STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Moorestown	895 Westfield Road Moorestown, NJ 08057

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. (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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, review of the facility's admission Agreement and facility policy review, the facility failed to provide information regarding a resident's right to choose an attending physician for one (Resident (R)1) of three sampled residents reviewed for facility's admissions process in a total sample of 21 residents. This had the potential R1's rights not to be upheld and honor his/her right to have a physician of his choice.Review of the facility's policy titled, admission Agreement dated 08/18, indicated, Policy statement All residents must have a signed and dated admission agreement on file. Policy Interpretation and Implementation 1. At the time of admission, the resident (or his/her representative) must sign an admission agreement (contract). 2. The admission agreement (contract) will reflect all charges for covered and non-covered items, as well as identify the parties that are responsible for payment of such services . 4. A copy of the admission agreement is provided to the resident or his/her representative (sponsor), and a copy placed in the resident's permanent file . Review of the facility's undated admission Agreement provided by the facility, specified . ARTICLE X RESIDENT'S PERSONAL PHYSICIAN OR OTHER PROVIDER 1. Personal Physician. Resident may choose a licensed personal physician. In the event that Resident does not choose a physician, Facility shall appoint one to provide services to Resident, as needed, at the Resident Parties' expense . 2. Personal Physician Without Facility Staff Privileges. Physicians and other healthcare providers who do not have staff privileges at the Facility are prohibited from providing healthcare services at the Facility, except in cases of life-threatening emergency. If Resident chooses a physician, dentist or other healthcare provider who does not have staff privileges at the Facility, Resident must travel, at Resident Parties' expense, to that healthcare provider to receive services from that provider . Review of R1's Durable Healthcare Power of Attorney (HCPOA) and Living Will [R1's name] which was signed by R1 on 05/04/16 and located under the Misc [Miscellaneous] tab of the resident's EMR, specified R1 had appointed F1 to serve as his Health Care Representative. R1's HCPOA and Living Will specified the following: . 1.3 Employ or Discharge Health Care Personnel- My Health Care Representative shall be authorized to employ or discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Health Care Representative shall deem necessary for my physical, mental, and emotional well-being and to pay them reasonable compensation . Review of R1's Resident Evaluation note, which was dated 10/09/24, timed at 11:04 AM and located under the Prog [Progress] Note tab of the electronic medical record (EMR), indicated, Resident Evaluation completed for [R1's name] arrived via stretcher . Review of R1's facility admission Record located under the Profile tab of the EMR revealed the resident was admitted to the facility on 10/24 with diagnoses which included dementia, abnormalities of gait and mobility, difficulty walking, and history of falling. Family Member (F)1 was listed as R1's Guardian and Emergency Contact #1. Review of R1's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/11/24, located in the MDS tab of the EMR, revealed R1 had a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated he/she had moderately impaired cognition. During an interview on 08/06/25 at 10:50 AM, F1 stated he/she was R1's HCPOA and was present with R1 when he/she arrived at the facility and was admitted on 10/24. F1 stated when R1 arrived at the facility on 10/24 staff took R1 and himself/herself to his/her room on the second floor. F1 stated there was not any type of admission conference with staff and staff did not provide R1 or himself/herself with any information about the facility or an admission agreement. F1 stated a Nurse Practitioner came into R1's room on 10/24 and had him/her sign a one-page form which he/she believed was a consent for treatment, but he/she was not provided any option to choose a physician for R1. F1 stated he/she discharged R1 from the facility Against Medical Advice (AMA) on 10/13/24. F1 explained that prior to or during R1's stay at the facility R1, himself/herself, or any other family member, never received any information on resident rights, admission information, or a facility admission agreement. F1 stated he/she would have liked to have received information regarding choosing a physician, so he/she could have made an informed decision on selecting a physician for R1. During an interview on 08/06/25 at 11:35 AM, the Admissions Director (ADMD) stated she was not employed at the facility when R1 was admitted in October 2024. The AD reviewed R1's information in the EMR and confirmed he/she was admitted to the facility on 10/24 and F1 was his/her HCPOA. The AD stated there was no information in R1's EMR that an admission Agreement was signed or the information was provided to R1's HCPOA or R1. The AD explained that the facility's admission Agreement should have been provided to R1's HCPOA on 10/24 when the resident was admitted to the facility and a copy of a resident's signed admission

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to provide a hazard free environment for one of five residents (Resident (R) 8) reviewed for accidents out of a total sample of 21 residents. During a staff assisted transfer R8 suffered harm when the metal frame of his/her bed which had exposed openings with rough edges cut his/her leg and resulted in a large laceration which required sutures at a hospital emergency room (ER) to close the wound.Review of the facility's policy titled, Safety and Supervision of Residents dated 07/21, indicated, Policy statement Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation Facility Oriented Approach to Safety . 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process: QAPI [Quality Assurance and Performance Improvement] reviews for safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization . Review of R8's facility admission Record located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on 04/25 with diagnoses which included abnormalities of gait and mobility, and history of falling. Review of R8's Care Plan located under the Care Plan tab of the EMR, revealed the following Focus area which was initiated on 04/30/25: At risk due to history of falls, impaired balance/poor coordination, medication side effects. A care plan intervention specified, Provide assistance to transfer and ambulate as needed. Review of R8's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/06/25, located in the MDS tab of the EMR, revealed R8 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated he/she was cognitively intact and required substantial assistance when transferring from chair to bed. Review of R8's Nursing/Clinical Notes located in the Prog [Progress] Note tab of the EMR revealed the following note written by Licensed Practical Nurse (LPN) 1 on 05/24/25 5:00 PM: This nurse notified by assigned CNA [Certified Nursing Assistant] that resident had obtained a skin tear to right lower shin. Skin tear acquired when CNA transferred resident from wheelchair to bed. Visible bleeding seen; this nurse cleaned and covered with dressing to contain the bleeding. Resident sent out to ER via Transport for possible stitches. Review of the facility's incident report of R8's leg laceration dated 05/24/25, provided by the facility and prepared by LPN1, indicated, Nursing Description: Resident obtained a skin tear while being transferred from wheelchair bed. Statements Per [CNA 1's name] Patient was being transferred to bed from wheelchair via stand/pivot. Transfer went smoothly, however patient expressed pain after sitting on bed. CNA noticed blood on patients' leg and alerted LPN. CNA states the bed frame had an area of metal tubing that did not have a cap on it and was exposed. CNA states she believes the patients leg made contact with the exposed bed frame, causing the laceration. Review of R8's 05/24/25 ER After Visit Summary located in the Misc [Miscellaneous] tab of the EMR specified, . You had a large laceration with absorbable sutures placed and then nine horizontal mattress sutures [type of stitch used in wound closure creating a wide, strong closure] placed. This was covered with 5 Steri- Strips . Diagnosis Laceration of right lower leg initial encounter . During an interview on 08/05/25 at 1:25 PM, Family Member (F)3 stated that he was notified by the facility on 05/24/25 that R8 had experienced a laceration to his/her leg and was being transported to the hospital for treatment. F3 stated R8's leg laceration required sutures to close the wound. F3 stated after R8 returned to the facility on [DATE] he viewed the resident's metal bed frame and observed the openings in the frame were still with rough edges that were not covered. During an interview on 08/05/25 at 2:20 PM, CNA1 stated on 05/24/25 she was transferring R8 from wheelchair to the bed and when R8 sat on the bed she noticed that the resident's leg was bleeding. CNA1 stated during the transfer R8's leg rubbed against the bed's metal frame, which had an open circular area with rough edges which caused the injury. CNA1 stated when she saw that the resident's leg was bleeding, she notified the nurse immediately. During an interview on 08/06/25 at 6:30 AM, LPN1 stated on 05/24/25 CNA1 informed her that R8's leg was bleeding, and she immediately went to the resident's room to check the resident's condition. LPN1 stated R8 had a large laceration to his/her right leg that was bleeding, and she notified the resident's physician and family. LPN1 explained that due to the size of the leg laceration and amount of bleeding she called Emergency Medical Services (EMS) to transport R8 to the hospital to see if he/she needed stitches. During an interview on 08/06/25 at 9:15 AM, the Director of Environmental Services (DES) stated the Administrator notified him

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and facility policy review, the facility failed to ensure that medications were administered in a sanitary manner for two of five (Residents (R)18 and R20) observed during medication administration out of a total sample of 21 residents. This failure could lead to potential resident infections due to contamination.Review of the facility policy titled, Administering Medications revised April 2019 revealed . 25. Staff follows established facility infection control procedures e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.1.During an observation on 08/05/25 at 8:20 AM of R18's medication administration revealed Licensed Practical Nurse (LPN)2 dropped a furosemide (a diuretic) tablet on the top of the medication cart and then put the tablet in the administration cup and administered the furosemide tablet to R18.During an interview on 08/05/25 at 8:30 AM LPN2 stated that because the pill only dropped on the medication cart, she put it in the administration cup. When asked how she had been trained she stated that she should have gotten a new pill and discarded the dropped pill.2.During an observation on 08/05/25 at 9:08 AM of R20's medication pass revealed LPN3 dropped a clopidogrel (an antiplatelet medication used to reduce the risk of heart disease and stroke) tablet and sertraline (an antidepressant) tablet on the top of the medication cart. LPN3 put both pills in the administration cup and administered the mediations to R20.During an interview on 08/05/25 at 9:50 AM LPN3 stated that she should have gotten new medications to replace the ones dropped on the cart. During an interview on 08/05/25 at 1:45 PM the Director of Nursing (DON) stated that it was not facility policy to administer medications that have been dropped.