STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315289	A. BUILDING ______ B. WING ______	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES PEDIATRIC FACILITY	**1304 LAUREL OAK 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
F 000	INITIAL COMMENTS Complaint #: NJ# 166667, 167982 Survey Dates: 10/5/23 Census: 119 Sample Size: 6 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		11/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/03/2023

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 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: NJ# 166667 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 10/4/23 and 10/5/23, it was determined that the facility's administration failed to ensure that the facility's policy "Reportable Events" was followed and implemented for an incident that occurred at the facility on NJ Ex.Order 26.4(b) The incident involved a Certified Nursing Assistant (CNA) who performed a procedure outside of her scope of practice. The facility also failed to report the actions of the CNA to the New Jersey Department of Health (NJDOH). This deficient practice was identified for Resident #3, 1 of 6 sampled residents and was evidenced by the following: According to the Admission Record, Resident #3 was readmitted on EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1	F 609	1. The facility determined that all residents have the potential to be affected by the deficient practice. 2. A Facility Reporting Incident Data and Analysis Yield (FRIDAY) form was submitted to NJDOH on 10/23/23. 3. The Reportable Event Record was sent via fax to the NJDOH on 11/1/23. 4. After review of the investigative record for resident #3 all administrative staff was in-serviced on the policies/procedures for mandatory requirement for reporting to the Department of Health with special emphasis on reporting unusual incidents on 11/1/23. 5. All incident reports will be reviewed weekly by DON/designee for compliance with current policy and procedure on Reportable Events. 6. QA results will be reported quarterly to the Quality Assurance Committee who will make the decision if the process has been resolved and is stable. The committee will also make recommendations for frequency intervals thereafter.	

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F 609	Continued From page 2 Review of Resident #3's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 revealed that Resident #3 had EX Order 26.4B1 EX Order 26.4B1. The MDS also showed that the resident was EX Order 26.4B1 and required total assist of one person for all Activities of Daily Living (ADLs). Review of the EX Order 26.4B1 "Progress Notes" revealed an "addendum to previous Note," completed by the Registered Nurse (RN), that 'EX Order 26.4B1) given with Nurse Practitioner (NP) present, EX Order 26.4B1 EX Order 26.4B1 noted 15-20 min [minutes] after, Patient was cleaned, EX Order 26.4B1, EX Order 26.4B1] EX Order 26.4B1, approx. [approximately] 3:30 PM returned to patient's room to follow up with clinical status and further results of EX Order 26.4B1 found EX Order 26.4B1, nursing supervisor made aware." Review of the facility's "Incident Report" on EX Order 26.4B1, completed by the RN Supervisor," revealed the CNA EX Order 26.4B1 EX Order 26.4B1 [Resident #3]. There was no order and no one instructed her to do so. It is beyond [the CNA's] scope of practice to do this." During an interview with the surveyor on 10/4/23 at 2:15 PM, the Director of Nursing (DON) stated that the RN administered a EX Order 26 to Resident #3 earlier in the day and went to lunch. Upon return from lunch, the RN noted that a EX Order 26.4B1 had been EX Order 26.4B1 Resident #3's EX Order 26.4B1. At which time, the RN had a discussion with the CNA and the CNA admitted to EX Order 26.4B1 The CNA stated, "I thought I was helping	F 609		

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F 609	Continued From page 3 you. I thought I was doing you a favor." At that time, the RN removed the EX Order 26.4B1 The DON further stated that the CNA should not have EX Order 26.4B1 into the resident because it was outside of her scope of practice. The DON also stated the incident was not reported to the NJDOH because the Licensed Nursing Home Administrator (LNHA), and the Director of Quality Safety and Compliance (DQSC) did not believe it was willful neglect, intent to harm or abuse of the resident. During an interview with the surveyor on 10/4/23 at 6:34 PM, the DQSC stated that only a RN or Licensed Practical Nurse (LPN) can EX Order 26.4B1 EX Order 26.4B1 and give a EX Order 26 to a resident with a physician's order (PO). When the surveyor inquired about the CNA EX Order 26.4B1 into Resident #3's EX Order 26.4B1, the DQSC stated, "The CNA did not realize she was working outside of her scope of practice, and she realized, afterwards, that it was something she should not have done." He further stated, "The CNA shouldn't have done the EX Order 26.4B1 because she wasn't educated on how to do it, nor was it in her scope of practice." The DQSC stated he did not feel as if the incident was willful neglect, intent to harm, or abuse to the resident, therefore, the facility did not report the incident to the NJDOH. During an interview with the surveyor on 10/5/23 at 1:00 pm, the LNHA stated if an incident occurred in the facility, he would collect all the facts related to the incident and then determine if it fell within the guidelines of a reportable event. The LNHA stated he was notified of the incident by the DQSC and the DON, that a CNA was trying to help the nurse and did something she	F 609		

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F 609	Continued From page 4 should not have done. The surveyor inquired how the CNA knew what fell under her certification, to which he replied, "All CNAs have certification and know what falls under their certification. The CNAs don't have the education required to complete that procedure EX Order 26.4B1 EX Order 26.4B1]." The LNHA further stated, "The CNA should have known that only a nurse could do that task with a physician's order; she's been here a long time." The LNHA continued, "The CNA had no willful intent to harm the resident, but used poor judgement when she took it upon herself to perform a procedure she was not authorized to do. We didn't feel as if it was willful neglect, intentional harm or abuse, so it was collectively decided that it shouldn't be reported to the NJDOH." The surveyor asked the facility administration how they determined that the actions of the CNA were not willful neglect, intentional harm or abuse of the resident. The facility could not provide an answer or any other documented evidence that the actions of the CNA had no willful neglect, intentional harm or abuse to the resident. Review of the facility's policy, "Reportable Events", reviewed/revised on 1/22, revealed under the "Purpose" section, "To comply with the New Jersey licensing standard 8:36-5.10 Reportable Events." Under the "Policy" section reflected that "Should any event occur that jeopardizes the health and safety of patients... immediate notification will be made to the Administrator or Administrator-on-call." Under the "Procedure" section indicated events that should be reported to the NJDOH by the designated Facility User include, but are not limited to: "m. any other unusual event as determined by the	F 609		

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F 609	Continued From page 5 Administrator." NJAC 8:39-9.4(f)	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: C#: NJ#166667 Based on interviews, medical records review, and review of other pertinent facility documentation on 10/4/23 and 10/5/23, it was determined that the facility failed to ensure that a Certified Nursing Assistant (CNA) worked within her scope of practice. The deficient practice was identified for Resident #3, 1 or 6 sampled residents reviewed and was evidenced by the following: According to the Admission Record (AR), Resident #3 was readmitted on EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1	F 689	1. Resident #3 was sent out to ED for further observation. The Certified Nursing Assistant was immediately removed from care on EX Order 26.4B1 Suspended pending further investigation, with intent to terminate on EX Order 26.4B1 2.All residents have the potential to be affected by this deficient practice. The Nursing Supervisor ensured all residents in Certified Nursing Assistant's care were not negatively affected. On 10/4/23, facility wide inspection was conducted to ensure there was no unsecured medical items left in resident's beds. None were identified. 3. Nursing staff were reeducated on proper storage of medical equipment and the immediate disposal of items after a procedure is completed. Ongoing education will be provided to all new staff, existing staff as needed basis on audits, and annually. A new process was	11/10/23

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F 689	Continued From page 6 EX Order 26.4B1 Review of Resident #3's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 revealed that Resident #3 had EX Order 26.4B1 EX Order 26.4B1 The MDS also showed that the resident was EX Order 26.4B1 and required total assist of one person for all Activities of Daily Living (ADLs). Review of Resident #3's Care Plan (CP) revealed a "Focus," initiated on EX Order 26.4B1 of "NJ Ex.Order 26.4(b)(1)." Under the "Goal" section, indicated that the resident "will have EX Order 26.4B1 every 24 hours." Under "Interventions," indicated to administer medications as ordered, EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 The CP revealed a "Focus," initiated on , that Resident #3 had a history of . Under the "Goal" section, reflected that Resident #3's "NJ Ex.Order 26.4(b)(1) will be relieved with nursing interventions." Under "Interventions," indicated to monitor and to administer as needed. Under the "Position" section for the aforementioned intervention reflected Licensed Practical Nurse (LPN). Review of Resident #3's physician's "Order Summary Report" for active orders as of revealed a physician order (PO) dated for for every hours as needed. There was also a PO, dated that reflected that an may be repeated one time "after the Registered Nurse (RN) assesses the documents	F 689	implemented for the Nurse Manager/Supv./designee to conduct daily room audit to ensure no medical items are left unsecured in resident room. Additionally, nursing staff were re-educated by the DON/designee on providing care only within their scope of practice. 4. The audits will be submitted monthly and reviewed by the Director of Quality Assurance Committee who will make the decision if the process has been resolved and is stable. The committee will also make recommendations for frequency intervals thereafter if necessary. Completion date will be by 11/10/23.	

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F 689	Continued From page 7 sounds and appearance ... Administer one EX Order 26.4B1 two hours after EX Order 26.4B1 . Review of the NJ Ex Order 26.4(at 12:53 PM "Progress Notes" revealed an "addendum to previous Note," completed by the Registered Nurse (RN), that EX Order 26.4B1) given with Nurse Practitioner (NP) present, EX Order 26.4B1 EX Order 26.4B1 15-20 min [minutes] after, Patient was cleaned, EX Order 26.4B1 , approx. [approximately] EX Order 2 PM returned to patient's room to follow up with clinical status and further results of EX Order 26.4B1 , EX Order 26.4B1 found EX Order 26.4B1 in patient, nursing supervisor made aware." Review of the facility's "Incident Report," completed by the RN Supervisor," revealed that the CNA ' EX Order 26.4B1 EX Order 26.4B1 into [Resident #3]. There was no order and no one instructed her to do so. It is beyond [the CNA's] scope of practice to do this." Review of The RN's statement indicated that the RN returned from lunch and went to re-assess Resident #3. The CNA was present in the room with an orientee and was noted standing over the resident. Resident #3 was observed with a EX Order 26.4B1 The RN asked the CNA who placed the EX Order 26.4B1 in the resident. The CNA told the RN that she did. Review of the RN Supervisor's statement revealed the RN went to lunch and upon her return had checked on Resident #3. The RN "found that someone had taken the EX Order 26.4B1 bag and used it as a EX Order 26.4B1 ." The CNA was at the bedside and admitted to EX Order 26.4B1 the EX Order 26.4B1	F 689		

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F 689	Continued From page 8 because she thought she was doing the RN a favor. The RN had informed her of what the CNA had done, and she immediately removed the CNA from patient care. Review of the facility's EX Order 26.4B1 "Department of Nursing Termination Notice" revealed under the "Statement of Problem" section that the CNA "performed duties outside of her scope of practice as a Certified Nursing Assistant by EX Order 26.4B1 on a resident on EX Order 26.4B1." Under the "Plan of Action" section indicated "Termination." During an interview with the surveyor on 10/4/23 at 1:44 PM, the RN stated she received an order from the NP to give a EX Order 26 after she reported Resident #3 has a EX Order 26.4B1 EX Order 26.4B1. The RN administered the EX Order 26 and the resident immediately had a EX Order 26.4B1. Resident #3's EX Order 26.4B1, and he/she appeared more comfortable. She cleaned the resident and went to lunch. Upon her return from lunch, she went to check on Resident #3's status and observed a EX Order 26.4B1 into the resident's EX Order 26.4B1. The RN stated she asked who ordered the EX Order 26.4B1 because resident did not have one when she left for lunch. She asked the CNA, who was present in the room at that time, but the CNA did not provide a response. She then proceeded to ask the other staff on the unit and reported the incident to the RN Supervisor. The RN assessed the resident, removed the EX Order 26.4B1, and EX Order 26.4B1 was noted at the time. During an interview with the surveyor on 10/4/23 at 2:15 PM, the Director of Nursing (DON) stated that the RN administered a EX Order 26 to Resident #3 earlier in the day and went to lunch. Upon return	F 689		

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F 689	Continued From page 9 from lunch, the RN noted that a EX Order 26.4B1 had been EX Order 26.4B1 into Resident #3's EX Order 26.4B1. At which time, the RN had a discussion with the CNA and the CNA admitted to EX Order 26.4B1 EX Order 26. The CNA stated, "I thought I was helping you. I thought I was doing you a favor." At that time, the RN removed the EX Order 26.4B1. The DON further stated that the CNA should not have EX Order 26.4B1 into the resident because it was outside of her scope of practice. During an interview with the surveyor on 10/4/23 at 3:00 PM, the RN Supervisor stated she was informed by the RN that a EX Order 26 had been administered with positive results. The RN Supervisor further stated she was informed by the RN, after her lunch break, she went to provide care to Resident #3 for the second time. At that time, the RN found a EX Order 26.4B1 into Resident #3's EX Order 26.4B1 The surveyor asked the RN supervisor about the EX Order 26.4B1 Incident Report she completed. She responded, the CNA took it upon herself to EX Order 26.4B1 into the resident's EX Order 26.4B1 to contain his/her EX Order 26.4B1. The RN Supervisor stated the CNA should not have EX Order 26.4B1 into the resident's EX Order 26.4B1 because it was outside her scope of practice. The CNA was removed from the assignment and sent to the conference room. The RN Supervisor added that the CNA knew she was not supposed to do that because she was EX Order 26.4B1) and stated, "I tried to help" and "I shouldn't have done that." During an interview with the surveyor on 10/4/23 at 6:34 PM, the Director of Quality Safety and Compliance (DQSC) stated that a LPN or RN can EX Order 26.4B1 and administer a EX Order 26 to a resident. The surveyor asked the DQSC about	F 689		

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F 689	Continued From page 10 the NJ Ex.Order 26.4(b) incident. The DQSC stated he received a call from the RN Supervisor and was informed that a CNA had gone into a resident's room and EX Order 26.4B1 into the resident's EX Order 26.4B1. The DQSC stated the CNA did not realize she was working outside of her scope of practice, and she realized, afterwards, that it was something she should not have done. The CNA was immediately suspended. The DQSC further stated the CNA should not have done a EX Order 26.4B1 EX Order 26.4B1 on Resident #3 because she was not educated on how to do it nor was it in her scope of practice. During an interview with the surveyor on 10/5/23 at 1:00 PM, the Licensed Nursing Home Administrator (LNHA) stated he was notified of the NJ Ex.Order 26.4(b) incident by the DON and the DQSC. The LNHA was informed that a CNA was trying to help the nurse and did something she should not have done. The surveyor asked how the CNA knew what fell under her scope of practice, to which he replied, "All CNAs have certification and know what falls under their certification. The CNAs don't have the education required to complete that procedure EX Order 26.4B1]. It is the RNs and LPNs who have the education." The LNHA further stated, "The CNA should have known that only a nurse could do that task with a physician's order; she's been here a long time." Review of the facility, "Invasive Procedure: Rectal Tubes," policy, with the effective date of 5/22, indicated under "Responsibility: RN, LPN." Review of the facility's policy "Job Description/Performance Evaluation" for CNAs, with the effective date of 5/07, revealed under the "Position Summary" section that the CNA	F 689		

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F 689	Continued From page 11 "Functions under the direction of a licensed practical nurse or registered professional nurse in providing direct patient care." N.J.A.C.: 8.39-27.1(a)	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315289	A. BUILDING _______ B. WING _______	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES PEDIATRIC FACILITY	**1304 LAUREL OAK ROAD VOORHEES, NJ 08043**

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F 842	Continued From page 12 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 166667 Based on interviews, Medical Record (MR)	F 842	1. A copy of the NJ universal transfer form for the [EX Order 26.4B1] transfer of resident #3 is currently awaiting confirmation from	

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F 842	Continued From page 13 review, and review of other pertinent facility documentation on 10/4/23 and 10/5/23, it was determined that the facility failed to maintain a complete MR which contained a Universal Transfer Form (UTF) for a resident who was sent to the hospital. The deficient practice was identified for Resident #3, 1 of 6 sampled residents, and was evidenced by the following: According to the Admission Record, Resident #3 was readmitted on EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1 Review of Resident #3's "Progress Notes" revealed a NJ Ex Order 26.4(b) at 7:01 PM "Medical Progress Note" completed by the Nurse Practitioner, that she was called by the Registered Nurse (RN) Supervisor and informed that Resident #3 was now EX Order 26.4B1 l. Under the "Assessment & Plan" section it reflected to send the resident to the emergency department (ER) for further evaluation of EX Order 26.4B1 Review of Resident #3's MR revealed no EX Order 2 for the EX Order 26.4B1 transfer to the hospital. Review of Resident #3's hospital "Discharge Summary" revealed an admission date of EX Order 26.4B1	F 842	the outside hospital, via their Medical Record Office, once received can be added to the electronic medical record. 2. All current residents have the potential of being affected by the deficient practice. 3. Registered Nurses and Nursing Supervisors were re-educated on ensuring that a copy of the NJ Universal transfer form is kept in the resident□s electronic medical record upon transfer to the hospital. Instructions are placed at each Charge Nurses workstation. Education related to the NJ universal transfer form will be included in the Registered nurses new hire education manuals and annual nursing education requirement. 4. The DON/designee will audit/review all hospital transfers from the previous day (Monday for weekends) to ensure the universal transfer form is uploaded in the resident□s medical record. The results will be reviewed by the QAA committee monthly until compliance has been determined.	

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	315289	A. BUILDING ______ B. WING ______	C 10/05/2023

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F 842	Continued From page 14 and a discharge date of [EX Order 26.4B1] During an interview with the surveyor on 10/4/23 at 4:25 pm, the Director of Nursing (DON) stated she was unable to locate the missing [EX Order 26.4B1] [EX Order 2] for Resident #3. The DON further stated the RN did not make a copy before sending it with the resident. At which time, the DON stated the RN should have made a copy for the resident's MR. Review of the facility policy titled, "Admissions, Discharges & Transfers: Universal Transfer Form," dated 1/12, revealed under the "Procedure" section that "5. A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with the patient when a patient is transferred as part of the patient's medical record." NJAC 8:39-35.2(k)	F 842		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315289 Y1	A. Building B. Wing Y2	11/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES PEDIATRIC FACILITY	1304 LAUREL OAK 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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 11/10/2023	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 11/10/2023	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 11/10/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO