STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Evesham	870 East Route 70 Marlton, NJ 08053

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. COMPLAINT #2083729, 2805511 Based on interviews, review of medical records and pertinent facility documentation on 5/1/26, it was determined that the facility failed to thoroughly investigate a fall after the resident reported to staff that their injury, which the facility labeled as injury of unknown origin was sustained from a fall. This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed for falls and was evidenced by the following:Resident #2 was no longer at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record revealed that Resident #2 was admitted to the facility with diagnoses that included but were not limited to: discitis (an infection of the intervertebral disc space) of the lumbar region, cirrhosis of liver, and difficulty walking. Review of the comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated 3/14/26 indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating that the resident's cognition was moderately impaired. Review of Resident #2's Care Plan (CP) revealed a focus related to the resident being at risk for falls due to having an unsteady gait which was initiated on 3/9/26. A review of an Incident Report (IR) provided by the facility, dated 3/12/26 at 9 AM, revealed that the resident had an injury of unknown origin. The resident was observed to have bruising around the left eye. The resident reported being unsure of how it happened. A review of Resident #2's progress notes (PN) revealed a physician note dated 3/13/26 at 2:19 PM, which revealed that the resident was assessed by a physician due to a recent fall causing bruising to the left eye. Further review of the PN revealed a nursing note dated 3/13/26 at 4:56 PM, which stated that the resident reported that the bruising on their eye occurred because the resident fell. According to the Facility Reportable Event (FRE) which the facility submitted to to the Department of Health on 3/12/26, a nurse observed a bruise on the resident's left eye while providing care. The resident was unsure how the bruise occurred at the time. The facility concluded that the injury was determined to be of unknown origin. No information was provided to the surveyor that the facility reassessed the incident as a result of a fall as indicated in the PN above. An interview was conducted on 5/1/26 at 1:40 PM, with Registered Nurse (RN #1) who stated that if a resident reported that they fell, she would report to a supervisor immediately, and an incident report would be completed along with a Risk Assessment. RN #1 stated that she remembered seeing Resident #2 with a black eye one morning and she reported it immediately. She further stated that the resident's family had mentioned that Resident #2's black eye was sustained when the resident fell in the bathroom. When the surveyor asked RN #1 what she did after the resident family's report, she stated that she told the nursing supervisor who informed her the injury was already being investigated. RN #1 further stated that she was not sure if a fall incident report was completed. The Surveyor requested for a list of all residents that had fallen at the facility in the month of March 2026 which did not include Resident #2. No documentation was provided that Resident #2's fall was investigated. An interview was conducted on 5/1/26 at 2:28 PM with the Assistant Director of Nursing (ADON), she stated that if a resident reported that they fell, she expected staff to start gathering information about the fall. She further stated that she expected that staff would complete an IR, and that an investigation would be initiated into the incident for the the team to determine if any (continued on next page)

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.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions needed to be updated and/or added to ensure that residents remained safe. In the presence of surveyor, ADON reviewed the PN for the resident which revealed that the resident had a fall. A joint interview was conducted on 5/1/26 at 4:35 PM with the ADON and the Licensed Nursing Home Administrator (LNHA). The surveyor asked if the facility was aware that the resident's report of a fall and they both stated yes. The surveyor asked if the facility's fall policy had been fully implemented and they stated that it had not. Review of the facility's Assessing Falls and Their Causes policy, revised March 2018, revealed that after a fall an IR would be completed within 24 hours of the fall by the nursing supervisor. The policy further revealed that an attempt to identify a cause would begin within 24 hours. Review of the facility's Accidents and Incidents - Investigating and Reporting policy, revised July 2017, revealed that, .The circumstances surrounding the accident or incident . along with any follow-up information and pertinent data would be included in the Report of Incident/Accident form. N.J.A.C. 8:39-27.1(a)