STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Voorhees Pediatric Facility	**1304 LAUREL OAK ROAD , VOORHEES, New Jersey, 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
F0000	INITIAL COMMENTS Complaint #: 2642805 Census: 111 Sample Size: 3 A Complaint Survey was conducted at Voorhees Pediatric Facility from 10/20/25 to 10/21/25, to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. During the survey, findings which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.15(c) F 600, as the facility failed to ensure a NJ Ex Order 26.4(b)(1) was protected from NJ Ex Order when on NJ Ex Order 26.4(b) at approximately 1:45 PM, the Certified Nursing Aide (CNA #1) NJ Ex Order 2 while attending to Resident #2, she heard CNA #2, who was attending to Resident #1's NJ Ex Order 26.4(b)(1) Resident #1 who was NJ Ex Order 26.4(b)(1). CNA #1 stated that she was unable to report the incident at the time to the U.S. FOIA (b) (6) , and reported the incident around 3:00 PM that day, to the U.S. FOIA (b) (6)). CNA #2 continued to care for Resident #1, and on 10/09/25, at approximately 2:00 PM, CNA #2 asked the Registered Nurse (RN #1) to assist her in NJ Ex Order 26.4(b)(1) Resident #1 onto the NJ Ex Order 26.4(b)(1). At that time, RN #1 observed that Resident #1 NJ Ex Order 26.4(b)(1) and had NJ Ex Order 26.4(b)(1) RN #1 questioned CNA #2 why Resident #1 was NJ Ex O and CNA #2 reported that she had NJ Ex Order 26.4 the resident. RN #1 did not report that NJ Ex Order 26.4(b) to her supervisor. During interviews on 10/20/25, with both RN #1 and CNA #2, they both confirmed Resident #1 was NJ Ex Order 26.4(b)(1), by CNA #2. The Administration was informed of the F 600 IJ and was provided the IJ template on 10/20/25 at 3:22 PM. An acceptable Removal Plan was received on 10/20/25 at 7:38 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring.	F0000		10/22/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315289	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2025

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F0000	Continued from page 1 The facility implemented a corrective action plan to remediate the deficient practice including on 10/09/25, when the U.S. FOIA was made aware, CNA #2 was immediately removed from resident care and suspended pending investigation and was NJ Exec Order 26.4b1 or NJ Ex Order 26.4(b) On NJ Ex Order 26, the NJ Exec Order 26.4b1 were notified, the facility started investigating, and Resident #1 was assessed. On 10/17/25, the facility reported CNA #2 to the New Jersey Department of Health (NJDOH) on the FRIDAY form and the Health Care Professional Responsibility and Reporting Enhancement Act. On 10/20/25, RN #1 was individually counseled and provided with remedial training; the facility's Abuse Prevention Policy was updated and redistributed to all staff to include termination for failure to report in a timely manner; quick reference posters for abuse reporting were installed in staff lounges; and a daily NJ Exec Or incident reporting audit was started and will be conducted by the U.S. FOIA or appointed designee daily for 30 days to verify timeliness of incident reporting, proper resident protection procedures, and staff compliance with facility policy. The surveyor verified the implementation of the Removal Plan on-site during the continuation of the survey and determined the immediacy for F 600 was removed as of 10/21/25 at 12:21 PM.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Complaint: 2642805	F0600	1. Corrective Action Taken for the Affected Resident(s): On 10/09/25, upon learning of the allegation, CNA #2 was immediately removed from resident care duties and suspended pending the outcome of the investigation. Resident #1 was immediately assessed on 10/9/25 by the Nurse Practitioner and found to have NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) noted. The Voorhees Police, NJDOH, and Medical Director were notified on 10/09/25 in accordance with reporting requirements. Mom of Resident #1 met with facility Administrator, Director of Social Work and Nurse Care Coordinator on 10/09/25 to discuss the allegation and the details of our investigation thus far. Counseling and emotional support services initiated for resident #1 and Mom by the Director of Social work. NJ Ex Order on NJ Ex Order 26.4(b)(1 were ordered and taken on NJ Ex Order 26 to ensure there were no NJ Ex Order 26.4(b)(1) due to the	10/22/2025

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F0600 SS = SQC-J	Continued from page 2 Based on interviews, review of the medical records, and review of other pertinent facility documents, it was determined that the facility failed to protect a NJ Ex Order 26.4(b)(1) resident (Resident #1) from NJ Ex Order a.) when the Certified Nursing Aide (CNA #1) NJ Ex Order 2 that she heard CNA #2 NJ Ex Order 26.4(b Resident #1 and CNA #1 did not report the NJ Ex Order 26.4(b)(1) immediately and b.) when the Registered Nurse (RN #1) was made aware that Resident #1 was NJ Ex Order 26.4(b)(1) from CNA #2 NJ Ex Order at them and RN #1 left the resident in CNA #2's care and did not immediately report it. This deficient practice was identified for 1 of 3 residents reviewed for abuse. On 10/09/25 at approximately 1:45 PM, CNA #1 alleged while attending to Resident #2, she heard CNA #2, who was attending to Resident #1's NJ Ex Order 26.4(b)(1) Resident #1 who was NJ Ex Order 26.4(b)(1). CNA #1 stated that she was unable to report the incident at the time to the U.S. FOIA (b) (6) and reported the incident around 3:00 PM that day, to the U.S. FOIA (b) (6)). CNA #2 continued to care for Resident #1, and on NJ Exec Order 26, at approximately 2:00 PM, CNA #2 asked RN #1 to assist her in NJ Ex Order 26.4(b)(1 Resident #1 onto the NJ Ex Order 26.4(b)(1). At that time, RN #1 observed that Resident #1 " NJ Ex Order 26.4(b)(and had NJ Ex Order 26.4(b)(1) ." RN #1 questioned CNA #2 why Resident #1 was NJ Ex O and CNA #2 reported that she NJ Ex Order 26.4(b) at the resident. RN #1 did not report that NJ Ex Order 26.4(b to her supervisor. During interviews on 10/20/25, with both RN #1 and CNA #2, they both confirmed Resident #1 was NJ Ex Order 26.4 on NJ Ex Order 26.4 , by CNA #2. The facility's failure to implement their abuse policy including protecting Resident #1 from NJ Ex Order by CNA #1 not immediately reporting CNA #2 for the NJ Ex Order 2 and for RN #1 not reporting CNA #2 after CNA #2 indicated that Resident #1 was NJ Ex Order 26.4(b)(1) because she NJ Ex Order 26.4 the resident, placed Resident #1 and all residents at risk for NJ Ex Order 2 This posed the likelihood of serious physical harm and psychological, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation. The IJ began NJ Ex Order 26.4 at 1:45 PM, when CNA #1 NJ Ex Order 2 she heard CNA #2 NJ Ex Order Resident #1 and did not immediately report it. The facility was notified of the IJ on 10/20/25 at 3:22 PM. The facility submitted an acceptable Removal Plan (RP) on 10/20/25 at 7:38 PM. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 10/21/25 at 12:21 PM.	F0600	Continued from page 2 accusation. Findings showed that there was NJ Ex Order 26.4 identified. Medical Director reviewed results on NJ Exec Order 26. Resident #1 was again assessed for NJ Ex Order 26.4(b)(1) the following day, NJ Exec Order 26, by the Nurse Practitioner. No NJ Ex Order 26.4(b)(1) noted. Resident #1 was NJ Ex Order 26.4(b)(1) and expressed NJ Ex Order 26.4(b)(1). Resident #1 care plan was updated on 10/10/25 to address NJ Ex Order 26.4(b)(1). CNA #1 received individual counseling and remedial education regarding mandatory abuse reporting requirements at the start of her shift on 10/11/25. This education emphasized failure to immediately report allegations of abuse, the duty to protect residents from further potential harm, immediate removal of alleged abuser from resident care. On 10/15/25, Medical Director examined Resident #1 NJ Ex Order for NJ Ex Order 26.4(b)(1) . No NJ Ex Order 26. or NJ Ex Order 26 noted. No NJ Ex O to NJ Ex Order 26.4(b)(1) or NJ Ex Order 26 ordered out of precaution. NJ Ex Ord revealed NJ Ex Order 26.4(b)(and no change from prior with no need for NJ Ex Order 26.4(b)(1) Following investigation, CNA #2's employment was NJ Exec Order 26.4b on NJ Exec Order 2. A report was filed with the Division of Consumer Affairs as well as the submission of the FRIDAY form to the NJDOH. Administrator, Director of Nursing, Assistant Director of Nursing, Care Coordinator and Director of Social Work met with NJ Exec O and NJ Ex sister on 10/17/25 to discuss our investigation and outcome. RN #1 received individual counseling and remedial education regarding mandatory abuse reporting requirements on 10/20/25. This education emphasized failure to immediately report allegations of abuse, the duty to protect residents from further potential harm, immediate removal of alleged abuser from resident care. Resident #1 continues to receive close NJ Ex Order 26.4(b)(1) by nursing and social services; no further distress has been noted. 2. Identification of Other Residents Who Could Be Affected: All residents in the facility have the potential to be	

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F0600 SS = SQC-J	Continued from page 3 The evidence was as follows: A review of the facility's policy titled "Safety: Abuse, Neglect and Exploitation" updated 5/21/25, included Policy: [name redacted] has an obligation to protect the welfare of its residents and to fully investigate and correct any circumstances bearing upon that welfare. The approach should be as proactive as possible. As such, all new employees shall be in-serviced about abuse and neglect as part of orientation, and all current employees shall review this information at least annually thereafter […] VI. Protection of the Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. If alone, do not leave the resident and pull the code bell for immediate help… A review of the Facility Reported Event (FRE) dated NJ Ex Order 26.4, submitted to the New Jersey Department of Health (NJDOH) revealed the following: On NJ Ex Order 26.4, at approximately 1:45 PM, a staff member (CNA #1) providing care to Resident #1's roommate heard NJ Ex Order 26.4(b)(1)." When she turned to investigate, she observed a nursing aide (CNA #2) NJ Ex Order 26.4(b)(1), appearing NJ Ex Order. Resident #1's NJ Ex Orde. At the time, Resident #1 had NJ Ex Order 26.4(b)(1) and NJ Ex Ord on their NJ Ex Order 2 The event was reported to the U.S. FOIA after the staff was unable to notify her immediate supervisor. The nursing aide [CNA #2] involved in NJ Ex Order 26.4(b)(1) was immediately removed from the unit and from all patient… The FRE included a summary of the investigation created by the U.S. FOIA which indicated that Resident #1 is NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) on staff for medical and clinical needs which results in CNA #2 being immediately removed from the unit and suspended. A further review of the FRE included a written statement from CNA #1, which indicated CNA #1, who was NJ Ex Order 26 away from Resident #1, NJ Ex Order 26.4(b)(1) and when CNA #1 turned her head and saw CNA #2 NJ Ex Order 26.4(b)(1) and it appeared she was NJ Ex Order 26.4 [Resident #1] NJ Ex Order 26.4(b)(1)." CNA #1 asked CNA #2 what she was doing, and CNA #2 replied she was going to get Resident #1 in NJ Ex Order 26.4(b)(1). The written statement also included CNA #1 was unable to notify her immediate supervisor and waited around an hour before reporting	F0600	Continued from page 3 affected by a failure to immediately report allegations of abuse. All residents assigned to CNA #2 were assessed by the Charge Nurse and Nurse Supervisor on 10/9/25. No injuries or psychosocial distress documented for any of the residents. 3. Systemic Changes to Prevent Recurrence: Facility's Abuse Prevention Policy was reviewed by the Administrator and Department Head/Quality Assurance Committee on 10/10/25 to reinforce immediate reporting requirements, protection of the resident from further contact with alleged abuser, and clear reporting hierarchy and timeframes. The Abuse, Neglect, and Exploitation Policy was reviewed and revised on 10/20/25 to emphasize immediate reporting to the supervisor, DON, or Administrator upon suspicion of abuse, immediate removal and protection of the alleged victim and separation from the accused staff member, zero tolerance for failure to report abuse or delay in reporting. This infraction will lead to immediate termination from employment. Updated policy was distributed to all staff on 10/20/25. Quick-reference abuse reporting posters were installed in staff lounges on 10/20/25. All facility staff on all sifts began mandatory Abuse Prevention and Reporting re-education 10/9/25. 4. Monitoring and Quality Assurance Plan: Beginning on 10/21/25, the DON or designee will conduct daily abuse incident reporting audits to verify timeliness, proper resident protection procedures and compliance with policy. These audits will be conducted daily for 30 days, then weekly for 90 days. Results will be reviewed at next Quality Assurance Performance Improvement meeting on 11/20/25. The Administrator and DON will review all incident investigations to ensure compliance with federal and state reporting requirements and staff adherence to timelines and will report data at next Quality Assurance Performance Improvement meeting on 11/20/25. On 10/21/25 the Administrator and Director of Nursing	

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F0600 SS = SQC-J	Continued from page 4 the incident to the U.S. FOIA According to the Admission Record (AR), Resident #1 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) [redacted]) and NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) [redacted]),and NJ Ex Order 26.4(b)(1) . According to the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, Resident #1's NJ Exec Order 26.4b1 under Section NJ indicated that the resident was NJ Ex Order 26.4(b)(1) . On 10/20/25 at 10:42 AM, the (b) (9) [redacted] and U.S. FOIA were interviewed together. The U.S. FOIA stated he educated CNA #1 to reach out right away when NJ Ex Order was suspected rather than waiting as CNA #1 did. The U.S. FOIA further stated that CNA #2 admitted in an interview with the U.S. FOIA (b) (6)) and the NJ Ex Orde on NJ Ex Order 26.4, that she had called Resident #1 'NJ Ex Order The U.S. FOIA stated that CNA #2 had a history of NJ Ex Order 26.4(b)(1) and that those other NJ Ex Order 26.4(b)(showed a 'NJ Exec Order 2 The U.S. FOIA agreed, and stated CNA #2's prior incidents "showed NJ Ex Order 26.4(b)(1) [redacted] " and that this incident was just when she was "caught." Both the U.S. FOIA and U.S. FOIA agreed that regardless of whether Resident #1 was NJ Ex Order 26.4(b)(1), CNA #2 was NJ Ex Order 26 towards Resident #1. On 10/20/25 at 11:04 AM, the surveyor conducted a telephone interview with CNA #1, who stated she was providing care for Resident #2 who was Resident #1's roommate, and she turned while providing care for Resident #2 because she thought she heard NJ Ex Order 26 [redacted] . CNA #1 stated that she did observe CNA #2's NJ Ex Orde [redacted] Resident #1. CNA #1 stated she was not sure what was happening, but after CNA #2 left the room, she went over to Resident #1 and saw that Resident #1 had NJ Ex Order 26.4(b)(1) and she requested to speak with the U.S. F who was busy at that time. CNA #1 stated 45 minutes went by and because she knew CNA #2 was supposed to NJ Ex Order 2 Resident #1, she left the unit to go find the U.S. FOIA and report CNA #2. CNA #1 further stated that she had worked with CNA #2 prior to this	F0600	Continued from page 4 began daily unannounced rounds on all units to specifically monitor staff interactions with residents and reinforce accountability. Audits will occur daily for 4 weeks, then weekly for an additional 4 weeks. Data will be reviewed at the next Quality Assurance Performance Improvement meeting on 11/20/25.	

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F0600 SS = SQC-J	Continued from page 5 incident and that CNA #2 was "easily agitated with NJ Ex [redacted] she provided care for and "complained about NJ Ex Order 26.4(b)(1) conditions such as NJ Ex Order 26.4(b)(1) and she got "very NJ Exec Order 2 NJ Exe frustrated and is NJ Exec O about it." On 10/20/25 at 11:29 AM, the surveyor conducted a telephone interview with CNA #2, who stated she had come back from her lunch break and saw that Resident #1 was NJ Ex Order 26.4(b)(1), which was NJ Ex Order 26.4(b)(1) CNA #2 stated she told Resident #1 that it was "NJ Ex Order and NJ Exe Resident #1's NJ Ex Or and went to go NJ Ex Order 26.4(b)(1 [redacted] to NJ Ex Orde Resident #1. CNA #2 then went on to state that she asked RN #1 to help NJ Ex Orde her on NJ Ex Order 2 Resident #1 on the NJ Ex Order 26.4(b)(1). CNA #2 then stated that RN #1 asked why Resident #1 NJ Ex Order [redacted], and CNA #2 replied saying "NJ Ex Order 26.4(b)(1) [redacted]." During an interview on 10/20/25 at 12:10 PM, RN #1 confirmed CNA #2 asked for her assistance in NJ Ex Order 2 Resident #1 NJ Ex Order 26.4(b)(1); that she had asked why Resident #1 NJ Ex Order 26.4(b)(1); and that CNA #2 had responded by stating, "[NJ Ex Order 26.4(b)(1)];" and that Resident #1 was left with CNA #2 to NJ Ex Order 26.4(b). When asked by the surveyor if that alarmed her, RN #1 stated that it did alarm her that CNA #2 NJ Ex Order 26.4 the resident, which was why she asked NJ Ex Order 26.4(b)(1) the resident and NJ Ex Order 26.4(b) them. When asked if she would consider that staff to resident NJ Ex Order 2 RN #1 stated NJ Ex Order would by NJ Ex Order 26.4(b)(1). RN #1 stated that she reported it to the U.S. FO after the U.S. FO pulled her aside to ask her about the incident. During an interview on 10/20/25 at 12:23 PM, the U.S. FO denied that RN #1 reported that CNA #2 had yelled at Resident #1 and had only reported to him that Resident #1 "NJ Ex Order 26.4(b)(1 and had NJ Ex Order 26.4(b)(1)" when being NJ Ex Order 26.4(b)(1). During an interview on 10/20/25 at 12:25 PM, the U.S. FOIA confirmed that he knew that RN #1 had been told that CNA #2 had admitted to NJ Ex Order 26.4 Resident #1 and stated that RN #1 could have stopped NJ Ex Order 26.4(b)(1 from occurring or inquired further as to what was going on. During an interview on 10/20/25 at 1:38 PM, the U.S. FOIA (stated that he was aware that CNA #2 had NJ Ex Order 2 Resident #1 during the time it took CNA #1 to report her NJ Ex Order 26.4(b)(1) against CNA #2, but he was not aware that CNA #2 had told RN #1 that CNA #2 had NJ Ex Order [redacted] Resident #1. The U.S. FOIA (further stated that the facility policy for NJ Exec Or was not followed, and that CNA #1 "could have done a much better job" in reporting	F0600		

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F0600 SS = SQC-J	Continued from page 6 the NJ Ex Order 26.4(b)(1) as there was a delay in timeliness. The U.S. FOIA (stated that timeliness of reporting was important because the NJ Ex Order 26.4(b)(1) in this incident was left with the resident and if a staff member suspected NJ Ex Order the facility's goal was to keep all residents safe and not leave NJ Ex Order 26.4(b)(with the residents. An acceptable Removal Plan was received on 10/20/25 at 7:38 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including on 10/09/25, when the U.S. FOIA was made aware, CNA #2 was immediately removed from resident care and suspended pending investigation and was NJ Exec Order 26.4b) on NJ Ex Order 26.4. On NJ Ex Order 26, the local police were notified, the facility started investigating, and Resident #1 was assessed. On 10/17/25, the facility reported CNA #2 to the NJDOH on the FRIDAY form and the Health Care Professional Responsibility and Reporting Enhancement Act. On 10/20/25, RN #1 was individually counseled and provided with remedial training; the facility's Abuse Prevention Policy was updated and redistributed to all staff to include termination for failure to report in a timely manner; quick reference posters for abuse reporting were installed in staff lounges; and a daily abuse incident reporting audit was started and will be conducted by the U.S. FOIA or appointed designee daily for 30 days to verify timeliness of incident reporting, proper resident protection procedures, and staff compliance with facility policy. The surveyor verified the implementation of the Removal Plan on-site during the continuation of the survey and determined the IJ for F 600 was removed as of 10/21/25 at 12:21 PM. NJAC 8:39-4.1(a)(5)	F0600		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2025

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S0000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 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.	S0000		10/22/2025
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day	S1680	1. Corrective Action Taken for the Identified Deficiency: No adverse resident outcomes were identified as a result of the staffing variance. The daily staffing #s for the upcoming week were immediately reviewed by the DON/designee and found to be in compliance with state requirements. 2. Identification of Other Residents at Risk: All residents have the potential to be affected if minimum staffing levels are not maintained. A review of staffing hours for the upcoming four weeks was conducted to verify compliance. No adverse resident outcomes were identified as a result of the staffing variance. 3. Systemic Changes to Prevent Recurrence: The facility will schedule the Nursing units as per state guidelines. This will be accomplished by offering additional shifts to current when needed. Additional support will be supplied by 3 of the Nursing Agencies contracted with the facility and bonus offerings.	10/22/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Voorhees Pediatric Facility	**1304 LAUREL OAK ROAD , VOORHEES, New Jersey, 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
S1680	Continued from page 1 Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 2642805 Based on review of the Nurse Staffing Reports for the weeks 10/5/25 and 10/12/25, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 10/05/25 Required Staffing Hours: 558.75 -10/09/25 had 536 actual staffing hours, for a difference of -22.75 hours. For the week of 10/12/25 Required Staffing Hours: 558.75 -10/18/25 had 552 actual staffing hours, for a difference of -6.75 hours.	S1680	Continued from page 1 The DON and Administrator implemented an automated staffing calculation tool on 10/21/25 that cross-verifies the daily census against required nursing hours based on resident acuity. Staffing Coordinator was educated on this new tool by the Director of Nursing on 10/21/25. Education was provided to all scheduling staff and nurse supervisors on NJ nurse staffing standards on 10/21/25. 4. Monitoring / Quality Assurance Plan: The Director of Nursing/designee will review the upcoming daily staffing sheets with the Staffing Coordinator to ensure that staff is appropriate based on resident census/acuity. This review will be conducted weekly for 4 weeks and then monthly for 3 months. Data will be reviewed at the next Quality Assurance Performance Improvement meeting on 11/20/25. Administrator will review Nursing Hppd each week and report variances back to Director of Nursing and Staffing Coordinator. Data will be reviewed at the next Quality Assurance Performance Improvement meeting on 11/20/25.	