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 _____	09/30/2021

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 STANDARD SURVEY: 09/30/21 CENSUS: 107 SAMPLE: 25 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) assessments for [redacted] residents (Resident [redacted]) reviewed for nutrition. This deficient practice was evidenced by: According to the Admission Record, Resident [redacted] was admitted with diagnoses, that included but	F 641	F641 All residents could be affected by this deficient practice. Resident [redacted]'s MDS was corrected for [redacted] and [redacted] To ensure full compliance, the MDS Coordinator, nursing staff and clinical dietitian will be re-educated on the facility policy/procedure for weight monitoring and reporting, more specifically the MDS	11/30/21

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

Electronically Signed | 10/15/2021

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F 641	Continued From page 1 were not limited to, [redacted]). Review of the Quarterly MDS, dated [redacted], included coding that the resident did not have a significant [redacted] of 5% or more in the last month or 10% or more in the last six months. Review of the Weights and Vitals Summary, dated 01/01/2020 - 12/31/2020, included the following weights: On 01/13/2020, the resident weighed [redacted] (kilograms) On 06/07/2020, the resident weighed [redacted] kg On 07/05/2020, the resident weighed [redacted] kg (a [redacted] weight loss in six months, and a [redacted] weight loss in one month) Review of the Nutrition/Dietary Note, dated 08/06/20, included, "[Resident [redacted]] demonstrating [redacted] of -[redacted] kg x 3 months ([redacted])." Review of the Quarterly MDS, dated [redacted] included coding that the resident did not have a significant [redacted] of 5% or more in the last month or 10% or more in the last six months. Further review of the Weights and Vitals Summary, dated 01/01/2020 - 12/31/2020, included the following weights: On 04/12/2020, the resident weighed [redacted] kg On 10/04/2020, the resident weighed [redacted] kg (a [redacted] weight loss in six months) Review of the Nutrition/Dietary Note, dated [redacted], included, "[kilocalorie] content of [enteral nutrition] regimen increased today in response to unplanned [redacted]	F 641	reporting requirements under [redacted] on [redacted]. The process will be monitored by the Director of Nursing. A random sample of 10 residents and their corresponding MDS [redacted] will be audited bi-weekly for 1 month and monthly thereafter. 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 11/30/2021.	

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F 641	Continued From page 2	F 641		

[approximately] 2-3 months ago and failure to [redacted] in interim."

During an interview with the survey team on 09/29/21 at 10:43 AM, the Registered Dietician stated that Resident [redacted] had a significant [redacted] t [redacted] in [redacted], but that the MDS Nurse was responsible for completing [redacted] Status, a portion of the MDS.

During a telephone interview with the survey team on 09/29/21 at 12:11 PM, the MDS Nurse stated she is responsible for completing [redacted] of the MDS. She further stated that she reviews the residents' weights in the electronic medical record to determine if there was a [redacted].

During an interview with the survey team on 09/29/21 at 2:24 PM, the Director of Nursing (DON) stated that she would expect the MDS Nurse to accurately complete [redacted] of the MDS.

During a follow-up interview with the survey team on 09/30/21 at 9:43 AM, the DON acknowledged that [redacted] of the quarterly MDS assessments dated [redacted] and [redacted] were coded incorrectly.

Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, included instructions for [redacted] Status. According to the manual, staff are to compare the resident's weight in the current observation period to his or her weight in the observation period 30 and 180 days ago, and if the current [redacted] than

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F 641	Continued From page 3 the weight in the observation period 30 and/or 180 days ago, calculate the percentage of [redacted] The manual further includes that staff are to code [redacted] as "yes, not on physician-prescribed [redacted] regimen" if the resident experienced a [redacted] of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight was not planned and prescribed by a physician.	F 641		
F 692 SS=E	NJAC 8:39-11.1 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692		11/30/21

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F 692	Continued From page 4 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to identify and address significant weight changes. This deficient practice was identified for 2 of 2 residents reviewed for nutrition (Residents [redacted] and [redacted]) and was evidenced by the following: 1. On 09/24/21 at 1:09 PM, the surveyor observed Resident #[redacted] lying in bed with his/her eyes closed. He/she was receiving [redacted] at a [redacted] r. According to the Admission Record, Resident [redacted] was over three years of age and was admitted with [redacted] which included, but were not limited to, [redacted]. Review of the Order Recap Report, dated [redacted], for Resident [redacted] revealed an order to administer [redacted] for nutrition, with a date of [redacted], and a specific order to check the resident's weight once, on [redacted] Review of the Order Summary Report, for Active Orders As of [redacted], revealed an order for weekly weights on night shift every Sunday, dated [redacted].	F 692	F692 All residents could be affected by this deficient practice. An immediate evaluation of Resident #[redacted] s abrupt [redacted] identified on 9/20/21 was a result of a [redacted] removal. The resident s medical nutritional plan was updated on [redacted]. An immediate evaluation of Resident [redacted] weight has indicated a stabilization of weight over the last three (3) quarters. The weight monitoring, documentation, and reporting policy will be updated with final approval from Medical Director, Clinical Dietician, and Director of Nursing by 10/22/21. To ensure full compliance, nursing, clinical dietitian and medical staff will be reeducated on the weight monitoring, documentation and reporting policy by 10/29/21. The Nursing Management team will review each weight report to ensure appropriate measurements are recorded and complete, and to monitor weight fluctuations. The Director of Nursing/Designee will complete weekly chart audits for six (6)) consecutive weeks and review all weight reports and residents with weight change to ensure that changes are identified and appropriate interventions have been put into place. In addition, care plans will be reviewed for updated information to reflect any specified interventions. Audited records will be 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	

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F 692	Continued From page 5 A review of the resident's [redacted] Medication Administration Record (MAR) included weights and dates as follows: [redacted] kilograms (kg) on 09/14/21 [redacted] kg on 09/19/21 [redacted] kg on 09/26/21 The weights obtained on 09/14/21, 09/19/21 and 09/26/21 were also recorded on the Weights and Vitals Summary for Resident [redacted] on 09/14/21, 09/20/21, and 09/27/21 respectively. The Weights and Vitals Summary further reflected explicit alerts referencing [redacted] of 10% on 09/14/21, 09/20/21, and 09/27/21. Review of the progress notes from [redacted] to [redacted] 1 included that the resident was last evaluated by the Registered Dietitian (RD) for nutritional status on [redacted] An "Orders - Administration Note," dated [redacted], revealed a one-time only order to weigh the resident, and reflected that the resident's [redacted] was removed, and that resident was wearing a pair of pants and a sweatshirt, during the weighing process. During an interview with the surveyor on 09/29/21 at 9:12 AM, the Licensed Practical Nurse (LPN) stated that weights for individual residents (children) are taken with the scale "zeroed," whereby the scale is calibrated to account for any extra clothing, covering, or other items, so that an accurate weight can be recorded. The LPN stated that she thinks the primary nurse is responsible for tracking weights. In addition, she stated that the computer program will alert significant weight changes with a "red asterisk." She further stated that if a significant weight change occurs, it is reported, according to a chain of command, and referenced nurses, nursing	F 692	resolved and is stable. The committee will also make recommendations for frequency intervals thereafter. Completion date will be 11/30/2021.	

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supervisors, the dietician, and physicians. According to the LPN, it is a "group effort," so that everyone involved in a child's care will be aware of changes and developments in status. Finally, the LPN confirmed that a child should be weighed again if there is a significant change in weight, that she thinks a change of five or more pounds would be considered a significant change, and the re-weight, due to a significant change, should likely be taken the next day.

During an interview with the surveyor on 09/29/21 at 9:24 AM, the Registered Nurse (RN) confirmed that she was the Nursing Manager for the [redacted] Unit. The RN stated that the physician's order determines the frequency of weight monitoring, the weights are recorded into the medical record, and the scale is calibrated to zero, to account for the presence of a diaper or other clothing worn by the child. These steps described are taken to obtain an accurate weight. The RN further stated the dietician and medical team monitor weights, and that nurses understand the need to report discrepancies in weights of children, so that weights can be repeated the next day if necessary, due to possible discrepancies. According to the RN, this process is important, because it will allow the dietician and medical team to evaluate the need for necessary adjustments and determine whether changes in weight occurred due to dietary or medical issues. The RN stated that a weight change of 5% would be considered a significant change and a repeated follow-up weight would ordinarily be obtained the next day.

During an interview with the surveyor, the Registered Dietician - Certified Specialist in Pediatrics (RD) stated that nurses oversee the

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weighing process, and the RD is primarily responsible for tracking weights. The RD would implement necessary changes in frequency of monitoring weights, if deemed appropriate, and based on developments or changes that occur. The RD further stated that a significant change in weight may or may not warrant the need to take an additional weight. The RD stated that a [redacted] in weight of 10% or more would be considered a significant change. In addition, a thorough assessment is done on a quarterly basis (every 3 months), if the RD is not otherwise informed of [redacted] changes, and a [redacted] of 10% during this period would be significant. A [redacted] of 10% or more within a week or less, would be considered very serious. The RD also acknowledged that not being informed of a [redacted] in weight, in a timely manner, could be a problem, because a significant weight change for which she is informed, would prompt her to reevaluate the resident sooner than the subsequent quarter.

The RD confirmed specific details about Resident [redacted] She stated that the resident's weight on 09/14/21 was [redacted] kg and that his/her weights were [redacted] kg on 09/20/21 and 09/27/21, using a mechanical-lift scale, bath scale, and then a mechanical-lift scale, respectively. The RD confirmed that the [redacted] was greater than 10%, the [redacted] was a significant one, and that she should have been notified of the significant change, either by nursing staff or directly by the individual who obtained the weights. The RD further stated that it was both important and necessary for her to be advised of the weight [redacted], so that further evaluations and possible interventions could have been implemented sooner. She confirmed that there was no

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evaluation of Resident [redacted]'s nutritional status since [redacted], due to her lack of awareness of the referenced weight changes. Finally, the RD stated that she did not receive any alert of the [redacted] through the computer system, further conveying that the computer program (electronic medical record) was designed for monitoring adults, rather than pediatric (child) groups. The RD stated that she had previously made a request for such an "alerting" system to be implemented, to no avail.

During an interview with the surveyor on 09/29/21 at 2:20 PM, the Director of Nursing (DON) stated that nurses take weights in accordance with physician's orders, there is accounting for clothes, and the scales are calibrated to ensure accurate weights are obtained. The DON further stated that a weight change of 5% or greater would be significant, it would be her expectation that a significant weight change would be addressed at the next available morning meeting, and that such meetings occur on every weekday. The DON acknowledged the weight [redacted], identified by the surveyor, was a significant change, because it was greater than 10%. The DON also clarified that the computer system (electronic medical record) did consist of a functioning "alert" system for weights but was uncertain as to which facility staff had access to this feature.

During a follow up interview with the surveyor on 09/30/21 at 9:10 AM, the DON acknowledged there was no evaluation or documentation regarding Resident [redacted]s weight change and that there should have been follow-up activity and documentation, due to the significant [redacted] in weight. The DON further stated that the

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resident's nutrition (feeding) order was current and remained unchanged, since October 2020. She also clarified that facility staff does receive alerts from the electronic medical record related to significant weight changes.

2. On 09/22/21 at 11:03 AM, the surveyor observed Resident [redacted] lying in bed. The resident did not respond to the surveyor's greeting.

According to the Admission Record, Resident [redacted] was over three years of age and was admitted with diagnoses which included, but were not limited to, [redacted]

Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had [redacted]. Further review of the MDS included that the resident received [redacted] or more of total calories through [redacted].

Review of the Weights and Vitals Summary, dated 01/01/2020 - 12/31/2020, included that the resident weighed [redacted] kg on 06/07/2020 and then [redacted] kg on 07/05/2020, a [redacted] ([redacted]) [redacted] in one month. There were no re-weights recorded for the month of July 2020.

Review of the Nutrition/Dietary Note, dated [redacted], included that the resident's usual body weight was [redacted] kg.

Review of the Nutrition/Dietary Note, dated [redacted], included that the resident was,

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"demonstrating [redacted] of [redacted] kg x 3 months ([redacted])" and, "[Resident] may benefit from 1[redacted] [redacted] in [kilocalorie] content of [redacted] to prevent further [redacted] and promote age appropriate [redacted] and [redacted]

Review of all Progress Notes for Resident [redacted] dated between [redacted] and [redacted] revealed no other documentation that identified and addressed the resident's significant [redacted].

Review of the Order Report Recap, dated [redacted] included a [redacted] order that was discontinued on [redacted] with a reason of "[redacted]" and a new order for an [redacted], with a start date of [redacted].

During an interview with the surveyor on 09/20/21 at 9:30 AM, the RN Supervisor of [redacted] Unit stated the primary nurse is responsible for obtaining the resident's weight and recording it in the electronic medical record. If the weight recorded in the electronic medical record is a significant change, it will appear in red and the nurse will re-weigh the resident. The RN Supervisor further stated that if there was a significant weight change, the nurse would notify the charge nurse, supervisor, dietician, and physician. The RN Supervisor defined a significant weight change as five pounds in either direction, depending on the size of the child.

During an interview with the survey team on 09/29/21 at 10:43 AM, the RD stated that the nursing staff was responsible for obtaining the residents' weights, and the RD was responsible for tracking the weights. The RD further stated that a 10% difference in weight from the

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resident's usual body weight would require a re-weight and follow up by the RD. The RD then confirmed that Resident [redacted] had a significant [redacted] in July 2020, but that she was not notified by the nursing staff and that she did not identify the significant [redacted] until August 2020, during the resident's quarterly assessment. The RD further stated that the [redacted] should have been addressed immediately upon obtaining the July 2020 weight.

During a telephone interview with the survey team on 09/29/21 at 12:11 PM, the MDS Nurse stated the weights section of the electronic medical record would alert if the current weight recorded is a significant weight change of 5% or 10% from the previous weight.

During an interview with the survey team on 09/29/21 at 2:24 PM, the DON stated that the nursing staff obtains the residents' weights and compares the current weight to the previous weight to determine if there is a significant weight change of 5%. The DON further stated that if a significant weight change was identified, the nursing staff should notify the RD and physician. The DON then confirmed that Resident [redacted] had a significant weight loss in July 2020 and stated that the weight loss should have been addressed at the time in July 2020.

A review of the facility's policy, "Voorhees Pediatric Facility Nursing Manual," effective 11/99 and revised 09/20, included it is necessary to re-weigh a resident if there is a 5% discrepancy from the previous weight.

The surveyor also obtained a reviewed the facility's policy, "Voorhees Pediatric Facility

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F 692	Continued From page 12 Nursing Manual" which referenced "Effective Date: Reviewed 3/11." According to the policy, there are criteria which require a need for comprehensive reassessment, including an unplanned [redacted] of 5-10% within one month, in children over 3 years of age.	F 692		
F 812 SS=E	NJAC 8:39 - 27.2 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to: a.) ensure food was stored in a manner to minimize the potential for cross contamination, b.) discard potentially hazardous	F 812	F812 1 &7. All staff, residents and visitors could be affected by this deficient practice. To ensure full compliance, the	11/30/21

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F 812	Continued From page 13 foods past their date of expiration, c.) maintain kitchen equipment in a clean and sanitary manner to prevent microbial growth, and d.) ensure staff consistently covered hair to minimize the potential for contamination. This deficient practice was identified in the main kitchen and on one of two resident units ([redacted] Unit) and was evidenced by the following: On 09/22/21 at 10:33 AM, the surveyor, in the presence of the Dining Service Director (DSD), observed the following during the kitchen tour: 1. The surveyor observed the DSD with a hat on his head and hair exposed out of the back of his hat. When interviewed, the DSD stated it was "alright" because he had a hat on. The DSD failed to address the hair exposed out of the back of his hat. 2. In the reach-in freezer, the surveyor observed a container labeled [redacted]" dated 07/19/21 with a use by date of 08/19/21. The surveyor further observed the container's label date had been altered to reflect 08/19/21 with a use by date of 09/19/21. 3. In the reach-in freezer, the surveyor observed a container of [redacted] dated 07/22/21 with a use by date of 08/22/21. The surveyor further observed the container's label had been altered to reflect the date of 08/22/21 with a use by date of 09/22/21. When interviewed, the DSD stated the container labeled "[redacted]" and the pureed cinnamon roll should not have been in the reach-in freezer. The DSD was unable to provide a response to the handwritten date changes noted on the labels.	F 812	food service staff was reeducated on the proper use of hair coverings on 10/4/21. The process will be monitored by the Food Service Director. Weekly QA audits will be conducted by the Food Service Director/Designee to insure 100% compliance. Results will be reported quarterly to the Administrator and Quality Assurance Committee who will make the decision if the process has been resolved and is stable. Completion date will be 11/30/21. 2. All staff, residents and visitors could be affected by this deficient practice. The [redacted] was thrown away immediately. All refrigerators, freezers, and dry storage areas were inspected for proper/secure storage of all food and non-food products. All dietary staff were reeducated on the procedure to properly label food items and the corrective action to take when food exceeds its use by date on 10/4/21. The process will be monitored by the Food Service Director/Designee during opening and closing inspections. The monitoring of food storage will be completed during the weekly sanitation inspection by the FSD/District/Regional manager to insure 100% compliance. Results will be reported quarterly to the Administrator and the Quality Assurance Committee who will make the decision if the process has been resolved and is stable. Completion date will be 11/30/21. 3. All staff, residents and visitors could be affected by this deficient practice. The [redacted] was thrown away	

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F 812	Continued From page 14 4. In the reach-in freezer, the surveyor observed a container of [redacted] dated 08/27/21 with a use by date of 09/01/21. The label further indicated a shelf life of five days. When interviewed, the DSD stated the container of [redacted] should not have been in the reach-in freezer and confirmed that the pureed cinnamon roll had a shelf life of five days. 5. A stack of clear plastic containers was stored on a multi-tiered cart. The surveyor observed a dead bug inside one of the plastic containers. When interviewed, the DSD stated that he was not aware of any bug issues and that he would inform the plant manager of the surveyor's findings. On 09/29/21 at 12:58 PM, the surveyor observed the following in the [redacted] Unit nourishment room: 6. The surveyor observed an ice scooper holder mounted on the wall next to the ice machine. The surveyor observed that the bottom of the ice scooper holder had build-up and was covered with a black unknown substance. On 09/29/21 at 1:32 PM, the surveyor, in the presence of the DSD, observed the following in the kitchen: 7. The surveyor observed the DSD with a hat on his head and hair exposed out of the back of his hat. 8. The surveyor observed an ice scooper holder mounted on the side of the ice machine. The surveyor observed that the ice scooper holder was bottomless and that the tip of the ice scooper	F 812	immediately. All refrigerators, freezers, and dry storage areas were inspected for proper/secure storage of all food and non-food products. All dietary staff were reeducated on the procedure to properly label food items and the corrective action to take when food exceeds its use by date on 10/4/21. The process will be monitored by the Food Service Director/Designee during opening and closing inspections. The monitoring of food storage will be completed during the weekly sanitation inspection by the FSD/District/Regional manager to insure 100% compliance. Results will be reported quarterly to the Administrator and the Quality Assurance Committee who will make the decision if the process has been resolved and is stable. Completion date will be 11/30/21. 4. All staff, residents and visitors could be affected by this deficient practice. The [redacted] was thrown away immediately. All refrigerators, freezers, and dry storage areas were inspected for proper/secure storage of all food and non-food products. All dietary staff were reeducated on the procedure to correctly identify shelf life, properly store and label food items and the corrective action to take when food exceeds its use by date on 10/4/21. The process will be monitored by the Food Service Director/Designee during opening and closing inspections. The monitoring of food storage will be completed during the weekly sanitation inspection by the FSD/District/Regional manager to insure 100% compliance.	

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F 812	Continued From page 15 came in contact with the rim of the ice machine. Upon further inspection, the surveyor noted that the rim of the ice machine was covered with white and black unknown substances. When interviewed, the DSD stated the tip of the ice scooper should not touch the rim of the ice machine and that he would inform maintenance. 9. In the walk-in refrigerator, the surveyor observed a pan of raw chicken wrapped in plastic stored directly on top of a pan of raw turkey breast wrapped in plastic. When interviewed, the DSD stated the raw chicken breast should not have been stored directly on top of the pan of raw turkey breast. A review of the facility's "Food Storage: Cold Foods" policy, with revision date of 04/2018, revealed that all foods would be arranged in a manner to prevent cross contamination. A review of the facility's "Staff Attire" policy, with revision date of 09/2017, revealed that all staff members would have their hair confined in a hair net or cap. A review of the facility's "Environment" policy, with the revision date of 09/2017, revealed that the DSD would ensure that the kitchen was maintained in a clean and sanitary manner. The policy further revealed that the DSD would ensure that routine cleaning was in place for all cooking equipment, food storage areas, and surfaces. NJAC 8:39-17.2(g)	F 812	Results will be reported quarterly to the Administrator and the Quality Assurance Committee who will make the decision if the process has been resolved and is stable. Completion date will be 11/30/21. 5. All staff, residents and visitors could be affected by this deficient practice. The clear storage bins were cleaned immediately and covered prior to service. All food storage containers were checked for food debris, covered and stored away properly. All dietary staff were reeducated on procedures for proper cleaning of storage containers and storage areas on 10/4/21. The process will be monitored by the Food Service Director/Designee during opening and closing inspections. The monitoring of food storage will be completed during the weekly sanitation inspection by the FSD/District/Regional manager to insure 100% compliance. Results will be reported quarterly to the Administrator and the Quality Assurance Committee who will make the decision if the process has been resolved and is stable. Completion date will be 11/30/21. 6.All staff, residents and visitors could be affected by this deficient practice. The ice scooper and holder were cleaned immediately, however the decision was made to permanently remove the ice machine from the A-Wing nutrition room and place it out of use in storage. 8.All staff, residents and visitors could be affected by this deficient practice. The ice scooper and holder were cleaned	

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F 812	Continued From page 16	F 812	immediately as well as the ice machine. In addition the scooper holder was raised immediately so that it did not touch the rim of the ice machine. To ensure full compliance, all dietary staff were reeducated on the proper cleaning and storage of service ware on 10/4/21. The process will be monitored by the Food Service Director/Designee during opening and closing inspections. The monitoring of food storage will be completed during the weekly sanitation inspection by the FSD/District/Regional manager to insure 100% compliance. Results will be reported quarterly to the Administrator and the Quality Assurance Committee who will make the decision if the process has been resolved and is stable. Completion date will be 11/30/21. 9.All staff, residents and visitors could be affected by this deficient practice. The turkey was thrown away immediately and chicken placed on the bottom shelf. All refrigerators, freezers, and dry storage areas were inspected for proper/secure storage of all food and non-food products. All dietary staff were reeducated on the procedure to properly store food items on 10/4/21. The process will be monitored by the Food Service Director/Designee during opening and closing inspections. The monitoring of food storage will be completed during the weekly sanitation inspection by the FSD/District/Regional manager to insure 100% compliance. Results will be reported quarterly to the	

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F 812	Continued From page 17	F 812	Administrator and the Quality Assurance Committee who will make the decision if the process has been resolved and is stable. Completion date will be 11/30/21.	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for	F 886		11/30/21

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F 886	Continued From page 18 conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that staff were tested for Coronavirus Disease 2019 (COVID-19) at a frequency per facility policy. This deficient practice was identified for 7 of 11 staff members reviewed for testing and was evidenced by the following:	F 886	F886 All staff, residents and visitors could be affected by this deficient practice. Clarification on outbreak testing requirements was communicated to all staff, including staff members RN, RNS, LPN, RT1, MD, RT2,TR via email on 10/7/21. To ensure full compliance, all	

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F 886	Continued From page 19 On 09/22/21 at 8:30 AM, the surveyor met with the Director of Nursing (DON), who stated that the facility was currently in an active COVID-19 outbreak (outbreak) and that there were two staff members that tested positive on [redacted] and [redacted]. The DON stated that staff were being tested weekly and that she based the frequency of the testing on the COVID-19 Activity Level Index (CALI) Weekly Report (a report that provides data on COVID-19 transmission risk by regions). The DON further stated that no residents had tested positive for COVID-19 during the current outbreak. The surveyor requested the facility's testing plan, line listing and the two most recent COVID-19 test results for staff. During an interview with the surveyor on 09/23/21 at 12:15 PM, the Infection Preventionist (IP) stated that all staff, vaccinated and unvaccinated, were tested weekly for COVID-19 and that the test results were tracked using testing logs located in the testing area. The IP stated that during an outbreak, testing could be done by contact tracing or facility-wide testing and confirmed the facility was conducting facility-wide testing. During a telephone interview with the surveyor, in the presence of the DON and IP, on 09/23/21 at 1:45 PM, the Local Health Department representative stated the facility should be testing all residents and staff every three to seven days per the facility's outbreak testing policy. A review of the facility staff 's most recent two COVID-19 test results and work schedule for the seven staff reviewed included the following: 1. A Registered Nurse (RN) tested negative for	F 886	staff, including staff members RN, RNS, LPN, RT1, MD, RT2,TR will be reeducated on the facility policy/procedure for COVID-19 testing by 10/22/21. The process will be monitored by the Director of Quality Safety and Compliance. A random sample of 20 staff members will be conducted weekly for the first month, biweekly for the second month and monthly thereafter. This entails the audit of Covid-19 testing logs to ensure compliance for testing every 3-7 days for vaccinated staff and 2x weekly testing for any unvaccinated staff. Frequency of testing is based on county positivity rates or outbreak testing. This will also include staff returning from vacation, Loa's, and per diem staff to ensure that they are testing on their date of return. These results will be reported quarterly to the Senior Leadership Committee who will make the decision if the process has been resolved and is stable. Completion date will be 11/30/21.	

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F 886	Continued From page 20 COVID-19 on [redacted] and [redacted] 1 (10 days apart). The RN worked on [redacted] without being tested. 2. A Registered Nurse Supervisor (RNS) tested negative for COVID-19 on 09/8/21 and 09/19/21 (11 days apart). The RNS worked on 09/16/21 without being tested. 3. A Licensed Practical Nurse (LPN) tested negative for COVID-19 on 09/07/21 and 09/17/21 (10 days apart). The LPN worked on 9/16/21 without being tested. 4. A Respiratory Therapist (RT #1) tested negative for COVID-19 on 09/7/21 and 09/15/21 (8 days apart). RT #1 worked on 09/14/21 without being tested. 5. A Medical Director (MD) tested negative for COVID-19 on 09/07/21 and 09/17/21 (10 days apart). The MD worked on 09/14/21 without being tested. 6. RT #2 tested negative for COVID-19 on 09/07/21 and 09/17/21 (10 days apart). RT #2 worked on 09/15/21 and 09/16/21 without being tested. 7. A Therapeutic Recreation (TR) staff member tested negative for COVID-19 on 09/07/21 and 09/17/21 (10 days apart). The TR worked on 09/14/21 and 09/16/21 without being tested. A review of the facility's "Voorhees Pediatrics Facility Infection Control Manual: Subject: Covid-19 Testing," revised 09/2021, included that testing of residents and staff would be based on current guidance from the Centers for Medicare &	F 886		

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F 886	Continued From page 21	F 886		

Medicaid Services (CMS), the New Jersey Department of Health (NJDOH), the Occupational Safety and Health Administration (OSHA), and the Centers for Disease Control and Prevention (CDC). The manual also included that all staff and residents that test negative would be retested every three to seven days until no new cases of COVID-19 infections for a period of at least 14 days since the most recent positive result.

A review of the NJDOH guidance titled, "Testing in Response to a Newly Identified COVID-19 Case in Long-term Care Facilities (LTCF)," dated 05/17/2021, included to continue to perform outbreak testing of all residents and healthcare professionals every three to seven days regardless of vaccination status until 14 days have elapsed since the most recent positive.

A review of the CDC guidance titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes," dated 09/10/21, included that if additional cases were identified, testing should continue facility-wide every three to seven days until there are no new cases identified for 14 days.

NJAC 8:39-5.1(a); 19.1(a)