STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315517	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Total Rehab Moorestown	212 Marter Avenue 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 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)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaints: NJ1875890, 2681814 Based on interviews, review of medical records, and review of facility documents, it was determined that the facility failed to develop and follow adequate fall prevention interventions on the care plan of a resident (Resident #2) who was at risk for falls. This deficient practice was identified for 1 of 3 residents (Resident # 2) reviewed for accidents and was evidenced by the following:A review of the admission Record for Resident #2 revealed the resident was admitted to the facility with diagnoses that included but were not limited to acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (condition where the heart does not pump blood as well as it should); type 2 diabetes mellitus without complications (condition where the body cannot use insulin correctly and sugar builds up in the blood); muscle weakness; other abnormalities of gait and mobility; need for assistance with personal care; and presence of left artificial hip joint. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 06/13/2025, revealed Resident #2 had a Brief Interview for Mental Status of 6 out of 15, indicating the resident was severely cognitively impaired. Further review of the MDS revealed the resident required substantial or maximal assistance (a helper does more than half of the effort and lifts or holds the resident's trunk or limbs) from staff to shower or bathe. A review of the facility, Fall Risk Predictive Factors, section of the Resident Evaluation- V2 document dated 06/06/2025, revealed that Resident #2 was assessed as a high risk for falls. A review of the Care Plan for Resident #2 revealed a focus initiated on 06/07/2025 related to Resident #2's need for assistance with activities of daily living (ADLs), interventions included provision of limited assistance from one staff member to shower or bathe. The CP for Resident #2 further revealed a focus initiated on 06/07/2025 related to the resident being at risk for falls due to a history of falls. Interventions related to falls included supervision of the resident at all times while in the shower, initiated and revised on 06/17/2025; and placing a towel on the shower chair to prevent the resident from slipping, initiated on 06/19/2025. Review of the untitled facility document dated 06/17/2025 at 11:40 AM, revealed under, Incident Description, that Resident #2 was observed laying on the bathroom floor with their legs outstretched. This section of the facility document further revealed that Certified Nursing (CNA) #1 stepped out of the resident's bathroom and into the resident's room to get a towel. When CNA #1 returned to the bathroom she observed Resident #2 sliding off the shower chair to the floor. Review of a Progress Note dated 06/17/2025 at 3:38 PM, written by Licensed Practical Nurse (LPN)#1 revealed that CNA #1 stated that she stepped into Resident #2's room to get another towel and when she returned to the bathroom, she observed the resident on the floor. The PN further revealed that Resident #2 explained that they slipped off the bath chair. An Accident/Incident Statement Form, dated 06/17/2025 at 11:40 AM, and signed by CNA #1 was reviewed. The handwritten statement revealed that CNA #1 took Resident #2 to the shower and realized that she needed another towel. CNA #1 left Resident #2 sitting on the shower chair while she got a towel from a few feet away. CNA saw Resident #2 sliding off the shower chair but could not reach the resident in time to prevent them from sliding off the chair. The surveyor attempted to reach CNA #1 for a telephone interview of 01/02/2026 but was unsuccessful. An interview was conducted with CNA #2 on 01/20/2026 at 1:52 PM. CNA #2 stated that when assisting residents with showering CNAs were supposed to bring everything needed for the task into the room. CNA #2 stated that CNAs were not supposed to leave residents alone in the shower or on the toilet. An interview was conducted with the Unit Manager (UM) on 01/02/2026 at 2:32 PM. The UM stated that typically staff should not leave residents on the shower chair in the shower. The UM stated that staff should bring everything they need into the bathroom before starting to bathe a resident and if they forgot something they should use the call bell to get assistance. The UM stated that if residents were left alone in the shower they could have fallen. The UM further stated that CNA #1 stepping out of the room while Resident #2 was seated on the shower chair could have led to the resident's fall. An interview was conducted with the Director of Nursing on 01/02/2026 at 2:40 PM. The DON stated that her expectation was that Resident #2 should have received bathing assistance of cueing and guiding as per their CP. During a follow up interview on 01/02/2026 at 3:36 PM, the DON stated that she considered it acceptable for CNA #1 to leave Resident #2 on the shower chair to step out of the bathroom to get a towel. The DON did not explain the difference between the level assistance Resident #2 required as indicated on the MDS and the level of assistance indicated on the CP. The facility's, Comprehensive Care Plans, policy with a review date of 08/2025 was reviewed. Under, Policy, the document revealed that it was the policy of the facility to develop and implement a comprehensive person-centered CP for each resident to meet the