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	09/12/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 31 residents reviewed. (Resident #63). This deficient practice was evidenced by the following:A review of Resident # 63's admission Recorded revealed the resident was admitted to the facility with the following but not limited to diagnosis, unspecified sequelae of cerebral infarction. (stroke)A review of Resident # 63's Electronical Medical Record (EMR) revealed physician's orders for escitalopram oxalate oral tablet 20 milligrams (MG) (a medication used to treat depression and anxiety). The EMR also revealed a physician's order for valproic acid 250mg/5 milliliters (a medication that can be prescribed to manage mood disorders) was to be given three times a day for mood.A review of Resident #63's Care Plan (CP) revealed a focus stating At risk for changes in mood related to diagnosis of depression with an initiated date of 07/07/2025.A review of Resident # 63's admission Minimal Data Set (MDS; an assessment tool) from 07/09/2025 revealed under section I that there was no active diagnosis for depression or mood disorders. Also, on the MDS in section N revealed that Resident # 63 was taking an antidepressant.During an interview on 09/11/2025 at 09:34 AM with the surveyor, the MDS coordinator said they review hospital records, care plans, lab work, x-rays and medications when completing the MDS. When asked if Resident # 63 should have a diagnosis depression on their MDS, the MDS coordinator stated, Absolutely it should be there, we missed thatDuring an interview on 09/11/2025 at 12:01 PM with the surveyor, the Director of Nursing, (DON) said it was important for the MDS to be accurate because if captures the level care the resident needs. The facility policy titled Resident Assessment revealed under POLICY INTERPRETATION AND IMPLEMENTATION that, 6. The resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessment.NJAC 8:39-11.2(e)1

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure nutritional formula connected to a feeding tube (surgically placed tube into the stomach to provide nutritional formula) was accurately labeled for 1 of 1 resident (Resident #7) reviewed for tube feeding. The deficient practice was evidenced by the following: On [DATE] at 08:25 AM, the surveyor observed a bottle of nutritional formula hanging from a pole that was connected to a feeding pump attached to Resident #7's feeding tube while he/she was in bed. The feeding pump was operating. At that time, the surveyor observed that the bottle was not labeled with the residents, name, start time or the amount that was to be infused. A review of Resident #7's admission Minimum Data Set (an assessment tool) dated [DATE], revealed that he/she had a feeding tube while a resident in the facility. A review of Resident #7's physician orders located in the electronic medical record (EMR) revealed an order for Glucerna 1.5 (nutritional formula) to be given at 65mL (milliliters) an hour via pump infusion through the feeding tube at 6:00 PM to infuse a total of 1300mL has infused. During an interview on [DATE] at 09:26 AM with the surveyor the, Registered Nurse Unit Manger (RNUM) said that when nutritional formula is hung it should be labeled with the name, date, time and volume to be infused. When the surveyor reviewed the findings of the unlabeled hanging formula bottle with the RNUM, she said It should be labeled. That is unacceptable.During an interview on [DATE] at 12:01 PM with the surveyor, the Director of Nursing (DON) said the hanging nutritional formula should be labeled with the date, time, and residents name. The DON said labeling is important to know exactly when the feeding started to make sure it has not expired or has been infusing for too long. A review of the facility policy titled, Enteral Tube Feeding via Continuous Pump updated on 11/2018, revealed under initiate feeding number 5., On the formula label document initials, date and time the formula was hung/administer, and initial that the label was checked against the order. NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. NJ Complaint: #360874 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to follow the prescriber's orders and acceptable professional standards and principles by administering medications past the required time frame. The deficient practice was identified for 1 of 1 resident reviewed for being free of significant med errors. The deficient practice was evidenced by the following: A review of Resident #121's admission record reflected that this resident had diagnosis which included but not limited to: surgical aftercare following surgery on the skin and heart failure (a weakened heart muscle). A review of Resident #121's physician's orders revealed the following orders but not limited to: 2/14/25 Aspirin tablet chewable 81 MG (milligram) give 1 tablet by mouth one time a day for coronary artery disease, Plavix tablet 75 MG give 1 tablet by mouth one time a day for coronary artery disease, gabapentin 300mg give 1 capsule by mouth three times a day for neuropathy. A review of Resident #121's Medication Administration Audit Report for February 2025 revealed the following medications were administered past the required time frame as follows: On 02/15/2025:Aspirin scheduled for 09:00 AM was given at 12:29 PM Plavix scheduled for 09:00 AM was given at 12:33 PMGabapentin scheduled for 09:00 AM was given at 12:32 PMOn 09/10/2025 at 10:41 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) stated that medications should be administered one hour before or one hour after the scheduled medication administration time. She said that the medications should be documented as administered right after they are given to the resident. Lastly, she said that medications should not be signed out late but should be documented if that occurred. On 09/11/2025 at 12:03 PM, during an interview with the surveyor, the Director of Nursing said that medications should be administered according to the physician orders and should be documented at the time of administration. A review of the facility policy titled, Administering Medications with a revision date of November 2017, reflected under number 11., Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. A review of the facility provided policy titled, Documentation of Medication Administration, with a revision date November 2022 reflected 3. documentation of medication administration includes at a minimum: e. date and time of administration. N.J.A.C.: 8.39-29.2 (d)