STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING ______ B. WING ______	06/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: 06/04/24 to 06/07/24 CENSUS: 23 SAMPLE SIZE: 12 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		7/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to a.) identify and NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 and b.) follow interventions implemented on the Care Plan (CP) for a resident identified as having NJ Exec Order 26.4b1. This deficient practice was identified for 1 (one) of 2 (two) residents (Resident #117) reviewed for NJ ex order 26.4b1 and was evidenced by the following: The Admission Record dated NJ Exec Order 26.4b indicated that Resident #117 had diagnoses which included, NJ ex order 26.4b1 The quarterly Minimum Data Set (MDS), an assessment that facilitates a resident's care, dated NJ ex order 26.4b1, indicated that the resident had NJ ex order 26.4b1 On 06/04/24 at 07:06 PM during tour, the surveyor observed Resident #117 lying in bed with the NJ Exec Order 26.4b1. The surveyor observed that the resident NJ ex order 26.4b1 The resident was not able to be interviewed due to NJ ex order 26.4b1. The surveyor also observed that the NJ ex order 26.4b1, and the NJ ex order 26.4b1. On 06/05/24 at 12:12 PM, the surveyor observed Resident #117 NJ ex order 26.4b1	F 610	1. Resident #117's NJ ex order 26.4b1 was immediately replaced during survey. The intervention of NJ ex order 26.4b was entered onto the TAR for shift-to-shift confirmation of compliance. 2. Director of Nursing and/or designee will complete skin checks for all Willowbrooke Court residents by 7/8 to ensure all bruises are identified with interventions in place. Root cause analysis will be completed to identify potential cause of bruising with appropriate interventions implemented. 3. Willowbrooke Court Staff will receive in-service education specific to their role, responsibility in identifying and reporting a bruise and taking proper follow-up actions by 7/8. Weekly skin checks will continue to be completed on all residents as per policy. All findings will be communicated and addressed appropriately. 4. Residents with cognitive deficits are potentially at higher risk to be affected by this deficient practice. An incident will be completed if the resident is cognitively impaired and unable to explain how his/her skin integrity is compromised. 5. Every bruise will be discussed daily in morning meeting. A bruise of unknown origin will be investigated thoroughly and interventions will be documented directly on the care plan. 6. Director of Nursing or designee will place appropriate interventions on the MAR or TAR for the nurse to ensure	

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F 610	Continued From page 2 The resident was NJ Exec Order 26.4b1 with the surveyor. The surveyor observed that both the resident's NJ ex order 26.4b1, and the surveyor NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] on the NJ ex order 26.4b1. The surveyor observed that the [redacted] NJ ex order 26.4b1 and the [redacted] on the right NJ ex order 26.4b1. The surveyor reviewed the residents Care Plan (CP) which revealed the following documentation: -Focus: That the resident NJ ex order 26.4b1 [redacted] The focus was initiated on NJ ex order 26.4b1. The CP reflected an NJ ex order 26.4b1 [redacted], that th NJ ex order 26.4b1 [redacted]. -Focus: The resident NJ ex order 26.4b1 [redacted] The surveyor reviewed the nursing Progress Notes (PN), dated NJ ex order 26.4b1 at 08:01 PM, which indicated that a nurse performed a weekly NJ Exec O assessment and that NJ ex order 26.4b1 [redacted]. This NJ Exec O assessment was performed after the surveyor's first observation of the NJ ex order 26.4b1. There was no documentation in the PN that the resident had a NJ ex order 26.4b1 [redacted] On 06/05/24 at 12:12 PM, the surveyor interviewed the US FOIA (B) (6) [redacted] who stated that the NJ ex order 26.4b1 the resident NJ ex order 26.4b1 [redacted]	F 610	shift-to-shift compliance. 7. A weekly audit will be created to assure compliance for three months or until 100% compliance is achieved. 8. Director of Nursing or designee will report any problematic issue and/or non-compliance to the administrator. 9. Nursing Director or designee will report audit results to the QAPI Committee which meets quarterly.	

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NJ ex order 26.4b1 by the resident's NJ ex order 26.4b1 . The US FOIA (B stated that the companion from NJ ex order 26.4b NJ ex order 26.4b1 to the resident from 7:00 - 9:00 AM and reported to her that the resident had a NJ ex order 26 on the NJ ex order 26.4b1 . The US FOIA (B stated that the companion also told her that she reported the NJ ex order 26.4b1 to the US FOIA (B) (6) that was providing care to the resident.

On 06/05/24 01:01 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that [redacted] was not notified that the resident had a NJ ex order 26.4b1 . NJ Ex [redacted] stated that the resident NJ ex order 26.4b1 but had a NJ ex order 26.4b US FOIA (B [redacted] that came in for a couple hours each morning to care for the resident. When the surveyor asked LPN #1 about the NJ ex order 26 on the resident's NJ ex order 26.4b1 , the US FOIA (B stated that [redacted] had not NJ ex order 26.4b1 . LPN #1 stated that if a resident NJ ex order 26.4b1 , then an incident report should have been completed and the NJ ex order 26.4b1 should have been NJ Exec Order 26.4b1 and assessed. [redacted] continued to add the resident should have been assessed for further NJ Exec Ord and an investigation should have been conducted. [redacted] explained that during the investigation the nurse would obtain statements from the staff going back three shifts and that the family and primary care physician would have been notified. [redacted] then stated that Resident #117 NJ ex order 26.4b1 [redacted]

On 06/06/24 at 10:06 AM, the surveyor reviewed the resident's medical records and there was still no documentation or assessment documented in the electronic medical record (EMR) regarding US ex order 26.4b1 .

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F 610	Continued From page 4 On 06/06/24 at 09:14 AM, the surveyor observed a staff member providing care to Resident #117. The staff member was interviewed and identified [redacted] as the US FOIA (B) (6) from [redacted] The [redacted] stated that [redacted] reported the [redacted] on the resident's NJ ex order 26.4b1 a NJ ex order 26.4b1 to the facility [redacted] and [redacted]. [redacted] stated that she did not remember what the [redacted] name was or what the [redacted] name was. The [redacted] also stated that the NJ ex order 26.4b1 [redacted], however [redacted] had not seen any [redacted] on the [redacted] on the right side since [redacted] had been caring for the resident. On 06/06/24 at 09:00 AM, the US FOIA (B) (6) [redacted] provided the surveyor incident and accident reports and investigations for the last [redacted] for Resident #117. There were no incident or accident investigation for the [redacted] of the NJ ex order 26.4b1, however there NJ ex order 26.4b1 [redacted] On 06/06/24 at 09:25 AM, the surveyor interviewed the [redacted] who stated that the resident's [redacted] had been [redacted] however the right [redacted] had NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 On 06/06/24 at 10:27 AM, the surveyor interviewed LPN #1 who stated that purpose of the CP was to assure that NJ ex order 26.4b1 [redacted]. [redacted] stated that the CP assured that all staff members knew what needs the resident had and to provide those needs [redacted] stated that [redacted] usually reviewed the residents CP quarterly when the skilled nursing assessment was completed. LPN #1 explained that nurses	F 610		

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F 610	Continued From page 5	F 610		

were made aware when skilled nursing assessment was due for a resident because it would trigger on the daily EMR when it was scheduled. LPN #1 stated explained that [redacted] was aware that Resident #117s [redacted] to US ex order 26.4b1, however had no explanation as to why the residents [redacted] US ex order 26.4b1 [redacted] stated that the [redacted] were completed when the resident's bath was scheduled. [redacted] stated that the [redacted]

On 06/06/24 at 10:37 AM, the surveyor interviewed the [redacted] who stated [redacted] were scheduled during first [redacted] day of the week and the nurse was responsible to assess the US ex order 26.4b1 such as US ex order 26.4b1. [redacted] stated that if the nurse identified a [redacted] or any other NJ Exec Order 26.4b1 then the nurse would be responsible to assess the area, document findings, complete an incident report incident of unknown origin, start an investigation, and get a statements from CNAs going back three shift. [redacted] stated that the nurse was also responsible to alert the practitioner and the resident's family. [redacted] also indicated that the nurses would be responsible to notify the [redacted]. The [redacted] explained the [redacted] process to the surveyor and stated that CPs were developed to assure that resident needs and preferences were identified, to include mitigating risk that could potentially negatively impact the resident and to mitigate those risk by formulating interventions to prevent accidents or incidents. [redacted] stated that an example of a resident risk would include a resident that had an issue with flailing arms and had the potential of [redacted] or developing [redacted]

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F 610	Continued From page 6	F 610		

NJ Exec Or from this behavior and the facility would NJ Exec the residents NJ Exec Order 26.4b1 or provide NJ Exec NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 to prevent NJ Exec Order 26.4b1.

On 06/06/24 at 11:41 AM, the surveyor interviewed LPN #2 who performed the NJ Ex Or for Resident #117 on NJ Ex Order 26.4b1 at 08:01 PM. LPN #2 stated that NJ ex order 26.4b1 were done once a week with . The US FOIA explained that the nurse usually performed the NJ ex order 26.4b1 with the US FOIA present. The US FOIA stated that asked the US FOIA that was assigned to the resident on the evening of how the residents NJ ex order 26.4b1 was, and the US FOIA told that the resident had NJ ex order 26.4b1. The US FOIA admitted that did not actually assess and visualize the residents' NJ ex or and that relied on the US FOIA to inform of any . stated that trusts the US FOIA and that the US FOIA was dependable to give an accurate description of the resident's condition. stated that the US FOIA did not report to that the resident had a on the .

On 06/06/24 at 12:08 PM, the surveyor interviewed the US FOIA who stated if the nurse performed a weekly NJ Exec assessment, the nurse should be visualizing the resident's NJ Exec and documenting the condition of the NJ Exec on the resident's progress notes. The US FOIA examined Resident #117's NJ Exec Order 26.4b1 in the presence of the surveyor and confirmed that the resident NJ ex or that NJ ex order 26.4b1 stated that would start the investigation. The US FOIA stated that when the surveyor reported the NJ Exec Orde to the US FOIA, the US FOIA should have started the accident and incident investigation, even if the NJ ex order 26.4b1 or in a

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NJ ex order 26.4b1. The NJ ex order also indicated that that nurse who performed the resident's NJ ex order 26.4b1 on NJ ex order 26.4b1 at 08:01 PM, should not have depended on the NJ ex order to give a description of the resident's NJ Exec O and should have assessed the resident's NJ Exec O herself. The NJ ex order also accompanied the surveyor to Resident #117's room and confirmed that the both the residents NJ ex order 26.4b1 should have been NJ Exec Order 26 as the CP interventions indicated.

On 06/07/24 at 09:01 AM, the surveyor team met with the NJ ex order and NJ ex order 26.4b1 who stated that an investigation was started regarding Resident #117's NJ ex order 26.4b1. indicated that the NJ ex order 26.4b1 must have NJ ex order 26.4b1 and was on an NJ ex order 26.4b1 in the Resident #117's room. indicated that a physician's order was obtained for the NJ ex order 26.4b1 NJ ex order 26.4b1 . also stated that the facility-initiated training related to NJ Exec O checks procedure and documentation of previous NJ Exec Order 26.4b1 and the incident reporting procedure.

The facility policy titled "Non-impaired Skin Integrity" dated 09/15, indicated that the facility strived to identify all residents at risk for developing impaired skin integrity, the level and nature of the risk and initiate the appropriate plan of care. The policy also indicated that the licensed nurse was responsible for initiating the appropriate interventions according to the resident's level of risk and performing weekly visual skin integrity checks were to be completed by the licensed nurse or designee on the resident's bath/shower day.

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F 610	Continued From page 8 The facility policy titled, "Incident Reporting/Injury Investigation Residents and Visitors" dated 03/19, indicated that the facility strived to ensure that incidents involving a resident or visitor were recorded, patterns, or trends of occurrences were investigated, and measures were implemented to alleviate or decrease further occurrences. The policy indicated that the description of the resident's incident/injury, resident status, intervention, and any relevant observation shall be documented in the electronic progress notes. The policy also indicated that resident incidents shall be reported to the nursing supervisor and that an incident report had been completed in its entirety and that upon receipt of a report of incident/injury the charge nurse of supervisor shall immediately evaluate the resident, provide any needed intervention, and complete all areas of the Incident Investigation form. The facility policy titled, "Person-Centered, Interdisciplinary Care Planning and Care Conference" dated 10/2022 reflected that the facility ensured that the person-centered, interdisciplinary care plan team members follow-through with their responsibilities and identify problems/needs and strengths and follow-up on the approaches. NJAC 8:3.9-4.1(a)5 NJAC 8:3.9-13.4(c)2i, ii	F 610		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		7/8/24

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F 812	Continued From page 9 §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 review of other 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. This deficient practice was evidenced by the following: On 06/05/24 from 8:56 AM to 9:25 AM, the surveyor, accompanied by the US FOIA (b)(6) observed the following in the kitchen: 1.) The US FOIA (b)(6) washed hands at a designated hand washing sink for 12 seconds. 2.) The step can style trash can at the employee hand washing sink had small flying insects (identified by the US FOIA (b)(6) as fruit flies) flying inside	F 812	1. All residents have the potential to be affected by this deficient practice. 2. Dietary Staff were immediately in-serviced during survey on the importance and procedures of the following topics: proper handwashing, proper use of beard guards, proper labeling of open food, storage of pans, and reporting of insects present in the kitchen. In-servicing continues and will be completed by 7/8. Cited topics will be reviewed at each daily service meeting in the kitchen. 3. A daily audit tool will be created and delivered for minimally 3 consecutive months and then until 100% compliance achieved to ensure compliance with each topic by all dietary staff. Culinary Director or designee will be responsible for completing this audit daily. 4. Incidents of non-compliance will be	

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F 812	Continued From page 10 and outside of the trash can when opened. When the surveyor stepped on the pedal to open the trash can, there was a white paper towel with an orange discoloration inside with small insects crawling on it. The [redacted] stated [redacted] would get someone to empty the trash can. 3.) In the refrigerator, identified as the Produce Refrigerator by the [redacted] there was a half pan of carrots sealed with plastic wrap. The half pan of carrots was not labeled with a date the carrots were prepared nor a use-by date. The [redacted] removed the half pan of carrots from the refrigerator. On 06/06/24 from 11:50 AM to 12:10 PM, the surveyor, accompanied by the [redacted] and [redacted], observed the following in the kitchen: 4.) Two (2) Line Cooks and [redacted] were wearing beard guards that did not cover their mustache facial hair. The [redacted] instructed the kitchen staff to pull their beard guards over their mustaches. 5.) A multi-tiered shelving unit, identified by the [redacted] as the storage area for clean and dry dishware, contained a stack of full pans and a stack of third pans that were wet nested. The surveyor lifted the pans to reveal there was liquid between the pans. The [redacted] instructed kitchen staff to re-wash the pans. During an interview with the surveyor on 06/06/24 at 12:50 PM, the [redacted] stated the following: 1.) The process for hand washing included washing hands for 15-20 seconds to "prevent	F 812	reported to the Culinary Director for the purpose of follow-up and delivering staff accountability. 5. Culinary Director will report any problematic issue and/or non-compliance to the Administrator and/or Executive Director. 6. Culinary Director or designeer will report audit findings to the QAPI Committee which meets quarterly.	

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F 812	Continued From page 11	F 812		

cross contamination and food-borne illnesses."

2.) The trash cans at the hand washing sink were designated for hand washing purposes only and that the trash cans should be emptied and kept clean for infection control purposes. The [redacted] further stated that pest issues, such as fruit flies, should be reported to management as "fruit flies can lay eggs and continue to spread if not eliminated."

3.) The sealed carrots should have been labeled with the date they were prepped and would be good for three (3) days since it was a prepared product.

4.) Beard guards, a type of hair restraint, should cover all facial hair, including mustaches, to prevent hair from entering food or food prep items, "since hair is full of bacteria."

5.) Dishware, such as pans, should be air dried before storing nested and if pans are wet nested, they should be re-washed because, "wet nesting promotes bacteria growth."

Review of the facility's Hand Washing Procedure from the Culinary Services Manual, revised 12/07, included, "Apply approximately one tablespoon of hand soap from proper dispenser to your hands. Join hands and work up a good lather for 20 seconds, in addition concentrate under nails, between fingers, and under wedding bands."

Review of the facility's Trash policy from the Environmental Services Manual, revised 08/2011, included, "All trash containers will be covered with a fitted metal or plastic cover, and "In order to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING _____ B. WING _____	06/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 12	F 812		

maintain sanitary conditions, trash containers should be lined with plastic liners." The policy did not address how to prevent and address pest issues related to trash cans in the kitchen.

Review of the facility's Date Marking Ready-To-Eat Foods policy from the Culinary Services Manual, revised 02/17, included, "All ready-to-eat foods will be labeled to include the following information: product name and date (month, day and year) the product was prepared or opened and the date the product should be used by."

Review of the facility's Food Storage Chart, revised 10/14, included under "3 days" for refrigerated storage was, "ready-to-cook foods prepared on site."

Review of the facility's Personal Appearance Standards from the Culinary Services Manual, revised 01/16, included, "Men with facial hair, mustache and or/beard, must wear a beard guard while in the production kitchen," and, "Hair restraints, such as hats, hair covering, or nets, and clothing that covers body hair shall be worn when in the production area where food is prepared or plated from a hot or cold work station."

Review of the facility's Ware Washing policy from the Culinary Services Manual, undated, included, "Allow cleaned items to air dry and cool completely before storing."

NJAC 18:39-17.2(g)

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
	030303	A. BUILDING: _____ B. WING _____	06/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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

Electronically Signed | 06/21/24

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)
315077	A. Building B. Wing	7/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD MOORESTOWN, NJ 08057

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 07/08/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 07/08/2024	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 6/7/2024	☐ 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
	315077	A. BUILDING **02** B. WING _____	**06/07/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 6/7/24, and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Willowbrooke Court Skilled Care at Evergreens is a two-story building with partial lower level utilities area, that was built in 2012. It is composed of Type II protected construction. The facility is divided into three smoke zones. The exterior diesel/natural gas (750 KW) generator does 100% of the building as per the Director of Physical Plant Services. The current occupied beds are 23 of 34 licensed beds. The building utilizes an electric fire pump and provided an upto date churn test log, last tested: 6/3/24.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/7/24, in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide a battery back-up emergency light above the interior emergency generator and fire pump transfer switches, independent of the building's	K 291	1. All residents have the potential to be affected by this deficient practice. 2. The deficienct emergency lighting of at least 1-1/2 hour duration in the lower level electrical room where the generator automatic transfer is located and the	7/22/24

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

Electronically Signed | 06/21/2024

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
	315077	A. BUILDING **02** B. WING _____	**06/07/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 1 electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 2 of 2 interior transfer switches and was evidenced by the following: 1). At 10:55 AM, the surveyor and the US FOIA (b observed in the lower level electrical room where the generator and transfer switch were located, that the room was not equipped with battery back-up emergency lighting of at least a 90 minute duration and was provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 2). At 11:15 AM, the surveyor and the US FOIA (b observed in the lower level fire pump room, that the transfer switch area, was not equipped with battery back-up emergency lighting of at least a 90 minute duration and was provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 At that time, the US FOIA (b confirmed the findings during the observation's above. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit on 6/7/24. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	lower level fire pump room will be installed within 30-days of this submitted plan of correction. 3. The repairment, upon completion, will be documented by the Director of Physical Plant Services (DPPS). All other areas that require emergency lighting were inspected on 6-7-24 and no deficiencies noted. 4. The Director of Physcial Plant Services or his designee will inspect on a monthly basis the lower-level electricasl room and the lower level fire pump room for a period of 3 consecutive months to ensure the emergency lighting is present and in compliance. 5. All finding will be reported to the monthly Safety Committee and the quarterly QAPI Committee to review and discuss.	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in	K 531		7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING **02** B. WING _____	**06/07/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 2 ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: During record review on 6/7/24, in the presence of the US FOIA (b)(6) it was determined that the facility failed to conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation for 2 of 2 devices. This deficient practice had the potential to affect 23 residents who resided at the facility and was evidenced by the following: At 11:02 AM, the surveyor asked the US FOIA for the Phase I and Phase II firefighters monthly recall documentation. The US FOIA indicated that currently the required monthly testing was not being performed. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 6/7/24.	K 531	1. All residents have the potential to be affected by this deficient practice. 2. The monthly fire service log will be done monthly by the elevator vendor during their monthly preventative maintenance visits to the community. 2. The repairment, upon completion, will be documented by the Dir of Physical Plant Services and kept in all elevator mechaniocal rooms on the campus. 3. The Dir of Physical Plant Services or his designee will inspect the fire test log paperwork on a monthly basis for 3 consecutive months to ensure that testing and forms are being done and completed. 4. All findings will be reported to the monthly Safety Committee and quarterly QAPI Committee to review and discuss.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING **02** B. WING _____	**06/07/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 3 NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. ASME/ANSI A17.3	K 531		
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 6/7/24, in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that 1 of 5 electrical outlets located next to a water source was equipped with a Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice had the potential to affect 3 of 23 residents residing in the facility was evidenced by the following: At 12:02 PM, the surveyor and the US FOIA (b) observed in the Physical Therapy room that a Hydrocollator was plugged into a regulator duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations.	K 912	1. All resident have the potential to be affected by this deficient practice. 2. The noted deficiency concerning the hydrocollator being plugged into a non-GFCI outlet will have a GFCI outlet installed within 30 days of this submitted plan of correction. 3. The GFCI outlet installation, upon completion, will be documented by the Dir of Physical Plant Services and added to our monthly GFCI testing. 4. The Dir of Physical Plant Services or designee will perform a monthly audit of GFCI outlet to ensure proper installation and test the outlet for 3 consecutive months to ensure facility is in compliance. 5. All finding will be reported to the	7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING **02** B. WING _____	**06/07/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 912	Continued From page 4 The US FOIA (b)(6) confirmed the finding at the time of observation. The US FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 6/7/24. NJAC 8:39 -31.2 (e) NFPA 99	K 912	monthly Safety Committee and the quarterly QAPI Committee to review and discuss.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in 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	K 918		7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING **02** B. WING _____	**06/07/2024**

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

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K 918	Continued From page 5 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, interview, and record review on 6/7/24, in the presence of the US FOIA (b)(6)), it was determined that the facility failed to a.) certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems, and b). ensure a remote manual stop station for their exterior 750-kilowatt (KW) diesel generator was installed, providing emergency power to 100% 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 was evidenced for 1 of 1 generator and had the potential to affect 23 residents residing in the facility and was evidenced by the following: 1.) At 9:44 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds for 12 of 12 times on the provided generator log. Currently, the US FOIA was performing monthly generator load testing, but did not indicate the required transfer times on the provided log dates: 6/21/23, 7/19/23, 8/11/23,	K 918	1. All residents have the potential to to be affected by this deficient practice. 2. The monthly generator report log will have a line item added to the checklist to log, in seconds, how long it takes to transfer to backup power(within 10 seconds). The generators will also have a remote emergency shut off switch installed outside the generator area within 30 days of the submitted plan of correction. 3. The emergency shut off switch installation, upon completion, will be documented by the Dir of Physical Plant Services. 4. The Dir of Physical Plant Services or designee will perform a monthly audit of the monthly generator log to ensure the log is printing and being filled out correctly for 3 consecutive months to ensure that all required documentation is in compliance. The Dir of Physical Plant Services or designee will ensure that the contracted generator vendor tests the emergency shut off button during their annual inspections to ensure facility is in compliance. 5. All finding will be reported to the monthly Saftey Committee and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING **02** B. WING _____	**06/07/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 6 9/20/23, 10/19/23, 11/13/23, 12/15/23, 1/15/24, 2/21/24, 3/20/24, 4/17/24 and 5/8/24. An interview was conducted with the US FOIA during document review, where he stated that currently he was not putting the transfer time on the provided generator monthly load test log. 2.) At 10:40 AM, the surveyor and the US FOIA observed the exterior 750 KW diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the US FOIA who 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 6/7/24. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	quarterly QAPI Committee to review and discuss.	

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
315077 Y1	A. Building 02 - NEW SKILLED NURSING B. Wing Y2	7/24/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD MOORESTOWN, NJ 08057

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	07/22/2024	LSC K0531	07/22/2024	LSC K0912	07/22/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	07/22/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/7/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO