STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10A100	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Standard Census: 25 Sample Size: 6 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 269	8:36-3.1(a) Appointment of Administrator (a) An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds, and on a half-time basis in facilities that have fewer than 60 licensed beds, in accordance with the definition of "full-time" and "half-time" at N.J.A.C. 8:36-1.3.	A 269		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 269	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that an Alternate Administrator (AA) be designated in writing to act in the absence of the Administrator, which had the potential to affect all 25 residents that resided at the facility at the time of the survey. This deficient practice was evidenced by the following: On 10/14/25 at 9:09 a.m., the surveyor interviewed the Assistant Director of Nursing (ADON) and inquired about the facility Administrator. The ADON stated that the facility Administrator was ill and would not be present during the survey. At 9:58 a.m., the surveyors interviewed the Director of Nursing (DON) regarding the appointment of an Alternate Administrator. The DON stated that if the Administrator had pre-planned time off, he designated in writing who would be the AA, but that since his absence was unexpected, there was no designated AA in writing. The DON then stated that the administrative team contacted the facility's regional office, and an AA would be coming to the facility and covered the facility until the Administrator returned. In the same interview, the DON stated the facility did not have a policy or procedure that designated the AA in writing.	A 269		

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A 735	Continued From page 2	A 735		
A 735	8:36-7.2(e)(1-5) Health Care Assmnt. and Health Service Plan (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to develop and implement a written Health Service Plan (HSP) for [redacted] and/or [redacted] services for 2 of 6 residents reviewed, Resident #s 1 and 3, This deficient practice was evidenced by the following: On 10/14/25 at 9:17 a.m., during the entrance conference, the surveyor requested a list of all	A 735		

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A 735	Continued From page 3 residents with a HSP from the Director of Nursing (DON). At 10:40 a.m., the surveyor reviewed Resident #1's Medical Record (MR) which revealed that the resident moved into the facility in [redacted] of [redacted] with diagnoses which included [redacted] to [redacted] and [redacted] During continued review of Resident #1's MR the surveyor observed consultations which indicated that Resident #1 was followed by [redacted] and [redacted] Care services. At 11:56 a.m. the DON provided the surveyor with a document titled "Services [redacted]". The DON stated that this was the list of all residents who had HSPs. On 10/15/25 at 10:40 a.m., the surveyor reviewed Resident #3's closed MR which revealed that the resident moved into the facility in [redacted], with diagnoses of [redacted] and [redacted] with [redacted] and [redacted] at the facility in [redacted]. During continued review of Resident #3's closed MR the surveyor observed a consultation which indicated that Resident #3 recieved [redacted] services. At 12:12 p.m., the surveyor interviewed the DON and Regional Director of Clinical Services (RDCS) regarding the HSPs. The DON and RDCS confirmed that HSPs were not developed for Resident #s 1 and 3. The DON and RDCS also confirmed that an HSP should have been developed for the residents who recieved outside care services. On 10/15/25 the surveyor reviewed the undated policy and procedure titled, "Health Service Plan"	A 735		

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A 735	Continued From page 4 which revealed, " ... Procedure 1. If the resident assessment indicates that the resident requires health care services, a health care assessment will be completed within 14 days of admission by a registered professional nurse, who will evaluate the following: ... Outside Services 2. based on the health care assessment a written health care plan shall be developed..."	A 735		
A 765	8:36-7.4(c)(1) Health Care Services (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as-needed basis, including and upon the resident's return to the facility from the hospital; This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to update the Health Service Plan (HSP) for 1 of 6 residents reviewed, Resident # 6. This deficient practice was evidenced by the following: On 10/15/25 at 11:05 a.m., the surveyor reviewed Resident # 6's Medical Record (MR), which revealed that Resident # 6 was admitted to the	A 765		

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A 765	Continued From page 5	A 765		

facility in [NJ Exec Order 2] with diagnoses of [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b1]).

The surveyor reviewed an incident report written by a Licensed Practical Nurse (LPN) at 8:45 p.m. on [NJ Exec Order]. The incident report revealed a Certified Nursing Assistant (CNA) notified the LPN after Resident # 6 [NJ Exe] in his/her room. During an assessment by the LPN, it was noted that the resident [NJ Exec Order 26.4b1] an [NJ Exec Order 26.4b] and [NJ Exec Ord] [NJ Exec Order 26.4b] on his/her [NJ Exec Order 26.4b1]. The incident report continued to reveal that the LPN contacted the resident's doctor, the Director of Wellness, and the Administrator.

Continued surveyor review of the MR revealed an undated document titled, "Service Plan Report", that indicated the facility instituted a health service plan regarding falls for Resident # 6, that was updated [NJ Exec Order 26] but not after the resident [NJ Exe] in [NJ Exec Order 2].

At 11:30 a.m., the surveyor reviewed an undated policy and procedure titled, "Health Service Plan", revealed " Procedure ... 12. The health care plan will be reviewed, and if necessary, ..., or as needed, based upon the resident's response to the care provided ,,,".

At 12:12 p.m., the surveyor interviewed the Director of Wellness (DOW), in the presence of the Regional Director of Wellness. The surveyor interviewed the DOW regarding resident assessments, in which the DOW stated that resident assessments were performed by a registered nurse upon admission into the facility, and after [NJ Exec O] or changes in a resident's status. The surveyor inquired about Resident # 6's Health Service Plan not being updated after he/she [NJ Exe] on [NJ Exec Order], the DOW did not have an

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A 765	Continued From page 6 answer.	A 765		
A 935	8:36-11.4(b) Administration of medications (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to administer a medication in accordance with the prescriber's orders for 5 of 6 residents reviewed, Resident #s 1, 2, 4, 5, and 6. This deficient practice was evidenced by the following: 1. On 10/14/25 at 10:40 a.m., the surveyor reviewed Resident #1's Medical Record (MR) which revealed that the resident moved into the facility in NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1. The surveyor reviewed the electronic Medication Administration Record (eMAR) dated from NJ Exec Order 26 through NJ Exec Order 26.4b1, which revealed the following blanks:	A 935		

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A 935	Continued From page 7 On NJ Exec Order 26.4b during the night shift the facility failed to complete the following orders: 1. NJ Exec Order 26.4b1 Order every shift NJ Exec Order 26.4b1 for proper placement prior to each NJ Exec Order 26.4 NJ Exec Or or medication administration. NJ Exec Order 26.4b1 at least NJ Exec Order 26.4b1 during NJ Exec Order 26.4 and 1 hours after. 2. NJ Exec Order 26.4b1 every shift NJ Exec Order 26.4b1 before and after medication administration.NJ Exec Order 26.4b1 each medication 3. NJ Exec Order 26.4b1 six times a day NJ Exec Orde every 4 hours with NJ Exec Order 26.4b1 ordered for 1:00 a.m. and 5:00 a.m. on NJ Exec Order 26.4 4. NJ Exec Order 26.4b1 Give 1 tablet via NJ Exec Order 26.4b1 at bedtime for NJ Exec Order 26.4b1 ordered for 6:00 a.m. On NJ Exec Order 26.4b1 the facility failed to administer the following 12:00 p.m. orders: 1. NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b 4 times per day NJ Exec Order 26.4b1 2. NJ Exec Order 26.4b1 six times a day NJ Exec Orde NJ Exec Order 26.4b1 every 4 hours with NJ Exec Order 26.4b1 of NJ Exec Order During continued surveyor review of Resident #1's MR the surveyor did not observe any documentation which indicated why the orders above were not administered as per the providers orders. 2. On 10/15/25 at 10:15 a.m., the surveyor reviewed Resident # 5's MR which reveaed that the resident moved into the facility in NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 and	A 935		

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A 935	Continued From page 8 NJ Exec Or The surveyor reviewed the eMAR dated from NJ Exec Order 26.4b1, which revealed the following blanks: The facility failed ot complete the following orders: 1. On NJ Exec Order 26.4b1 at 10:00 p.m. which is used for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 2. On NJ Exec Order 26.4b1 at 10:00 p.m. which is used for NJ Exec Order 26.4b1. 3. On NJ Exec Order 26.4b1 at 10:00 p.m. which is used for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 4. On NJ Exec Order 26.4b1 at 10:00 p.m. which is used for NJ Exec Order 26.4b1. 5. On NJ Exec Order 26.4b1 at 9:00 p.m. which is used for NJ Exec Order 26.4b1 6. On NJ Exec Order 26.4b1 at 9:00 p.m. which is used for NJ Exec Order 26.4b1. 7. On NJ Exec Order 26.4b1 2 tablets) at 10:00 p.m. which is used for NJ Exec Or 8. On NJ Exec Order 26.4b1 at 10:00 p.m. which is used for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 9. On NJ Exec Order 26.4b1 at 10:00 p.m. which is used for NJ Exec Order 26.4b1. During continued surveyor review of Resident # 5's MR, the surveyor did not observe any documentation which indicated why the orders above were not administered as per the provider's orders. 3. At 10:30 a.m., the surveyor reviewed Resident # 4's MR which revealed that the resident moved into the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 and NJ Exec O	A 935		

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A 935	Continued From page 9 The surveyor reviewed the electronic Medication Administration Record (eMAR) dated from [redacted] through [redacted] which revealed the following blanks: The facility failed to complete the following orders: 1. On [redacted] the resident's [redacted] was not checked at 6:00 a.m. 2. On [redacted] at 9:00 p.m. which is used for [redacted] During continued surveyor review of Resident # 4's MR, the surveyor did not observe any documentation which indicated why the orders above were not administered as per the prescriber's orders. 4. At 10:40 a.m., the surveyor reviewed Resident #2's MR which revealed that the resident moved into the facility in [redacted], with diagnoses which included [redacted] and [redacted] The surveyor reviewed the MAR dated from [redacted], which revealed the following blanks: On [redacted] the facility failed to complete the following orders which were scheduled for 9:00 p.m.: 1. [redacted]) Give 2 tablets by mouth at bedtime for [redacted] 2. [redacted] Give 1 tablet by mouth at bedtime for [redacted]. [redacted] During continued surveyor review of Resident #2's MR the surveyor did not observe any documentation which indicated why the orders above were not administered as per the	A 935		

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A 935	Continued From page 10 provider's orders. 5. At 11:05 a.m., the surveyor reviewed Resident # 6's MR, which revealed that the resident moved into the facility in NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1 [redacted]). The surveyor reviewed the eMAR dated NJ Exec Order through NJ Exec Order 26.4b1 which revealed the following blanks: The facility failed to complete the following orders: 1. On NJ Exec Order 26.4b1 at 6:00 a.m. which is used for NJ Exec Order 26.4b1. 2. On NJ Exec Order 26.4b1 at 6:00 a.m. which is used for NJ Exec Order 26.4b1. 3. On NJ Exec Order 26.4b1 at 6:00 a.m. which is used for NJ Exec Order 26.4b1. 4. On NJ Exec Order 26.4b1 at 6:00 a.m. which is used for NJ Exec Order 26.4b1. 5. On NJ Exec Order 26.4b1 at 8:00 p.m. which is used for NJ Exec Order 26.4b1. During continued surveyor review of Resident # 6's MR, the surveyor did not observe any documentation which indcated why the orders above were not administered per the prescriber's orders. At 12:12 p.m., the surveyor interviewed the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) regarding medication administration. The DON stated that once a week a Registered Nurse (RN) reviewed the eMAR to ensure medication was administered in accordance with provider's orders. The DON also stated that if a blank was observed on the eMAR by the RN during the weekly review a progress note was documented in the Resident	A 935		

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A 935	Continued From page 11 chart. Additionally, the DON confirmed that blanks were in the eMAR and there was no document which addressed the missed medication dose. On 10/15/25 the surveyor reviewed the undated policy and procedure titled, "Documentation of Medication Administration" which revealed, "... Procedure... 6) The R.N., L.P.N., or CMA who omits any medication for any reason designates such by the initialing the time block, then circling the time block to indicate omission. The R.N., L.P.N.[Licensed Practical Nurse], or CMA [Certified Medication Aide] documents on the back of the MAR and the progress noted if necessary ..."	A 935		
A1089	8:36-16.3(b) Ventilation (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observation and interview on	A1089		

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A1089	Continued From page 12 10/15/2025 in the presence of the Director of Environmental Services (DES) and Regional Environmental Director (RED), it was determined the facility failed to ensure means of ventilation was provided for every bathroom by either a window with an operable area or by mechanical ventilation for 3 of 13 rooms observed in accordance with N.J.A.C. 8:36-16.3 (b). The deficient practice was evidenced by the following: Observations during a facility tour between 10:00 AM and 11:55 AM revealed, the exhaust fans in the resident bathrooms were not operational when tested for rooms 117, 130 and 133. The exhaust fans were the only source of ventilation in the bathrooms. In interviews at the times the RED and DES confirmed the observations. The facility's Acting Administrator, RED and DES were informed of the deficient practice at the Life Safety exit conference at 3:20 PM.	A1089		

CARE ONE
At Moorestown

POC #4
Rec'd 1/9/26
Reviewed 1/9/26

Care One at Moorestown Assisted Living Facility
Plan of Correction
Standard Survey October 15, 2025

A 269

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   On 11/3/25, The Administrator immediately appointed a covering Administrator to cover any absences of the Facility's Administrator.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice.**

   All Residents residing in the facility have the potential to be affected by this practice.

3. **What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur.**

   The Vice President of Operations provided in-service education to the Administrator on 10/25/25. Education included the appointment of an Administrator in accordance with CFR 836-3.1(a). The Administrator verbalized understanding of the education.

   On 11/03/25, the Facility's Administrator secured a written formal letter for an Alternate Administrator in the absence of the Administrator of record.

   The Alternate Administrator is an executive Director at a neighboring facility.

   On 11/03/25, the Administrator provided in-service education to the Facility's leadership team on the appointment of an alternate Administrator and have his/her contact information in case the Administrator of record in unavailable.

   The Vice President of Operations provided in-service education to the New Administrator on 12/12/25.

   Posting for alternate administrator is available at the reception area, staff verbalized understanding of its location.

4. **How the facility will monitor its corrective action to ensure that the deficient practice will not recur.**

   The Vice President of Operations or designee will review the coverage by the alternate Administrator weekly x 3 weeks then monthly 3 months with both the Administrator and alternate administrator. The findings will be presented to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI committee will review and provide recommendation for further audits as needed. The QAPI Committee meets monthly.

5. **Completion Date:** 12/12/25

A 735

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Resident #1 Health Service Plan was created on 10/15/2025, to include Outside Services.

   Resident #3 was discharged from the facility on [redacted] 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 requiring Health Service Plans have the potential to be affected by this practice.

   What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur.

   On 10/15/25, the Regional Director of Clinical Services reviewed the policy titled, "Health Service Plan". No revisions were necessary.

   On 10/17/25, the Regional Director of Clinical Services provided in-service education to the Director of Nursing (DON). Education was on the facility's Policy titled, "Health Service Plan," which includes, "...If the resident assessment indicates that the resident requires health care services, a health care Assessment will be completed within 14 days of admission by a registered professional nurse, who will evaluate the following: ...Outside Services 2. Based on the health assessment a written health care plan shall be developed..." The DON acknowledged understanding of the education.

   On 10/17/25, the Director of Nursing (DON) provided in-service education to the Registered Nurses (RNs) on the facility's policy titled, "Health Service Plan." Education included that all residents in need of health care services, will have a care assessment will be completed within 14 days by a registered nurse (RN). RNs verbalized understanding of the education.

   From 10/15/25-10/17/25 The Director of Nursing and/or designee conduct audits of 100% of residents utilizing Outside Services to ensure a health care assessment and health service plan have been created. There were no untoward findings.

3. **How the facility will monitor its corrective action to ensure that the deficient practice will not recur.**

   Audits will be conducted on 10% of the residents by the Director of Clinical Services or Designee weekly x 4 weeks, then monthly x 3 months with results provided to the Administrator and the Quality Assurance Performance Improvement Committee (QAPI). The QAPI committee will review and provide recommendation for further audits as needed.

   The QAPI Committee meets monthly.

4. **Completion Date:** 12/5/2025

A 765

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   On 10/17/25, the Director of Nursing (DON) updated Resident #6 Health Service Plan (HSP) to reflect new intervention after the [redacted]

   Resident #6 had [redacted] related to this practice.

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 in place or systemic changes will be made to ensure that the deficient practice will not recur.**

   On 10/15/25, the Regional Director of Clinical Services reviewed the policy titled, "Health Service Plan". No revisions were necessary.

   On 10/17/25, the Regional Director of Clinical Services provided in-service education to the Director of Nursing (DON) on the facility's policy titled, "Health Service Plan" which included, "Procedure ...12. The health care plan will be reviewed, and if necessary, ..., or as needed, based upon the resident's response to the care provided..." The DON verbalized understanding that the health service plan will be reviewed and updated post a fall incident.

   On 10/17/25, the Regional Director of Clinical Services provided in-service education to the Director of Nursing (DON). Education was on the facility's Policy titled, "Health Service Plan," which includes, "...If the resident assessment indicates that the resident requires health care services, a health care Assessment will be completed within 14 days of admission by a registered professional nurse, who will evaluate the following: ...Outside Services 2. Based on the health assessment a written health care plan shall be developed..." The DON acknowledged understanding of the education.

   On 10/17/25, the Director of Nursing (DON) provided in-service education to the Registered Nurses (RNs) on the facility's policy titled, "Health Service Plan." Education included that all residents in need of health care services, will have a care assessment will be completed within 14 days by a registered nurse (RN). RNs verbalized understanding of the education.

   From 10/15/25-10/17/25 The Director of Nursing and/or designee conduct audits of

100% of residents utilizing Outside Services to ensure a health care assessment and health service plan have been updated.

4. **How the facility will monitor its corrective action to ensure that the deficient practice will not recur.**

   The Director of Clinical Services or Designee will conduct audits of 100% of residents' Health Service Plans (HSP) post fall incident, to ensure interventions are implemented. Audits will be conducted daily x 5 days, then weekly x 3 weeks, then monthly x 3 months. Results of the audits will be provided to the Administrator and to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months. The QAPI committee will review and provide recommendation for further audits as needed. The QAPI Committee meets monthly.

5. **Completion Date:** 12/5/2025

A 935

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

On [redacted] the Director of Nursing (DON) assessed Resident #1. Family and Attending notified.

On [redacted] the DON notified Resident #1's family member and the attending physician of the unsigned Medication Administration Record (MAR) including the night shift [redacted] orders, the [redacted] as well as the unsigned orders for [redacted] and [redacted] on [redacted] at 12:00pm. The attending physician gave no new orders.

On [redacted] the DON assessed Resident #5. Family and Attending notified.

On [redacted] the DON notified Resident #5's family member and attending physician of the unsigned Medication Administration Record (MAR) for [redacted] at 10pm. [redacted] at 10:00pm [redacted] at 10:00pm.. [redacted] at 10:00pm... [redacted] at 9:00pm... [redacted] at 9:00pm... [redacted] at 10:00pm.. [redacted] at 10:00pm... [redacted] at 10:00pm." The attending physician gave no new orders.

On [redacted] the DON assessed Resident#4. Family and Attending notified.

On [redacted] the DON notified Resident #4's family member and attending physician of the unsigned Medication Administration Record (MAR) for [redacted] the resident's [redacted] at 6:00am. [redacted] (2 tabs) at 9:00pm." The attending physician gave no new orders.

On [redacted] the DON assessed Resident #2. Family and Attending notified.

On [redacted] the DON notified Resident #2's family member and attending physician of the unsigned Medication Administration Record (MAR) for [redacted] give 2 tablets at bedtime... [redacted] at bedtime." The attending physician gave no new orders.

On [redacted] the DON assessed Resident #6. Family and Attending notified.

On [redacted] the DON notified Resident #6's family member and attending physician of the unsigned Medication Administration Record (MAR) for [redacted] at 6:00am.. [redacted] at 6:00am. [redacted] at 6:00am.. [redacted] at 6:00am... [redacted] at 8:00pm. The attending physician gave no new orders.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents with medication orders have the potential to be affected by this practice.

3. **What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur.**

   On 10/15/25, the Regional Director of Clinical Services reviewed the policy titled, "Documentation of Medication Administration". No revisions were necessary.

   On 10/17/25 The Director of Nursing (DON) provided a Clinical Practice Referral to the Certified Medication Aides (CMAs) and the Licensed Practical Nurses (LPNs) who left the Medication Administration Records (MARs) unsigned. The Clinical Practice Referral included education on the facility's policy titled, "Documentation of Medication Administration" "Procedure...6) the R.N., L.P.N., or CMA who omits any medication for any reason designates such by the initialing the time block, then circling the time block to indicate omission. The R.N., L.P.N. [Licensed Practical Nurse], or CMA [Certified Medication Aide] documents on the back of the MAR and the progress note if necessary." Staff acknowledged understanding of the education.

   On 10/17/25- 10/20/25 the DON provided in-service education to the LPNs, RNs and CMAs working the 7-3pm, 3-11pm, and 11-7am shifts. Education included the facility's policy titled, "Documentation of Medication Administration" "Procedure...6) the R.N., L.P.N., or CMA who omits any medication for any reason designates such by the initialing the time block, then circling the time block to indicate omission. The R.N., L.P.N. [Licensed Practical Nurse], or CMA [Certified Medication Aide] documents on the back of the MAR and progress note if necessary." Staff acknowledged understanding of the education.

   On 11/01/2025 the Director of Nursing (DON) conducted an audit of 100% of residents' Medication Administration Records (MARS) for the last 30 days to ensure all medications were signed as administered or documented appropriately if not administered. There were no untoward findings of the audit.

   On 10/17/25 -10/20/25, the Director of Nursing conducted medication pass observations with the CMAs, LPNs and Registered Nurse (RN).

   On 1/2/26, the Assisted Living: Documentation of Medication Administration policy was updated to include: "3. Documentation of medication administration includes, as a minimum:..f. Reason(s) why a medication was withheld, not administered, or refused (as applicable)."

On 1/2/26-1/6/26, Certified Medication Aides (CMAs); Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were provided in-service education by the Director of Nursing (DON) on the facility's updated policy titled, "Assisted Living: Documentation of Medication Administration." Education included "3. Documentation of medication administration includes, as a minimum:..f. Reason(s) why a medication was withheld, not administered, or refused (as applicable)." Staff verbalized understanding of education.

4. **How the facility will monitor its corrective action to ensure that the deficient practice will not recur.**

   The Director of Nursing (DON) or designee will conduct audits of 10 randomly sampled residents' Medication Administration Records (MARs) to ensure all medications are signed as administered or documented appropriately if not administered. Audits will be conducted daily x 5 days, then weekly x 4 weeks, then monthly x 3 months. Results of the audits will be provided to the Administrator and to the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee will review and provide recommendation for further audits as needed.

   The QAPI Committee meets monthly.

5. **Completion Date:** 1/2/26 and Ongoing

Assisted Living: Documentation of Medication Administration

Policy Statement

A medication administration record is used to document all medications administered.

Policy Interpretation and Implementation

1. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's electronic medication administration record (eMAR). Paper medication administration records (MARs) may be used when there is a system outage and the eMAR is not available, in accordance with emergency preparedness plans.
2. Administration of medication is documented immediately after it is given.
3. Documentation of medication administration includes, as a minimum:
    a. the resident's name;
    b. name and strength of the drug;
    c. dosage;
    d. route of administration;
    e. date and time of administration;
    f. reason(s) or reason code(s) why a medication was withheld, not administered, or refused (as applicable);
    g. electronic signature or initials, signature, and title of the person administering the medication;
    h. resident response to the medication, if applicable (e.g., PRN, pain medication, etc.).

A 1089

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   On 10/15/25, the Director of Environmental Services (DES) immediately replaced the belt on the drive motor for the exhaust fans. The exhaust fans were then fully operational in the bathrooms for the unoccupied rooms: 117, 130 and 133.

   There were no residents adversely affected by this practice.

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 in place or systemic changes will be made to ensure that the deficient practice will not recur.**

   On 10/15/25 the Regional Environmental Director provided in-service education to the Director of Environmental Services (DES) on the requirement under N.J.A.C 8:36-16.3(b) to maintain ventilation for every bathroom by either a window with an operable area or by mechanical ventilation. The DES verbalized understanding of the education.

   The Director of Environmental Services (DES) conducted an inspection of all resident bathrooms in the facility on 10/15/25 to ensure exhaust fans in the resident bathrooms were fully operational. There were no other findings of the inspection.

4. **How the facility will monitor its corrective action to ensure that the deficient practice will not recur.**

   The Director of Environmental Services or Designee will conduct inspections of all resident bathroom exhaust fans weekly to ensure they are operable. Audits will be conducted weekly on an on-going basis with results provided to the Administrator and to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months. The QAPI committee will review and provide recommendation for further audits as needed.

   The QAPI Committee meets monthly.

5. **Completion Date:** 10/20/2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
10A100 Y1	A. Building B. Wing Y2	1/12/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT MOORESTOWN	895 WESTFIELD ROAD MOORESTOWN, NJ 08057

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0269	Correction	ID Prefix A0735	Correction	ID Prefix A0765	Correction
Reg. # 8:36-3.1(a)	Completed	Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. # 8:36-7.4(c)(1)	Completed
LSC	12/12/2025	LSC	12/05/2025	LSC	12/05/2025
ID Prefix A0935	Correction	ID Prefix A1089	Correction	ID Prefix	Correction
Reg. # 8:36-11.4(b)	Completed	Reg. # 8:36-16.3(b)	Completed	Reg. #	Completed
LSC	01/02/2026	LSC	10/20/2025	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	
10/15/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO