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 04/11/2023

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 Deficiencies were issued related to Intakes: NJ00110496 Deficiencies were cited at F600, F656, F689, and F710. NJ00107644 Deficiencies were cited at F684 and F710. Survey Census: 107 Resident 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 SURVEY. A Complaint survey was conducted by Healthcare Management Solutions LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 04/05/23 at 9:07 PM, the Administrator and the Quality Safety Coordinator were notified of Immediate Jeopardy (IJ) at: F600: Neglect. The Immediate Jeopardy began on NJ Exec. Order 26:4B when the facility neglected to ensure staff safely secured R5 in the wheelchair which resulted in R5 EX Order 26.4B1 by R5's EX Order 26.4B1; and subsequently failed to take actions to prevent future accidents caused by "human error."	F 000		

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

Electronically Signed | 05/02/2023

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 000	Continued From page 1 F656: Comprehensive Care Plans. The Immediate Jeopardy began on [NJ Exec. Order 26.4.b] when R5 [EX Order 26.4B1] after being [EX Order 26.4B1] by staff in R5's [EX Order 26.4B1] Individualized [EX Order 26.4B1] safety interventions were not included on the care plans of all [EX Order] residents, including R5, who utilized [EX Order 26.4B1] in the facility. F689: Accident Hazards. The Immediate Jeopardy began on [NJ Exec. Order 26.4.b.] when staff [EX Order 26.4B1] [redacted] in R5 [EX Order 26.4B1] by R5's [EX Order 26.4] [EX Order 26.4B1] R5 and the other [EX Order 2] residents who utilized [EX Order 26.4B1] did not have care plan interventions or physician's orders for [EX Order 26.4B1] safety. During the exit conference on 04/06/23 at 8:15 PM, the Administrator and the Quality Safety Coordinator were notified the IJ remained for F600, F656 and F689. The facility submitted an acceptable removal plan on 4/6/2023. The removal plan was verified as implemented on site by surveyors on 4/7/2023.	F 000		
F 600 SS=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	F 600		5/12/23

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F 600	Continued From page 2 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 # NJ00110496 Based on interviews, review of records, and the facility policy, the facility neglected to ensure one resident out of four residents (Resident (R) 5) reviewed for EX Order 26.4B1 was safely secured in the wheelchair to prevent EX Order 26.4B1 EX Order 26.4B1 On EX Order 26.4B1, the facility's failure resulted in EX Order 26.4B1 Following the incident, the facility determined human error as the cause and neglected to take measures to prevent future accidents. On 04/05/23 at 9:07 PM, the Administrator and the Quality Safety Coordinator (QSC) were notified of an Immediate Jeopardy (IJ) for F600 Neglect. The Immediate Jeopardy began on NJ Exec. Order 26:4.b.1 when the facility neglected to ensure staff safely secured R5 in the wheelchair which resulted in R5 EX Order 26.4B1 by R5's EX Order 26.4B1; and subsequently failed to take actions to prevent future accidents caused by "human error." The Administrator and QSC were informed that immediate jeopardy was still present and ongoing at the time of exit from the survey on 04/06/23 at	F 600	1. All residents could be affected by this deficient practice. After the initial event, Resident #5's specialty wheelchair was immediately sequestered for evaluation by the Director of Rehabilitative Services and found to be in good working order and returned to service. In addition, resident #5 was placed in the chair and the seating system was reevaluated and assessed and the chair NJ Exec. Order 26:4.b.1 . Staff (newly hired and existing), including clinical staff, leadership and ancillary staff are required to attend a rehabilitation in-service on specialized wheelchair operation presently and on an annual basis. This includes proper placement, positioning and securement. The competency checklist will be completed and become a permanent part of the staff member's personnel file. This competency is part of the orientation process with a required sign-off by a preceptor. The department's manager/designee will sign-off that this education was completed. Department Heads will conduct monthly audits of all new hires, to ensure that the required information is completed. The DON/designee will conduct a daily rounding audit of residents (4 per day)	

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F 600	Continued From page 3 8:15 PM. The facility submitted an acceptable removal plan on 4/6/2023. The removal plan was verified as implemented on site by surveyors on 4/7/2023. Findings include: Review of the facility's policy titled "Safety: Abuse & Neglect," dated September 2015, revealed "The facility has an obligation to protect the welfare of its residents. . ." Review of the facility's policy titled "Wheelchair Positioning," dated April 2004, revealed "To position resident in a therapeutic and safe adaptive seating device, in order to provide increased mobility and to insure proper positioning . . . once resident is positioned in the wheelchair secure the seat belt to prevent any unexpected movement or fall . . . Align the resident's trunk support and secure all straps on chair . . . Place feet on the foot rests and secure with foot straps if present . . . Ensure that any type of head or neck support system is properly in place and supporting the resident properly . . . Place lap tray on wheelchair if present . . . " Review of R5's undated "ADMISSION RECORD" located on the electronic medical record (EMR) revealed R5 was initially admitted to the facility on EX Order 26.4B1 and readmitted on EX Order 26.4B1 with multiple diagnoses to include EX Order 26.4B1 [redacted] and used a wheelchair for EX Order 26.4B1. Review of R5's quarterly "Minimum Data Set	F 600	who are up in their wheel chairs to ensure proper application of wheel chair safety devices. The audits will be submitted monthly and reviewed by the Director of Quality, Safety and Compliance. 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. Completion date will be by Friday, May 12, 2023.	

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(MDS)" with an Assessment Reference Date (ARD) of [redacted] and located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" was not completed and R5 was assessed by staff as [redacted] and used a [redacted].

Review of R5's "Physician's Orders," dated [redacted], under the "Orders" tab located on the EMR lacked an order for [redacted].

Review of R5's "Medication Administration Record [MAR]" and "Treatment Administration Record [TAR]," [redacted], under "Orders" tab located on the EMR revealed there were no orders for [redacted].

Review of R5's "Care Plan" under "Care Plan" tab located on the EMR revealed no interventions for [redacted].

Review of R5's '[redacted] SHEET," [redacted], revealed ". . . [redacted] Initiated . . . " 2:08 PM.

Review of R5's "Progress Note," [redacted] PM, under "Progress Notes" tab located on R5's EMR revealed " . . . was sent out to . . . ED [emergency department] for evaluation after having a [redacted] and requiring bagging with [redacted]. [redacted] returned with [redacted] . . . "

Review of R5's "ED Provider Notes," provided by the QSC, [redacted] ". . . presents to the ED via EMS [Emergency Medical Services] for evaluation of [redacted] . . . found belted into [redacted] [sic] slumped over into top

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EX Order 26.4B1 . . . EMS reports on their examination pt [patient] had EX Order 26.4B1 EX Order 26.4B1 . . . Physical Exam . . . EX Order 26.4B1 . . Transfer to [hospital] for observation . . . "

Review of R5's "PEDIATRIC HISTORY AND PHYSICIAL," EX Order 26.4B1 provided by the Director of Nursing (DON) revealed " . . . presenting as a direct admission . . . for concerns of accidental EX Order 26.4B1 . . . per report . . . patient was left in wheelchair estimated to be unattended 30-40 minutes, found to have NJ Exec. Order 26:4.b.1 EX Order 26.4B1 . Patient found to NJ Exec. Order 2 . Reported that no EX Order 26.4B1] initiated and pulses intact . . . was EX Order 26.4B1 Per report, facility staff was EX Order 26.4B1 when EMS arrived . . . Review of Systems . . . EX Order 26.4B1 . . . Skin . . . EX Order 26.4B1 EX Order 26.4B1 . . EX Order 26.4B1 . EX Order 26.4B1 . . . Intermittently having EX Order 26.4B1 with EX Order 26.4B1

Review of R5's "REPORTABLE EVENT RECORD/REPORT," NJ Exec. Order 26:4.b , provided by QSC revealed "Type of incident: Resident Care . . . Child was up in wheel chair [sic] awaiting therapy. Child was found to be NJ Exec. Order 26:4.b.1 .

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F 600	Continued From page 6 [R5] had slid down in the chair with [R5's EX Order 26 . [R5] was EX Order 26.4B1 [R5] responded NJ Exec. Order 26:4.b.1 and began NJ Exec. Order 26:4.b.1]. [R5] did not require any EX Order 26.4B1 . . . Prior to the event was plan of care developed that addressed this issue . . . Custom wheelchair with EX Order 26.4B1 for NJ Exec. Order 26:4.b.1 EX Order 26.4B1 monitoring . . . ". During an interview on 04/04/23 at 2:22 PM, Licensed Practical Nurse (LPN) 1 recalled entering R5's room on EX Order 26.4B1 because Certified Nursing Assistant (CNA) 1 was heard frantically yelling for help. LPN 1 recalled witnessing R5's EX Order 26.4B1 from R5's EX Order 26.4B1 by the EX Order 26.4B1 . LPN1 stated R5's EX Order 26.4B1 LPN1 stated R5 was EX Order 26.4B1 , EX Orde NJ Exec. Order 26:4.b.1 and R5's EX Order 26.4B1 . LPN1 stated R5's EX Order 26.4B1 R5. LPN1 stated Registered Nurse Charge (RNC) 3 entered R5's room and transferred R5 to the EX Order and began EX Order 26.4B1 . LPN1 verified R5's care plan did not include an intervention to NJ Exec. Order 26 the resident in the NJ Exec. Order 26:4.b.1 During an interview on 04/04/23 at 3:22 PM, LPN2 stated the facility did not require staff to demonstrate knowledge or skills of buckling the resident's safety belts or harness on their wheelchairs during their yearly training. LPN2 stated R5 required a EX Order 26.4B1 EX Order 26.4B1 to secure R5 in the wheelchair.	F 600		

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During a brief interview on 04/04/23 at 3:45 PM, the QSC reported CNA1 was not available for interview.

During an interview on 04/05/23 at 11:48 AM, the DON stated she went to R5's room on EX Order 26.4B1 because R5's code bell was alarming, and staff were providing R5 with EX Order 26.4B1 EX Order 26.4B1 via and EX Order 26.4B1 when she arrived. The DON stated R5 developed EX Order 26.4B1 EX Order 26.4B1 . The DON stated R5's EX Order 26.4B1 was possibly related to the EX Order 26.4B1 around R5's EX Order 26.4 and EX Order 26.4B1 . The DON stated the facility investigated R5's room accident/incident and determined the cause was due to human error. The DON stated the staff failed to ensure R5's NJ Exec. Order 26:4.b.1 to ensure R5 could not NJ Exec. Order 26 of the wheelchair. The DON stated the facility did not identify R5's physician's orders, care plan, or TAR did not include NJ Exec. Order 26:4.b.1 and should have. The DON stated the nurse manager was responsible for ensuring R5's care plan included those interventions and did not. The DON stated the facility's omission of the resident's care plan interventions for NJ Exec. Order 26:4.b.1 or physician's orders did not occur to the leadership while investigating R5's incident accident. The DON stated no training or education was provided for staff on wheelchair safety following R5's incident.

During an interview on 04/05/23 at 1:30 PM, Registered Nurse (RN) 1 stated she was providing care for R5 on EX Order 26.4B1 the date of the

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incident, and was taking lunch break at the time. RN1 stated she transferred R5 from the bed to the wheelchair prior to the lunch break and had secured and buckled R5's chest harness, lap belt, and had placed R5's feet on R5's footrest and buckled R5's feet. RN1 stated R5's physician's orders, TAR, or care plan NJ Exec. Order 26:4.b.1 [redacted] RN1 stated she was informed of what and how to strap R5 into the wheelchair via another staff member. RN1 stated she was a new employee at the facility and gained employment in NJ Exec. Order 26:4.b.1.

During an interview on 04/05/23 at 4:53 PM, Registered Nurse Charge (RNC) 3 recalled going to R5's room on EX Order 26.4B1 because CNA1 was yelling and on the way the code bell was heard alarming. RNC3 recalled when entering R5's room, R5's EX Order 26.4B1 [redacted] R5's EX Order 26.4 and R5's EX Order 26.4B1 was around R5's EX Order 26. RNC3 stated R5 was EX Order 26.4B1 from the wheelchair. RNC3 stated R5 was EX Order 26.4B1 EX Order 26.4B1 [redacted]. RNC3 recalled unclasping R5's chest harness and EX Order 26.4B1 R5's EX Order 26.4B1 [redacted], transferring R5 to the EX Order 26.4B1 [redacted]. RNC3 recalled R5 had developed EX Order 26.4B1 on the EX Order 26.4B1 [redacted]. RNC3 stated R5 was required to have the wheelchair lap belt secured but did not and RNC3 was unsure why. RNC3 stated the staff "just know" the residents should be secured while in their wheelchairs. RNC3 stated all the residents' wheelchairs were different. RNC3 stated the facility's residents with wheelchairs did not have interventions on their care plans to secure them on their wheelchairs with their safety straps which increased their risk for accidents. RNC3 stated the facility provided

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some wheelchair training upon hire, but it was not resident individualized care.

During a brief interview on 04/05/23 at 6:40 PM, the QSC reported EX Orde residents at the facility utilized EX Order 26.4B1 .

During an interview on 04/06/23 at 2:22 PM, Nurse Practitioner (NP) 1 recalled going to R5's room on EX Order 26.4B1 because the code bell was alarming, and the staff were providing EX Order 26.4B1 EX Order 26.4B1 to R5. NP1 stated R5 developed EX Order 26.4B1 and mouth. NP1 stated R5's EX Order 26.4B1 was EX Order 26.4B1 around R5's EX Order 26 and caused EX Order 26.4B1. NP1 stated the residents' care plan interventions guided all the facility's staff directives for providing care for the residents and should contain interventions for wheelchair safety and harness. NP1 stated R5's incident/accident was discussed with the facility's Medical Director but they did not discuss care plan interventions or physician orders for wheelchair safety for the residents. NP1 was unsure why they did not think about all the rest of the children utilizing wheelchair safety and entering orders for the other resident but should have. NP1 stated the facility did not provide her with wheelchair safety education at the start of employment in NJ Exec. Order 26:4.b.1. NP1 stated R5's incident was a preventable accident, and the facility should have ensured the nursing staff were competent to secure the child in the wheelchair. NP1 stated the residents' wheelchair safety belts and harness were a safety hazard.

During an interview on 04/06/23 at 4:41 PM, the Social Services Director (SSD) stated residents' care plan interventions were the drivers of the

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care the facility provided for the residents. The SSD stated the facility did not include "every little thing" on the residents' care plans that utilized wheelchairs. The SSD stated the facility did not conduct a care conference after R5's accident/incident. The SSD stated R5's care plan was not revised to include interventions NJ Exec. Order 26:4.b.1 R5 NJ Exec. Order 26:4.b.1 after the accident. The SSD stated NJ Exec. Order 26:4.b.1 was not an intervention that needed to be included on the resident's care plan because the staff "just knew" about securing the residents to their wheelchairs and it was not something that needed to be on the resident's care plan or interventions.

During an interview on 04/06/23 at 5:54 PM, the Medical Director stated she was one of the first staff in R5's room on EX Order 26.4B1 because R5's code bell was alarming. The Medical Director stated R5 began NJ Exec. Order 26:4.b.1 and had a EX Order 26.4B1 but became EX Order 26 and developed EX Order 26.4B1 The Medical Director stated EX Order 26.4B1 was not something related to EX Order 26.4B1 but developed from EX Order 26.4B1 of EX Order 26.4B1. The Medical Director stated EX Order 26.4B1 was something seen during an EX Order 26.4B1 of a EX Order 26.4B1 . The Medical Director stated she examined R5 and talked to the staff. The Medical Director stated R5 was not on the EX Order 26.4B1 which caused EX Order 26.4B1 The Medical Director stated she absolutely thought the incident could have been prevented. The Medical Director stated she thought R5's accident was a result of a human error by the nurse that put R5 in the wheelchair. The Medical Director stated they looked at R5's wheelchair and determined the wheelchair was adequate and decided the incident was caused because the EX Order 26.4B1 correctly.

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F 600	Continued From page 11 The Medical Director stated she expected the resident's care plans to include wheelchair safety interventions, chest straps, neck braces, tray, leg straps, and waist belt and she was unsure why it was not included. The Medical Director stated she expected the resident's physician's orders to have wheelchair safety interventions, chest straps, neck braces, tray, leg straps, and waist belt and she was unsure why it was not included. The Medical Director stated it was her responsibility to ensure the residents' care and orders were correct. The Medical Director stated she had been at the facility for years, and it had never been on their radar to include resident's physician's orders for wheelchair safety and different devices like chest straps and such even though the staff utilized the resident's TAR to provide care. The Medical Director stated the only explanation that they had was NJ Exec. Order 26:4.b.1 [redacted] and they put R5 in the annex to have closer supervision but did not put any interventions or other actions in place for R5 or the other [redacted] residents with NJ Exec. Order 26:4.b.1 [redacted].	F 600		
F 656 SS=L	NJAC:8:39-4.1 (a) 5 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		5/12/23

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	315289	A. BUILDING _____ B. WING _____	C 04/11/2023

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F 656	Continued From page 12 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint # NJ00110496	F 656	1. All residents could be affected by this deficient practice. Resident #5, #15, #18	

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F 656	Continued From page 13 Based on interviews, review of records, and review of facility policy, the facility failed to ensure for all EX Order2 of EX Order2 residents utilizing EX Order 26.4B1 that their care plans addressed NJ Exec. Order 26:4.b.1 [redacted] The facility's deficient practice resulted in R5 EX Order 26.4B1 EX Order 26.4B1 [redacted] when the resident was NJ Exec. Order 26:4.b.1 in the wheelchair. On 04/05/23 at 9:07 PM, the Administrator and the Quality Safety Coordinator (QSC) were notified of an Immediate Jeopardy (IJ) at F656: Develop/Implement Comprehensive Care Plan. The Immediate Jeopardy began on EX Order 26.4B1 when R5 EX Order 26.4B1 [redacted] after being NJ Exec. Order 26:4.b.1 by staff in R5's EX Order 26.4B1 Individualized NJ Exec. Order 26:4.b.1 interventions were not included on the care plans of all EX Order residents, including R5, who utilized wheelchairs in the facility. The Administrator and QSC were informed that immediate jeopardy was still present and ongoing at the time of exit from the survey on 04/06/23 at 8:15 PM. The facility submitted an acceptable removal plan on 4/6/2023. The removal plan was verified as implemented on site by surveyors on 4/7/2023. Findings include: 1. The facility's policy for comprehensive care plans was requested but was not provided for review. Review of R5's undated electronic medical record	F 656	and #23 care plan are updated to include specifics related to their NJ Exec. Order 26:4.b.1 [redacted]. An audit was conducted of all current residents that utilize a specialized wheel chair to ensure that a care plan is in place. A new process was added in which the Director of Rehabilitative Services/designee will communicate to the clinical team at morning huddle and through the EMR any time a change has been made in a specialty wheelchair device specific to a resident. All existing care plans will be updated as necessary. Monthly audits will be conducted by the Director of Quality, Safety and Compliance. 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. Completion date will be by Friday, May 12, 2023.	

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F 656	Continued From page 14 (EMR) "ADMISSION RECORD" revealed R5 was initially admitted to the facility on EX Order 26.4B1 and readmitted on EX Order 26.4B1 with multiple diagnoses to include NJ Exec. Order 26:4.b.1 [redacted] Review of R5's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] and located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" was not completed and R5 was assessed by staff as EX Order 26.4B1 EX Order 26.4B1 and used a EX Order 26.4B1 . Review of R5's "Care Plan" under the EMR "Care Plan" tab revealed R5's care plan lacked interventions for NJ Exec. Order 26:4.b.1 [redacted] Review of R5's "Progress Note," [redacted], under the EMR "Progress Notes" tab ". . . was sent out to . . . NJ Exec. Order 26:4.b.1 [redacted] . . ." Review of R5's "ED Provider Notes," provided by QSC and dated [redacted], revealed ". . . presents to the ED via EMS [redacted] . . . EMS reports on their examination pt had [redacted] . . . Physical Exam . . [redacted] present . . . Skin . .	F 656		

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F 656	Continued From page 15 . Diffused [redacted] to [redacted] . . . Medical Decision Making/Plan . . . Likely [redacted] event . . . Transfer to [hospital] for observation..." Review of R5's "PEDIATRIC HISTORY AND PHYSICIAL," [redacted] provided by the Director of Nursing (DON) revealed ". . . presenting as a direct admission . . . for concerns of [redacted] . . . per report . . . patient was left in [redacted] estimated to be unattended 30-40 minutes, found to have [redacted]. Patient found to [redacted] and was [redacted] with [redacted]. Reported that no [redacted] initiated and [redacted] . . . was [redacted]. Per report, facility staff was [redacted] patient when EMS arrived . . . Review of Systems . . . [redacted] . . . Skin . . . [redacted] . . . [redacted] . . . Intermittently having [redacted] but [redacted] . . ." Review of R5's "REPORTABLE EVENT RECORD/REPORT," [redacted]3, provided by QSC revealed "Type of incident: Resident Care . . . Child was up in wheel chair [sic] awaiting therapy. Child was found to be [redacted]. [R5] had [redacted] with [R5's] [redacted] [R5] was placed in the bed, [redacted] was called, and [redacted] with [redacted]. [R5] [redacted]. [R5] did not require any	F 656		

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[redacted] . . . Prior to the event was plan of care developed that addressed this issue . . . Custom NJ Exec. Order 26:4.b.1 [redacted] . . ."

During an interview on 04/04/23 at 2:22 PM, Licensed Practical Nurse (LPN) 1 recalled entering R5's room on [redacted] because Certified Nursing Assistant (CNA) 1 was heard frantically yelling for help. LPN 1 recalled witnessing R5's [redacted] from R5's [redacted] by the [redacted]. LPN1 stated R5's [redacted] was not on the seat of the [redacted] but was [redacted] with R5's [redacted]. LPN1 stated R5 was [redacted] not [redacted] and R5's [redacted]. LPN1 stated R5's [redacted] or secured around R5. LPN1 stated Registered Nurse Charge (RNC) 3 entered R5's room and transferred R5 to the bed and began [redacted]. LPN1 verified R5's care plan did not include an intervention to secure the resident in the [redacted]

During an interview on 04/05/23 at 11:48 AM, the Director of Nursing (DON) stated she went to R5's room on [redacted] because R5's code bell was alarming, and staff were providing R5 with [redacted] via and [redacted] when she arrived. The DON stated R5 [redacted] The DON stated R5's [redacted] R5's [redacted]. The DON stated the facility investigated R5's room accident/incident and determined the cause was due to human

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error. The DON stated the staff failed to ensure R5's seat belt was strapped/closed to ensure R5 could not slip out of the wheelchair. The DON stated the facility did not identify that R5's care plan did not include care or safety for the use of the wheelchair including the seat belt, chest harness or footrest and should have. The DON stated the nurse manager was responsible for ensuring R5's care plan included those interventions and did not. The DON stated the facility's omission of the resident's care plan interventions for safety of wheelchairs or physician's orders did not occur to the leadership while investigating R5's incident accident.

During an interview on 04/05/23 at 1:30 PM, Registered Nurse (RN) 1 stated she was providing care for R5 on [redacted] the date of the incident, and was taking lunch break at the time. RN1 stated she transferred R5 from the bed to the wheelchair prior to the lunch break and had secured and buckled R5's chest harness, lap belt; and had placed R5's feet on R5's footrest and buckled R5's feet. RN1 stated R5's care plan did [redacted] NJ Exec. Order 26:4.b.1 [redacted]. RN1 stated she was informed of what and how to strap R5 into the wheelchair via another staff member. RN1 stated she was a new employee at the facility and gained employment in [redacted] NJ Exec. Order 26:4.b.1 [redacted]

During an interview on 04/05/23 at 4:53 PM, Registered Nurse Charge at (RNC) 3 recalled going to R5's room on [redacted] because CNA1 was yelling and on the way the code bell was heard alarming. RNC3 recalled when entering R5's room, R5's [redacted] R5's [redacted], and R5's [redacted]

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R5's [redacted]. RNC3 stated R5 was [redacted]. RNC3 stated R5 was [redacted]. RNC3 recalled [redacted] R5's [redacted] and [redacted], transferring R5 to the bed and providing [redacted] RNC3 recalled R5 had developed [redacted]. RNC3 stated R5 was required to have the wheelchair [redacted] but did not and RNC3 was unsure why. RNC3 stated the staff "just know" the residents should be secured while in their [redacted].

During an interview on 04/06/23 at 2:22 PM, Nurse Practitioner (NP) 1 stated she went to R5's room on [redacted] because the code bell was alarming, and the staff were providing [redacted] R5. NP1 stated R5 [redacted] and mouth. NP1 stated R5's [redacted] R5's [redacted] and caused [redacted] NP1 stated she discussed R5's incident/accident with the facility's Medical Director but did not discuss care plan interventions [redacted] for the residents. NP1 stated R5's incident was a preventable accident, and the facility should have ensured the nursing staff were competent to secure the [redacted]. NP1 stated the residents' wheelchair [redacted] were a [redacted].

During an interview on 04/06/23 at 4:41 PM, the Social Services Director (SSD) stated the facility did not conduct a care conference after R5's accident/incident. The SSD stated R5's care plan was not revised to include interventions [redacted] after the accident. The SSD

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stated wheelchair safety was not an intervention that needed to be included on the residents' care plan because the staff "just knew" about securing the residents to their wheelchairs.

During an interview on 04/06/23 at 5:54 PM, the Medical Director stated she was one of the first staff in R5's room on [redacted] because R5's code bell was alarming. The Medical Director stated R5 began [redacted] and had a [redacted] but became [redacted] The Medical Directors stated [redacted] was not something related to [redacted] but [redacted] The Medical Director stated [redacted] was something seen during an [redacted]. The Medical Director stated she examined R5 and talked to the staff. The Medical Director stated R5 was not on the wheelchair properly and that caused NJ Exec. Order 26:4.b.1. The Medical Director stated she absolutely thought the incident could have been prevented. The Medical Director stated she thought R5's accident was a result of a human error by the nurse that put R5 in the wheelchair. The Medical Director stated they looked at R5's wheelchair and determined the wheelchair was adequate and decided the incident was caused because the NJ Exec. Order 26:4.b.1 [redacted] The Medical Director stated she expected the residents' care plans to include wheelchair NJ Exec. Order 26:4.b.1 [redacted] and she was unsure why it was not included. The Medical Director stated it was her responsibility to ensure the residents' care and orders were correct. The Medical Director stated the only explanation that they had was NJ Exec. Order 26:4.b.1 was not NJ Exec. Order 26:4.b.1 at all and they

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F 656	Continued From page 20 put R5 in the annex to have closer supervision but did not put any interventions or plans in place for R5. 2. Review of R18's undated EMR "ADMISSION RECORD" revealed R18 was initially admitted to the facility on [redacted] and readmitted on [redacted] with multiple diagnosis to include [redacted]. Review of R18's quarterly "MDS" with an ARD of 02/16/23, located in the EMR "MDS" tab, revealed a "BIMS" was not assessed and R18 was assessed by staff as [redacted] and used a [redacted]. Review of R18's "Care Plan," target date [redacted] and located under the EMR "Care Plan" tab, revealed no interventions for [redacted]. 3. Review of R15's undated EMR "ADMISSION RECORD" revealed R15 was initially admitted to the facility on [redacted] and readmitted on [redacted] with [redacted]. Review of R15's quarterly "MDS" with an ARD of [redacted] located in the EMR "MDS" tab, revealed a "BIMS" was not assessed and R15 was assessed by staff as [redacted] and used a [redacted]. Review of R15's "Care Plan," located under the EMR "Care Plan" tab with a target date of [redacted] revealed no interventions for [redacted]	F 656		

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4. Review of R23's undated EMR "ADMISSION RECORD" revealed R23 was initially admitted to the facility on [redacted] and readmitted on [redacted] with multiple diagnosis to include [redacted]

Review of R23's quarterly "MDS" with an ARD of [redacted] and located in the EMR "MDS" tab, revealed a "BIMS" was not assessed and R23 was assessed by staff as [redacted] and used a [redacted].

Review of R23's "Care Plan," located under the EMR "Care Plan" tab with a target date of [redacted], revealed no interventions for [redacted]

During an interview on 04/05/23 at 11:48 AM, the DON stated the facility's omission of the resident's care plan interventions for safety of wheelchairs or physician's orders did not occur to the leadership while investigating R5's incident accident. The DON confirmed residents were not care planned for wheelchair safety.

During an interview on 04/05/23 at 4:35 PM, Registered Nurse Charge (RNC) 3 stated the staff "just know" the residents should be secured while in their wheelchairs. RNC3 stated all the residents' wheelchairs were different. RNC3 stated the facility's residents with wheelchairs did not have interventions on their care plans to secure them on their wheelchairs with their safety straps which increased their risk for accidents. RNC3 stated the facility provided some wheelchair training upon hire, but it was not

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F 656	Continued From page 22 resident individualized care. During a brief interview on 04/05/23 at 6:40 PM, the QSC reported [redacted] resided at the facility utilizing [redacted] with safety harness/straps. During an interview on 04/06/23 at 2:22 PM, NP1 stated the residents' care plan interventions guided all the facility's staff directives for providing care for the residents and should contain interventions for wheelchair safety and harness. NP1 stated she discussed R5's incident/accident with the facility's Medical Director but did not discuss care plan interventions for NJ Exec. Order 26:4.b.1 for the residents. NP1 stated she was unsure why she did not think about all the rest of the residents utilizing NJ Exec. Order 26:4.b.1 and entering orders for the other resident, but she should have. NP1 stated the residents' wheelchair NJ Exec. Order 26:4.b.1 [redacted] During an interview on 04/06/23 at 4:41 PM, the SSD stated residents' care plan interventions were the drivers of the care the facility provided for the residents. The SSD stated the facility did not include "every little thing" on the residents' care plans that utilized wheelchairs. The SSD stated wheelchair safety was not an intervention that needed to be included on the residents' care plan because the staff "just knew" about securing the residents to their wheelchairs and it was not something that needed to be on the residents' care plan or interventions. During an interview on 04/06/23 at 5:54 PM, the Medical Director stated she expected the residents' care plans to include wheelchair safety interventions, chest straps, neck braces, tray, leg	F 656		

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F 656	Continued From page 23 straps, and waist belt and she was unsure why it was not included. The Medical Director stated it was her responsibility to ensure the residents' care and orders were correct. The Medical Director stated the facility did not put any interventions or plans in place for R5 or the other [redacted] residents with NJ Exec. Order 26:4.b.1 [redacted]	F 656		
F 684 SS=D	N.J.A.C.: 8:39-27.1 (a) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ00107644 Based on record review, interviews, and policy review, the facility failed to ensure one resident out of three residents (Residents (R)23) reviewed for quality of care, with a diagnosis of [redacted] was administered [redacted]]. The facility's deficient practice resulted in R23 [redacted] and admitted to the hospital on [redacted]	F 684	1. All residents could be affected by this deficient practice. Resident #23 physician's orders were updated to include specific information on frequency and if indicated dosing for [redacted]. Education was provided by the Director of Quality, Safety and Compliance to the medical staff addressing the elements of specific orders for NJ Exec. Order 26:4.b.1. In addition, Resident #23 care plan has been updated to include information on administration for [redacted]. A new process has been established in which NJ Exec. Order 26:4.b.1 are	5/12/23

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F 684	Continued From page 24 Findings include: Review of the facility's policy titled "Physician Services," dated April 2023, revealed ". . . The resident's attending physician has oversight in the resident's assessment and care planning, monitoring changes in resident's medical status, providing consultant or treatment when called by the facility, and overseeing a relevant plan of care . . . " 1. Review of R23's undated "ADMISSION RECORD" located on the electronic medical record (EMR) revealed R23 was initially admitted to the facility on [redacted] and readmitted on [redacted] with [redacted] Review of R23's quarterly "Minimum Data Set [MDS]" with an Assessment Reference Date (ARD) of [redacted]3 and located in the EMR under the "MDS" tab, revealed "Brief Interview for Mental Status [BIMS]" was not completed and R23 was assessed by staff as [redacted] Review of R23's "Physician's Orders," dated [redacted] and located under the EMR "Orders" tab lacked orders for [redacted] medication. Review of R23's "Medication Administration Record [MAR]" and "Treatment Administration Record [TAR]" for NJ Exec. Order 26:4.b.1 [redacted] under the EMR "Orders" tab, lacked orders	F 684	currently reviewed at a weekly care coordination meeting with members of the medical staff, care coordinators and transport services; and information imparted to the charge nurse and nurse manager of the respective wing. That information is placed in the charge nurse communication book. Monthly audits specific to residents identified as receiving infusion therapy will be conducted by the Director of Quality, Safety and Compliance. 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. Completion date will be by Friday, May 12, 2023.	

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F 684	Continued From page 25 for [redacted] Review of R23's "Care Plan" under the EMR "Care Plan" tab revealed ". . [redacted] . . . [redacted] as ordered. . ." date initiated [redacted] and did not indicate the frequency. Review of R23's progress notes in the EMR "Progress Notes" tab revealed: a. [redacted] ". . . supervisor spoke with . . . PA [physician assistant] [redacted] . . . lab values are showing that a [redacted] may be occurring . . . requested if symptoms get [redacted] to call right away . . ." b. [redacted] ". . . having [redacted]] . . . total of [redacted] [sic] this shift . . ." c. [redacted] ". . . supervisor spoke with DR [doctor] . . . regarding resident [redacted] x 3 today . . [redacted] were reported to be large and [redacted] . . ." d. [redacted] . . " Review of R23's "History & Physical" under the "MISC" tab located on the EMR revealed: a. [redacted] "Complaint: [redacted] for [redacted] weeks . . . [redacted] likely [redacted] (likely due to delays of the [redacted] and set off by the recent [redacted]) . . . [redacted] Screen negative today . . . PLAN start [redacted] .." by the Medical Doctor. b. [redacted] "Patient with [redacted] and resolution of [redacted]].	F 684		

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F 684	Continued From page 26 Symptoms improving on [NJ Exec. Order 26]s . . . Likely has [NJ Exec] flare triggered by her recent [redacted] . . ." by Medical Doctor Gastrointestinal. c. [NJ Exec. Order 26:4.b] ". . .Hospitalist Daily Progress Note . . . Patient presented with [redacted] likely due to [redacted] due to delays of the last [redacted] by recent [NJ Exec. Order 26:4.b.1]. . ." by the Hospitalist. During an interview on 04/06/23 at 12:07 PM, the Nurse Manager (NM, a Registered Nurse) stated R23 had a diagnosis of [redacted] and was treated with [redacted]. The NM stated he was unsure of R23's schedule for receiving infusions. The NM verified R23 did not have orders for [redacted] on the EMR. The NM verified R23's care plan interventions did not have [redacted] schedule and should. The NM stated R23's [redacted] dose was administered late but he was unsure of the exact date or why it occurred other than a nurse did not order the supplies. During an interview on 04/06/23 at 3:03 PM, Nurse Practitioner (NP) 1 stated R23 had a diagnosis of [redacted] and required [redacted] every six weeks. The NP verified R23's did not have a physician's order in the EMR for [redacted] and should have. The NP1 stated R23 missed doses of [redacted] at the facility, and it caused her to [redacted] with her [redacted] and R23 was sent to the hospital by the facility. During an interview on 04/06/23 at 6:37 PM, the Medical Director stated she expected residents to have physician's orders for their [redacted] medication infusions along with the frequency of administration. The Medical Director stated it was	F 684		

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F 684	Continued From page 27 a terrible thing that R23 [redacted] administration late and R23 suffered the consequences. The Medical Director stated R23 was provided with [redacted] by the facility. The Medical Director stated R23 was sent to the hospital emergency room for treatment and evaluation. N.J.A.C. : 8:39-27.1 (a)	F 684		
F 689 SS=K	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: Complaint # NJ00110496 Based on interviews, review of records, and the facility policy, the facility neglected to ensure one resident out of [redacted] residents (Resident (R) 5) residing at the facility who utilized wheelchairs was safely secured in the wheelchair to prevent accident hazards. On [redacted], the facility's failure resulted in actual harm to R5 due to [redacted] harness. The facility failed to have care planned interventions or physician's orders for [redacted] in place for four of four residents (R5, R18, R23, and R15) reviewed for [redacted] and [redacted] other residents utilizing wheelchairs in the	F 689	1. All residents could be affected by this deficient practice. Res #5, #15, #18 and #23 physician orders and care plans have been updated. In addition, all other residents using a specialty wheelchair have been identified and care plans and physician orders have been updated - specific to his/her specialty wheelchair. Monthly audits will be conducted by the Director of Quality, Safety and Compliance. 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	5/12/23

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F 689	Continued From page 28 facility, increasing the risk of accident hazards for all [NJ Exec. O] residents. On 04/05/23 at 9:07 PM, the Administrator and the Quality Safety Coordinator (QSC) were notified of an Immediate Jeopardy (IJ) for F689: Accident Hazards. The Immediate Jeopardy began on [redacted] when staff failed to safely secure R5 in the [redacted] which resulted in R5 [redacted] by R5's [redacted]. R5 and the other [NJ Exec. O] residents who utilized wheelchairs did not have care plan interventions or physician's orders for [NJ Exec. Order 26:4.b.1]. The Administrator and QSC were informed that immediate jeopardy was still present and ongoing at the time of exit from the survey on 04/06/23 at 8:15 PM. The facility submitted an acceptable removal plan on 4/6/2023. The removal plan was verified as implemented on site by surveyors on 4/7/2023. Findings include: Review of the facility's policy titled "Wheelchair Positioning," dated 04/04, revealed "To position resident in a therapeutic and safe adaptive seating device, in order to provide increased mobility and to insure proper positioning . . . once resident is positioned in the wheelchair secure the seat belt to prevent any unexpected movement or fall . . . Align the resident's trunk support and secure all straps on chair . . . Place feet on the foot rests and secure with foot straps if present . . . Ensure that any type of head or neck support system is properly in place and supporting the resident properly . . . Place lap tray on wheelchair if present . . ."	F 689	thereafter. Completion date will be by Friday, May 12, 2023. 2. All residents could be affected by this deficient practice. Resident #5's specialty wheelchair was immediately sequestered after the initial event for evaluation by the Director of Rehabilitative Services and found to be in good working order. No other resident uses this type of wheel chair. In addition, resident #5 was placed in the chair and the seating system was reevaluated and assessed [NJ Exec. Order 26:4.b.1] [redacted] Staff (newly hired and existing), including clinical staff, leadership and ancillary staff are required to attend a rehabilitation in-service on specialized wheelchair operation presently and on an annual basis. This includes proper placement, positioning and securement. The competency checklist will be completed and become a permanent part of the staff member's personnel file. This competency is part of the orientation process with a required sign-off by a preceptor. The department's manager/designee will sign-off that this education was completed. Department Heads will conduct monthly audits of all new hires, to ensure that the required information is completed. The DON/designee will conduct a daily rounding audit of residents (4 per day) who are up in their wheel chairs to ensure proper application of wheel chair safety devices. The audits will be submitted monthly and reviewed by the Director of	

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F 689	Continued From page 29 1. Review of R5's undated electronic medical record (EMR) "ADMISSION RECORD" revealed R5 was initially admitted to the facility on [redacted] and readmitted on [redacted] with multiple diagnoses to include [redacted]. Review of R5's quarterly "Minimum Data Set [MDS]" with an Assessment Reference Date (ARD) of [redacted] located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" was not completed and R5 was assessed by staff as [redacted] and used a [redacted]. Review of R5's "Physician's Orders," dated [redacted] under the EMR "Orders" tab revealed there were no orders for wheelchair NJ Exec. Order 26:4.b.1. Review of R5's "Medication Administration Record [MAR]" and "Treatment Administration Record [TAR], dated [redacted], under the EMR "Orders" tab revealed there were no orders for wheelchair NJ Exec. Order 26:4.b.1. Review of R5's "Care Plan" under EMR "Care Plan" tab revealed the care plan lacked interventions for wheelchair NJ Exec. Order 26:4.b.1. Review of R5's 'NJ Exec. Order 26:4.b.1 SHEET" [redacted] revealed ". . . NJ Exec. Order 26:4.b.1 Initiated . . ." 2:08 PM. Review of R5's "Progress Note," [redacted] PM. under the EMR "Progress Notes" tab	F 689	Quality, Safety and Compliance. 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. Completion date will be by Friday, May 12, 2023.	

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F 689	Continued From page 30	F 689		

revealed ". . . was sent out to . . . ED [emergency department] for NJ Exec. Order 26:4.b.1 after having a NJ Exec. Order 26:4.b.1 . . ."

Review of R5's "ED Provider Notes," provided by QSC and dated [redacted], revealed ". . . presents to the ED via EMS [emergency medical services] for evaluation of [redacted] . . . found [redacted] . . . . . ss [redacted] and had [redacted] . . . EMS reports on their examination pt [patient] [redacted] . . . Physical Exam . . . [redacted] present . . . Skin . . . [redacted] as a result of [redacted]] to [redacted] . . . Medical Decision Making/Plan . . . Likely [redacted] event . . . Transfer to [hospital] for observation . . ."

Review of R5's hospital "PEDIATRIC HISTORY AND PHYSICIAL," dated [redacted] and provided by the Director of Nursing (DON), revealed ". . . presenting as a direct admission . . . for concerns of accidental [redacted] . . . per report . . . patient was left in wheelchair estimated to be unattended 30-40 minutes, found to have [redacted] Patient found to be NJ Exec. Order 26:4.b.1 and was [redacted] with return of s [redacted] . Reported that no [redacted]] initiated and NJ Exec. Order 26:4.b.1 . . . was [redacted] and had [redacted] on . . . [redacted] Per report, facility staff was [redacted] when EMS arrived . . . Review of Systems . . . [redacted] . . .

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F 689	Continued From page 31 Skin . . . [redacted] . . . [redacted] . . ." Review of R5's "REPORTABLE EVENT RECORD/REPORT" [redacted] provided by QSC revealed "Type of incident: Resident Care . . . [redacted] [sic] awaiting therapy. [redacted]. [R5] had [redacted] [R5 [redacted]. [R5] was placed in the bed, code was called, and [redacted] [R5] responded to [redacted]. [R5] did not require any [redacted] . . . Prior to the event was plan of care developed that addressed this issue . . .Custom wheelchair with NJ Exec. Order 26:4.b.1 [redacted] During an interview on 04/04/23 at 2:22 PM, Licensed Practical Nurse (LPN) 1 recalled entering R5's room on [redacted] because Certified Nursing Assistant (CNA) 1 was heard frantically yelling for help. LPN 1 recalled witnessing R5's [redacted] from R5's [redacted] by the [redacted]. LPN1 stated R5's [redacted] of the wheelchair but was [redacted] R5's [redacted] LPN1 stated R5 was [redacted], [redacted] and R5's [redacted]. LPN1 stated R5's [redacted] R5. LPN1 stated Registered Nurse Charge (RNC) 3 entered R5's room and transferred R5 to the bed and began [redacted]. LPN1 verified R5's care plan did not include an	F 689		

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intervention to secure the resident in the wheelchair NJ Exec. Order 26:4.b.1 [redacted]

During an interview on 04/04/23 at 3:22 PM, LPN2 stated the facility did not require her to demonstrate her knowledge or skills of buckling the resident's safety belts or harness on their wheelchairs during their yearly training. LPN2 stated R5 required a NJ Exec. Order 26:4.b.1 [redacted].

During a brief interview on 04/04/23 at 3:45 PM the QSC reported CNA1 was not available for interview.

During an interview on 04/05/23 at 11:48 AM, the DON stated she went to R5's room on [redacted] because R5's code bell was alarming, and staff were providing R5 with [redacted] when she arrived. The DON stated R5 developed [redacted] around [redacted]. The DON stated R5's [redacted] was possibly related to the [redacted] around R5's [redacted]. The DON stated the facility investigated R5's room accident/incident and determined the cause was due to human error. The DON stated the staff failed to ensure R5's seat belt was strapped/closed to ensure R5 could not slip out of the wheelchair. The DON stated the facility did not identify R5's physician's orders, care plan, or TAR did not include NJ Exec. Order 26:4.b.1 [redacted] and should have. The DON stated the nurse manager was responsible for ensuring R5's care plan included those interventions and did not. The DON stated the

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facility's omission of the residents' care plan interventions for NJ Exec. Order 26:4.b.1 or physician's orders did not occur to the leadership while investigating R5's incident accident.

During an interview on 04/05/23 at 1:30 PM, Registered Nurse (RN) 1 stated she was providing care for R5 on [redacted] and was taking lunch break at the time of the incident. RN1 stated she transferred R5 from the bed to the wheelchair prior to the lunch break and had secured and buckled R5's chest harness, lap belt; and had placed R5's feet on R5's footrest and buckled R5's feet. RN1 stated R5's physician's orders, TAR, or care plan did not include NJ Exec. Order 26:4.b.1 [redacted]. RN1 stated she was informed of what and how to strap R5 into the wheelchair via another staff member. RN1 stated she was a new employee at the facility and gained employment in NJ Exec. Order 26:4.b.1.

During an interview on 04/05/23 at 4:53 PM, Registered Nurse Charge (RNC) 3 stated she went to R5's room because she heard CNA1 yelling and, on the way, she heard the code bell alarming. RNC3 stated when she entered R5's room she found R5's lap belt was not secured around R5's waist, and the chest harness was around R5's [redacted] RNC3 stated R5 was [redacted] RNC3 stated R5 was [redacted]. RNC3 stated she [redacted] R5's [redacted] and [redacted] R5's [redacted], transferred R5 to the bed and began providing [redacted]. RNC3 stated she noted R5 developed [redacted] on the [redacted] RNC3 stated R5 was required to have the wheelchair lap belt secured but did not and she

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F 689	Continued From page 34 was unsure why. During an interview on 04/06/23 at 2:22 PM, Nurse Practitioner (NP) 1 stated she went to R5's room on [redacted] because the code bell was alarming, and the staff were providing [redacted] to R5. NP1 stated R5 developed [redacted]. NP1 stated R5's [redacted] was possibly related to the [redacted] around R5's [redacted]. NP1 stated she discussed R5's incident/accident with the facility's Medical Director but did not discuss care plan interventions or physician orders for [redacted] for the residents. NP1 stated she was unsure why she did not think about all the rest of the children utilizing wheelchair safety and entering orders for the other resident, but she should have. NP1 stated R5's incident was a preventable accident, and the facility should have ensured the nursing staff were competent to secure the child in the wheelchairs. NP1 stated the residents' wheelchair [redacted]. During an interview on 04/06/23 at 4:41 PM, the Social Services Director (SSD) stated the facility did not conduct a care conference after R5's accident/incident. The SSD stated R5's care plan was not revised to include interventions to secure her on her wheelchair after her accident. The SSD stated [redacted] was not an intervention that needed to be included on the resident's care plan because the staff just knew about securing the residents to their wheelchairs and it was not something that needed to be on the resident's care plan or interventions. During an interview on 04/06/23 at 5:54 PM, the	F 689		

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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 689	Continued From page 35	F 689		

Medical Director stated she was one of the first staff in R5's room on [redacted] because R5's code bell was alarming. The Medical Director stated R5 began [redacted] and had a [redacted] and developed [redacted]. The Medical Director stated [redacted] developed from obstruction of the [redacted]. The Medical Director stated [redacted] was something seen during an autopsy of a [redacted] due to [redacted] The Medical Director stated she examined R5 and talked to the staff. The Medical Director stated R5 was not on the wheelchair properly and caused [redacted]. The Medical Director stated she absolutely thought the incident could have been prevented. The Medical Director stated she thought R5's accident was a result of a human error by the nurse that put R5 in the wheelchair. The Medical Director stated they looked at R5's wheelchair and determined the wheelchair was adequate and decided the incident was caused because her lap belt was not clasped correctly. The Medical Director stated she expected the residents' care plans to include [redacted] and she was unsure why it was not included. The Medical Director stated she expected the resident's physician's orders to have [redacted] and she was unsure why it was not included. The Medical Director stated it was her responsibility to ensure the residents' care and orders were correct. The Medical Director stated the only explanation that they had was the lap belt was not secured properly or not secured at all and they put R5 in the annex to have closer supervision but did not put any interventions or plans in place for R5.

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F 689	Continued From page 36 2. Review of R18's undated EMR "ADMISSION RECORD" revealed R18 was initially admitted to the facility on [redacted] and readmitted on [redacted] with multiple diagnosis to include [redacted] Review of R18's quarterly "MDS" with an ARD of [redacted], located in the EMR "MDS" tab, revealed a "BIMS" was not assessed and R18 was assessed by staff as [redacted] and used a [redacted]. Review of R18's "Physician's Orders" [redacted] under the "Orders" tab located on the EMR revealed no order for NJ Exec. Order 26:4.b.1 [redacted]. Review of R18's "MAR" and "TAR" [redacted] under "Orders" tab located on the EMR revealed no order for NJ Exec. Order 26:4.b.1 [redacted]. Review of R18's "Care Plan," target date [redacted] and located under the EMR "Care Plan" tab, revealed no interventions for [redacted] 3. Review of R15's undated EMR "ADMISSION RECORD" revealed R15 was initially admitted to the facility on [redacted] and readmitted on [redacted] with multiple diagnosis to include [redacted] Review of R15's quarterly "MDS" with an ARD of [redacted], located in the EMR "MDS" tab, revealed a "BIMS" was not assessed and R15 was assessed by staff as [redacted] and used a [redacted].	F 689		

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F 689	Continued From page 37 Review of R15's "Physician's Orders" NJ Exec. Order 2 under the "Orders" tab located on the EMR revealed no order for NJ Exec. Order 26:4.b.1 . Review of R15's "MAR" and "TAR" NJ Exec. Orde under "Orders" tab located on the EMR revealed no order for NJ Exec. Order 26:4.b.1 . Review of R15's "Care Plan," located under the EMR "Care Plan" tab with a target date of NJ Exec. Order 26:4.b.1 , revealed no interventions for NJ Exec. Order 26:4.b.1 4. Review of R23's undated EMR "ADMISSION RECORD" revealed R23 was initially admitted to the facility on and readmitted on with multiple diagnosis to include Review of R23's quarterly "MDS" with an ARD of and located in the EMR "MDS" tab, revealed a "BIMS" was not assessed and R23 was assessed by staff as under the "Orders" tab located on the EMR revealed no order for NJ Exec. Order 26:4.b.1 . Review of R23's "MAR" and "TAR" NJ Exec. Orde under "Orders" tab located on the EMR revealed no order for NJ Exec. Order 26:4.b.1 . Review of R23's "Care Plan," located under the EMR "Care Plan" tab with a target date of NJ Exec. Order 26:4.b.1 , revealed no interventions for NJ Exec. Order 26:4.b.1	F 689		

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F 689	Continued From page 38	F 689		

During an interview on 04/04/23 at 3:22 PM, LPN2 stated the facility did not require her to demonstrate her knowledge or skills of buckling the residents' safety belts or harness on their wheelchairs during their yearly training.

During an interview on 04/05/23 at 11:48 AM, the DON stated the facility's omission of the residents' care plan interventions for [redacted] or physician's orders did not occur to the leadership while investigating R5's incident accident.

During an interview on 04/05/23, RNC3 stated the staff "just know" the residents should be secured while in their wheelchair. RNC3 stated all the residents' wheelchairs were different. RNC3 stated the facility's residents with wheelchairs did not have interventions on their care plans to secure them on their wheelchairs with their safety straps which increased their risk for accidents. RNC3 stated the facility provided some wheelchair training upon hire, but it was not resident individualized care.

During a brief interview on 04/05/23 at 6:40 PM, the QSC reported [redacted] resided at the facility utilizing wheelchairs with safety harness/straps.

During an interview on 04/06/23 at 2:22 PM, NP1 stated she discussed R5's incident/accident with the facility's Medical Director but did not discuss care plan interventions or physician orders for wheelchair safety for the residents. NP1 stated she was unsure why she did not think about all the rest of the residents utilizing wheelchair safety and entering orders for the other residents, but she should have. NP1 stated the facility did not

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F 689	Continued From page 39 provide her with wheelchair safety education at the start of her employment in NJ Exec. Order 26:4.b.1. NP1 stated the residents' wheelchair safety belts and harness were a safety hazard. During an interview on 04/06/23 at 4:41 PM, the Social Services Director (SSD) stated residents' care plan interventions were the drivers of the care the facility provided for the residents. The SSD stated the facility did not include "every little thing" on the residents' care plans that utilized wheelchairs. The SSD stated wheelchair safety was not an intervention that needed to be included on the residents' care plan because the staff just knew about securing the residents to their wheelchairs and it was not something that needed to be on the residents' care plan or interventions. During an interview on 04/06/23 at 5:54 PM, the Medical Director stated she expected the residents' care plans to include wheelchair safety interventions, chest straps, neck braces, tray, leg straps, and waist belt and she was unsure why it was not included. The Medical Director stated she expected the residents' physician's orders to have wheelchair safety interventions, chest straps, neck braces, tray, leg straps, and waist belt and she was unsure why it was not included. The Medical Director stated it was her responsibility to ensure the residents' care and orders were correct. The Medical Director stated she had been at the facility for years, and it had never been on their radar to include residents' physician's orders for wheelchair safety and different devices like chest straps and such even though the staff utilized the residents' TAR to provide care. The Medical Director stated the facility did not put any interventions or plans in	F 689		

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F 689	Continued From page 40 place for R5 or the other NJ Exec. O residents with NJ Exec. Order [redacted]	F 689		
F 710 SS=G	N.J.A.C. 8:39-27.1 (a) Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Complaint # NJ00110496, NJ00107644 Based on record review, interviews, and policy review, the facility failed to ensure [redacted] of [redacted] residents utilizing wheelchairs at the facility had physician orders for NJ Exec. Order 26:4.b.1. This resulted in actual harm when Resident (R) 5 was not appropriately secured in the wheelchair and [redacted]. The facility failed to ensure two residents out of three residents (R23, R18)	F 710	1. All residents could be affected by this deficient practice. Res #5, physician orders have been updated. In addition, all other residents using a specialty wheelchair have been identified and care plans and physician orders have been updated - specific to his/her specialty wheelchair. A new process was added in which the Director of Rehabilitative Services/designee will communicate to	5/12/23

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F 710	Continued From page 41 reviewed for physician services had physician's orders included for [redacted].) The facility's deficient practice increased R23 and R18's resident's risk of treatment (medication administration) overlooked and not administered. Findings include: Review of the facility's policy titled "Physician Services" April 2023 revealed ". . .The resident's attending physician has oversight in the resident's assessment and care planning, monitoring changes in resident's medical status, providing consultant or treatment when called by the facility, and overseeing a relevant plan of care for the resident . . . prescribe an appropriately regimen . . . Physician orders . . . shall be maintained in accordance . . ." 1. Review of R5's undated "ADMISSION RECORD" located on her electronic medical record (EMR) revealed R5 was initially admitted to the facility on [redacted] and readmitted on [redacted] with multiple diagnoses to include [redacted] Review of R5's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] and located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" with a score of was not assessed and R5 was assessed by staff as [redacted] and used a [redacted].	F 710	the clinical team at morning huddle and through the EMR any time a change has been made in a specialty wheelchair device specific to a resident. Monthly audits will be conducted by the Director of Quality, Safety and Compliance. 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. Completion date will be by Friday, May 12, 2023. 2. All residents could be affected by this deficient practice. Res #18 and #23 physician orders were updated to reflect frequency of doses and specific dosing of [redacted] when indicated. Res #18 and #23 care plans have been updated to included frequency of doses and monitoring for side effects NJ Exec. Order 26:4.b.1 [redacted] In addition, common side effects have been added to the care plan specific to [redacted]. Education was provided by the Director of Quality, Safety and Compliance to the medical staff addressing the elements of specific orders for infusion therapy. A new process has been established in which infusion orders are currently reviewed at a weekly care coordination meeting with members of the medical staff, care coordinators and transport services; and information imparted to the charge nurse and nurse manager of the respective wing. That information is placed in the charge nurse communication book. Monthly audits specific to residents	

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F 710	Continued From page 42 Review of R5's "Physician's Orders," dated [redacted] and located under the EMR "Orders" tab, lacked orders for [redacted]. Review of R5's "Medication Administration Record [MAR]" and "Treatment Administration Record [TAR]" [redacted] under EMR "Orders" tab lacked orders for [redacted] Review of R5's hospital "PEDIATRIC HISTORY AND PHYSICIAL," dated [redacted] and provided by the Director of Nursing (DON), revealed ". . . presenting as a direct admission . . . for concerns of [redacted] . . . per report . . . patient was left in wheelchair estimated to be unattended 30-40 minutes, found to have [redacted] Per report, facility staff was [redacted] patient when EMS [emergency medical services] arrived . . . Review of Systems . . . [redacted] . . . Skin . . . [redacted] . . ." Review of R5's "REPORTABLE EVENT RECORD/REPORT," dated [redacted] and provided by the Quality Safety Coordinator	F 710	identified as receiving infusion therapy will be conducted by the Director of Quality, Safety and Compliance. 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. Completion date will be by Friday, May 12, 2023.	

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(QSC), revealed "Type of incident: Resident Care . . . Child [redacted] [sic] [redacted] Child was found to be [redacted] [R5] had [redacted] [R5's] [redacted], and [redacted] [R5] was placed in the bed, [redacted] was called, and [redacted] . [R5] [redacted] and began [redacted]. [R5] did not require any [redacted] . . Prior to the event was plan of care developed that addressed this issue . . . [redacted]

During an interview on 04/04/23 at 2:22 PM, Licensed Practical Nurse (LPN) 1 stated she entered R5's room because Certified Nursing Assistant (CNA)1 was heard frantically yelling for help. LPN 1 recalled witnessing R5's [redacted] R5's [redacted] LPN1 stated R5's [redacted] was not on the seat of the wheelchair but was [redacted] g with R5's [redacted]. LPN1 stated R5's was [redacted], and R5's [redacted]. LPN1 stated R5's [redacted] t [redacted] or [redacted] R5. LPN1 stated Registered Nurse Charge (RNC) 3 entered R3's room and transferred R3 to the bed and began [redacted]. LPN1 verified R5's care plan did not include an intervention to secure R5 in the [redacted] with [redacted] .

During an interview on 04/05/23 at 11:48 AM, the DON stated she went to R5's room on [redacted] because R5's code bell was alarming, and staff were providing R5 with [redacted]

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[redacted] when she arrived. The DON stated R5 developed [redacted]. The DON stated R5's [redacted] was possibly related to the [redacted] around R5's [redacted] The DON stated the facility investigated R5's room accident/incident and determined the cause was due to human error. The DON stated the staff failed to ensure R5's [redacted] R5 could not slip out of the wheelchair. The DON stated the facility did not identify R5's physician's orders, care plan or TAR did not include NJ Exec. Order 26:4.b.1 [redacted] and should have. The DON stated the facility's omission of the resident's physician's orders for NJ Exec. Order 26:4.b.1 [redacted] did not occur to the leadership while investigating R5's incident accident.

During an interview on 04/05/23 at 1:30 PM, RN1 stated she was providing care for R5 on [redacted] and was taking lunch break at the time of the incident. RN1 stated she transferred R5 from the bed to the wheelchair prior to the lunch break and had secured and buckled R5's [redacted], [redacted] R5's [redacted]. RN1 stated R5's physician's orders, TAR, or care plan did not NJ Exec. Order 26:4.b.1 [redacted]. RN1 stated she was informed of what and how to strap R5 into the wheelchair via another staff member. RN1 stated she was a new employee at the facility and gained employment in NJ Exec. Order 26:4.b.1.

During an interview on 04/05/23 at 4:53 PM, Registered Nurse Charge (RNC)3 stated she went to R5's room because she heard CNA1

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yelling and, on the way, she heard the code bell alarming. RNC3 stated when she entered R5's room she found R5's [redacted] around R5's waist, and the [redacted] was [redacted] R5's [redacted] RNC3 stated R5 was [redacted]. RNC3 stated R5 was [redacted]. RNC3 stated she unclasped R5's [redacted] and [redacted] R5's [redacted], transferred R5 to the bed and began providing [redacted]. RNC3 stated she noted R5 developed [redacted] on the [redacted] and [redacted] RNC3 stated R5 was required to have the wheelchair lap belt secured but did not and she was unsure why. RNC3 stated the staff "just know" the residents should be secured while in their wheelchair. RNC3 stated all the resident's wheelchairs were different. RNC3 stated the facility's residents with wheelchairs did not have interventions on their care plans to secure them on their wheelchairs with their safety straps which increased their risk for accidents. RNC3 stated the facility provided some wheelchair training upon hire, but it was not resident individualized care.

During a brief interview on 04/05/23 at 6:40 PM, the QSC reported [redacted] resided at the facility utilizing [redacted] with [redacted].

During an interview on 04/06/23 at 2:22 PM, Nurse Practitioner (NP) 1 stated she went to R5's room on [redacted] because the code bell was alarming, and the staff were providing [redacted] to R5. NP1 stated R5 developed [redacted] The NP stated R5's [redacted] was possibly related to the [redacted] around R5's [redacted]. NP1 stated the

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residents' care plan interventions guided all the facility's staff directives for providing care for the residents and should contain interventions for wheelchair safety and harness. The NP1 stated she discussed R5's incident/accident with the facility's Medical Director but did not discuss care plan interventions or physician orders for NJ Exec. Order 26:4.b.1 for the residents. The NP1 stated she was unsure why she did not think about all the rest of the children utilizing wheelchair safety and entering orders for the other resident, but she should have. The NP1 stated the facility did not provide her with wheelchair safety education at the start of her employment in NJ Exec. Order 26:4.b.1. The NP1 stated R5's incident was a preventable accident, and the facility should have ensured the nursing staff were competent to secure the child in the wheelchairs. The NP1 stated the residents' wheelchair safety belts and harness were a safety hazard.

During an interview on 04/06/23, the Medical Director stated she was one of the first staff in R5's room on [redacted] because R5's code bell was alarming. The Medical Director stated R5 began NJ Exec. Order 26:4.b.1 and had a [redacted] but became [redacted] The Medical Director stated [redacted] was not something related to NJ Exec. Order 26:4.b.1 but developed from NJ Exec. Order 26:4.b.1 [redacted]. The Medical Director stated [redacted] was something seen during an autopsy of a decreased body due to [redacted]. The Medical Director stated she examined R5 and talked to the staff. The Medical Director stated R5 was not on the wheelchair properly and caused R5's NJ Exec. Order 26:4.b.1. The Medical Director stated she absolutely thought the incident could

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F 710	Continued From page 47	F 710		

have been prevented. The Medical Director stated she thought R5's accident was a result of a human error by the nurse that put R5 in the wheelchair. The Medical Director stated they looked at R5's wheelchair and determined the wheelchair was adequate and decided the incident was caused because the lap belt was not clasped correctly. The Medical Director stated she expected the residents' care plans to include [redacted] and she was unsure why it was not included. The Medical Director stated she expected the resident's physician's orders to have [redacted] she was unsure why it was not included. The Medical Director stated it was her responsibility to ensure the residents' care and orders were correct. The Medical Director stated she had been at the facility for years, and it had never been on their radar to include resident's physician's orders for wheelchair safety and different devices like chest straps and such even though the staff utilized the resident's TAR to provide care. The Medical Director stated, "the only explanation that we had was the lap belt was not secured properly or not secured at all and we put [R5] in the annex to have closer supervision" but did not put any interventions or plans in place for R5 or the other [redacted] residents with safety straps/harness on their wheelchairs.

2. Review of R23's undated EMR "ADMISSION RECORD" revealed R23 was initially admitted to the facility on [redacted] and readmitted on [redacted] with multiple diagnosis to include [redacted]

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 04/11/2023

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 710	Continued From page 48 [redacted] Review of R23's quarterly "Minimum Data Set [MDS]" with an Assessment Reference Date (ARD) of [redacted] and located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score was not completed and R23 was assessed by staff to be [redacted] and used a [redacted]. Review of R23's "Physician's Orders," from [redacted] under the EMR "Orders" tab, lacked orders for [redacted] medication. Review of R23's "MAR" and "TAR," from NJ Exec. Order 26:4.b.1 [redacted] under EMR "Orders" tab, lacked orders for [redacted] Review of R23's "Care Plan" under the EMR "Care Plan" tab revealed ". [redacted] . . . [redacted] . . . [redacted] as ordered. . ." date initiated [redacted] and did not indicate the frequency. Review of R23's "History & Physical" under the EMR "MISC" tab revealed: a. [redacted] "Chief Complaint: [redacted] NJ Exec. Order 26:4.b.1) . . . today . . . [redacted] . . ." by Physician. b. [redacted] "Patient with improving [redacted] and resolution of [redacted]. [redacted] improving on [redacted] . . . Likely has	F 710		

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 04/11/2023

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VOORHEES PEDIATRIC FACILITY	1304 LAUREL OAK ROAD VOORHEES, NJ 08043

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F 710	Continued From page 49 [redacted] triggered by her recent [redacted] . . ." by Medical Doctor Gastrointestinal. c. [redacted] ". . .Hospitalist Daily Progress Note . . . Patient presented with [redacted] likely due to [redacted] flare due to delays of the last two [redacted] and complicated by recent [redacted] . . ." by the Hospitalist. During an interview on 04/06/23 at 12:07 PM, the Nurse Manager (NM, a Registered Nurse) stated R23 had a diagnosis of [redacted] and was treated with [redacted]. The NM stated he was unsure of R23's schedule for receiving infusions. The NM verified R23 did not have orders for [redacted] on the EMR. The NM verified R23's care plan intervention did not have [redacted] schedule and should. The NM stated R23's [redacted] dose was administered late but he was unsure of the exact date or why it occurred other than a nurse did not order the supplies. During an interview on 04/06/23 at 3:03 PM, NP1 stated R23 had a diagnosis of [redacted] and required [redacted] every six weeks. NP1 verified R23's did not have a physician's order on the EMR for [redacted] and should have. NP1 stated R23 missed doses of [redacted] at the facility and it caused R23 to flare up with [redacted] and R23 was sent to the [redacted] by the facility. During an interview on 04/06/23 at 6:37 PM, the Medical Director stated she expected residents to have physician's orders for their [redacted] medication infusions along with the frequency of administration. The Medical Director stated it was a terrible thing that R23's [redacted] administration late and R23 suffered the	F 710		

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	315289	A. BUILDING _____ B. WING _____	C 04/11/2023

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 710	Continued From page 50	F 710		

consequences. The Medical Director stated R23 was provided with [redacted] The Medical Director stated R23 was sent to the hospital emergency room for treatment and evaluation.

3. Review of R18's undated EMR "ADMISSION RECORD" revealed R18 was initially admitted to the facility on [redacted] and readmitted on [redacted] with multiple diagnosis to include [redacted]

Review of R18's quarterly MDS with an ARD of [redacted] and located in the EMR "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" was not completed at R18 was assessed by staff as [redacted].

Review of R18's "Physician's Orders," dated [redacted] and located in EMR "Orders" tab included:
a. ". . . follow up . . . on [redacted] . . . [redacted] . . ." dated [redacted].
b. There was no order for [redacted]

Review of R18's "MAR" and "TAR," dated [redacted] and located under the EMR "Orders" tab did not include orders for [redacted].

Review of R18's "Care Plan" under the EMR "Care Plan" tab ". . [redacted] disease. . ." initiated [redacted] revised on [redacted] and did not have an intervention for [redacted] medication administration.

During an interview on 04/06/23 at 3:03 PM, NP1 stated R18 had a diagnosis of [redacted] disease and required [redacted] every four weeks. NP1 confirmed R18 did not have a

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 04/11/2023

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 710	Continued From page 51 physician's order on the EMR for [redacted]. NP1 stated R18's physician's order on R18's EMR should include the [redacted] administration. NP1 verified R18's care plan did not have interventions for [redacted] medication or specify the frequency of his doses or to [redacted] and should. N.J.A.C. : 8:39-27.1 (a)	F 710		

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	5/25/2023 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 F0600	Correction	ID Prefix F0656	Correction	ID Prefix F0684	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25	Completed
LSC	05/25/2023	LSC	05/25/2023	LSC	05/25/2023
ID Prefix F0689	Correction	ID Prefix F0710	Correction	ID Prefix	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.30(a)(1)(2)	Completed	Reg. #	Completed
LSC	05/25/2023	LSC	05/25/2023	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO