

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/13/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VOORHEES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043		
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F 000	INITIAL COMMENTS Complaint NJ#'s: 168726, 168827, 170583, 171220, 171435, 172440, 172519, 173606, 174162, 175632, 176860, 180809, and 180914 Survey Date: 1/2/25 to 1/10/25 Census: 179 Sample: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		2/21/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
02/03/2025

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.

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F 550	<p>Continued From page 1</p> <p>provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the residents' dining experience was provided in a manner to promote dignity and respect of the residents.</p> <p>This deficient practice was identified in 1 of 5 units observed (the 100 unit) and was evidenced by the following:</p> <p>1.) On 1/9/25 at 10:00 AM, during the surveyor-conducted resident council meeting, 4 of 4 residents (Resident #6, #60, #71 and #98) who attended the meeting stated that roommates did not get served their meal trays at the same time.</p> <p>2.) On 1/7/25 at 9:27 AM, the surveyor observed</p>	F 550	<p>Immediate corrective action for residents affected by deficient practice: Breakfast trays that were missing were immediately prepared and delivered to the residents by the U.S. FOIA (b)(6). The Breakfast tray for Resident #117 was immediately prepared and delivered to the resident by the U.S. FOIA (b)(6). The Breakfast tray that was missing toast for Resident #20 was immediately prepared and delivered to the resident by the U.S. FOIA (b)(6).</p> <p>Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. No adverse effects of the deficient</p>		

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F 550	<p>Continued From page 2</p> <p>the breakfast meal on the high end of the 100 unit and Resident #71 was delivered his/her breakfast tray. Resident #71 stated "we don't get our meal trays delivered at the same time." At that time, the surveyor observed Resident #117 (Resident #71's roommate) standing at his/her doorway of their room and stated, "I'm waiting for my breakfast tray."</p> <p>At 9:38 AM, the surveyor observed several residents on the unit had not received their breakfast trays. The Certified Nursing Assistant (CNA #4) confirmed with the surveyor that the following residents had not received their breakfast trays and that she had called the kitchen for the following seven (7) breakfast trays: Resident #20, #56, #80, #88, #112, #113, and #117.</p> <p>At 9:57 AM, the surveyor observed a food truck delivered to the U.S. FOR unit with the missing breakfast trays. The nursing staff delivered the breakfast trays to the residents. At that time, the surveyor observed that Resident #20's tray contained only oatmeal and not toast, which was listed on the meal ticket. At 10:02 AM, CNA #4 called the kitchen to obtain a new tray for Resident #20 that included the toast. At that time, CNA #4 stated that Resident #11 had not recieved a breakfast tray yet and then called the kitchen to obtain Resident #111's breakfast tray. The CNA did not give Resident #20 his/her tray with the missing item.</p> <p>At 10:14 AM, the surveyor observed the NO EXEM ORG deliver a breakfast tray to Resident #111. At 10:15 AM, the surveyor showed the U.S. FOR Residents #20's breakfast tray, that was still in the food truck, was missing the toast. The</p>	F 550	<p>practices were noted for any of the residents.</p> <p>Measures put in place to ensure the deficient practice will not occur for those residents affected: Beginning on January 20, 2025, Dietary staff were educated by the Regional Dietary Director on the process to manage dining tray distribution order to ensure roommates are served meals together. Beginning on February 3, 2025, nursing staff were re-educated by the Staff Development and Food Services Director regarding the Meal Distribution Policy to ensure residents meal tray contains food items that accurately match the resident meal ticket.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Food Services Director/designee will audit the dining tray order report daily x4 weeks and then x2 weekly x2 months. Food Services Director/designee will audit tray item accuracy daily x4 weeks and then x2 weekly x2 months. Nursing Unit Manager/designee will audit to verify meal accuracy and the timely delivery of meals to residents daily x4 weeks and then x2 weekly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.</p>		

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F 550	<p>Continued From page 3</p> <p>U.S. FOIA (b) stated she will get the resident a new breakfast tray. The U.S. FOIA (b) stated she was trying to find out what happened that all the breakfast trays were not delivered at the same time.</p> <p>At 10:25 AM, the surveyor observed Resident #20's breakfast tray delivered to the unit.</p> <p>On 1/8/25 at 1:19 PM, the surveyor interviewed the U.S. FOIA (b)(6), in the presence of the U.S. FOIA (b)(6) and the survey team, who stated that her expectation would be that meal trays would not be missing from the food trucks. The U.S. FOIA (b)(6) further stated that unit 100 was the last unit to be served breakfast, usually around 9:15 AM, and that residents in the same room should be served their trays at the same time. The U.S. FOIA (b)(6) further stated that it was important that residents are served meals at the same time because it was their resident's right.</p> <p>A review of the facility's "Promoting/Maintaining Resident Dignity" policy, dated 9/1/24, included that all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident's rights.</p> <p>A review of the facility's "Meal Distribution" policy, revised September 2017, included that the nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents.</p> <p>NJAC 8:39-4.1(a)12</p>	F 550			

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F 584 F 584 SS=E	Continued From page 4 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584 F 584		2/21/25	

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F 584	<p>Continued From page 5 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint #: NJ180809</p> <p>Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident environment, equipment and living areas in a safe, sanitary, and homelike manner for 3 of 35 residents (Resident #106, #107, and #126) and air temperature log for 5 of 5 units observed during environmental rounds.</p> <p>This deficient practice was evidenced by the following:</p> <p>1.) On 1/3/2025 at 12:13 PM, the surveyor toured the [REDACTED] Unit, which was noted to be chilly in the hallway near Room [REDACTED]. The hatch door leading to the attic was observed to be partially open. The [REDACTED] took the air temperature, which registered at 65 degrees.</p> <p>A review of the Air Temperature audit logs from 12/1 2024 to 1/8/25 revealed the following:</p> <p>On 12/3/2024: The [REDACTED] Unit shower room was documented as 70 degrees. The [REDACTED] Unit shower room was documented as 70 degrees. The [REDACTED] Unit shower room was documented as 69 degrees.</p> <p>On 12/18/2024:</p>	F 584	<p>Immediate corrective action for residents affected by deficient practice: The resident toilet was immediately cleaned 1.3.25 Resident toilet seat was immediately replaced 1.3.25 Hatch door leading to attic was immediately closed 1.3.25</p> <p>Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. No adverse effects of the deficient practices were noted for any of the residents.</p> <p>Measures put in place to ensure the deficient practice will not occur for those residents affected: Beginning 1.6.25 all Environmental Services Staff were re-educated by the Environmental Services Manager on proper daily room and bathroom cleaning procedures to ensure resident environment equipment, and living areas in a safe, sanitary, manner. Beginning 1.9.25 the Maintenance Director/designee will complete air temperature logs daily to ensure a comfortable and safe temperature range of 71F to 81F is maintained.</p>		

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F 584	<p>Continued From page 6</p> <p>The [REDACTED] Unit, resident's room 110 was documented as 69 degrees. The [REDACTED] Unit resident's room 214 was documented as 69 degrees.</p> <p>On 12/31/2024: The [REDACTED] Unit shower room was documented as 70 degrees. The [REDACTED] Unit shower room was documented as 69 degrees.</p> <p>On 1/7/2025: The [REDACTED] Unit shower room was documented as 69 degrees. The [REDACTED] Unit shower room was documented as 67 degrees. The [REDACTED] Unit shower room was documented as 68 degrees.</p> <p>On 1/8/2025 at 11:47 AM, the [REDACTED] U.S. FOIA (b)(6) stated in the presence of the [REDACTED] NJ Exec Order 26.4b1 and the survey team, that the temperature should be comfortable and should not go below 65 degrees. He further stated the residents usually like it warmer. At that time, the [REDACTED] U.S. FOIA (b)(6) stated she was unaware that the air temperature should be maintained between 71 to 81 degrees.</p> <p>2.) On 1/2/25 at 10:07 AM, the surveyor observed Resident #126 sitting on the edge of the bed. The resident stated their main concern with the facility was the cleanliness of the bathroom. The resident stated their roommate would often leave [REDACTED] NJ Exec Order 26.4b1 and that the housekeeping staff did not come to clean the bathroom until hours later. The resident then</p>	F 584	<p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Environmental Services Manager/designee will conduct twice daily environmental rounds to ensure the resident environment, equipment and living area is safe, clean and homelike 2x/week x4 weeks and then x1 weekly x2 months. Maintenance Director /designee will audit air temperature logs daily x4 weeks and then x2 weekly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.</p>		

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F 584	<p>Continued From page 7</p> <p>asked the surveyor to look at their bathroom because there had been [redacted] since approximately 2:00 AM that morning. When the surveyor opened the resident's bathroom door, there was a [redacted] noted and [redacted] on [redacted].</p> <p>The surveyor reviewed the medical record for Resident #126.</p> <p>A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's [redacted].</p> <p>3.) On 1/2/25 10:25 AM, during the initial tour of the [redacted] Unit, the surveyor observed Resident # 106's bathroom and the toilet had a [redacted].</p> <p>[redacted]. The white toilet seat was in a up position with [redacted] that were visible to the resident. The surveyor observed [redacted].</p> <p>[redacted] At that time, the surveyor interviewed Resident #106 who stated that they uses the bathroom and was not sure when it was last cleaned.</p> <p>On 1/3/25 at 8:16 AM, the surveyor observed Resident #106's bathroom and observed the white toilet seat was in the up position with [redacted].</p> <p>[redacted]</p> <p>A review of Resident #106's Admission record, an admission summary, revealed the resident had diagnoses which included, [redacted].</p>	F 584			

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F 584	<p>Continued From page 8</p> <p>U.S. FOIA (b)(6) .</p> <p>A review of the resident's quarterly MDS, dated U.S. FOIA (b)(6) included the resident had a BIMS score of U.S. FOIA (b)(6), which indicated that the resident's U.S. FOIA (b)(6). Further review of the MDS revealed the resident was NJ Exec Order 26.4b1 .</p> <p>On 1/3/25 at 12:40 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated the housekeepers cleaned the residents' rooms three times during their 7:00 AM to 3:00 PM shift. The U.S. FOIA (b)(6) further explained that the housekeepers were expected to make morning rounds at 7:00 AM to empty resident room trash cans and inspect the room for any immediate need for cleaning. The U.S. FOIA (b)(6) stated after the housekeepers' first break, they cleaned resident rooms until the end of their shift when they made their final rounds in each resident room. The U.S. FOIA (b)(6) also stated there was a porter from 2:00 PM to 10:00 PM, but no housekeeping staff from 10:00 PM to 7:00 AM.</p> <p>At that time, the surveyor informed the U.S. FOIA (b)(6) of Resident #126's dirty toilet that had been U.S. FOIA (b)(6) at 2:00 AM and not yet cleaned by 10:00 AM during the surveyor's observation. The U.S. FOIA (b)(6) stated the housekeeper should have seen the dirty toilet during their 7:00 AM rounds and cleaned the toilet for infection control reasons. The U.S. FOIA (b)(6) further stated that Resident #106's bathroom should have been addressed on the 7:00 AM rounds.</p> <p>4.) On 1/3/25 at 11:47 AM, during a tour of the U.S. FOIA (b)(6) Unit, the surveyor interviewed Resident #107 who stated that they had spoken the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) about their toilet</p>	F 584			

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F 584	<p>Continued From page 9</p> <p>seat being NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. The resident stated that the U.S. FOIA (b)(6) indicated that at the very least they would NJ Exec Order 26.4b1. Resident #107 further stated that the bathroom was cleaned on U.S. FOIA (b)(6).</p> <p>A review of Resident #107's Admission Record revealed that the resident had diagnosis which included, NJ Exec Order 26.4b1.</p> <p>A review of Resident #107's quarterly MDS, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1.</p> <p>On 1/3/25 at 12:06 PM, the surveyor interviewed Housekeeper (HK) #1 who stated that resident rooms were cleaned daily. HK #1 stated that she did not know when Resident #107's room was cleaned last because she worked on a different unit.</p> <p>At that time, HK #1 accompanied the surveyor into Resident #107's bathroom. The surveyor showed HK #1 two areas of NJ Exec Order 26.4b1 and HK #1 stated these could come off. HK #1 then proceeded to spray the toilet seat and the surrounding area of the toilet with disinfectant cleaner and wiped it with a rag and both the NJ Exec Order 26.4b1 was removed. HK #1 stated, "that was not discoloration."</p> <p>Resident #107 was present at that time and stated that we thought the NJ Exec Order 26.4b1 was</p>	F 584			

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F 584	<p>Continued From page 10</p> <p>██████████, but ██████████." Resident #107 stated that the toilet was so much cleaner now.</p> <p>On 1/3/25 at 12:32 PM, the surveyor interviewed the ██████████ who stated that he had spoken with Resident #107 and the toilet seat should have been replaced after ██████████, and he referred the task to a U.S. FOIA (b)(6) verbally but had not documented it. The ██████████ stated that it was an ██████████, and it should have been done.</p> <p>On 1/3/25 at 1:04 PM, the surveyor interviewed the ██████████ who stated that he spoke with Resident #107 in the hall a couple of weeks ago and told the resident that he would get him/her a new toilet seat but then the resident requested a new toilet instead. The ██████████ stated that he could have replaced the toilet seat right away.</p> <p>On 1/3/25 at 1:12 PM, the surveyor observed the ██████████ outside of Resident #107's room with a new toilet seat after surveyor inquiry.</p> <p>On 1/8/25 at 1:22 PM, the surveyor interviewed the ██████████ who stated that any staff member who sees a dirty toilet could notify housekeeping to clean the bathroom. The ██████████ further stated it was important to ensure a resident's toilet was cleaned promptly for ██████████ control reasons and because it was the resident's environment.</p> <p>A review of the facility's "Routine Cleaning and Disinfection" policy, dated 9/1/24, included that the facility is to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the</p>	F 584			

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F 584	Continued From page 11 development and transmission of infections to the extent possible. Routine cleaning and disinfection of frequently touched or visible soiled surfaces will be performed in common area, residents' rooms and at time of discharge.	F 584			
F 658 SS=E	<p>NJAC 8:39-31.4(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint NJ #'s:168726, 168827, and 175632</p> <p>Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure medications were administered within the physician's order scheduled time in accordance with professional standards of practice for 2 of 35 residents (Resident #86 and #160) reviewed for professional standards of practice.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through</p>	F 658	<p>Immediate corrective action for residents affected by deficient practice: Resident #86 U.S. FOIA (b)(6) was notified by the U.S. FOIA (b)(6) on NJ Exec Order 26.4b1 and resident #86 was immediately assessed by the U.S. FOIA for adverse reactions with none noted. On 1/3/2025, resident #160 had the NJ Exec Order 26.4b1 removed, an investigation was initiated, the primary care physician was notified, and new orders were initiated as appropriate. Resident #160 was immediately assessed by the U.S. FOIA (b)(6) for adverse reactions with none noted.</p> <p>Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice.</p>	2/21/25	

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F 658	<p>Continued From page 12</p> <p>such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>1.) On 1/2/25 at 10:27 AM, during the initial tour, the surveyor observed Resident #86 lying in bed sleeping.</p> <p>On 1/3/25 at 10:22 AM, the surveyor reviewed the medical record for Resident #86.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Exec Order 26.4b1 [REDACTED]</p> <p>A review of the Medication Administration (Admin) Audit Report from NJ Exec Order 26.4b1 revealed the following:</p> <p>NJ Exec Order 26.4b1 [REDACTED] give NJ Exec Order 26.4b1 [REDACTED]:</p>	F 658	<p>An audit was conducted on 1/7/2025 by the Unit Managers of all current resident's medication administration to ensure timely administration and documentation of administered medication and concerns addressed as appropriate with the Medical Director. An audit was conducted by the Unit Managers on 1/3/2025 on all medication and treatment carts to ensure all medications are available with no concerns noted.</p> <p>Measures will be put in place to ensure deficient practice will not occur for those residents affected: On 1/3/2025, re-education was initiated by the Educator for Licensed Nurses on facility policy for Medication Administration Policy, Medication orders, and Medication Errors with emphasis on ensuring medications are administered following the six rights of medication administration.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Director of Nursing/Designee will conduct audits of 5 random residents to ensure medications are available and administered within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Audits will be completed weekly x4 weeks then monthly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly</p>		

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F 658	Continued From page 13 scheduled for 8:00 AM. NJ Exec Order 26.4b1 [REDACTED], give NJ Exec Order 26.4b1 [REDACTED] NJ Exec Order 26.4b1 [REDACTED] [REDACTED] NJ Exec Order 26.4b1 [REDACTED] NJ Exec Order 26.4b1 [REDACTED] U.S. FOIA (b)(6) [REDACTED] NJ Exec Order 26.4b1 [REDACTED] NJ Exec Order 26.4b1 [REDACTED] NJ Exec Order 26.4b1 [REDACTED] NJ Exec Order 26.4b1 [REDACTED] was changed to NJ Exec Order 26.4b1 [REDACTED] In June 2024, medications were documented as administered late (not within the 60 minutes prior to or after the scheduled timeframe) a total of 47 times. In July 2024, medications were documented as	F 658	Meetings over the duration of the audit process to ensure compliance and reassessed for further action.		

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F 658	<p>Continued From page 14 administered late a total of 58 times.</p> <p>In August 2024, medications were documented as administered late a total of 34 times.</p> <p>A review of the Progress Notes (PN) from June 2024 to August 2024 did not reveal the physician was notified of the late administration of the medications.</p> <p>On 1/7/25 at 10:51 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #3) who stated that medications should be administered one (1) hour before or 1 hour after the scheduled time. LPN/UM #3 stated that it was important for medications (meds) to be administered within the timeframe because some medications needed to be taken with food, or pain meds taken before [REDACTED] care. She further stated that if not administered within the timeframe the medications could interfere with one another. LPN/UM #3 stated that it was a medication error if the meds were not administered as scheduled and it should be reported to the supervisor.</p> <p>On 1/7/25 at 10:58 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that medications should be administered 1 hour before or 1 hour after the scheduled time. She stated that it was important to administer within those timeframes because the resident's NJ Exec Order 26.4b1 [REDACTED] could be affected. She then stated it was also important to administer meds during the scheduled time to prevent the resident from being "double dosed." LPN #1 stated that it was considered a medication error, and the physician should be notified to see if they still wanted the medication</p>	F 658			

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F 658	<p>Continued From page 15 to be administered.</p> <p>On 1/7/25 at 12:20 PM, the U.S. FOIA (b)(6) stated that nurses had an hour window which was one hour before or one hour after to administer the medications. She further stated that meds should be administered within the one-hour window as it may interfere with the next dosage. The U.S. FOIA (b)(6) stated if the meds are not administered within the one-hour window the expectation would be that the nurse notify the physician. At that time, the surveyor and the U.S. FOIA (b)(6) reviewed the Medication Audit report which revealed there were 13 nurses that did not administer medications within the one-hour window.</p> <p>On 1/8/25 at 8:43 AM, the surveyor interviewed the NJ Exec Order 26.4b1 who stated she spoke with some of the nurses regarding the times and they indicated that the medications were not administered late but that they documented late because the "unit was busy."</p> <p>On 1/9/25 at 9:55 AM, the U.S. FOIA (b)(6) stated in the presence of the U.S. FOIA (b)(6) and the survey team that she attempted to contact the 13 nurses and six (6) nurses responded they administered the medications on time but documented late. The U.S. FOIA (b)(6) acknowledged the nurses should document once the medications were administered.</p>	F 658			






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F 658	<p>Continued From page 16</p> <p>2.) On 1/3/25 at 10:22 AM, during medication pass observation, the surveyor observed a Licensed Practical Nurse (LPN #3) administer medications to Resident #160. At that time, Resident #160 stated he/she had [redacted] LPN #3 and the surveyor observed Resident #160 [redacted] s. LPN #3 [redacted] Resident #160 stated he/she had [redacted] and it has been [redacted]. At that time, LPN #3 and the surveyor reviewed the active physician's orders (PO) which revealed there was not a physician order for [redacted]. LPN # stated she will call the doctor to inform them of the [redacted]</p> <p>On 1/3/25 at 9:18 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated that she was made aware of the [redacted] that were on Resident #160's [redacted] without a PO and would start an investigation.</p> <p>On 1/3/24 at 9:23 AM, the surveyor reviewed the medical record for Resident #160.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, [redacted]</p> <p>A review of the admission Minimum Data Set (MDS), an assessment tool, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident 's [redacted]</p>	F 658			

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F 658	<p>Continued From page 17</p> <p>NJ Exec Order 26.4b1. Further review of the MDS revealed that the resident had NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 review of the individual comprehensive care plan (ICCP) included focus area, dated NJ Exec Order 26.4b1, that the resident had NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 Interventions included: monitor/record/report to nurse resident complaints of NJ Exec Order 26.4b1 or requests for NJ Exec Order 26.4b1 treatment.</p> <p>A review with Order Summary Report (OSR), dated as of NJ Exec Order 26.4b1, included the following PO:</p> <p>A PO, dated NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 The OSR did not reveal a PO for NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 prior to surveyor inquiry.</p> <p>A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reveal a PO for NJ Exec Order 26.4b1</p> <p>A review of the NJ Exec Order 26.4b1 progress notes did not reveal any documentation of NJ Exec Order 26.4b1 being applied to Resident #160's NJ Exec Order 26.4b1 prior to the observation on NJ Exec Order 26.4b1.</p> <p>On 1/6/24 at 1:43 PM, the surveyor conducted a follow up interview with LPN/UM #1 who stated that the NJ Exec Order 26.4b1 was notified and a PO for NJ Exec Order 26.4b1 was obtained. LPN/UM#1 stated that NJ Exec Order 26.4b1 should not have been applied without a</p>	F 658			

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F 658	<p>Continued From page 18 PO.</p> <p>On 1/7/25 at 8:47 AM, the U.S. FOIA (b)(6) provided the surveyor an incident report for a medication error regarding NJ Exec Order 26.4b1 without a PO.</p> <p>On 1/8/25 at 9:50 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the NJ Exec Order 26.4b1 have been applied to Resident #160's NJ Exec Order without a physician's order. The U.S. FOIA (b)(6) stated that she would have expected the nurses to call the physician to obtain a PO before applying the NJ Exec Order 26.4b1.</p> <p>A review of the facility's "Medication Administration" policy, dated 9/1/24, included the following: "10. Ensure the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, and right documentation. 11. Review the MAR to identify medication to be administered. 12. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician."</p> <p>A review of the facility's "Medication Orders" policy, dated 9/1/24, included that medication should be administered only upon a signed order of a person lawfully authorized to prescribe. The policy further revealed that the facility shall ensure medications will be administered as follows: a) according to physician's orders, b) per manufactures specifications and c), in accordance with accepted standards and principles which apply to professional providing</p>	F 658			

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F 658	Continued From page 19 services. A review of the facility's "Medication Errors" policy, dated 9/1/24, included, "Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber 's order... a. Medications administration not in accordance with the prescriber's order. Examples include, but not limited to: i. incorrect dose, route of administration, dosage form, time of administration... c. Medications administered not in accordance with professional standards and principles... 7. If a medication error occurs... c. Document actions taken in the medical record.	F 658			
F 677 SS=D	NJAC 8:39-29.2(d) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00174162 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) provide  care to a resident who required assistance with the activities of daily living (ADL) and b.) implement the comprehensive care plan. This deficient practice was identified for 1 of 8 residents (Resident #118) reviewed for activities of daily living.	F 677	Immediate corrective action for residents affected by deficient practice: On 1.8.2025, resident #118  by the  U.S. FOIA  , and a  NJ Exec Order 26 consult was placed. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice.	2/21/25	

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F 677	<p>Continued From page 20</p> <p>This deficient practice was evidenced as follows:</p> <p>1.) On 1/7/25 at 11:07 AM, during an NJ Exec Order 26.4b1, while accompanied by Licensed Practical Nurse/Unit Manager (LPN) #1 and Certified Nurse Assistant (CNA) #2, the surveyor observed Resident #118 NJ Exec Order 26.4b1.</p> <p>NJ Exec Order 26.4b1. The LPN/UM#1 stated that the resident NJ Exec Order 26.4b1. Resident #118's NJ Exec Order 26.4b1.</p> <p>NJ Exec Order 26.4b1</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Exec Order 26.4b1.</p> <p>NJ Exec Order 26.4b1</p> <p>A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed the resident had an NJ Exec Order 26.4b1.</p> <p>NJ Exec Order 26.4b1</p>	F 677	<p>An audit was completed by the Unit Managers on 1.8.2025 on all residents to ensure fingernails were trimmed and clean with no concerns noted.</p> <p>What measures will be put in place to ensure that deficient practice will not occur for those residents affected: On 1.3.2025, re-education was initiated by the Educator for Licensed Nurses and Certified Nursing Assistants on facility policy for Activities of daily living (ADL□s) and Comprehensive Care Plans with emphasis on ensuring residents nails are trimmed and clean and following the care plan.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Director of Nursing/Designee will conduct audits of 5 residents to ensure that proper nail care is being provided. Audits will be completed weekly x4 weeks then monthly x2 months.</p> <p>Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly Meetings over the duration of the audit process to ensure compliance and reassessed for further action.</p>	

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F 677	<p>Continued From page 21</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [redacted], that the resident has a potential [redacted] NJ Exec Order 26.4b1. The interventions included: [redacted] NJ Exec Order 26.4b1 and keep [redacted] NJ Exec Order 26.4b1. Keep [redacted] NJ Exec Order 26.4b1. Assist resident with [redacted] NJ Exec Order 26.4b1 will be assessed on a weekly basis and findings documented, monitor/document [redacted] NJ Exec Order 26.4b1.</p> <p>On 1/8/2025 at 8:43 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1, who stated that the [redacted] NJ Exec Order 26.4b1 was responsible for cleaning the [redacted] NJ Exec Order 26.4b1 as needed and [redacted] NJ Exec Order 26.4b1 them to prevent [redacted] NJ Exec Order 26.4b1. The surveyor and LPN/UM#1 made a follow-up visit with the resident. At that time, Resident #118's [redacted] NJ Exec Order 26.4b1. LPN/UM #1 confirmed that the resident's nails were [redacted] NJ Exec Order 26.4b1.</p> <p>On 1/8/2025 at 9:56 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] who stated that the CNAs should check the residents' fingernails when they are performing care and clean them when they are [redacted] NJ Exec Order 26.4b1. She further stated that the resident's [redacted] NJ Exec Order 26.4b1 should be kept short and clean to prevent an [redacted] NJ Exec Order 26.4b1. The [redacted] U.S. FOIA (b)(6) stated that the care plan should be followed.</p> <p>A review of the facility's Activities of Daily Living (ADLs) policy, dated 9/1/2024, included "Care</p>	F 677			

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F 677	Continued From page 22 and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; ...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." A review of the facility's "Comprehensive Care Plans" policy, date 9/1/2024, included "The policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment."	F 677			
F 687 SS=E	NJAC 8:39-27.2 (g) Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by:	F 687		2/21/25	

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F 687	<p>Continued From page 23 Complaint #: NJ175632</p> <p>Based on observation, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to [redacted] and services for 1 of 1 resident (Resident #86) reviewed for [redacted].</p> <p>This deficient practice was evidenced by the following:</p> <p>On 1/2/25 at 10:27 AM, during the initial tour the surveyor observed Resident #86 lying in bed sleeping.</p> <p>On 1/3/25 at 10:22 AM, the surveyor reviewed the medical record for Resident #86.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Exec Order 26.4b1 [redacted]</p> <p>A review of the individual comprehensive care plan (ICCP) included a focus area, dated [redacted] that the resident had [redacted]. Interventions included: NJ Exec Order 26.4b1 [redacted]</p> <p>On 1/7/25 at 10:32 AM, the surveyor observed the resident lying in bed, dressed and their [redacted]. At that time, the surveyor was unable to observe the resident's [redacted]</p> <p>On 1/7/25 at 10:34 AM, the surveyor interviewed</p>	F 687	<p>Immediate corrective action for residents affected by deficient practice: On 1.8.2025, resident #86 received [redacted] applied by the CNA. On 1.7.2025, resident #86 was placed on the schedule to be seen by [redacted] on the next visit.</p> <p>Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. On 1.8.2025, An audit was completed by the Unit Managers on all residents to ensure residents had received foot care with no concerns noted. On 1.8.2025, An audit was completed by the Regional Clinical Director on all residents to ensure podiatry services were received as required, orders placed as needed.</p> <p>What measures will be put in place to ensure the deficient practice will not occur for those residents affected: On 1.7.2025, re-education was initiated by the Educator for Licensed Nurses and Certified Nursing Assistants on facility policy for Activities of daily living (ADL□s) and Skin Integrity - Foot Care with emphasis on importance of inspecting feet, providing foot care and application of treatments as needed.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Director of Nursing/Designee will conduct audits of 5 residents per unit to</p>		

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F 687	<p>Continued From page 24</p> <p>the Licensed Practical Nurse (LPN #1) who stated that she was an agency nurse but that the U.S. FOIA (b)(6) came and performed morning (AM) care. At that time, the surveyor and LPN #1 entered Resident #86's room. LPN #1 removed the resident's U.S. FOIA (b)(6). She stated that she was unsure when the last time the resident's U.S. FOIA (b)(6). LPN #1 stated that the U.S. FOIA (b)(6) should have NJ Exec Order 26.4b1 to the resident's NJ Exec Order 26.4b1 and as needed.</p> <p>On 1/7/25 at 10:40 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #3) who stated that the U.S. FOIA (b)(6) came every other month. She further stated that the NJ Exec Order 26.4b1 the residents NJ Exec Order 26.4b1, and the NJ Exec Order 26.4b1 LPN/UM #3 stated that the resident was very U.S. FOIA (b)(6) during care especially if he/she did not know the person.</p> <p>On 1/8/25 at 8:43 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the resident was last seen by the U.S. FOIA (b)(6) in NJ Exec Order 26.4b1. She further stated that since the resident was NJ Exec Order 26.4b1 the U.S. FOIA (b)(6) office put the resident on the U.S. FOIA (b)(6) unless the facility called for the resident to be seen. The U.S. FOIA (b)(6) stated that the facility was unaware that the resident was on that list. When asked who was responsible for performing NJ Exec Order 26.4b1 to the resident, the U.S. FOIA (b)(6) stated the CNAs.</p> <p>On 1/8/25 at 8:58 AM, the surveyor interviewed LPN #2 who stated she was an agency nurse but that the CNAs should NJ Exec Order 26.4b1 and the</p>	F 687	<p>ensure that proper foot care is being provided including podiatric services. Audits will be completed weekly x4 weeks then monthly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly Meetings over the duration of the audit process to ensure compliance and reassessed for further action.</p>	

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F 687	<p>Continued From page 25</p> <p>nurse should assess the resident's ^{NJ Exec O} during the ^{NJ Exec Order 26.4b1}</p> <p>On 1/8/25 at 9:02 AM, the surveyor interviewed the ^{U.S. FC} who stated that she came Monday to Friday and was with her residents for one (1) to two (2) hours. She stated that she performed AM care by washing the resident from head to toe. The ^{U.S. FC} stated that she performed ^{NJ Exec Order 26.4b1} once but was then advised that the nurses ^{NJ Exec Order 26.4b1}. The ^{U.S. FC} then stated that during AM care, she also provided ^{NJ Exec O} care. When asked did she perform ^{NJ Exec O} care yesterday ^{NJ Exec Order 26.4b1}, the ^{U.S. FC} replied "yes" around 8:30 AM. At that time, the surveyor informed the ^{U.S. FC} of the appearance of the resident's ^{NJ Exec O} yesterday around 10:30 AM. When asked did she perform ^{NJ Exec Order 26.4b1} the ^{U.S. FC} stated no, someone else applied ^{NJ Exec Order 26.4b1}</p> <p>On 1/8/25 at 9:10 AM, the ^{U.S. FOIA (b)(6)} was present in the room and stated the resident's ^{NJ Exec Order 26.4b1} " so ^{NJ Exec O} asked a CNA to ^{NJ Exec Order 26.4b1} The ^{U.S. FOIA} stated that the resident's ^{NJ Exec Order 26.4b1} " and she always had to tell an aide to ^{NJ Exec Order 26.4b1} for the resident.</p> <p>On 1/8/25 at 1:09 PM, the ^{U.S. FOIA (b)(6)} provided an email confirming the resident was last seen by the ^{U.S. FOIA (b)(6)} and would not be placed back on the list to be seen unless requested by the facility.</p> <p>On 1/8/25 at 2:30 PM, the ^{U.S. FOIA (b)(6)} stated in the presence of the ^{U.S. FOIA (b)(6)} and the survey team</p>	F 687			

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F 687	Continued From page 26 that the [U.S. FOIA (b)(6)] were responsible for performing [NJ Exec Order 26.4b] and that the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] should be looking at the resident's [NJ Exec Order 26.4b1] and inform the nurse if the resident's [NJ Exec Order 26.4b1] [redacted]. On 1/9/25 at 9:55 AM, the [U.S. FOIA (b)(6)] stated in the presence of the [U.S. FOIA (b)(6)], and the survey team that the resident was scheduled to be seen by the [U.S. FOIA (b)(6)] after surveyor inquiry. The [U.S. FOIA (b)(6)] acknowledged that [U.S. FOIA (b)(6)] should be performed daily during care. A review of the facility's "Activities of Daily Living (ADLs)" policy dated 9/1/24, included, "Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care." A review of the facility's "Skin Integrity - Foot Care" policy dated 9/1/24, included, "1. The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical conditions. 2. Assessment Risk c. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task.	F 687			
F 698 SS=E	NJAC 8:39-27.1(a);27.2 (g) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		2/21/25	

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F 698	<p>Continued From page 27</p> <p>require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to adjust medication administration times to accommodate for scheduled [NJ Exec Order 26] times.</p> <p>This deficient practice was identified for 1 of 1 resident (Resident # 33) reviewed for [NJ Exec Order 26] and was evidenced by the following:</p> <p>On 1/2/24 at 10:15 AM, the surveyor observed that Resident #33 was not in his/her room. Per the staff, Resident #33 was at [NJ Exec Order 26].</p> <p>On 1/7/24 at 10:18 AM, the surveyor interviewed Resident #33 who stated that his/her [NJ Exec Order 26.4b1] was ordered [NJ Exec Order 26.4b1] a day and he/she did not receive the medication at noon on his/her [NJ Exec Order 26] days. The resident stated the [NJ Exec Order 26.4b1] medication was scheduled for [NJ Exec Order 26.4b1], and the nurses were supposed to send the medication with him/her to [NJ Exec Order 26] for the [NJ Exec Order 26] dose. Resident #33 further stated that he/she had [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4b1] the day before. Resident #33 stated that the medication was not adjusted around her [NJ Exec Order 26] times or sent with her to [NJ Exec Order 26] to be taken on her [NJ Exec Order 26] days at noon.</p> <p>On 1/3/25 at 11:32 AM, the surveyor reviewed the medical record for Resident #33.</p>	F 698	<p>Immediate corrective action for residents affected by deficient practice: On 1/8/2025, resident #33's medication administration record was reviewed by the U.S. FOIA (b)(6) [redacted] and adjusted to accommodate scheduled [NJ Exec Order 26] times.</p> <p>Identify those individuals who could be affected by the deficient practice: All residents who receive dialysis have the potential to be affected by the deficient practice. The potential residents affected orders were reviewed on 1/8/2025 by the Regional Clinical Director to ensure medication administration times were adjusted to accommodate scheduled dialysis times with no concerns noted.</p> <p>What measures will be put in place to ensure the deficient practice will not occur for those residents affected: On 1/8/2025, re-education was initiated by the Educator for Licensed nurses on facility policy for Medication Administration and Hemodialysis with emphasis on importance of timing medication administration times around dialysis schedule to ensure medications are not missed.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies</p>		

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F 698	<p>Continued From page 28</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to [REDACTED]</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [REDACTED], included the resident had a Brief Interview for Mental Status score of [REDACTED] which indicated the resident's [REDACTED]. Further review of the MDS revealed the resident received [REDACTED] while a resident at the facility.</p> <p>A review of the individual comprehensive care plan (ICCP) included a focus area, dated [REDACTED] that the resident needed [REDACTED] related to renal failure and that the resident went to [REDACTED] on Mondays, Wednesdays, and Fridays with a 10:00 AM pick up time. The ICCP did not include any interventions to schedule medications around the resident's scheduled [REDACTED] times.</p> <p>A review of the Order Summary Report (OSR), dated as of [REDACTED], included the following physician orders (PO): A PO, dated [REDACTED], for [REDACTED] on [REDACTED] with a chair time of 10:00 AM and a pickup time of 9:00 AM. A PO, dated [REDACTED], for [REDACTED].</p> <p>A review of the [REDACTED] Medication Administration Record (MAR) included</p>	F 698	<p>will not recur: The Director of Nursing/Designee will conduct audits of 3 random residents who receive dialysis to ensure there are no medications being scheduled while residents are at dialysis. Audits will be completed weekly x4 weeks then monthly x2 months. Results of the audits will be reported to the Administrator reviewed at the Monthly Quality Assurance Meeting and Quarterly Meetings over the duration of the audit process to ensure compliance and reassessed for further action.</p>	

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F 698	<p>Continued From page 29</p> <p>the following PO:</p> <p>A PO, dated NJ Exec Order 26.4b1 [REDACTED] [REDACTED] Hold for [REDACTED] The medication was scheduled to be administered at NJ Exec Order 26.4b1 [REDACTED].</p> <p>A review of the NJ Exec Order 26.4b1 MAR included the following PO:</p> <p>A PO, dated NJ Exec Order 26.4b1 [REDACTED] [REDACTED] Hold for NJ Exec Order 26.4b1 [REDACTED] The medication was scheduled to be administered at NJ Exec Order 26.4b1 [REDACTED].</p> <p>On 1/8/25 at 9:23 AM, the surveyor interviewed Licensed Practical Nurse (LPN #5) who stated that if a medication was scheduled during the time the resident was at NJ Exec Order 26 [REDACTED], then the nurse would not administer that medication.</p> <p>On 1/8/25 at 9:40 PM, the surveyor interviewed the LPN # 4 who stated NJ Exec Order 26 [REDACTED] residents' medication administration times were scheduled around their NJ Exec Order 26 [REDACTED] times and that the medication was scheduled during the NJ Exec Order 26 [REDACTED] time, the nurse should reach out to the physician to adjust the medication times. LPN#4 further stated that medication could not be sent with the resident to NJ Exec Order 26 [REDACTED] because "we are not a pharmacy and cannot dispense medication."</p> <p>On 1/8/25 at 9:40 AM, the surveyor interviewed LPN/Unit Manager (LPN/UM #1) who stated that [REDACTED] residents' medications should not be scheduled during NJ Exec Order 26 [REDACTED] times and that the nurse should have called the doctor to get the medication times changed. The LPN/UM #1</p>	F 698			

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F 698	<p>Continued From page 30</p> <p>further stated that medication could not be sent with the resident to [REDACTED].</p> <p>On 1/8/24 at 9:44 AM, the surveyor interviewed the [REDACTED] who stated that medication should not be scheduled during [REDACTED] times when the residents is not at the facility and nurses should have called the doctor to get the medication times changed on [REDACTED] days. The [REDACTED] further stated that medication could not be sent with the resident to [REDACTED]. The [REDACTED] stated that she had spoken with Resident #33 prior, and that the resident wanted to take the medication at 12 noon and for the facility to send the medication with her for the 12-noon dose on [REDACTED] days. The [REDACTED] stated that she had informed the resident that the facility could not send medication to [REDACTED].</p> <p>On 01/08/25 at 1:19 PM, the [REDACTED] in the presence of the [REDACTED] and survey team was made aware that the PO for [REDACTED] medication was scheduled at noon on [REDACTED] days.</p> <p>A review of the facility's "Medication Administration" policy, dated 9/1/2024, included that the six rights of medications were administered as followed: right resident, right drug, right dosage, right route, right time, and right documentation.</p> <p>A review of the facility's "Hemodialysis" policy, dated 9/1/2024, included the licensed nurse will communicate to the dialysis facility via telephonic communication or written communication, to include timely medication administration (initiated,</p>	F 698		

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F 698	Continued From page 31 held, or discontinued) by the nursing home.	F 698			
F 804 SS=E	<p>NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)</p> <p>§483.60(d) Food and drink Each resident receives and the facility provides-</p> <p>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint #: NJ175632, 176860</p> <p>Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to ensure appetizing and palatable temperature of food for 1 of 1 lunch meal on 1 of 5 nursing units (300 Unit).</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 1/3/25 at 9:21 AM, the surveyor conducted a Resident Council meeting which included four residents (Resident #6, #60, #71 and #98). All four residents informed the surveyor that the food was served cold and was not appetizing or recognizable.</p> <p>On 1/7/25 at 11:17 AM, the surveyor informed the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)</p>	F 804	<p>All residents have the potential to be affected by the deficient practice. No adverse effects of the deficient practices were noted for any of the residents.</p> <p>Measures put in place to ensure the deficient practice will not occur for those residents affected: Beginning 1.30.25, the Food Services Director/Designee will Inservice food services staff on food preparation techniques to ensure food is served at a safe and appetizing temperature. Beginning 2.3.25 Staff Educator will Inservice nursing staff on Food Distribution Policy to ensure timely delivery of meals to maintain palatability.</p> <p>Monitoring of measures or systemic</p>	2/21/25	

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F 804	<p>Continued From page 32</p> <p>U.S. FOIA (b)(6)) that they wanted to observe a lunch meal service for the day including food temperatures. The U.S. FOIA (b)(6) stated that all hot foods should be above 135 F on the food service line. The surveyor asked the U.S. FOIA (b)(6) to calibrate a thin probe thermometer in their presence, which the U.S. FOIA (b)(6) completed using an ice bath, and the thermometer reached 32 F (degrees Fahrenheit).</p> <p>On 1/7/25 at 11:46 AM, the surveyor observed the U.S. FOIA (b)(6) who took the following food temperatures from the steam table:</p> <p>Swedish meatballs 184 F Rice 191 F Green beans 178 F Beets 163 Mashed potatoes 159 F Ground meatballs 171 F Puree green beans 148 F Turkey patties 178 F Turkey patty puree 145 F Gravy 193 F Sauce 189 F Meatballs without sauce 158 F Pasta 170 F.</p> <p>On 1/7/25 at 11:56 AM, the U.S. FOIA (b)(6) began serving the lunch meal on the tray line. The U.S. FOIA (b)(6) utilized plastic insulated domes and bases, heated plate liners, and heated plates to maintain temperature.</p> <p>On 1/7/25 at 12:02 PM, the Dietary Aide (DA) #2 left the kitchen with meal cart for the U.S. FOIA (b)(6) Unit Day Room. At this time, the surveyor, the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) accompanied DA #2 with a thin probed thermometer that was calibrated to 32 F.</p>	F 804	<p>changes to ensure that the deficiencies will not recur: Food Services Director/Designee will audit 3 test trays weekly x4 weeks and then x2 weekly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.</p>		

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F 804	<p>Continued From page 33</p> <p>On 1/7/25 at 12:04 PM, DA #2 arrived at the [REDACTED] Unit with the meal cart and left the meal cart on the nursing unit.</p> <p>On 1/7/25 at 12:05 PM, Nursing signed receipt for the meal cart delivery and began to distribute the meal trays to the residents in the day room and to those residents who dined in their rooms.</p> <p>On 1/7/25 at 12:22 PM, the [REDACTED] informed the surveyor that all the residents' meal trays had been served. At that time, the [REDACTED] stated that hot items should be 135 F and cold items should be less than 40 F. The [REDACTED] then served the surveyor the puree test tray and poured coffee into the mug located on the tray.</p> <p>On 1/7/25 at 12:22 PM, the surveyor observed the [REDACTED] obtain the following temperatures from the puree sample tray:</p> <p>Puree green beans 116 F Puree meat balls 112 F Puree mashed potatoes 118 F Puree apple sauce 68 F</p> <p>At that time, the [REDACTED] stated that the hot food items should be maintained at 135 F to ensure that they do not fall into the danger zone. The [REDACTED] stated that the canned apple sauce was not refrigerated and should have been chilled first and served below 40 F or below to remain out of the food temperature danger zone. The [REDACTED] explained that if food temperatures were in the danger zone it meant that they were not at the proper temperature.</p> <p>On 1/7/25 at 12:28 PM, the surveyor observed</p>	F 804		

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F 804	<p>Continued From page 34</p> <p>the [REDACTED] obtain the following temperatures from the regular sample tray:</p> <p>Green beans 120 F Rice 128 F Meatballs 126 F Mandarin oranges 64 F Coffee 128 F Hot water 140 F</p> <p>At that time, the [REDACTED] stated that hot beverages were served from carafes on the unit and should be served between 170 F and 180 F. The [REDACTED] further stated that the Mandarin oranges were canned fruit and were not refrigerated prior to the meal service and should be served at less than 40 F.</p> <p>2. On 1/8/25 at 08:55 AM, The surveyor requested and was served both a regular and puree breakfast test tray for palatability. Both of the meal trays were provided without a meal ticket to indicate what food items were served. The surveyors sampled scrambled eggs with red and green peppers, wheat toast, and a slice of ham that were of regular consistency. The scrambled eggs with red and green peppers on both the regular and puree tray lacked both seasoning and taste. On the pureed tray, there was a brown pureed substance that had a brown liquid around it that was not identifiable and had a pasty taste and texture.</p> <p>A review of the facility's "Meal Distribution" policy dated September 2017, revealed the following:</p> <p>...Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining.</p>	F 804			

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F 804	Continued From page 35 A review of the facility's "Food Preparation" policy dated September 2017, revealed the following: ...The Dining Services U.S. FOIA (b)(6) will be responsible for food preparation techniques which minimize the amount of time food items are exposed to temperatures greater than 41 F and/or less than 135 F, or per state regulations ... On 1/9/25 at 10:19 AM, in the presence of the U.S. FOIA (b)(6)) stated that she was surprised that the food temperatures were a Resident Council concern because they had improved.	F 804			
F 806 SS=D	NJAC 8:39-17.4(a)(2) Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Complaint #: NJ172440 Based on observation, interview, record review, and review of facility documents, it was	F 806	All residents have the potential to be affected by the deficient practice. No adverse effects of the deficient practices were noted for any of the	2/21/25	

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F 806	<p>Continued From page 36</p> <p>determined that the facility failed to ensure that resident dietary preferences were accurately identified and implemented for 4 of 21 residents (Resident #20, #39, #107, and #275) reviewed for dining and was evidenced by the following:</p> <p>On 1/3/25 at 10:00 AM, during a surveyor-conducted resident council meeting, 4 out of 4 residents (Residents #6, #60, #71 and #98) stated that condiments such as cream, sugar, mustard, and mayonnaise would not be on the meal trays and that the facility did not honor food preferences on their meal tickets. The residents also stated that when they ask for a substitute food item than what was on their meal ticket, it can take a long time for another meal tray, or they don't get it at all.</p> <p>1. On 1/3/25 at 11:36 AM, the surveyor observed Resident #107 seated in a wheelchair in his/her room. The resident stated that his/her meal ticket listed no bread, no citrus, and no tomato, but received bread on his/her meal tray.</p> <p>On 1/3/25 at 1:02 PM, the surveyor reviewed the medical record for Resident #107.</p> <p>A review of the Admission Record revealed that the resident had diagnosis which included but were not limited to: NJ Exec Order 26.4b1</p> <p>[REDACTED]</p> <p>A review of the resident's quarterly Minimum Data Set (MDS), and assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which</p>	F 806	<p>residents.</p> <p>Immediate corrective action for residents affected by deficient practice: 222 The Dining services director reviewed with resident #107 specific food item preferences and updated the resident meal ticket The Dining services director reviewed resident #107 to ensure no bread was clearly noted on resident meal ticket. Dining services provided condiment supplies to units including but not limited to resident #275 unit 4. Resident #39 was provided with a sandwich according to patient food item preference. The Dining services director reviewed resident #39 meal ticket to ensure the sandwich is clearly noted. Resident #20 was provided with a replacement breakfast tray that included toast, diet jelly, and margarine. The Dining services director reviewed resident #20 meal ticket to ensure food item preferences are clearly noted</p> <p>Measures put in place to ensure the deficient practice will not occur for those residents affected: Beginning on January 30, 2025, the Food Services Director/Designee will visit residents to review specific menu selection preferences. Beginning on January 20, 2025, Dietary staff were educated by the Regional Dietary Director on the process to manage resident menu selection changes based on preferences.</p>		

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F 806	<p>Continued From page 37 indicated the resident's NJ Exec Order 26.4b1.</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4b1, that the resident had a need for a NJ Exec Order 26.4b1. Interventions included: Provide NJ Exec Order 26.4b1 as ordered NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 compliance and educate family members on maintaining correct NJ Exec Order 26.4b1 when NJ Exec Order 26.4b1 outside facility or bringing in NJ Exec Order 26.4b1.</p> <p>A review of the Order Summary Report revealed an order dated NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1.</p> <p>On 1/6/25 at 1:02 PM, the surveyor received a Grievance Form that was completed by the facility's U.S. FOIA (b)(6) on NJ Exec Order 26.4b1 and indicated that the resident's family member reported a problem with tray accuracy and alleged that the resident received a biscuit on his/her tray. The NJ Exec Order 26.4b1 documented that the meal ticket was verified and indicated no bread.</p> <p>A review of the progress notes included a Health Status Note (HSN), dated NJ Exec Order 26.4b1 which indicated that the resident had a cinnamon bun [trade name redacted] in a napkin and was educated that he/she was not allowed to have bread, and he/she responded, "I only ate half." Further review of the progress notes revealed that there was no documentation that detailed that the resident was served a biscuit on NJ Exec Order 26.4b1 as indicated on the grievance form.</p> <p>On 1/6/25 at 1:37 PM, the surveyor observed the resident's meal tray and confirmed tray accuracy. The surveyor confirmed that the resident had no bread, no citrus, and no tomato listed on their</p>	F 806	<p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Food Services Director/Designee will conduct 5 resident satisfaction interviews weekly x4 weeks and then x2 weekly x2 months. Food Services Director/Designee will conduct Resident Food committee meetings monthly. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.</p> <p>Date of Completion 2.21.2025</p>		

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F 806	<p>Continued From page 38 meal ticket as preferences.</p> <p>On 1/7/25 at 11:00 AM, the surveyor interviewed the [REDACTED] who stated that on [REDACTED] the resident's family member called her to the resident's room and showed her the resident's meal tray with a meal ticket that indicated no bread products, and the resident was given a biscuit. The [REDACTED] stated that she went to the kitchen and verified that going forward no other bread products would be on the tray.</p> <p>On 1/7/25 at 12:21 PM, the surveyor interviewed [REDACTED] U.S. FOIA (b)(6) who stated that the meal ticket should match what is on the tray. The [REDACTED] U.S. FOIA (b)(6) further stated that a dry biscuit should not have been served to the resident and should match what was on the meal ticket.</p> <p>On 1/8/25 at 10:09 AM, the surveyor interviewed the [REDACTED] U.S. FOIA (b)(6) who stated that the resident's current diet was a ground consistency. The [REDACTED] U.S. FOIA (b)(6) stated that there was a concern for [REDACTED] NJ Exec Order 26.4b1 if the resident was served a biscuit. The [REDACTED] was present and stated that if bread were served it should have had gravy on it to ensure that it was moistened and soft.</p> <p>On 1/8/25 at 2:02 PM, the surveyor interviewed the [REDACTED] U.S. FOIA (b)(6) in the presence of the surveyor team who stated that it was her expectation for staff to follow the resident's dietary preferences and diet orders.</p> <p>2.) On 1/3/25 at 11:56 AM, the surveyor observed</p>	F 806			

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F 806	<p>Continued From page 39</p> <p>Resident #275 seated alone at a table in the dining room. The resident stated that he/she had not yet received his/her meal tray.</p> <p>On 1/3/25 at 11:58 AM, the surveyor observed Licensed Practical Nurse/Unit Manager (LPN/UM) #4 serve Resident #275 his/her meal tray. The resident stated that he/she had not received margarine that was listed as meal preference on his/her meal ticket, or salt and pepper. LPN/UM #4 provided the surveyor with margarine, salt and pepper when requested. When the surveyor asked LPN/UM #4 why the resident had not received margarine or salt and pepper on his/her tray, he stated that he was unsure why the resident had not received margarine as indicated on his/her meal ticket, or salt and pepper.</p> <p>3.) On 01/06/25 at 01:38 PM, the surveyor observed Resident #39's lunch meal tray ticket that included a chicken pot pie, dinner roll, ham and cheese sandwich with lettuce, tomato, and mayonnaise, tossed salad with dressing, deluxe fruit salad, hot coffee, and apple juice. The surveyor observed that Resident #39's lunch tray did not include the ham and cheese sandwich with lettuce, tomato, and mayonnaise. At that time, Certified Nursing Assistant (CNA # 4) stated that there was a ham and cheese sandwich on top of the meal cart and gave the sandwich to the resident. Resident #39 stated, "my meal ticket has that I'm supposed to get lettuce and tomato on my sandwich." The sandwich did not have lettuce and tomato.</p> <p>On 1/6/25 at 1:41 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #6) who stated that it was every day that items were missing from residents' meal trays. LPN #6</p>	F 806			

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F 806	<p>Continued From page 40</p> <p>stated that she would call the kitchen and let them know when items would be missing from the meal trays.</p> <p>On 1/8/25 at 11:14 AM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6), who confirmed that Resident #39 had a food preference of a ham and cheese sandwich with lettuce, tomato, and mayonnaise on his/her meal ticket.</p> <p>4.) On 1/7/25 at 9:35 AM, the surveyor observed breakfast meal delivery on the NJ Exec Unit. The surveyor observed CNA #3 stated she had called the kitchen and requested a new breakfast tray for Resident # 20 because the tray was missing toast.</p> <p>On 1/7/25 at 9:57 AM, Resident #20's breakfast tray was delivered to the NJ Exec unit. The surveyor observed Resident # 20's meal ticket on the tray that included oatmeal, toast, diet jelly, margarine, hot tea, and orange juice. The surveyor observed the meal tray did not include the toast, the diet jelly, or the margarine. At 10:15 AM, the surveyor and the U.S. FOIA (b)(6) confirmed that the toast, diet jelly, and margarine were missing from the tray. The U.S. FOIA stated "I will get the resident a new tray. I am trying to find out what happened to the breakfast trays this morning." At 10:25 AM, Resident # 20 received the breakfast tray that included the toast, diet jelly, and margarine.</p> <p>On 1/8/25 at 1:19 PM, the surveyor interviewed the U.S. FOIA (b)(6), in the presence of the U.S. FOIA (b)(6),</p>	F 806			

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F 806	Continued From page 41 the U.S. FOIA (b)(6) , and the survey team, who stated that she would expect the kitchen would have someone checking that everything on the meal tray matches the meal ticket. The U.S. FOIA (b)(6) further stated that it was important that the facility followed the meal ticket, the diet order, and the residents' preferences because it is the residents right. A review of the facility "Meal Distribution" policy, dated September 2017, revealed that the nursing staff will be responsible for verifying meal accuracy and timely delivery of meals to residents/patients. The policy further included: All meals will be assembled in accordance with the individualized diet order, plan of care, and preferences...	F 806			
F 812 SS=F	NJAC 8:39-17.4(a)1, e Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		2/21/25	

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F 812	<p>Continued From page 42</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following:</p> <p>On 1/2/25 from 10:00 AM until 10:51 AM, the surveyor observed the following in the presence of the U.S. FOIA (b)(6):</p> <ol style="list-style-type: none"> 1. There was no trash can at the handwashing sink at the entrance to the galley of the kitchen. The nearest trash can was covered with a lid and failed to contain a foot pedal. The U.S. FOIA stated that the lid was normally removed during food service. 2. The oven in the galley of the kitchen was heavily soiled. The U.S. FOIA stated that it was cleaned two weeks ago. 3. The lower double convection oven in the galley of the kitchen was soiled with a thick, black substance. The U.S. FOIA stated that it was recently cleaned. The U.S. FOIA failed to provide the surveyor with documented evidence to account for when the ovens were cleaned at that time. 4. Dietary Aide (DA) #1 who operated the dish machine wore a beard guard beneath his chin which left both his mustache and beard exposed. The U.S. FOIA stated that the beard guard should have fully covered his beard. The U.S. FOIA then instructed DA #1 to donn (put on) an alternative facial 	F 812	<p>A trash can with a foot-pedal-operated-lid was replaced at the handwashing sink at the entrance to the galley of the kitchen on 1.2.25.</p> <p>The oven in the galley of the kitchen was thoroughly cleaned on 1.2.25.</p> <p>1:1 education was provided to the Dietary Aide (DA) #1, who operated the dish machine that wore a beard guard beneath his chin which left both his mustache and beard exposed was in-serviced immediately regarding always keeping his beard guard in place properly while in the kitchen on 1.2.25</p> <p>Unit 100 Pantry missing temperature log was immediately replaced on the refrigerator/freezer on 1.6.25.</p> <p>The forty-six (46) ounce carton of thickened water that was opened and not dated was immediately thrown away and education was provided to all nursing staff regarding our policy of opening thickened liquids, dating when opened and indicating the use-by date on the container so nursing knows when to discard on 1.6.25.</p> <p>Unit 100 Pantry missing thermometer in the freezer was immediately replaced on 1.6.25</p> <p>Since the 200 Unit Pantry refrigerator temperature was 30 degrees Fahrenheit (F) and the temperature log indicated that the refrigerator minimum/maximum range</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/13/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VOORHEES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043		
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F 812	<p>Continued From page 43 covering that covered both his beard and mustache.</p> <p>On 1/6/25 from 11:53 AM until 12:39 PM, the surveyor observed the following in the Nursing Unit Pantries:</p> <ol style="list-style-type: none"> In the NJ Exec 9 Unit Pantry in the presence of Licensed Practical Nurse (LPN) #4, the surveyor observed that there was no temperature log on the refrigerator and freezer. LPN #4 stated that we are supposed to have a temperature log and staff were required to check the temperatures and sign the log on every shift. A forty-six (46) ounce carton of thickened water was opened and was not dated. LPN #4 stated that it was supposed to be dated when opened. There was no thermometer in the freezer. A container of ice cream that was stored in the freezer was hard to the touch. LPN #4 stated that a thermometer was required to be in the freezer to ensure that food items were maintained at the proper temperature. In the NJ Exec 9 Unit Pantry in the presence of Certified Nursing Assistant (CNA) #1, the refrigerator temperature was 30 degrees Fahrenheit (F). The temperature log indicated that the refrigerator minimum/maximum range was 34 F to 40 F. Further review of the temperature log revealed that the last recorded refrigerator temperature on 1/6/25 was 42 F. CNA #1 stated that she would notify maintenance. A forty-six (46) ounce carton of orange juice was opened and was not dated. CNA #1 stated 	F 812	<p>was 34 F to 40 and temperature log revealed that the last recorded refrigerator temperature on 1/6/25 was 42 F, all dietary and nursing staff were immediately educated on documenting accurate temperatures and communicating to maintenance if temperature is out of range on 1.6.25.</p> <p>The forty-six (46) ounce carton of orange juice in the 200 Unit Pantry that was opened and not dated was immediately thrown away and education was provided to all nursing staff regarding our policy of opening juices, dating when opened and indicating the use-by date on the container so nursing knows when to discard on 1.6.25.</p> <p>The clear plastic cup, with a convenience store logo, in the 200 Unit Pantry refrigerator that contained ice and was not labeled or dated was immediately discarded and education was provided to all nursing staff regarding labeling and dating all resident food items and when those items should be discarded on 1.6.25.</p> <p>Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. No adverse effects of the deficient practices were noted for any of the residents.</p> <p>Measures put in place to ensure the deficient practice will not occur for those residents affected: Beginning on January 2, 2025, dietary</p>		

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F 812	<p>Continued From page 44</p> <p>that she would throw it out because it could only be in the refrigerator for 48 to 72 hours.</p> <p>6. In the freezer, there was a clear plastic cup with a convenience store logo that contained ice and was not labeled or dated. CNA #1 stated that the cup belonged to an unsampled resident and was usually stored in the resident's room. CNA #4 stated that it was an infection control issue if the cup was brought to the freezer from the resident's room.</p> <p>During a follow-up visit to the kitchen on 1/7/25 from 11:17 AM until 12:02 PM, the surveyor observed the following in the presence of the [REDACTED]</p> <p>1. The [REDACTED] washed his hands for eleven seconds outside of the stream of running water and then proceeded to rub his hands together under the stream of running water before he dried his hands and donned gloves. The [REDACTED] then proceeded to obtain food temperatures from the steam table.</p> <p>2. The [REDACTED] then doffed (removed) his gloves and failed to perform hand hygiene before he opened the chef's refrigerator and removed a bag of cheese and placed it on a cutting board. The [REDACTED] then proceeded to assemble and prepare grilled cheese sandwiches.</p> <p>On 1/7/25 at 12:45 PM, in a later interview with the [REDACTED], he stated that he stated that the whole process of handwashing was twenty seconds and included the time that it took to rinse the hands in water. The [REDACTED] further stated that there was no policy that directed a specific amount of time to</p>	F 812	<p>staff were re-educated by the Food Services Director and Regional Dietary Director regarding the requirement to always have a foot operated trash can by all handwash sinks to maintain proper infection control practice.</p> <p>Beginning on January 2, 2025, dietary staff were re-educated by the Food Services Director and Regional Dietary Director regarding the requirement to maintain all ovens and equipment in a clean and sanitary manner.</p> <p>Beginning on January 2, 2025, dietary staff were re-educated by the Food Services Director and Regional Dietary Director regarding the requirement to always have hair and beard nets in place while in the kitchen.</p> <p>Beginning on January 6, 2025, all nursing and dietary staff were re-educated by the Food Services Director, District Food Services Director and facility Educator regarding all items must indicate an open-date and use-by date.</p> <p>Beginning on January 6, 2025, dietary staff were re-educated by the Food Services Director, Regional Dietary Director and facility Educator regarding the requirement to always have a temp log and thermometer on/in each refrigerator/freezer, ensure the temp log is completed accurately and that all refrigerator/freezer temperatures are in proper range per policy.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Food Services Director/designee will audit</p>		

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F 812	<p>Continued From page 45</p> <p>lather the hands outside of the stream of running water. The [REDACTED] stated that hand washing was required after gloves were doffed (removed) only if touching ready to eat food.</p> <p>On 1/8/25 at 10:39 AM, during an interview with the Regional Director of Operations (RDO) #2, in the presence of the [REDACTED] and the survey team, RDO #2 stated that it was a top priority to maintain a temperature log for the refrigerator and freezer because we want to know what the temperatures were to ensure that the refrigerator and freezer were working properly. RDO #2 stated that a thermometer was required in both the refrigerator and freezer to ensure that the temperature was maintained below 41 F in the refrigerator and close to zero for the freezer. RDO #2 stated that staff should notify maintenance to adjust it.</p> <p>RDO #2 further stated that once opened, thickened liquids should be refrigerated and used within seven days so that nursing would know when to discard it.</p> <p>On 1/8/25 at 11:25 AM, the surveyor interviewed the [REDACTED] who stated that the process for hand washing was to turn on the water, wet the hands, apply soap, lather the hands scrubbing vigorously under the nails and the tops of the hands for twenty seconds or more, rinse the hands under water with the hands pointed downward, then dry the hands with a paper towel and discard it and use additional paper towels to turn off the faucet and discard them. The [REDACTED] stated that you were supposed to scrub with soap for twenty seconds out of the stream of running water to loosen up the dirt and germs and then rinse the hands under the stream</p>	F 812	<p>the presence and use of foot operated trash cans by all hand sinks, proper wearing of hair and beard guards, and that ovens and equipment are maintained in a clean and sanitary condition 2x/week x4 weeks and then x1weekly x2 months. Director of Nursing/designee will audit Open-date and Use-by date of all food in pantries 2x/week x4 weeks and then x1weekly x2 months. Food Services Director/designee will audit Open-date and Use-by date of all food in pantries 2x/week x4 weeks and then x1weekly x2 months. Food Services Director/designee will audit all pantry refrigerator/freezers to ensure temp logs and thermometers are present and temps are within range daily x4 weeks and then x2 weekly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/13/2025
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F 812	<p>Continued From page 46</p> <p>of water. The NU further stated that her expectation was for everyone to sanitize their hands before donning and doffing gloves.</p> <p>On 1/8/24 at 12:13 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that all facial hair should be covered, and beard guards should not be worn beneath the chin in order to keep hair from getting into the dishes.</p> <p>On 1/8/25 at 2:21 PM, the U.S. FOIA (b)(6) stated that hands should be washed for twenty seconds with friction prior to rinsing them.</p> <p>A review of a facility "Staff Attire" policy dated September 2017, revealed the following: All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained.</p> <p>A review of a facility "Food Preparation" policy dated September 2017, revealed the following: All staff will practice proper hand washing techniques and glove use. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination.</p> <p>A review of a facility, "Food Storage: Cold Foods" policy dated April 2018, revealed the following: All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated will be appropriately stored in accordance with the FDA (Food and Drug Administration) Food Code. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded.</p>	F 812			

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F 812	<p>Continued From page 47</p> <p>All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.</p> <p>A review of a facility, "Hand Hygiene" policy dated 9/1/24, revealed the following: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene technique when using soap and water: Wet hands with water... Apply to hands the amount of soap recommended by the manufacturer. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse hands with water. Dry thoroughly with a single-use towel. Use a clean towel to turn off the faucet. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.</p> <p>NJAC 8:39-17.2 (g); 19.4</p>	F 812			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/13/2025
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VOORHEES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043
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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 171220, 172519, and 180914 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 2 of 3 weeks of complaint staffing. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with the Human Resource Director and Staffing Coordinator, who were both able to reiterate minimum staffing requirements for nursing homes. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. No adverse effects of the deficient	2/21/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

02/03/25

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/13/2025
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S 560	<p>Continued From page 1</p> <p>30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift.</p> <p>One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One (1) care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>1. For the week of Complaint staffing from 01/28/2024 to 02/03/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows:</p> <p>-01/29/24 had 17 CNAs for 151 residents on the day shift, required at least 19 CNAs. -01/30/24 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/31/24 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. -02/01/24 had 16 CNAs for 149 residents on the day shift, required at least 19 CNAs. -02/02/24 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. -02/03/24 had 17 CNAs for 153 residents on the</p>	S 560	<p>practices were noted for any of the residents.</p> <p>Measures put in place to ensure the deficient practice will not occur for those residents affected:</p> <p>The facility will continue to focus recruitment and retention strategies as follows: identify vacant positions daily and attempt to fill positions with current CNA staff or agency.</p> <p>The Administrator and Director of Nursing will work diligently with Corporate Recruiters to advertise, recruit and hire sufficient CNA staff.</p> <p>Administrator to continue work with Human Resources and Staffing Manger to offer shift bonuses and flexible work schedules.</p> <p>Administrator and Human Resources will continue to focus on recruitment and employer sponsorship of qualified candidates for enrollment is a Certified Nursing Assistant Training and Competency program.</p> <p>Administrator and Human Resources will continue to develop an employee retention program designed to engage employees, promote a positive work environment and enhance job satisfaction.</p> <p>The Administrator educated the Staffing Coordinator on process to project staffing needs based on facility census fluctuations to meet mandated ratios.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>Administrator/Designee to audit the effectiveness of hiring strategies to include open CNA and Licensed Nurse positions</p>	
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New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VOORHEES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043
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S 560	<p>Continued From page 2</p> <p>day shift, required at least 19 CNAs.</p> <p>2. For the week of Complaint staffing from 03/24/2024 to 03/30/2024, the facility was efficient in CNA staffing for residents on 7 of 7 day shifts as follows:</p> <ul style="list-style-type: none"> -03/24/24 had 14 CNAs for 163 residents on the day shift, required at least 20 CNAs. -03/25/24 had 13 CNAs for 162 residents on the day shift, required at least 20 CNAs. -03/26/24 had 18 CNAs for 162 residents on the day shift, required at least 20 CNAs. -03/27/24 had 19 CNAs for 161 residents on the day shift, required at least 20 CNAs. -03/28/24 had 19 CNAs for 160 residents on the day shift, required at least 20 CNAs. -03/29/24 had 19 CNAs for 159 residents on the day shift, required at least 20 CNAs. -03/30/24 had 18 CNAs for 159 residents on the day shift, required at least 20 CNAs. <p>On 1/7/25 at 2:23 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one direct care staff for 10 residents on the 3:00 PM - 11:00 PM shift, and one direct care staff for 14 residents on the 11:00 PM - 7:00 AM shift. The SC further stated the facility meets those ratios as best as they can, but due to call outs and shifts not being covered by agency, the facility was "probably short sometimes."</p> <p>On 1/8/25 at 1:20 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one</p>	S 560	<p>vs. new hires, reporting on successful strategies-to-hire based on percentages, and turnover rates.</p> <p>The duration of all audits will consist of completion 1x weekly x4 weeks then continue 1x weekly x2 months.</p> <p>Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>	
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New Jersey Department of Health

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S 560	<p>Continued From page 3</p> <p>direct care staff for 10 residents on the 3:00 PM - 11:00 PM shift, and one direct care staff for 14 residents on the 11:00 PM - 7:00 AM shift. The LNHA further stated that the facility aims to meet the staffing ratios.</p> <p>A review of the facility's "Nursing Services and Sufficient Staff" policy, implemented 9/1/24, did not include the New Jersey minimum requirements for staffing.</p>	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315219	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing		DATE OF REVISIT 2/25/2025	Y3
NAME OF FACILITY COMPLETE CARE AT VOORHEES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0658	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	02/21/2025	LSC	02/21/2025	LSC	02/21/2025
ID Prefix F0677	Correction	ID Prefix F0687	Correction	ID Prefix F0698	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(b)(2)(i)(ii)	Completed	Reg. # 483.25(l)	Completed
LSC	02/21/2025	LSC	02/21/2025	LSC	02/21/2025
ID Prefix F0804	Correction	ID Prefix F0806	Correction	ID Prefix F0812	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(d)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	02/21/2025	LSC	02/21/2025	LSC	02/21/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/13/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060414	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/25/2025
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NAME OF FACILITY COMPLETE CARE AT VOORHEES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043
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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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/21/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/13/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315219	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VOORHEES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043		
(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) COMPLETION DATE	
E 000	Initial Comments	E 000			
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/09/2025, 01/10/2025 and 01/13/2025 and Complete Care at Voorhees was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Complete Care at Voorhees is a one-story building that was built in 1985. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator powers approximately 100% of the building as per the U.S. FOIA (b)(6) The facility has 190 certified beds and the Census was 179.	K 000			
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies	K 293		2/21/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/03/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315219	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VOORHEES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043		
(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) COMPLETION DATE	
K 293	<p>Continued From page 1 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/09/2025 in the presence of facilities U.S. FOIA (b)(6) [REDACTED] it was determined that the facility failed to provide four (4) illuminated exit signs to clearly identify the exit access paths to reach an exit discharge door in accordance with Life Safety Code 101, 2012 Edition 19.2.10.1, 7.7, 7.10.5.2.1, 7.10.6.3, 7.10.7 and 7.10.8.1</p> <p>This deficient practice had the potential to affect the 179 Residents in the facility and was evidenced by the following:</p> <p>Observations on 01/09/2025 at approximately 10:56 AM, the surveyor observed inside the outside enclosed courtyard adjacent to the 100's Unit, no evidence of two (2) illuminated exit signs to clearly identify the exit access path to reach an exit.</p> <p>Observations on 01/09/2025 at approximately 11:01 AM, the surveyor observed inside the outside enclosed courtyard adjacent to the 400's Unit no evidence of two (2) illuminated exit signs to clearly identify the two (2) exit access path to reach an exit.</p> <p>A review of the facility provided lay-out identified the facility is a single-story (1) building with two (2) outside enclosed (surrounded by the building) center courtyards that Residents, Visitors and Staff could use.</p>	K 293	<p>All residents have the potential to be affected by the deficient practice. No adverse effects of the deficient practices were noted for any of the residents.</p> <p>Measures put in place to ensure the deficient practice will not occur for those residents affected: The Regional Maintenance Director educated facility Maintenance Director on Exit Signage and testing of Exit Signage. Four (4) Exit signs were installed 2/17/2025 . Two exit courtyard signs adjacent to Unit 1 and two exit courtyard signs adjacent to Unit 4. Photos of completed work attached.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Maintenance Director /Designee to audit proper location and operation of exit signs. The duration of all audits will consist of completion 1x weekly x4 weeks then continue 1x weekly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315219	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VOORHEES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043		
(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) COMPLETION DATE	
K 321	<p>Continued From page 3 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 01/09/2025 in the presence of facility U.S. FOIA (b)(6) [REDACTED], it was determined that the facility failed to ensure that 1 of 8 fire-rated doors inspected to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice had the potential to affect the 179 Residents in the facility and was evidenced by the following:</p> <p>Observations on 01/09/2025 at approximately 9:22 AM revealed the door to the Medical Records office (adjacent to the Physical Therapy area) had no means to self close. The surveyor observed inside the room, six (6) four drawer cabinets filled with combustible medical records and other combustible medical records on open shelving. The surveyor measured and recorded the room to be 9 feet by ten feet, This is 90 square feet which is larger than 50 square feet. With this door not smoke resistant, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.</p> <p>The U.S. FOIA (b)(6) confirmed the finding at the time of observation.</p> <p>The U.S. FOIA (b)(6) [REDACTED] were informed of the deficient practice during the Life Safety Code survey exit on 01/13/2025 at approximately</p>	K 321	<p>All residents have the potential to be affected by the deficient practice. No adverse effects of the deficient practices were noted for any of the residents.</p> <p>Measures put in place to ensure the deficient practice will not occur for those residents affected: The Regional Maintenance Director educated facility Maintenance Director on Hazardous Area Enclosures One (1) closure was installed 2/13/2025 on the Medical Records office door. Photo of completed work attached.</p> <p>Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Maintenance Director /Designee to audit door closer to ensure the door closes automatically. The duration of all audits will consist of completion 1x weekly x4 weeks then continue 1x weekly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315219	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VOORHEES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043		
(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) COMPLETION DATE	
K 321	Continued From page 4 12:35 PM. NJAC 8:39-31.2 (e)	K 321			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315219	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 2/25/2025
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NAME OF FACILITY COMPLETE CARE AT VOORHEES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 EVESHAM ROAD VOORHEES, NJ 08043
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # _____	Completed
LSC K0293	02/21/2025	LSC K0321	02/21/2025	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 1/13/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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