrator regarding completion of Preadmission Screening and Resident Review level 1 assessments when residents are newly diagnosed with a mental illness. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit 3 residents newly diagnoses with a mental illness to ensure a new Preadmission Screening and Resident Review level 1 assessment was completed. The audit will be conducted weekly x4 weeks. All audit findings will be presented to the QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 644	Continued From page 7 N.J.A.C. 8:39.5.1(a)	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 656	Continued From page 8 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined the facility failed to develop a comprehensive person-centered care plan for a resident with [redacted] This deficient practice was identified for Resident #27, 1 of 24 residents reviewed for care plans and was evidenced by the following: On 04/10/24 at 10:06 AM, during the initial tour of the facility Resident #27 told the surveyor he/she had[redacted] The surveyor asked if he/she received[redacted]medication and the resident replied, "Oh they are so busy". The surveyor asked the resident to rate the [redacted] on a [redacted] and the resident said it was a [redacted], meaning [redacted]. Review of the Admission Record revealed Resident #27 had medical diagnoses which included but were not limited to [redacted] Review of the Admission Minimum Data Set (MDS), an assessment tool dated[redacted], indicated the resident had a Brief Interview of Mental Status of[redacted], which	F 656	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #27 was discharged. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with pain have the potential to be affected. An audit was conducted on all residents with pain, no other residents were found to have been affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Licensed nurses were educated regarding implementation of comprehensive person-centered care plans for residents with pain.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 656	Continued From page 9 indicated the resident was NJ Exec Order 26.4b1. Section NJ Exec Order 26.4b1 conditions, showed the resident had NJ Exec Order 26.4b1 and was receiving NJ Exec Order medications when necessary. On 04/12/24 at 12:10 PM, the surveyor reviewed the following orders: NJ Exec Order 26.4b1, give two tablets by mouth every six hours as needed for NJ Exec Order 26.4b1 Do not exceed NJ Exec Order 26.4b1 in 24 hours. NJ Exec Order 26.4b1 NJ Exec Order 26.4 every shift for NJ Exec Order NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Give as needed for NJ Exec Order 26.4b1 On 04/12/24 at 12:24 PM, the surveyor reviewed the Medication Administration Record (MAR) which showed that for the month of NJ Exec Order 26.4b1 the resident's NJ Exec O was assessed every shift. Twice the resident had a NJ Exec Order 26.4b1 meaning NJ Exec O, and once the resident had a NJ Exec Order 26.4b1, meaning NJ Exec Order 26.4b1 On 04/15/24 at 01:17 PM, the surveyor reviewed the care plan which did not include a focus of . At the same time, the surveyor interviewed the NJ Exec Order 26.4b1 regarding the NJ Exec O care plan. The care plan was then updated with a NJ Exec Order 26.4b1 after surveyor inquiry. On 04/17/24 at 01:10 PM, the surveyor reviewed the most recent physician progress note which indicated the following documentation under the physician assessment: NJ Exec Order 26.4b1	F 656	4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing/Designee will audit 5 residents with pain to ensure a comprehensive person-centered care plan was implemented. The audit will be conducted weekly x4 weeks. All audit findings will be presented to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 656	Continued From page 10 [redacted] On 04/22/24 at 11:55 PM, the surveyor reviewed the policy titled, "Care plans, Comprehensive Person-Centered", the policy was dated 04/25/22. Under number eight it indicated that services are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. On 04/22/24 at 12:38 PM, the surveyor reviewed the policy titled, "Pain Assessment and Management", a policy dated 11/10/22. Under the section titled, "Defining Goals and Appropriate Interventions", number one indicated that the pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan.	F 656		
F 658 SS=E	NJAC 8:39-11.2 (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: NJ Complaint # NJ00169132, NJ00171624 Based on observations, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) obtain a physician's order for residents to be discharged from the facility prior to discharge, b). change a[redacted] as	F 658	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #35 was assessed by a licensed nurse. All findings were within [redacted]	5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 11 ordered by the physician (Resident #84), c.) follow physician orders to offload a residents [redacted] while in bed (Resident #467), d.) follow physician order to check for [redacted] every two hours (Resident #468), and e.) maintain medication records that were complete with staff signatures according to professional standards of clinical practice for Resident #35, 1 of 29 residents reviewed for professional standards. This deficient practice was identified for 3 of 3 residents (Residents #88, #34 and #46) on 2 of 2 nursing units ([redacted]) and 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	F 658	Resident□s #34, #46, #84, #88, #467, #468 have been discharged. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. An audit was conducted on all residents with central lines, no other residents were found to have been affected. An audit was conducted on all resident with orders for heel offloading, no other residents were found to have been affected. An audit was conducted on the Medication/Treatment administration records with corrective action taken as indicated. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Licenses nurses were educated by the Director of Nursing/Designee regarding the policy for obtaining physicians orders for discharge. Licensed nurses were educated by the Director of Nursing/Designee regarding the policy for central line dressing changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 12 restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." a. The surveyor reviewed Resident #88, Resident #34, and Resident #46's closed medical records. Review of the physician orders revealed that none of the resident's had a physician's order placed in the medical record prior to resident discharge from the facility. On 04/17/24 at 12:45 PM, during an interview with both the U.S. FOIA (b)(6)) in the presence of the survey team, the LNHA stated that she confirmed that Resident #88, Resident #34 and Resident #46 did not have a physician's order to be discharged from the facility but were required to. On 04/18/24 at 8:49 AM, the surveyor interviewed the U.S. FOIA (b)(6) and asked why Resident #88 and Resident #34 did not have discharge orders placed in their medical records prior to being discharged from the facility. NJ Exec Order 26.4b stated a discharge order was required to be obtained from the physician prior to resident discharge. U.S. FOIA (b)(6) stated the nurse must have forgotten to put the order in the computer. U.S. FOIA (b)(6) further stated that the assigned desk duty nurse was responsible to put the discharge order in the computer prior to a resident being discharged from the facility. On 04/18/24 at 8:55 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that a discharge order was required prior to resident discharge from the facility. U.S. FOIA (b)(6) stated the doctor was notified and a discharge	F 658	Licenses nurses were educated by the Director of Nursing/Designee regarding inputting orders to ensure documentation on the Medication/Treatment Administration Records. Licenses nurses were educated by the Director of Nursing/Designee regarding the policy for Medication/Treatment Administration Record omissions and timely signing of the Medication/Treatment Administration Records. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing /Designee will audit 3 residents with central lines to ensure dressing changes are completed according to facility policy. The Director of Nursing /Designee will audit 3 discharged residents to ensure discharge orders are obtained according to facility policy. The Director of Nursing /Designee will audit 3 resident Medication/Treatment Administration Records to ensure medications and treatments are signed for according to facility policy. The Director of Nursing /Designee will audit 3 residents with orders for heel offloading to ensure orders are input to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 13 order was obtained prior to resident discharge. U.S. FOIA (b)(6) stated that she was responsible to put the order in the computer. U.S. FOIA (b)(6) further stated that it must have been a nursing oversight that a discharge order not placed in the computer before Resident #46 was discharged from the facility. Review of the facility policy, "Discharging a Resident without a Physician's Approval" (Revised 10/22) revealed the following: An order for an approved discharge must be signed and dated by a physician and recorded in the resident's medical record no later than seventy-two (72) hours after the discharge. b. On 04/10/24 at 10:21 AM, during the initial tour of the facility Resident #84 was in the bed awake. The resident told the surveyor that he/she was on NJ Exec Order 26.4b1) "NJ Exec Order 26.4b1". The surveyor asked the resident about NJ Exec Order 26.4b1 access and the resident showed the surveyor a NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1 NJ Exec O and said it was a "NJ Exec Order 26.4b1 The surveyor asked if the staff were NJ Exec Order 26.4b1 or if the NJ Exec Order 26.4b had a date and the resident showed the surveyor the NJ Exec Order 26.4b that was dated NJ Exec Order 26.4b. The resident then told the surveyor that "NJ Exec Order 26.4b1 maybe they didn't NJ Exec Order 26. it because it may come out soon". Review of Resident #84's Admission Record (an admission summary) revealed that the resident had medical diagnoses which included but were	F 658	reflect documentation on the Treatment Administration Records. The audits will be conducted weekly x4 weeks. All audit findings will be presented to the QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 14 not limited to NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the most recent Minimum Data Set (MDS), an assessment tool dated [redacted], which indicated the resident had a Brief Interview of Mental Status of [redacted], which indicated the resident was NJ Exec Order 26.4b1. On 04/12/24 at 09:52 AM, the surveyor reviewed the physician orders which showed the following order dated [redacted] NJ Exec Order 26.4b1 [redacted] needleless [redacted] with weekly NJ Exec Order 26.4b1 and after [redacted]. If NJ Exec Order 26.4b1 is used, [redacted] at time of NJ Exec Order 26.4b1. [redacted] and [redacted] of any [redacted] related complications present. [redacted] is [redacted] and [redacted] & [redacted] properly [redacted] are present. After reviewing the physician orders, it revealed the resident was NJ Exec Order 26.4b1. On 04/12/24 at 10:01 AM, the surveyor reviewed the care plan which showed a focus of [redacted] and potential for complications. The care plan was initiated [redacted]. One of the interventions included: NJ Exec Order 26.4b1 per physician order and as needed if [redacted] or [redacted] On 04/12/24 at 11:42 AM, the surveyor reviewed the Treatment Administration Record (TAR) for Resident #84 which showed the resident was	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 15	F 658		

scheduled for a NJ Exec Order 26.4b1 [redacted] on NJ Exec Order 26.4b1 and it was left blank, meaning not signed as completed by the nursing staff. Further review of the TAR showed that the NJ Exec Order 26.4b1 [redacted].

On 04/17/24 at 11:48 AM, the surveyor interviewed facility Licensed Practical Nurse (Agency LPN #1) regarding care of NJ Exec Order 26 [redacted] The surveyor asked what was the date that on a NJ Exec Order 26.4b1 indicated and Agency LPN#1 said, "That is the date that it was NJ Exec Order 26.4b1 The surveyor asked how often the NJ Exec Order 26.4b1 [redacted] and Agency LPN#1 said, "weekly and as needed". The surveyor then asked where the NJ Exec Order 26.4b [redacted] would be documented when completed by the nursing staff and Agency LPN#1 said it would be documented in the Medication Administration Record (MAR) or TAR. Agency LPN#1 said, "It will pop up for the weekly changes on the MAR or TAR and there will also be an area for the as needed changes".

On 04/18/24 at 10:50 AM, the surveyor reviewed the policy titled, "Central Venous Catheter Care and Dressing Changes", a policy with a revision date of 03/2022. Under the general guidelines section of the policy, number 3 indicated to change the catheter dressing if it becomes damp, loosened or visibly soiled and at least every seven days for transparent dressing. Review of the documentation section indicated that the medical record should include the date and time the dressing was changed.

c. On 04/17/24 at 11:08 AM, the surveyor reviewed the physician orders for Resident #467 which showed an order to NJ Exec Order 26.4b1 while in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 658	Continued From page 16	F 658		

NJ Exec Order 26.4b1. It was ordered on NJ Exec Order 26.4b1.

The surveyor reviewed Resident #467 Admission Record which revealed the resident was admitted to the facility for NJ Exec Order 26.4b1. Medical diagnoses included but were not limited to NJ Exec Order 26.4b1 Review of the Admission Minimum Data Set (MDS) indicated the resident had a Brief Interview of Mental Status score of NJ Exec Orde, which indicated the resident had NJ Exec Order 26.4b1. Review of NJ Exec Order 26.4b1 indicated the resident was at risk for NJ Exec Order 26.4b1

On 04/17/24 at 11:30 AM, the surveyor reviewed Resident #467's Medication Administration Record (MAR) and the Treatment Administration Record (TAR). The order for NJ Ex Order 26.4b1 was not documented on either record.

On 04/17/24 at 11:46 AM, the surveyor reviewed the NJ Exec Order 26.4b1 task list which included NJ Ex Order 26.4b1 marked as "for your information". There was no documentation by the NJ Exec Orde that the task was completed, tolerated, or refused by the resident.

On 04/17/24 at 11:52 AM, the surveyor interviewed Agency LPN #1 regarding residents with orders to NJ Exec Order 26.4b1 while in bed and was that a task that would be documented if done. Agency LPN #1 said, "If it was a physician order it would pop up on the MAR or TAR for nursing to sign it as done".

On 04/17/24 at 1:20 PM, the NJ Exec Order 26.4b1 met with the surveyor and provided a care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 658	Continued From page 17 plan that showed NJ Exec Order 26.4b1 while in bed. The intervention was initiated on NJ Exec Order 26.4. The surveyor asked where it was documented from the order date of NJ Exec Order 26.4 until the care plan intervention was initiated on NJ Exec Order 26.4b and the U.S. FOIA (b)(responded, "I understand".	F 658		

d.) On 4/16/24 at 9:56 AM, the surveyor reviewed Resident #468's closed medical records. Review of the resident's Admission Record indicated Resident #468 was admitted to the facility with diagnosis which included but were not limited to NJ Exec Order 26.4b1 [redacted]).

Review of the resident's admission MDS indicated the resident had a BIMS score of NJ Ex[redacted]out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 18	F 658		

of 15, which indicated NJ Exec Order 26.4b1 [redacted]

Review of the physician orders included an order with a start date of NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 [redacted] Must be NJ Exec Order 26. [redacted]

Review of Resident #468's TAR for NJ Exec Order 26.4b1 [redacted] revealed the following missing or blank documentation areas for the physician's order to check placement every two hours:
NJ Exec O[redacted] 4 PM, 6 PM, 8 PM, 10PM
NJ Exec Ord[redacted] 4 AM, 6 AM
NJ Exec Ord[redacted] 4 AM, 6 AM
NJ Exec Ord[redacted] 10 AM
NJ Exec Orde[redacted] 2 PM

On 4/17/24 at 11:09 AM, the surveyor interviewed NJ Exec Orde[redacted] who stated that when administering medication or performing ordered treatments, nurses should document in the electronic medical record. She further stated there should be no blanks in the TAR and that if it is blank, it would indicate it was not done. LPN2 also informed the surveyor that there are appropriate codes to use in the TAR to indicate why a treatment was not completed, for example, if the resident was unavailable at that time, but it should still be documented and not left blank.

On 4/17/24 at 11:15 AM, the surveyor interviewed the U.S. FOIA (b) [redacted] who confirmed that there should not be any blanks in documentation on the TAR and nursing staff should use one of the available numeric codes to document why a treatment was not done. The U.S. FOIA (b)(6) [redacted] stated she did not agree with the adage "if it's not documented, it's not done" stating, "I would say it was done, just forgot to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 19 sign it." While presenting the [redacted] with the blank documentation in the resident's TAR to check for [redacted] placement, the [redacted] stated, "the resident has [redacted] on in the picture" referring to the picture used on the medical record for resident identification. Review of the facility's "Charting and Documentation" policy with edited date 5/27/2022 included but was not limited to: "4. The following information is to be documented in the resident's medical record: a. objective observations; b. medications administered; c. treatments or services performed; d. changes in the resident's condition; e. events, incidents or accidents involving the resident; and f. progress toward or changes in the care plan goals and objectives." e. According to the admission record Resident #35 was admitted with diagnoses that included, but were not limited to, [redacted] The surveyor reviewed the [redacted] Minimum Data Set, an assessment tool, and observed that the facility had identified Resident #35 as not being [redacted]. On 4/16/24 at 9:51 AM, the surveyor reviewed the March and April Medication Administration Record (MAR) for Resident #35. When medications are ordered by the physician, the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 20	F 658		

order is placed on the MAR. When administered by the nurses, the nurse will sign their initials on the MAR indicating that they have given the medication.

The surveyor noted a NJ Exec Order 26.4b1 physician's order (PO) for the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 give 1 tablet by mouth at bedtime. The surveyor observed a blank on the MAR, there were no nurse's initials indicating administration on NJ Exec Order 26.4b1. The surveyor observed a PO NJ Exec Order 26.4b1 1 capsule by mouth in the morning. The MAR had a blank on NJ Exec Order 26.4 at 2200. The surveyor observed a PO for NJ Exec Order 2 NJ Exec Order 26.4b1) NJ Exec Orde ordered on NJ Exec Order 26.4 give 1 tablet by mouth at bedtime. The MAR had blanks on the MAR on NJ Exec Order 26.4b1. The surveyor observed a PO for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 ordered on NJ Exec Order 26.4 give 1 tablet by mouth in the evening. The MAR had blanks on NJ Exec Order 2, NJ Exec Order 26.4, NJ Exec Order 26.4, and NJ Exec Order 26 at 1700. The surveyor observed a PO for NJ Exec Order 26.4b1) ordered on NJ Exec Order 26 give 1 tablet by mouth in the evening. The MAR had blanks on NJ Exec Order 26.4b1 at 1700. The surveyor observed a PO for NJ Exec Order 26.4b1 ordered on NJ Exec Order 26.4 give 1 tablet by mouth at bedtime. The MAR had blanks on NJ Exec Order 26.4b1 at 2100. The surveyor observed a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) ordered on NJ Exec Order 26.4b1 give 1 tablet two times a day. The MAR had blanks on NJ Exec Order 26.4b1 at 1700 and on NJ Exec Order 26.4 at 0900. The surveyor observed a PO for NJ Exec Order 26.4b1 give 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 21	F 658		

tablet two times a day. The MAR blanks on NJ Exec Order 26.4b1 at 1700 and on NJ Exec Order 26.4 at 0900. The surveyor observed a PO for NJ Exec Order 26.4b1 give 1 tablet by mouth every morning and at bedtime. The MAR had blanks on NJ Exec Order 26.4b1 at 0900. The surveyor observed a PO for NJ Exec Order 26.4b1 give 1 tablet every 12 hours. The MAR had blanks on NJ Exec Order 26.4b1 at 0900. The surveyor observed a PO NJ Exec Order 26.4b1 rdered on NJ Exec Order 26.4 give 1 tablet once a day. The MAR had a blank on NJ Exec Order 26.4 at 0900. The surveyor observed a PO for NJ Exec Order 26.4b1 t) ordered on NJ Exec Order 26. give 1 tablet by mouth once a day. The MAR had a blank on NJ Exec Order 26.4 at 0900.

There was no documented evidence in the medical record that Resident #35 experienced a NJ Exec Order 26.4b1 for not receiving the medications.

During an interview on 4/16/24 at 9:58 AM, Licensed Practical Nurse (LPN)1 stated that If there is a blank in the MAR the medication was not signed out. She would assume that if the MAR was not signed out, the medication was not given.

During an interview on 04/16/24 at 10:15 AM the U.S. FOIA (b)(6) stated that if the MAR is blank, it means the medication was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 658	Continued From page 22 not signed out. If not signed out there is no way of knowing if a medication was given or not. A review of facility provided policy titled " Documentation of Medication Administration" edited on 04/06/2023, reflected that administration of medication is documented immediately after it is given. Documentation of medication administration includes at minimum: g. initial, signature, and title of the person administering the medication.	F 658		
F 689 SS=D	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a safety device used to prevent residents from [redacted] was in place for 1 of 3 residents reviewed for accidents (Resident #35). This deficient practice was evidenced by: According to the admission record Resident #35 was admitted with diagnoses that included, but	F 689	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. An NJ Exec Order 26.4b1 evaluation was completed for Resident #35. Resident #35 was noted not at risk for [redacted] and the NJ Exec Order 26.4b1 order was [redacted].	5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 689	Continued From page 23 were not limited to, NJ Exec Order 26.4b1 . The surveyor reviewed the NJ Exec Order 26.4 Minimum Data Set (MDS), an assessment tool, and observed that the facility had identified Resident #35 as not being NJ Exec Order 26.4b1. The MDS reflected that Resident #35 had no NJ Exec Order 26.4b1 during the lookback period and he/she used an NJ Exec Order 26.4b1 daily. During initial tour on NJ Exec Order 26.4b1 at 10:45 AM, the surveyor observed Resident # 35 in the activity area painting. According to the Registered U.S. FOIA (b)(6)) Resident #35 utilized an NJ Exec Order 26.4b1 On 04/11/24 at 10:27 AM, the surveyor observed Resident #35 in the room NJ Exec Order 26.4b1 The resident did not have an NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1. On 04/12/24 at 9:30 AM, the surveyor observed Resident #35 in the room on the telephone. The resident did not have an NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 The surveyor spoke to a staff member who is familiar with this resident. The staff member stated that Resident #35 had never tried to leave the facility. On 04/15/24 at 10:54 AM and 12:57 PM, the surveyor observed Resident #35 in bed. The resident did not have an NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 The surveyor reviewed Resident #35's Physician's Orders. There was an order dated NJ Exec Order 26.4b1 every shift NJ Exec Order 26.4b1. Check placement	F 689	2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents at risk for elopement have the potential to be affected. An audit was conducted on all residents at risk for wandering/elopement, no other residents were found to have been affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Licensed nursing staff were educated by the Director of Nursing/Designee on the facilities elopement/wandering and wander guard policy. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing /Designee will audit all residents at risk for elopement to ensure their evaluations are accurate and their wander guards are in place/checked as ordered. The audit will be conducted weekly x4 weeks. All audit findings will be presented to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 689	Continued From page 24 and function every shift. The NJ Exec Order 26.4b1 Medication Administration Record reflected that the NJ Exec Order 26.4b1 was in place each shift from NJ Exec Order 26.4b1 A review of Resident # 35's care plans reflected a focus of NJ Exec Order 26.4b1 . The interventions included but were not limited to check for replacement and function of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) as indicated. During an interview on 04/16/24 09:51 AM, the Lisensed Practical Nurse1 (LPN1) stated that NJ Exec Order 26.4b1 require a physician's order. LPN1 furthered that the nurses check for placement and function each shift and document in the MAR. She stated that if the NJ Exec Order 26.4b1 is missing then the nurse should replace the NJ Exec Order 26.4b1 immediately. On 04/16/24 at 09:58 AM LPN1and the surveyor visualized Resident #35. LPN1 confirmed that Resident #35 should have an NJ Exec Order 26.4b1 on NJ Exec Order 26.4b but did not. LPN1 stated that she did not thouroughly check Resident #35 to ensure that the NJ Exec Order 26.4b1 was in place. During an interview on 04/16/24 at 10:10 AM, the RN/NM stated the nurses should ensure that an NJ Exec Order 26.4b1 is in place and if not on the resident it should be replaced. When the surveyor informed the U.S. FOIA (b)(6) that Resident #35 did not have an NJ Exec Order 26.4b1 in place she stated that the nurses should have replaced the NJ Exec Order 26.4b1 .	F 689	QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 689	Continued From page 25 During an interview on 04/16/24 at 12:01 PM, the [NJ Exec Order 26.4b1]) stated that the PO for the [NJ Exec Order 26.4b1] for Resident #35 was dated [NJ Exec Order 26.4b1]. She stated that Resident #35 was reassessed for the need for the [NJ Exec Order 26.4b1] in [NJ Exec Order 26.4b1] and it was determined that he/she did not need the [NJ Exec Order 26.4b1] but the PO was not updated. The [U.S. FOIA (b)(6)] stated that the nurses were not following the PO for the [NJ Exec Order 26.4b1]. A review of the facility policy Wandering and Elopements revised March 2019 reflected that the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.	F 689		
F 690 SS=D	NJAC 8:39 - 27.1 (a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 690	Continued From page 26 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and pertinent facility documentation, it was determined that the facility failed to provide appropriate and sufficient services based upon current standards of practice and the resident's comprehensive care plan to document [redacted] in the Treatment Administration Record (TAR). The deficient practice was identified for 1 of 2 residents (Resident # 72) investigated for [redacted] The deficient practice was evidenced by the following: A review of Resident # 72's Minimum Data Set (MDS; an assessment tool) dated [redacted] under section, '[redacted] revealed that he/she had an	F 690	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #72 was assessed by a licensed nurse. The resident□s [redacted] was within [redacted] were observed/reported. The interdisciplinary team met and determined that urinary output is measured at the very end of a shift, while wrapping up their shift and transferring assignments to the oncoming nurse inputting resident output data was inadvertently omitted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 690	Continued From page 27 NJ Exec Order 26.4b1 [redacted] A review of Resident # 72's Electronic Medical Record (EMR) revealed under the section, "Diagnoses" that he/she was diagnosed with NJ Exec Order 26.4b1 [redacted] A review of Resident # 72's EMR under the section, "Orders" revealed a physician's order to, "Measure and record NJ Exec Order 26.4b1 output [redacted] [every] shift every shift for NJ Exec Order 26.4b1." The order became active on NJ Exec Order 26.4b1. A review of Resident # 72's EMR under the section, "Care Plan" revealed an intervention to, 'NJ Exec Order 26.4b1 [redacted]". The intervention was initiated on NJ Exec Order 26.4b1 A review of Resident # 72's Treatment Administration Record for March, 2024 revealed blank sections of documentation to measure and record NJ Exec Order 26.4b1 every] shift on the following dates and shifts: NJ Exec Order 26.4b1 night shift blank NJ Exec Order 26.4b1 day shift blank NJ Exec Order 26.4b1 night shift blank NJ Exec Order 26.4b1 day shift blank NJ Exec Order 26.4b1 night shift blank NJ Exec Order 26.4b1 evening & night shift blank NJ Exec Order 26.4b1 day shift blank A review of Resident # 72's Treatment Administration Record for NJ Exec Order 26.4b1	F 690	2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with indwelling urinary catheters have the potential to be affected. An audit was conducted on all residents with indwelling urinary catheters, no other residents were found to have been affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Licensed nursing staff were in-serviced by the Director of Nursing/designee regarding the facilities policy for documenting output of indwelling urinary catheters. Licensed nursing staff were in-serviced by the Director of Nursing/designee that urinary catheter output should be measured and documented approximately 1 hour prior to the end of the shift to avoid inadvertent omissions on the Medication/Treatment administration record. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 690	Continued From page 28 revealed blank sections of documentation to measure and record NJ Ex Order 26.4b1 every shift on the following dates and shifts: NJ Exec Order 26.4b1 day shift blank NJ Exec Order 26.4b1 day shift blank NJ Exec Order 26.4b1 day shift blank NJ Exec Order 26.4b1 night shift blank NJ Exec Order 26.4b1 day shift blank NJ Exec Order 26.4b1 day shift blank On 04/17/2024 at 12:29 PM during an interview with the surveyor, the U.S. FOIA (b)(6) replied, "Document in the MAR [Medication Administration Record] or TAR if there is an order for it." Secondly, the U.S. FOIA (b) replied, "No" when the surveyor asked should the Treatment Administration Record be left blank. Lastly, the U.S. FOIA (b) replied, "I wouldn't say it was or was not. It could be they forgot to document it." A review of the facility policy with a revised date of August 2022, titled, "Catheter Care, Urinary" revealed under section, "Input/Output" to, "2. Follow the facility procedure for measuring and documenting input and output." A review of the facility policy titled, "Medication and Treatment Orders" did not reveal pertinent information.	F 690	The Director of Nursing /Designee will audit 3 residents with indwelling urinary catheters to ensure output is documented on the Treatment administration record. The audit will be conducted weekly x4 weeks. All audit findings will be presented to the QAPI committee for review monthly and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
F 695 SS=D	N.J.A.C. § 8:39-27.1 (a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 695	Continued From page 29 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 maintain the necessary care and maintenance of NJ Exec Order 26.4b1 equipment for 3 of 4 residents, reviewed for NJ Exec Order 26.4b1 care. This deficient practice was evidenced by the following: On 04/10/2024 at 10:02 AM during initial tour, the surveyor observed Resident # 53 NJ Exec Order 26.4b1 not labeled, and the bag that held the NJ Exec Order 26.4b1 when not in use was dated NJ Exec Order 26.4b1 ." According to the Admission Record, Resident #53 was admitted to the facility with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the Order Summary Report for resident # 53, revealed a physician order for NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1 [redacted]) every shift for NJ Exec Order 26.4b1 There was no order to change NJ Exec Order 26.4b1 weekly. On 04/15/2024 at 11:21 AM during an observation of other residents on NJ Exec Order 26.4b1, the surveyor observed Resident # 15's NJ Exec Order 26.4b1 [redacted]	F 695	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #15 and #53 was discharged. A physicians order was obtained to NJ Exec Order 26.4b1 Resident #17□s disposable NJ Exec Order 26.4b1 equipment weekly. All of Resident #17□s disposable NJ Exec Order 26.4b1 equipment was discarded, replaced and dated. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with disposable respiratory equipment have the potential to be affected. An audit was conducted on all residents with disposable respiratory equipment, no other residents were found to have been affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Licensed nursing staff were educated by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 695	Continued From page 30 NJ Exec Order 26.4b1) NJ Exec Order 2 and NJ Exec Orde laying on the bed side table not stored in a bag. The surveyor also observed Resident # 17's NJ Exec Order 26.4b1 not in a bag, and the NJ Exec Order 26.4b1 laying across the bed. A review of the Admission Record revealed, Resident # 15 was admitted to the facility with diagnoses including but not limited to, NJ Exec Order 26.4b1 A review of the Order Summary Report for resident # 15, revealed a physician order for NJ Exec Order 26 every shift for NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 every 6 hours for NJ Exec Order 26.4b1. There was no order to change . A review of the Admission Record revealed, Resident # 17 was admitted to the facility with diagnoses including but not limited to, NJ Exec Order A review of the Order Summary Report for resident # 17, revealed a physician order for NJ Exec Order 26.4b1 There was also an order to change NJ Exec Order 26.4b1 disposable supplies weekly and as needed.	F 695	the Director of Nursing/Designee on the facilities policy for storage of disposable respiratory equipment when not in use. As well as replacement of and dating of disposable respiratory equipment. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing/Designee will audit 3 residents with disposable respiratory equipment to ensure orders for replacement are in place, equipment is stored and dated according to facility policy. The audit will be conducted weekly x4 weeks. All audit findings will be presented to the QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 695	Continued From page 31 During an interview on 04/15/2024 at 11:06 AM with the surveyor, The U.S. FOIA (b)(6) said we change respiratory tubing weekly, we label the NJ Exec Order 2 and bag with the date. US FOIA (b)(6) also said the NJ Exec Order 2 is placed in the bag when not in use. When asked how do you know when to change the NJ Exec Order 2 NJ Exec Order 26.4b1 stated, "there are orders, we change them on Tuesday's" The NJ Exec Order 26.4b1 agrees there should be orders for changing the NJ Exec Order 2 weekly. During an interview on 04/15/2024 at 11:16 AM with surveyor, The US FOIA (b)(6)) said the US FOIA (b)(6) changs the NJ Exec Order 26.4b1 NJ Exec Order 2 once a week, they date the NJ Exec Order 2 and the bags. The US FOIA (b) said there aren't orders in for the weekly change due to the nurses don't change them. The US FOIA (b) agreed that NJ Exec Order 26.4b1 should be placed in the bag when not in use. A review of the facility policy titled, "Departmental (Respiratory Therapy)- Prevention of Infection" with an edited date of 03/18/2024 revealed under "Infection Control Considerations Related to Oxygen administration" 6. "Change the oxygen cannulae and tubing every seven (7) days. Or as needed."; 8. "Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use". Revealed under "Infection Control Consideration Related to Medication Nebulizers/Continuous Aerosol:" 7." Store circuit in plastic bag, marked with date and residents name, between uses."; 9. "Discard the administration "set up" every seven (7) days.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 695	Continued From page 32 N.J.A.C. § 8:39-27.1(a)	F 695		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Complaint # NJ163924 Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a U.S. FOIA (b)(6) worked 7 days a week for at least 8 consecutive hours a day for 1 of 7 days reviewed for the week of 04/30/2023 through 05/06/2023 under the Sufficient and Competent Nurse Staffing Task. The deficient practice was evidenced by the following: A review of the Nurse Staffing Report completed by the facility for the week of 04/30/2023 through 05/06/2023 revealed the facility documented one US FOIA (b)(6) as having worked on	F 727	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were noted as affected in the Statement of Deficiencies. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. No residents were identified as having been affected.	5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 727	Continued From page 33 NJ Exec Order 26.4b1 during the day shift. A review of the facility provided schedule for U.S. FOIA (b)(6) revealed the previous U.S. FOIA (b)(6) was scheduled. However, the Nurse Staffing Report, completed by the Facility revealed a resident census of 87. On 04/15/2024 at 12:49 PM during an interview with the surveyor, the U.S. FOIA (b)(6) confirmed that the previous U.S. FOIA (b)(6) was counted as the US FOIA on duty. A review of the facility policy with a revised date of August 2022 titled, "Staffing, Sufficient and Competent Nursing" revealed under the section titled, "Sufficient Staff" that, "3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RN may be scheduled more than eight (8) hours depending on the acuity needs of the resident." N.J.A.C. § 8:39-25.2 7(h)	F 727	3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The US FOIA (b)(6) was educated by the Administrator and Director of Nursing regarding ensuring the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administer/Designee will audit the nursing schedule to ensure the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The audit will be conducted weekly x4 weeks. All audit findings will be presented to the QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
F 761 SS=D	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 appropriate accessory and cautionary	F 761		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 761	Continued From page 34 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 policy review, it was determined that the facility failed to ensure that medications were stored appropriately. This deficient practice was identified in two (2) of four (4) medication carts inspected on one (1) of two (2) units. This deficient practice was evidenced by the following: On 04/12/2024, Surveyor #1 was observing medication pass on the 100 unit. At 08:40 AM, Agency Licensed Practical Nurse #2 (Agency LPN #2) left medication cart 2 in the hallway, locked, with a grey box of individual medication envelopes on top of the cart, in the hallway on the opposite side of the hallway from room [redacted] while he went into room [redacted] to take the resident's vital signs. Surveyor #1 stayed with the medication	F 761	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The medication totes (grey box holding individual medication envelopes) were immediately placed into the drawer of the medication cart which was then securely locked by the nurses (Agency Licensed Practical Nurse #2 and Agency LPN#3). Agency LPN#2 and Agency LPN#3 were immediately provided in-service re-education on proper storage of medication totes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 761	Continued From page 35 cart. While Agency LPN #2 was in room [NJ Exec O] another resident wheeled past the medication cart. When Agency LPN #2 came back to the medication cart at 08:43 AM, Surveyor #1 asked if the cart should've been left in the hallway the way it was. Agency LPN #2 stated, "Sorry, the medications should not have been left on top of the cart." On 04/12/2024 at 09:07 AM, Surveyor #1 approached medication cart 3 on the [NJ Exec O] unit and noted a grey box with individual medication envelopes on top of the locked unattended medication cart. When Agency LPN #3 approached the medication cart, Surveyor #1 asked if the medication cart should've been left in the hallway as it was. Agency LPN #3 stated that the cart was okay, then added that she's only been to this facility a few times. On 04/12/24 at 09:23 AM, Surveyor #1 interviewed the [U.S. FOIA (b)(6)] who stated that the grey boxes with medication envelopes should not be left on top of the medication carts if the medication nurses walk away from the cart. On 04/17/24 at 12:35 PM, Surveyor #1 interviewed the [U.S. FOIA (b)(6)] who stated that the individual medication envelopes should not have been left on top of the medication cart unattended. A review of the facility policy "Administering Medications" edited on 5/21/19, revealed: #19. "During administration of medications ... No medications are kept on top of the cart. ..." On 04/11/2024 at 10:37 AM during a tour of the [NJ Exec O] Unit communal shower room, Surveyor # 2	F 761	There were no residents identified as having a [NJ Exec Order 26.4b1] by the storage of the medication totes. The (2) sealed bottles containing Acetic Acid Irrigation Solution 1000ml were immediately removed from the cabinet in the 200-unit communal shower room and discarded by the Unit Manager in the appropriate means. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Director of Nursing immediately provided verbal education as well as visual aids including demonstration to Agency LPN #2 and Agency LPN #3 on the proper storage of the medication totes, including the need to maintain the totes in the drawer of the securely locked medication cart when not in use. Agency LPN #2 and Agency LPN #3 returned demonstration of the skill for proper storage of the medication tote. The Director of Nursing provided in-service re-education to all nurses on the proper storage of medication totes when not in use – totes are to be stored in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 761	Continued From page 36 observed two, sealed plastic bottles filled with clear liquid located in an opened cabinet on the wall. Upon closer observation, the bottles both had pharmacy labels. The labels revealed that the bottles contained, NJ Exec Order 26.4b1 [redacted]). The labels revealed the name of an unsampled resident. On the same date at 10:41 AM during an interview with Surveyor # 2, U.S. FOIA (b)(6) [redacted] replied "I didn't know these were in here and they should not be in here." when Surveyor # 2 asked is there a any reason the bottled were in there. U.S. FOIA (b)(6) confirmed that the bottles belong in a medication cart or in the medication room. On 04/17/2024 at 12:29 PM during an interview with Surveyor # 2, the U.S. FOIA (b)(6) [redacted]) replied, "No" when asked if prescribed medications be stored in the shower room cabinets. The U.S. FOIA (b) [redacted] confirmed that prescribed medications should be stored in a treatment cart of medication cart. A review of the facility policy titled, "Medication Labeling and Storage" revised February 2023 revealed under, "Policy Heading" that, "The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls..."	F 761	the securely locked medication cart. The Director of Nursing provided in-service re-education to nurses on the facility's policy on the proper storage of drugs and biologicals. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing/designee will conduct daily rounds x 2 weeks, then weekly rounds x 4 weeks, then monthly rounds x 3 months to audit proper storage of drugs and biologicals including medication totes when not in use. The Director of Nursing/designee will provide on-the-spot re-education as needed to the nurses. The results of the audits will be presented to the QAPI committee monthly x 3 months. The QAPI committee will review and determine the need for further audits or action as needed.	
F 812 SS=D	N.J.A.C. 8:39-29.4(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 812	Continued From page 37 §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: Based on observation, interview, and pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness in 1 of 2 Pantries, Pantry on Unit 1. This deficient practice was evidenced by the following: On 04/12/2024 at 09:42 AM during observations of the pantry on Unit 1, the surveyor observed 3 frozen meals, and a container of rice pudding not labeled in the freezer. On 04/16/2024 at 10:11 AM during a second observation of the pantry on Unit 1, the surveyor observed, a burger not labeled or dated in the refrigerator. Also observed in the refrigerator was a muffin tin covered with in foil with the edge	F 812	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were noted as affected in the Statement of Deficiencies. All unlabeled and uncovered items were discarded. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 812	Continued From page 38 folded back and a muffin exposed, and a cup with pink liquid without a lid not dated or labeled. During an interview with the surveyor on 04/10/2024 at 09:22 AM, the US FOIA (b)(6) [redacted] they said that the pantries on the nursing floor are managed by housekeeping and nursing. During an interview with the surveyor on 04/16/2024 at 10:13 AM with Licensed Practical Nurse (LPN) # 3. The LPN # 3 stated "all food should be labeled and dated, if they aren't they get thrown away." During an interview with the surveyor on 04/17/2024 at 10:01AM, the U.S. FOIA (b)(6) [redacted] said all food should be labeled and dated. When asked if all food should be covered the [redacted] replied with "yes". During an interview with the surveyor on 04/17/2024 at 10:33 AM, the U.S. FOIA (b)(6) [redacted] stated, "the golden rule is that if it is not labeled it is thrown out." A review of a facility provided policy revised on March 2022 titled "Foods Brought by Family/Visitors" revealed under, "Policy Interpretation and implementation" that "5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility food." The policy also revealed under section 5., "b. Perishable foods are stored in re-sealable containers with tight-fitting lids. Containers are labeled with the resident's name, the item and the "use by" date."	F 812	An audit was conducted on all food storage areas, no residents were identified as having been affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Nursing and housekeeping staff were educated by the Administrator regarding the facility policy on Food Brought by Family/Visitors. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Housekeeping/Designee will audit unit pantries to ensure food/drink is stored and labeled according to facility policy. The audit will be conducted weekly x4 weeks. All audit findings will be presented to the QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(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 812	Continued From page 39 N.J.A.C. 18:39-17.2(g)	F 812		

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
	156002	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaints: NJ # 170784, 171624, 163924, 152604, 152868, 153743, 158278, 167786, 169132, 168547 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint: # 163924, 171624, 170784, 167786, Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility leadership team has met on ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified staffing needs. 2) How the facility will identify other residents having the potential to be	5/3/24

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

Electronically Signed | 04/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156002	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 04/30/2023 to 05/06/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -05/01/23 had 7 CNAs for 78 residents on the day shift, required at least 10 CNAs. -05/02/23 had 6 CNAs for 77 residents on the day shift, required at least 10 CNAs. -05/03/23 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs. -05/04/23 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -05/05/23 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -05/06/23 had 5 CNAs for 84 residents on the day shift, required at least 10 CNAs.	S 560	affected by the same deficient practice. Any resident has the potential to be affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The facility has implemented a significant above market rate for nurses and certified nursing assistants (see attachment), tuition reimbursement (see attachment), and employee referral bonus programs (see attachment). The facility has implemented an incentive program including referral bonuses for employees referring staff where appropriate. The facility continues to conduct ongoing job fairs, internally and externally with immediate interviews and contingency offers. The facility implemented an expedited onboarding process to new hires. The facility will use agency staff as needed to meet staffing needs. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The DON and/or Designee meets with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156002	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 2. For the 2 weeks of Complaint staffing from 05/21/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -05/21/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/22/23 had 6 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/23/23 had 8 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/24/23 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/25/23 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/26/23 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/27/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/28/23 had 11 CNAs for 90 residents on the day shift, required at least 12 CNAs. -05/28/23 had 6 total staff for 99 residents on the overnight shift, required at least 7 total staff. -05/29/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -05/29/23 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -05/30/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -06/01/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -06/02/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -06/03/23 had 7 CNAs for 100 residents on the day shift, required at least 12 CNAs.	S 560	staffing coordinator daily to review facility census, call outs if any, and staffing needs. The DON and/or Designee will monitor call outs and staffing ratios weekly until the requirement is met. The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156002	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 3. For the 2 weeks of Complaint staffing from 12/17/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/17/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -12/18/23 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. -12/19/23 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. -12/20/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -12/21/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -12/22/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -12/23/23 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -12/24/23 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -12/25/23 had 7 CNAs for 103 residents on the day shift, required at least 13 CNAs. -12/26/23 had 7 CNAs for 103 residents on the day shift, required at least 13 CNAs. -12/27/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -12/28/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/29/23 had 8 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/30/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. 4. For the 2 weeks of Complaint staffing from 02/11/2024 to 02/24/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 3 of 14 overnight shifts as follows:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156002	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 -02/11/24 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/12/24 had 8 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/13/24 had 8 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/14/24 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/14/24 had 8 total staff for 121 residents on the overnight shift, required at least 9 total staff. -02/15/24 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/16/24 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/17/24 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -02/17/24 had 8 total staff for 123 residents on the overnight shift, required at least 9 total staff. -02/18/24 had 10 CNAs for 123 residents on the day shift, required at least 15 CNAs. -02/19/24 had 7 CNAs for 119 residents on the day shift, required at least 15 CNAs. -02/20/24 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/21/24 had 9 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/22/24 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/23/24 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/24/24 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -02/24/24 had 6 total staff for 112 residents on the overnight shift, required at least 8 total staff. 5. For the 2 weeks of staffing prior to survey from 03/24/2024 to 04/06/2024, the facility was deficient in CNA staffing for residents on 13 of 14	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156002	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 day shifts, deficient in total staff for residents on 2 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 3 of 14 overnight shifts as follows: -03/24/24 had 7 CNAs for 103 residents on the day shift, required at least 13 CNAs. -03/24/24 had 6 total staff for 103 residents on the overnight shift, required at least 7 total staff. -03/25/24 had 7 CNAs for 103 residents on the day shift, required at least 13 CNAs. -03/25/24 had 9 total staff for 103 residents on the evening shift, required at least 10 total staff. -03/25/24 had 3 CNAs to 9 total staff on the evening shift, required at least 4 CNAs. -03/25/24 had 6 total staff for 103 residents on the overnight shift, required at least 7 total staff. -03/26/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -03/27/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -03/29/24 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -03/30/24 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -03/31/24 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -04/01/24 had 4 CNAs for 103 residents on the day shift, required at least 13 CNAs. -04/02/24 had 5 CNAs for 103 residents on the day shift, required at least 13 CNAs. -04/03/24 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -04/04/24 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -04/05/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -04/05/24 had 7 total staff for 106 residents on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156002	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6 the overnight shift, required at least 8 total staff. -04/06/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -04/06/24 had 10 total staff for 106 residents on the evening shift, required at least 11 total staff. -04/06/24 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff. On 04/17/24 at 12:29 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) replied, "Yes" when the surveyor asked if she was aware of the New Jersey staffing law. The LNHA concluded by stating, "We hire and have the employees to meet that ratio."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315464 Y1	A. Building B. Wing Y2	6/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

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 F0584	Correction	ID Prefix F0644	Correction	ID Prefix F0656	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	05/03/2024	LSC	05/03/2024	LSC	05/03/2024
ID Prefix F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0690	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	05/03/2024	LSC	05/03/2024	LSC	05/03/2024
ID Prefix F0695	Correction	ID Prefix F0727	Correction	ID Prefix F0761	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	05/03/2024	LSC	05/03/2024	LSC	05/03/2024
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/03/2024	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	
4/18/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315464	A. Building B. Wing	6/18/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 05/03/2024	ID Prefix F0727 Reg. # 483.35(b)(1)-(3) LSC	Correction Completed 05/03/2024	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
156002	A. Building B. Wing	6/18/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/03/2024	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	
4/18/2024	☐ 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
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 Care One at Evesham is a single (1) story, Type II (protected construction) and was built in August 2000. The facility is divided into 6-smoke zones. The exterior 50 KW diesel generator does approximately 40% of the building. The facility is licensed for 144 beds and at entrance was occupying 102 beds.	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 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	K 222		5/3/24

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

Electronically Signed | 04/29/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 222	Continued From page 1 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 REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/16/24, in the presence of U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that egress doors equipped with a delayed 15-second egress feature were labeled with a sign that read, "Push Until Alarm Sounds, Door	K 222	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The #6 exit/egress door was labeled with a sign that reads "Push Until Alarm	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 222	Continued From page 2 Can Be Opened in 15-Seconds." This deficient practice had the potential to affect 51 residents who resided at the facility and was evidenced for 1 of 5 egress doors by the following in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.4(2). At 10:45 AM, the surveyor,U.S. FOIA (b)(6) observed at the #6 exit/egress door, that the set of door's were equiped with a with a delayed 15-second egress feature, but the set of doors were not provided with a sign indicating: "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." TheU.S. FOIA (b)(6) both confirmed the above findings during the observation. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/16/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.2.2.2.4(2) NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(4)	K 222	Sounds, Door Can Be Opened in 15-Seconds." (see attachment 'K222') 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. An audit was conducted on all egress doors equipped with a delayed 15-second egress feature to ensure appropriate signage was in place. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Environmental Services Director educated the facility's US FOIA (b)(6) regarding appropriate signage for egress doors equipped with a delayed 15-second egress feature. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit all egress doors equipped with a delayed 15-second egress feature for appropriate signage. The audit will be conducted weekly x4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 222	Continued From page 3	K 222	weeks, then monthly x 3 months. All audit findings will be presented to the QAPI committee monthly x 3 months for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews conducted on 4/16/24, in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. This deficient practice was observed in 2 of 4 areas and had the potential to affect 51 residents who resided at the facility and was evidenced by the following: 1). At 11:16 AM, the surveyor, in the presence of the U.S. FOIA (b)(6), observed in the 200-side day room that 2 wall light switches shut-off all 6 light fixtures in the occupied day- room (11-residents). 2). At 12:15 PM, the surveyor, in the presence of	K 281	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Electrician contracted to install lighting connected to generator to ensure continuous illumination of the means of egress in the 200-side day room and main dining room, permit pending. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	6/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 281	Continued From page 4 the [redacted] observed in the main occupied dining room, (12- residents) that 4-wall light switches shut-off 16 light fixtures. The areas were not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The U.S. FOIA (b)(6) both confirmed the finding's at the time of observations. The US FOIA (b)(6) was informed of these findings at the Life Safety Code survey exit conference on 4/16/24. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	An audit was conducted on all means of egress to ensure continuous illumination in operation or capable of automatic operation without manual intervention. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Environmental Services Director educated the facility's US FOIA (b)(6) [redacted] regarding the requirement for continuous illumination of the means of egress in operation or capable of automatic operation without manual intervention. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit all means of egress to ensure continuous illumination in operation or capable of automatic operation without manual intervention. The audit will be conducted weekly x4 weeks, then monthly x 3 months. All audit findings will be presented to the QAPI committee monthly x 3 months for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 281	Continued From page 5	K 281	*Photos will be provided once completed. Pending completion of project.	
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 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 4/16/24,	K 321	1) How the corrective action will be	5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 321	Continued From page 6 in the presence of the U.S. FOIA (b)(6) [redacted] 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 in 7 of 9 hazardous storage areas observed and had the potential to affect 51 residents who resided at the facility and was evidenced by the following: 1.) At 10:32 AM, the surveyor, U.S. FOIA (b)(6) observed in resident room #115, that the room was being used for hazardous storage. The room was greater than 50 square feet in size and required an auto-close device installed on the door. The room was observed to have old wooden furniture, mattresses and filled combustible cardboard boxes. The U.S. FOIA (b)(6) confirmed that resident room #115 was converted into a temporary storage room and required a door with a self-closing device. 2.) At 10:49 AM, the surveyor, U.S. FOIA (b)(6) observed in utility wing of the facility, that the following doors were compromised from be identified with a fire rating: Laundry soiled clothes entrance, door label is painted over. Kitchen door, door label is painted over. Kitchen door to the dining room, door label is painted over.	K 321	accomplished for those residents found to have been affected by the deficient practice. Room #115 was equipped with an auto-close device (see attachment #321 Room #115 auto-close device") and the old wooden furniture, mattresses and cardboard boxes were removed. (see attachment #115 Room) The painted over door labels in the Laundry soiled clothes entrance, kitchen door, kitchen door to the dining room, environmental services storage room, main electrical room, and mechanical room, were cleaned and all paint was removed. (see attachment "K321 Painted Over Door Labels") 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. An audit was conducted on all hazard storage areas to ensure auto-closure devices and free from unnecessary combustible materials. An audit was conducted on all fire rated doors to ensure labels were visible. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 321	Continued From page 7 Environmental services storage room, door label is painted over. Main electrical room, door label is painted over. Mechanical room, door label is painted over. The[redacted], both confirmed the findings during the observations. The[redacted] was informed of the findings at the Life Safety Code Exit Conference on 4/16/24. NJAC 8:39-31.2(e)	K 321	The Regional Environmental Services Director educated the facility's [redacted] regarding hazardous storage requirements and fire rating door label visibility. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit all hazardous storage areas to ensure that fire-rated doors to hazardous areas were self-closing and free from unnecessary combustible materials, labeled and were separated by smoke resisting partitions and to ensure that fire rating door labels are visible. The audit will be conducted weekly x4 weeks, then monthly x 3 months with results reported to QAPI committee monthly. All audit findings will be presented to the QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces	K 347		6/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 347	Continued From page 8 open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/16/24, in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that areas open to the corridor were provided with smoke detection in accordance with NFPA 101, 2012 Edition, Section 19.3.6.1 and 19.3.4.5.2. This deficient practice could affect 51 residents and was observed in 1 of 1 occupied open areas by the following: At 10:50 AM, the surveyor, U.S. FOIA (b)(6) observed in the 200 open occupied day room open to the corridor by the nurse station, was not provided with smoke detection. The U.S. FOIA (b)(6) both confirmed the finding, at the time of the observation. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 4/16/24. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 347	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Electrician contracted to install smoke detection in the 200 open day room, permit pending. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. An audit was completed on all facility areas to ensure all areas were equipped with proper smoke detection. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The US FOIA (b)(6) [redacted] educated by the Regional Environmental Services Director regarding the requirement for all areas open to the corridor being provided with smoke detection. Quote from electrician, Purchase Order Number submitted to NJ Department of Health via email. 4) How the facility will monitor its	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 347	Continued From page 9	K 347	corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit all areas open to the corridor to ensure proper smoke detection. The audit will be conducted weekly x4 weeks, then monthly x 3 months. Fire protections preventative maintenance program will inspect the facility for proper smoke detection every 6 months. The QAPI committee meets on a monthly basis. All audit findings will be presented to the QAPI committee for review and action as appropriate, monthly. The QAPI committee will determine the need for further audits and/or action as indicated.	
K 353 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	K 353		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 353	Continued From page 10 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 This REQUIREMENT is not met as evidenced by: Based on interview and record review on 4/15/24, in the presence of the[redacted] it was determined that the facility failed to a.) ensure that 5 of 5 private property fire hydrants were flow tested as per the National Fire Protection Association (NFPA) 20, 25; and b.) to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC 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.c). maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25, This deficient practice was evidenced for the following fire sprinkler system issues, and had the potential to affect 102 residents who resided at the facility and was evidenced by the following: a). At 9:30 AM, the surveyor reviewed all related documentation from the fire sprinkler vendor with the most recent report dated: 3/29/24. The report from the facility vendor indicated under deficiencies that 5 of 5 fire hydrants, did not have the required 5-year flow test and the facility could not provide any prior records indicating so as required by NFPA 25.	K 353	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The 5 fire hydrants were flow tested by approved vendor. The ceiling tiles in the med room and in physical therapy were replaced. (see attached "#353 Ceiling Tiles) The 5 year internal obstruction inspection of the sprinkler system pipe was completed. The out of service dry valve was replaced. (see attached "#353 Out of Service Valve) The results of the quick response sprinklers testing were obtained. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. An audit was completed on all ceiling tiles	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 353	Continued From page 11 The U.S. FOIA (b)(6) indicated that the flow test was scheduled, but not currently completed. b)-1, At 10:15 AM, the surveyor accompanied by the U.S. FOIA (b)(6) observed in the med room across from the therapy gym, that a 2' x 2' ceiling tile had a broken corner. b)-2, At 11:07 AM, the surveyor accompanied by the U.S. FOIA (b)(6) observed physical therapy closet, that a 2' x 2' ceiling tile was warped with stains not fitting into the drop ceiling tile channels, also conduit pipe was installed into the drop ceiling and the ceiling tiles were over cut leaving an approximately 1" gap around the pipe. The U.S. FOIA (b)(6) both confirmed the findings above during the observations. c)-1, On 4/15/24 the surveyor reviewed all fire sprinkler documentation from the facility vendor. The most recent report dated: 2/12/24 indicated: the required 5-year internal obstruction investigation of the pipe was conducted 5/5/2018, over 5-years 11 months ago. The U.S. FOIA indicated it was scheduled but currently not completed as of 4/16/24. c)-2, On 4/15/24 the surveyor reviewed all fire sprinkler documentation from the facility vendor. The most recent report dated: 2/12/24 indicated: The dry system accelerator is currently out of service, dry valve is a reliable model D. The valve needs to be repaired or replaced as per the vendor documentation. The U.S. FOIA indicated the repair was scheduled but currently not completed as of 4/16/24.	K 353	to ensure there were no areas of penetration. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Environmental Services Director educated the facility's US FOIA (b)(6) regarding requirement for annual fire hydrant flow testing, ceiling tiles remaining free from penetrations, requirement for internal obstruction inspection of the sprinkler system pipe done every 5 years with results and completing required repairs/replacements based on fire sprinkler testing/inspection documentation from the facility vendor. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit ceiling tiles for penetration during facility rounds. The audit will be conducted weekly x4 weeks, then monthly x 3 months with findings reported to QAPI committee monthly x 3 months. The Maintenance Director will submit all sprinkler testing/inspections to the administrator for review quarterly to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 353	Continued From page 12 c)-3, On 4/15/24 the surveyor reviewed all fire sprinkler documentation from the facility vendor. The most recent report dated: 2/12/24 indicated: the quick response sprinklers were sent out for testing on: 1/28/22, and the test results are unknown if the sprinklers passed or failed. The [redacted] indicated he was not aware of the test results and he would call the facility vendor. No further information was provided at the LSC exit on 4/16/24. The [redacted] was notified of the findings at the Life Safety Code exit conference on 4/16/24. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 13 NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems	K 353	ensure all systems functioning, results are noted and repairs/replacements are completed in a timely manner. The Maintenance Director will submit results of fire hydrant flow testing to the administrator for review annually to ensure timely completion. All audit findings will be presented to the QAPI committee monthly for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
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	K 363		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 363	Continued From page 13 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 REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/16/24, in the presence of the NJ Exec Order 26.4b1 [redacted], it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified in 21 of 38 resident rooms observed, and was evidenced by the following:	K 363	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Doors #101, #212, #228 and $240 were adjusted to prevent it from rubbing into the frame. (see attachment "Doors") #228 door frame was repaired. (see attachment "Doors") #109: The latch, strike plate was installed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 363	Continued From page 14 During the building tour on 4/16/24, from 9:15 AM to 12:45 PM, the surveyor, in the presence of the U.S. FOIA (b)(6) toured the facility and observed the following compromised resident room doors in the following areas: #101: door rubs onto its frame #109: will not latch, strike plate missing #111: loose hardware #114: door is warped at the top #117: door is warped at the top #118: door is warped at the top #120: door is warped at the top #122: door is warped at the top #123: door is warped at the top #125: door is warped at the top #202: top of door is warped #203: door hits the latch and will not close, loose hardware #206: loose hardware #208: striker plate is bent, door will not latch properly #212: door rubs into its frame #228: door rubs onto the top of its frame, door finish damaged #229: loose hardware #235: loose hardware #237: loose hardware #240: loose hardware and door rubs onto its frame #241: loose hardware At the time of observations, the surveyor interviewed the U.S. FOIA (b)(6), who both confirmed the above findings. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/16/24.	K 363	(see attachment "Doors") The loose hardware noted on doors #111, #241, #206, #203, #229, #235 and #237: was tightened/replaced. (see attachment "Doors") #208: The striker plate was replaced. (see attachment "Doors") #203: The door latch was adjusted to allow the door to close. (see attachment "Doors") The warped doors #114, #117, #118, #120, #122, #123, #125 and #202 were replaced. (see attachment "Doors") 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. An audit was completed on all corridor doors to ensure that they are able to resist the passage of smoke 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Environmental Services Director educated the facility's US FOIA (b)(6) regarding requirements for corridor door inspection to ensure that they are able to resist the passage of smoke as well as completing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 363	Continued From page 15 NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	timely repairs/replacements. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit corridor doors during facility rounds to ensure they able to resist the passage of smoke. The audit will be conducted weekly x4 weeks, then monthly x 3 months, with results reported to the Administrator. All audit findings will be presented to the QAPI committee monthly x 3 months for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 511	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/16/24, in the presence of[NJ Exec Order 26.4b1 [redacted]), it was determined that the facility failed to maintain electrical panels free of obstructions that would delay access to the panels in an emergency. This deficient practice had the potential to affect 102 residents who resided at the facility and was evidenced for 2 of 4 electrical rooms observed by the following: 1. At 10:22 a.m., the surveyor, [NJ Exec Order 26.4b1], observed in the Long Term care wing, that 5-electrical panels (EB, PB-1, PB-2, LB-1 and LB-2) in the electric closet were blocked by boxes and miscellaneous open boxes of maintenance parts. 2. At 10:42 a.m., the surveyor, [NJ Exec Order 26.4b1] observed in the maintenance shop electrical closet, that boxes of floor tiles were blocking the DE electrical wall panel. An interview was conducted with the[U.S. FOIA (b)(6) [redacted] at the time of the observation's, who both stated and agreed that the electrical panel's must be kept free of any obstructions that would delay shutting breakers off in the event of an emergency. The[US FOIA (b)(6)] was informed of the finding's at the Life Safety Code exit conference on 4/16/24. NJAC 8:39-31.2(e) NFPA 70-2011 article 110.26(A)	K 511	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The items blocking the electrical panels on the long-term care wing and maintenance shop were immediately removed. (see attached "Electrical panels") 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. An audit was completed to ensure all electrical panels were unobstructed 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Environmental Services Director educated the facility's [US FOIA (b)(6) [redacted] regarding ensuring electrical panels are maintained free from obstruction. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 511	Continued From page 17	K 511	put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit electrical panels during facility rounds to ensure they are free from obstruction. The audit will be conducted weekly x4 weeks, then monthly x 3 months. All audit findings will be presented to the QAPI committee monthly x 3 months for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 4/16/24, in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to conduct in-house and/or vendor fire drills	K 712	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 712	Continued From page 18 with varying activation types and simulation of emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice had the potential to affect 102 residents who resided at the facility and was evidenced by the following: Based on document review and interview on 4/15/24, with the U.S. FOIA (b)(6) the facility fire drill reports revealed method for the simulation of emergency fire conditions and alarm transmission signals were not varied: Date: type of alarm transmission signal: Pull, Smoke or Page - 3/13/24 in-house transmission signal-undetermined - 2/17/24 in-house transmission signal-undetermined - 1/15/24 in-house transmission signal-undetermined - 12/5/23 in-house transmission signal-undetermined - 11/ /23 missing drill - 10/12/23 transmission signal-undetermined - 9/9/23 transmission signal-undetermined - 8/23/23 transmission signal-undetermined - 7/19/23 transmission signal-undetermined - 6/8/23 transmission signal-undetermined - 5/25/23 transmission signal-undetermined - 4/20/23 transmission signal-undetermined	K 712	Fire drills were conducted with varying activation types and simulation of emergency fire conditions. The varying activation types and simulation of emergency fire conditions were documented on the fire drill documentation 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Environmental Services Director educated the facility's US FOIA (b)(6) regarding the requirement for fire drills to have varying activation types and simulation of emergency fire conditions documented on drill documentation. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit fire drill documentation to ensure fire drills have varying activation types and simulation of emergency fire conditions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 712	Continued From page 19 The findings were verified by the NJ Exec Order 26.4b1 at the time of record review. They indicated that currently the fire drills were not descriptive as to the type of device used to activate the fire alarm system, (pull, page and smoke) including the location and type of fire simulation used to train staff members on the above dates. The US FOIA (b)(6) was informed of the finding, at the Life Safety Code exit conference on 4/16/24. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712	The audit will be conducted monthly x3 months. All audit findings will be presented to the QAPI committee monthly x 3 months for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
K 918 SS=E	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		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 20 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 4/16/24, in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure a remote manual stop station for their exterior 50 KW diesel generator was installed, providing emergency power to approximately 40% of the Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice had the potential to affect 102 residents who resided at the facility and was evidenced by the following: At 10:40 AM, the surveyor, US FOIA (b)(6) [redacted] observed the 50 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location.	K 918	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. An electrician has been contracted to install remote manual stop station for the 50 kilowatt diesel generator, permit pending. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The US FOIA (b)(6) [redacted] was educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 21 An interview was conducted during the time of the observation with the U.S. FOIA (b)(6), who both stated and confirmed that the 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. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/16/24. 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	by the Administrator regarding the requirement for the 50 kilowatt diesel generator to have a remote manual stop station. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit the remote stop station function monthly. The audit will be conducted monthly x3 months. All audit findings will be presented to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and/or action as indicated.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 920	Continued From page 22 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/16/24, in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard and was identified in four (4) of eight (8) areas observed and had the potential to affect 102 residents who resided at the facility and was evidenced by the following: 1. At 10:18 AM, the surveyor, NJ Exec Order 26.4b1 observed in the business office, that a printer was plugged into an orange extension cord. The orange extension cord was then plugged into a multi-outlet power strip, that was then plugged	K 920	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The brown household extension cord in the business office was immediately removed and discarded. The household extension cord in room #108 was immediately removed and discarded. The household extension cord in the maintenance office was immediately removed and discarded. (se The refrigerator in social services was immediately plugged directly into the duplex wall outlet and power strip was removed. All supporting photos, appropriately labeled, provided to the Department of Health via email attachment. 2) How the facility will identify other residents having the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING 01 B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(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 920	Continued From page 23 into a duplex wall outlet. 2. At 10:22 AM, the surveyor, U.S. FOIA (b)(6) observed in the social services that a refridgerator was plugged into a multi-outlet power strip. The power strip was then plugged into a duplex wall outlet. 3. At 10:48 AM, the surveyor, U.S. FOIA (b)(6) observed in resident room #108 that at bed #1, a brown household grade extension cord was plugged into a resident's personnel fan and phone charging plug. The brown extension cord was then plugged into a duplex wall outlet. 4. At 11:42 AM, the surveyor, U.S. FOIA (b)(6) observed in the maintenance office, that a brown household grade extension cord was plugged into a duplex wall outlet. The brown extension cord did not have anything plugged into it at the time of survey. The U.S. FOIA (b)(6) both confirmed the finding's, during the observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code Exit Conference on 4/16/24. NJAC 8:39-31.2(e)	K 920	affected by the same deficient practice. All residents have the potential to be affected. An audit of all facility areas was completed to ensure appropriate use of extension cords and power strips in the facility. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The US FOIA (b)(6) was educated by the Regional Environmental Services Director regarding appropriate use of extension cords and power strips in the facility. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Administrator/Designee will audit the facility for inappropriate use of extension cords and power strips during facility rounds. The audit will be conducted weekly x4 weeks, and monthly x 3 months with results reported to QAPI committee monthly. All audit findings will be presented to the QAPI committee monthly for review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING **01** B. WING _____	**04/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	**870 EAST ROUTE 70** **MARLTON, NJ 08053**

(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 920	Continued From page 24	K 920	action as appropriate. The QAPI committee, that meets on a monthly basis, will determine the need for further audits and/or action as indicated.	

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
315464 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

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	06/03/2024	LSC K0281	05/03/2024	LSC K0321	05/03/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0347	06/14/2024	LSC K0353	05/03/2024	LSC K0363	05/03/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0511	05/03/2024	LSC K0712	05/03/2024	LSC K0918	05/03/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0920	05/03/2024	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	
4/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO