STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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: Complaint COMPLAINT #: NJ00173941; NJ00187543 CENSUS: 69 SAMPLE SIZE: 3 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 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;	A 401		

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
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 401	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00173941; NJ00187543 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure the resident's right to live in safe conditions was enforced for 2 of 3 residents, Resident #2 and Resident #3, when the residents NJ Ex Order 26. 4B1 . This deficient practice was evidenced by the following: 1. On 5/19/24, the Department of Health (DOH) received a Facility Reportable Event (FRE) completed by the former Administrator for an NJ Ex Order 26. 4B1 . The FRE indicated that Resident #2, a resident diagnosed with NJ Ex Order 26. 4B1, attended an activity in the facility's lobby at 1:45 p.m., and that at 1:50 p.m., the resident was observed NJ Ex Order 26.4(b)(1) in front of NJ Ex Order 26.4(b)(1). The surveyor reviewed the Medical Record (MR) of Resident #2, who was admitted to the facility in NJ Ex Order 26. 4B1 . The surveyor reviewed a Progress Note (PN) dated NJ Ex Order 26.4(, written by a Registered Nurse (RN), which indicated that care staff brought Resident #2 back into the NJ Ex Order 26. and that the resident was NJ Ex Order 26.4 The surveyor also reviewed Resident #2's "Service Plan Report," initiated on NJ Ex Order 26.4(, which indicated, NJ Ex Order 26. 4B1 ." At 11:44 a.m., the surveyor toured Resident #2's NJ Ex Order 26. 4B1 neighborhood and observed the resident sitting in the dining room with other residents. Resident #2 was NJ Ex Order 26.4(b)(1)	A 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 401	Continued From page 2 but NJ Ex Order 26.4 to participate in an interview with the surveyor. At 11:45 a.m., the surveyor interviewed Caregiver #1 in Resident #2's neighborhood unit to inquire if there were any residents in the neighborhood at NJ Ex Order 26. 4B1. The caregiver stated that there were no residents at risk for NJ Ex Order 26. 4B1. The surveyor then inquired how staff would know if there were residents at risk for NJ Ex Order 26. 4B1, and Caregiver #1 stated that it would be indicated on the unit's assignment sheet. The surveyor reviewed the assignment sheet provided by Caregiver #1 and noted that there was no mention of residents at risk for NJ Ex Order 26. 4B1. At 12:22 p.m., during an interview with the concierge, the surveyor inquired how the concierge knew which residents were at NJ Ex Order 26. 4, and the concierge provided the surveyor with a printed list of NJ Ex Order 26. 4B1 residents, their NJ Ex Order 26.4(and names. Resident #2 and Resident #3 were included on this list. At 12:42 p.m., the surveyor interviewed Certified Medication Aide (CMA) #3, who worked in Resident #2's neighborhood when the resident NJ Ex Order 26.4, to inquire how she knew which residents were at NJ Ex Order 26. 4B1 and to inquire about what happened on NJ Ex Order 26.4(b)(1). CMA #3 stated that she did not know which residents were NJ Ex Order 26. 4B1. In addition, CMA #3 stated that during a lobby activity on NJ Ex Order 26.4(, she and a caregiver observed Resident #2 NJ Ex Order 26.4(b)(1) and brought the resident NJ Ex Order 26. 4B1. CMA #3 stated that during that time, the NJ Ex Order 26.4(b)(1) could only be opened with a "NJ Ex Order 26. 4B1" that was kept with the former NJ Ex Order 26.4(b)(1) and that when Resident #2 was NJ Ex Order 26.4(b)(1), the former NJ Ex Order 26.4(b)(1) was at the rear of the lobby	A 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 401	Continued From page 3 talking to visitors. At 1:00 p.m., the surveyor interviewed the Activity Assistant Director (AAD) to inquire how activity staff knew which residents were at NJ Ex Order 26. 4 [redacted]. The AAD stated that there was an NJ Ex Order 26. 4B1 list at the front desk in the lobby and that residents at NJ Ex Order 26. 4B1 were also discussed during morning meetings. The surveyor inquired if the AAD worked on NJ Ex Order 26.4(b)(when Resident #2 NJ Ex Order 26. 4B1 during an activity in the lobby, and the AAD stated that she did. The AAD stated that on NJ Ex Order 26.4(b) a visitor observed Resident #2 NJ Ex Order 26.4(b)(1) the NJ Ex Order 26.4(b)(1). The AAD stated that at that time, NJ Ex Order 26.4(b)(1) had a "NJ Ex Order 26. " to open the NJ Ex Orde [redacted] and that the former NJ Ex Order 26.4(b)(1) had her back towards the NJ Ex Order 26.4(b)(1) as she spoke to a visitor, and Resident #2 NJ Ex Order 26. 4. The surveyor reviewed a "Summary and Conclusion," dated NJ Ex Order 26.4(b), which indicated, "[redacted]." At 3:53 p.m., the surveyor interviewed the Administrator to inquire how staff knew which residents were at NJ Ex Order 26. 4B1, and the Administrator stated that NJ Ex Order 26. 4B1 residents were identified in the electronic health records and that NJ Ex Order 26.4 [redacted] of NJ Ex Order 26. 4B1 residents were at the front desk. The surveyor inquired if staff were aware that the NJ Ex Order 26. 4B1 list was located at the front desk, and the Administrator stated that they were. The surveyor reviewed an in-service dated 5/16/24, titled, "Main door to be watched during main events/group & big activities; Elopement,"	A 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 401	Continued From page 4 which revealed that Caregiver #1 (NJ Ex Order 26. 4B1) and CMA #3 (NJ Ex Order 26. 4B1) did not receive the in-service training. The surveyor also reviewed an in-service dated NJ Ex Order 26.4(b) titled, "Residents who are high risk for NJ Ex Order 26.4(b)(1) which revealed that Caregiver #1 also did not receive this in-service training. The facility failed to monitor Resident #2 and the facility's NJ Ex Order 26.4(b)(1 to ensure the resident's safety and security. In addition, two of four staff interviewed were not able to identify residents at NJ Ex Order 26. 4B1 or identify an NJ Ex Order 26. 4B1 identification system. Further, all facility staff did not receive the previously mentioned in-service trainings following Resident #2's NJ Ex Order 26. 4B1. 2. On 6/23/25, the DOH received a FRE completed by the facility's interim Administrator for an NJ Ex Order 26. 4B1 . The FRE indicated that that at approximately 6:15 p.m., a visitor notified the NJ Ex Order 26.4(b)(1) that Resident #3, a resident diagnosed with NJ Ex Order 26. 4B1 . The FRE indicated that at 6:30 p.m., a Licensed Practical Nurse and two other care staff responded and found Resident #3 NJ Ex Order 26.4(NJ Ex Order 26. 4B1. In addition, the FRE indicated that Resident #3 NJ Ex Order 26. 4B1 in one of the facility's NJ Ex Order 26. 4B1 neighborhoods. The surveyor reviewed the MR of Resident #3, who was admitted to the facility in NJ Ex Order 26. 4B1 . The surveyor also reviewed Resident #3's "Medication Review Report," which indicated that the resident had an order dated	A 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 401	Continued From page 5	A 401		

NJ Ex Order 26. 4B1 . In addition, the surveyor reviewed Resident #3's "Service Plan Report," initiated on NJ Ex Order 26.4(b), which indicated that Resident #3 '*NJ Ex Order 26. 4B1* ."

At 12:13 p.m., the surveyor toured Resident #3's *NJ Ex Order 26. 4B1* neighborhood and observed the resident NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(1). The surveyor was not able to interview Resident #3.

At 12:30 p.m., the surveyor interviewed the Maintenance Assistant (MA) to inquire how often the facility's doors were checked, and the MA stated that all facility NJ Ex Order 2 were checked daily and that the checks were documented. The surveyor inquired if the MA was on duty when Resident #3 *NJ Ex Order 26. 4B1*, and the MA stated that he was not. The surveyor then requested documentation of the NJ Ex Order 26.4(b)(1).

The MA provided the surveyor with a document titled, "Daily Maintenance Rounds," dated NJ Ex Order 26.4(b)(1), which indicated that NJ Ex Order 26.4 functioned properly on NJ Ex Order 26.4(b)

At 2:37 p.m., the surveyor interviewed Caregiver #2, who worked in Resident #3's neighborhood when the resident *NJ Ex Order 26. 4B1*, to inquire as to what happened. Caregiver #2 stated that Resident #3 *NJ Ex Order 26. 4B1* . Caregiver #2 explained that prior to Resident #3's *NJ Ex Order 26. 4B1*, she observed the resident watch television in the library room. Caregiver #2 stated that she went across the hall to put items in the laundry, and that when she returned, another caregiver in the neighborhood asked of Resident #3's whereabouts. Caregiver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 401	Continued From page 6	A 401		

#2 stated that at that time, the NJ Ex Order 26.4(b)(1) paged the caregivers to the NJ Ex Order 26.4(b)(1) for an emergency, and that the concierge informed the caregivers that a visitor observed a resident NJ Ex Order 26.4(b)(1). Caregiver #2 stated that the caregivers NJ Ex Order 26.4(b)(1) and observed Resident #3 NJ Ex Order 26. 4B1 .

At 3:53 p.m., the surveyor interviewed the Administrator to inquire about Resident #3's NJ Ex Order 26. 4B1 . The Administrator stated that she was out of State when Resident #3 NJ Ex Order 26.4 and that an interim Administrator covered the facility. The Administrator explained that she received a phone call from the interim Administrator on NJ Ex Order 26. 4B, who informed her of Resident #3's NJ Ex Order 26. 4B1. The Administrator stated that during the investigation, staff observed NJ Ex Order 26.4(b)(1) in Resident #3's neighborhood NJ Ex Order 26.4(b)(1). The Administrator stated that the NJ Ex Order 26.4(b)(1) required a key to NJ Ex Order 26.4(b)(1), and that NJ Ex Order 26.4(b)(1) to a staff parking lot. The Administrator also stated that it was possible that NJ Ex Order 26.4(b) was used by staff even though staff knew that they were to only use the NJ Ex Order 26.4(b)(1) The surveyor inquired how staff were able NJ Ex Order 26 through the NJ Ex Order 26.4(b)(1) if a key was required to open it. The Administrator stated that she was told that the former Maintenance Director (MD) gave keys to some staff for the NJ Ex Order 26.4(b)(1) The Administrator stated that the current MD stated that he checked the NJ Ex Order 26.4(b)(1) 10:00 a.m. on NJ Ex Order 26.4(b)(and that the NJ Ex Orde was locked. The Administrator stated that the MD stated that he thought he was the only staff member with a key to open the NJ Ex Order 26.4(b)(1) because he thought he collected all the key copies that were handed out by the former MD.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 401	Continued From page 7 The surveyor reviewed an in-service dated NJ Ex Order 26.4(b) titled, "NJ Ex Order 26.4(b)(1)," which revealed that Caregiver #2 did not receive the in-service training following Resident #3's NJ Ex Order 26. 4B1. The surveyor reviewed an "Investigative Summary and Conclusion," dated NJ Ex Order 26.4(, which indicated that Resident #3 NJ Ex Order 26. 4B1 , which was NJ Ex Order 26.4(b)(1) at the time the resident was NJ Ex Order 26. 4B1. At 4:22 p.m., during exit conference, the Regional Director of Clinical Services stated that the NJ Ex Order 26.4(b)(1) in Resident #3's neighborhood would be switched from NJ Ex Order 2 to NJ Ex Order 26.4(b)(1) on 7/11/25, which would allow the NJ Ex Order 26.4(b)(1) automatically. The surveyor reviewed the facility policy titled, "2 Dementia Care Unit," revised on 2/14/2014, which indicated, "Process ... 2. Provide a safe and secure environment including the use of elopement risk identification and reduction practices and equipment ... 8. Provide ongoing monitoring of each resident and assess for changes in cognition, behavior, or physical function ..." The surveyor also reviewed the facility's policy titled, "Emergency Procedure-Missing Resident," revised in 8/2018, which indicated, "Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety ...." Lastly, the surveyor reviewed the facility's policy titled, "6 Dementia Care Unit Activities Program," revised on 7/3/18, which indicated, " ... Sufficient	A 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 401	Continued From page 8 center staff will be provided to meet the safety and programmatic needs of the resident. 4. Activities may not be limited to the unit, however, the resident must be assessed by the interdisciplinary team (IDT) as to the appropriateness of the resident participating in activities off the unit. Sufficient staff must be available for resident safety. The resident, if appropriate, will be allowed to leave the unit but will be escorted and supervised at all times including special events, entertainment, and parties ...."	A 401		
A 553	8:36-5.7(b) General Requirements (b) The facility shall have a policy and procedure that addresses how policy and procedure manuals will be made available to residents, guardians, designated responsible individuals, prospective applicants, and referring agencies. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to develop and implement a Policy and Procedure (P&P) that addressed how P&P manuals would be made available to residents, guardians, designated responsible individuals, prospective applicants, and referring agencies, and representatives of the Department of Health (DOH). This deficient practice was evidenced by the following: On 7/10/25 at 9:39 a.m., during entrance conference, the surveyor requested the facility's P&P manual, and the Administrator stated that the facility's P&P manual was electronic. At this	A 553		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 553	Continued From page 9 time, the surveyor requested access to the electronic P&P manual, and the Administrator stated that she did not think access could be given and that she would find out. The surveyor requested the table of contents for the electronic P&P manual. The Administrator did not provide the surveyor with access to the electronic P&P manual. Surveyor review of the "2024 Care One Electronic Policy Manual Listing," provided by the Administrator revealed no P&P listed that addressed facility's P&P manual availability. At 3:29 p.m., upon further surveyor's interview of the Administrator to inquire if the facility had a P&P that addressed how P&Ps should be made available to residents, staff, responsible parties, state agencies, and representatives of the NJDOH, the Administrator again stated that she would check. At 3:49 p.m., the Administrator stated that she was not able to locate a P&P on P&P availability, and that she asked the Vice President of Education and Clinical Standards (VPECS) to look for the policy. At 3:53 p.m., the Administrator stated that the VPECS confirmed that there was no P&P Availability policy. The facility failed to provide the surveyor with access to the facility's P&P manual.	A 553		
A 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if	A 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 563	Continued From page 10 after business hours, followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, any elopements; and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00187543 Based on interview, record review, and review of pertinent facility documents it was determined that the facility failed to notify the Department of Health (DOH) in writing within 72 hours after 1 of 3 residents [redacted], Resident #3. This deficient practice was evidenced by the following: On 6/23/25, the DOH received a Facility Reportable Event (FRE) completed by the facility's interim Administrator on 6/22/25 for an [redacted]. The FRE indicated that Resident #3 [redacted] in one of the facility's [redacted] neighborhoods.	A 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK	301 N STANWICK 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 563	Continued From page 11 During the survey on 7/10/25 at 3:53 p.m., the surveyor interviewed the Administrator regarding the timeframe for sending a written confirmation to the NJDOH of a resident's [redacted], and the Administrator stated that the facility had 24 hours. The surveyor then inquired the reason the DOH was not notified of the previously mentioned [redacted] in writing within 72 hours. The Administrator stated that she was out of State when Resident #3 [redacted] and that after she was notified of the [redacted] by the interim Administrator, she immediately called the DOH to notify them of the [redacted]. However, the Administrator stated that the FRE was completed by the interim Administrator, and not her. The surveyor reviewed the facility's policy titled, "Unusual Occurrence Reporting," revised in 12/2007, which indicated, "As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors ... 3. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within fort-eight (48) hours of reporting the event or as required by federal and state regulation ...."	A 563		

Harmony
VILLAGE
at CareOne Stanwick Road

Harmony Village Care One at Stanwick Rd.
ID # 03A004
Complaint Survey July 10, 2025
POC Updated: September 15, 2025

A401 – 8:36-4.1(a)(22) Resident Rights (Resident #2)

1. How will the corrective action be accomplished for those residents who are found to have been affected by the deficient practice?
   a. On [redacted], Resident #2 was witnessed by a visitor [redacted] alongside [redacted] at the same time. Resident #2 was immediately and [redacted] the community.
   b. The RN updated Resident #2 service plan to reflect [redacted] on [redacted].
   c. Resident #2 [redacted] was added to the [redacted] document kept at the [redacted] for immediate reference on [redacted] by the [redacted]
   d. New lobby procedure during group programming implemented on 5/16/24 by (previous) Executive Director, requiring a staff member to be present at the [redacted] for the duration of all lobby activities. This is ongoing and still in place today.
   e. In-service provided to staff regarding the new lobby procedure and elopement protocol on 5/16, 5/28 and 5/29/24 by RN and Executive Director.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
   a. Due to their dementia diagnoses, all residents, especially current elopement risks, have the potential to be affected by unsecured exit doors not being properly monitored by staff.

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

a. The interdisciplinary team (RN/Director of Wellness, Executive Director, Resident Services Director, Wellness Nurse, Dementia Care Specialist) will discuss at the daily morning meeting, and as needed throughout the day, if any residents are exit-seeking or at risk of elopement.
b. Service plans will be updated the same day by the RN when a new elopement risk is identified.
c. Photos in the elopement risk document at the front desk will be updated by the concierge the same day, when a new elopement risk is identified.
d. Mandatory elopement risk identification training will be covered during new hire orientation by the Regional Employment Coordinator and Dementia Care Specialist.
e. "Lobby duty" procedures (a staff member monitoring the front door during all group activities) will be reinforced at monthly staff meetings by the Executive Director.
f. Staff will be informed through a written communication binder and verbally at shift change meetings by the LPN/RN when a resident service plan has been updated to reflect an elopement risk.
g. The Resident Services Director will update staff assignment sheets the same day a new elopement risk is added to a resident's service plan. Updated sheets will be distributed at the start of each shift, and staff will be informed of the change.

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 in place to monitor the continued effectiveness of the systemic change.

a. Elopement risks will be reviewed at quarterly QAPI meetings on an on-going basis by the interdisciplinary team.
b. Resident Services Director will coordinate with Activities Director daily to schedule and monitor staff assigned to "lobby duty" each day there are group lobby activities.
c. The Executive Director or designee will conduct weekly staff knowledge checks. These will include on-the-spot questions asking staff to identify elopement risks in their assigned neighborhood (unit) and to locate the elopement risk document.

Harmony
VILLAGE
at CareOne Stanwick Road

5. Completion date: June 30th, 2024

A401 – 8:36-4.1(a)(22) Resident Rights (Resident #3)

1. How will the corrective action be accomplished for those residents who are found to have been affected by the deficient practice?
   a. Resident #3 was last seen at 5:50pm by caregivers on [redacted] and [redacted] at 6:15pm by a visitor. Resident # 3 was safely [redacted] the community at that time by the LPN and caregiver.
   b. The RN updated Resident #3 service plan to reflect [redacted] on [redacted]
   c. Resident #3 [redacted] was added to the [redacted] document kept at the [redacted] for immediate reference on [redacted] by th[redacted]
   d. On [redacted], the Maintenance Director checked and confirmed all [redacted] were secured immediately following Resident #3 [redacted] to ensure all residents were in a safe environment.
   e. On 6/18/25, [redacted] Controls were contacted for an estimate on the scope of work to switch [redacted] where the [redacted] occurred to [redacted] replacing the existing [redacted]
   f. On 7/15/25, [redacted] concluded the work on [redacted] and converted it into [redacted] for additional security.
   g. Upon review of all resident service plans by the RN, photos in the [redacted] document at the [redacted] were updated by the [redacted] with all potential [redacted] on 6/18/25.
   h. Staff were reeducated on the [redacted] document location, the risks of an unsecured door and proper [redacted] procedures on 6/20/25 by the interim Executive Director (A.M.).
   i. The Resident Services Director will update staff assignment sheets the same day a new [redacted] is added to a resident's service plan. Updated sheets will be distributed at the start of each shift, and staff will be informed of the change.

Harmony
VILLAGE
at CareOne Stanwick Road

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    a. Due to their dementia diagnoses, all residents, especially current elopement risks, have the potential to be affected by unsecured exit doors.

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.
    a. The interdisciplinary team (RN/Director of Wellness, Executive Director, Resident Services Director, Wellness Nurse, Dementia Care Specialist) will discuss at the daily morning meeting, and as needed throughout the day, if any residents are exit-seeking or at risk of elopement.
    b. Service plans will be updated the same day by the RN when a new elopement risk is identified.
    c. Photos in the elopement risk document at the front desk will be updated by the concierge the same day upon identifying an elopement risk.
    d. Mandatory elopement risk identification training will be covered during new hire orientation by the Regional Employment Coordinator and Dementia Care Specialist.
    e. Staff will be informed through a written communication binder and verbally at shift change meetings by the LPN/RN when a resident service plan has been updated to reflect an elopement risk.
    f. Elopement risks will be reviewed at the monthly all-staff meetings by the Executive Director on an ongoing basis.

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 in place to monitor the continued effectiveness of the systemic change.

    a. The Executive Director or designee will conduct audits of external door security weekly for 3 months, then monthly thereafter.
    b. The Executive Director or designee will conduct weekly staff knowledge checks. These will include on-the-spot questions asking staff to identify elopement risks in their assigned neighborhood (unit) and to locate the elopement risk document.
    c.

d. Elopement risks will be reviewed at quarterly QAPI meetings on an on-going basis by the interdisciplinary team.
e. Elopement risks will be reviewed at monthly all-staff meetings by the Executive Director on an ongoing basis.

5. Completion date: August 27, 2025

A553 – 8:36-5.7(b) General Requirements

1. How will the corrective action be accomplished for those residents who are found to have been affected by the deficient practice?
    a. A written policy titled "Availability of Policies and Procedures" was created by the Vice President of Education (L.C.) and implemented on 8/22/25.
    b. The leadership team members were educated on the new policy by the Executive Director on 8/22/25.
    c. All other team members were educated on the new policy by the Executive Director on 9/2/25.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    a. Without a policy in describing the availability of policy and procedure, all residents, visitors, responsible parties and prospective employees 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.
    a. The full policy and procedure manual is now available by PDF when requested by residents and visitors including surveyors, responsible parties and prospective employees.
    b. To ensure the P&P manual is up to date, upon request, a team member will contact the Vice President of Education (L.C.) requesting the current P&P policies via PDF, which will then be emailed to the person making the request.

c. The electronic manual was updated with the new policy "Availability of Policies and Procedures" on 8/22/25 by the Vice President of Education.
d. All staff were educated on the updated policy and procedure on 9/2/25 by the Executive Director.
e. A new notice was displayed in the lobby entrance on 8/23/25 that policy manuals are available in PDF form, via email, upon request.

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 in place to monitor the continued effectiveness of the systemic change.
    a. The Executive Director will review this policy at all-staff meetings monthly for 3 months and then quarterly thereafter.
    b. Staff will be educated by the Regional Employment Coordinator upon hire on the procedure to access policy and procedure manuals.
    c. P&P manual access will be reviewed at QAPI meetings biannually by the interdisciplinary team.

5. Completion date: September 2, 2025

A563 – 8:36-5.10(a)(2) General Requirements

1. How will the corrective action be accomplished for those residents who are found to have been affected by the deficient practice?
    a. While the primary Executive Director (E.G.) was out of state, the interim Executive Director (A.M.) notified E.G. by phone of Resident #3's [redacted]. E.G. immediately called in the reportable event. Since E.G. was not on-site, A.M. was responsible for the investigation, follow-up, and written report. The acting Executive Director submitted the report late to the DOH on 7/22/25. The primary Executive Director was not aware of the late submission until her return to the community on 6/24/25. Moving forward, the primary Executive Director will submit written reportable events within 72 hours, 100% of the time. If there is an interim Executive Director, that person will be given clear instructions to submit a written reportable within 72 hours in the primary Executive Director's absence.

Harmony
VILLAGE
at CareOne Stanwick Road

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    a. All residents have the potential to be affected by this deficient practice, as delayed response to major events puts their safety at risk.

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

    a. Policy and procedure was reviewed clarifying the 72-hour compliance window of written reportable events with all leadership team members by the primary Executive Director upon her return on 6/24/25.
    b. The primary Executive Director will educate alternate or interim Executive Directors on their responsibility to complete the AAS-45 and the required steps for completion, including the mandatory 72-hour window for submission.

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 in place to monitor the continued effectiveness of the systemic change.
    a. The Executive Director will review all facility reportable events each month for six months to ensure they were submitted within required time frames.

5. Completion date: August 27, 2025 all tags accepted 9/18/25 [redacted] NJ Ex Order 26. 4BI

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
03A004 Y1	A. Building B. Wing Y2	9/18/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK ROAD	301 N STANWICK 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 A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 09/15/2025	ID Prefix A0553 Reg. # 8:36-5.7(b) LSC	Correction Completed 09/15/2025	ID Prefix A0563 Reg. # 8:36-5.10(a)(2) LSC	Correction Completed 09/15/2025
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	
7/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 6THF12