STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315219	A. BUILDING **01** B. WING _____	**09/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	**3001 EVESHAM ROAD** **VOORHEES, NJ 08043**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/26/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/26/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Voorhees is a one-story building that was built in 1985. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does approximately 100 % of the building as per the Administrator. The current occupied beds are 145 of 190.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		10/28/23

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

Electronically Signed | 10/20/2023

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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K 222	Continued From page 1 Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be	K 222		

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COMPLETE CARE AT VOORHEES, LLC	**3001 EVESHAM ROAD** **VOORHEES, NJ 08043**

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K 222	Continued From page 2 permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit doors were equipped with a readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that read as follows PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS and located on the door leaf adjacent to the release device in the direction of egress in accordance with NFPA 101 (2012 edition) Life Safety Code, section 7.2.1.6.1.(4). This deficient practice had the potential to affect 11 residents. Findings include: An observation on 09/26/23 at 1:23 PM revealed the exit door, located in Unit Five and adjacent to Room 508, was a 15-second delay egress door and did not have a sign that read PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. During an interview at the time of the observation, the Maintenance Director confirmed the 15-second delay egress door did not have the required signage. He stated when the unit was	K 222	Residents affected by deficient practice: The facility failed to ensure exit doors were equipped with a readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in.(3.2 mm) in stroke width on a contrasting background that read as follows PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS and located on the door leaf adjacent to the release device in the direction of egress in accordance with NFPA 101 (2012edition) Life Safety Code, section 7.2.1.6.1.(4). Identify those individuals who could be affected by the deficient practice: 11 residents had the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: 9/26/2023 □ remaining delayed egress doors throughout the facility were inspected and found to have appropriate signage.	

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K 222	Continued From page 3 renovated and painted, the signage had been removed. NJAC 8:39-31.1(c), 31.2(e)	K 222	9/26/2023 - the delayed egress Exit door by resident room 508-509 was re-equipped with a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that read as follows PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS and located on the door leaf adjacent to the release device in the direction of egress in accordance with NFPA 101 (2012 editions) Life Safety Code, section 7.2.1.6.1(4). 9/29/2023 – Education provided to the Maintenance Department regarding the requirements to ensure all delayed egress exit doors in the means of egress are readily accessible and free of all obstructions to full instant use in case of fire or emergencies and to ensure that all delayed egress exit doors are properly functioning, with appropriate signage, as intended Measures or systemic changes to ensure that the deficiencies will not recur: Maintenance Director/designee to conduct delayed egress door sign inspection audit. The duration of all audits will consist of completion one-time weekly x 4 weeks then two times monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	315219	A. BUILDING **01** B. WING _____	**09/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 4	K 353		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure sprinklers that had signs of leakage; was painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or was in the improper orientation were replaced. This deficient practice had the potential to affect 11 residents. Findings include: An observation on 09/26/23 at 1:09 PM revealed the fusible link for the sprinkler head, located in Unit Five and adjacent to Therapy, was covered with a white substance.	K 353	Residents affected by deficient practice: The facility failed to ensure sprinklers that had signs of leakage; was painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or was in the improper orientation were replaced. Identify those individuals who could be affected by the deficient practice: 11 residents had the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice:	10/28/23

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K 353	Continued From page 5 An observation on 09/26/23 at 1:15 PM revealed the fusible link for the sprinkler head, located in Unit Five Mechanical Room, was covered with a black substance. During an interview at the time of the observations, the Maintenance Director confirmed the fusible links for the sprinkler heads were covered with a white substance and a black substance. He stated it was dust and/or soot on the fusible links. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	All facility sprinkler heads were immediately checked to ensure all fusible links were free of any soot, dust, or other substances. Maintenance Director was re-educated on the requirements that all sprinklers need not have signs of leakage, be painted, other than by the sprinkler manufacturer, be corroded, damaged, or loaded; or be in the proper orientation, and if identified, be replaced accordingly, in accordance with the NFPA guidelines. 9/29/2023 □ Maintenance Director removed the soot/black substance from the fusible link for the sprinkler head located in the Unit 5 Mechanical Room. This sprinkler head was inspected by Licensed Vendor, post cleaning, and was deemed operable and not needed to be changed. 10/4/2023 □ Licensed Vendor replaced the sprinkler head on Unit 5, adjacent to Therapy Gym. Measures or systemic changes to ensure that the deficiencies will not recur: Maintenance Director/designee to conduct sprinkler head inspection audits, facility wide. The duration of all audits will consist of completion one-time weekly x 4 weeks then two times monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure fire extinguishers were not obstructed from view and were provided with means to indicate the extinguishers' location. This deficient practice had the potential to affect 145 residents. Findings include: An observation on 09/26/23 at 1:03 PM revealed the fire extinguisher, located in Unit 5 and adjacent to Therapy, was in a recessed cabinet. The fire extinguisher was obstructed from view from the hallway and did not have a means to indicate the extinguisher's location. An observation on 09/26/23 at 1:43 PM revealed the fire extinguisher, located in Lobby, was in a recessed cabinet. The fire extinguisher was obstructed from view and did not have a means to indicate the extinguisher's location. During an interview at the time of the observations, the Maintenance Director confirmed the fire extinguishers needed signage to indicate their locations. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	Residents affected by deficient practice: The facility failed to ensure fire extinguishers were not obstructed from view and were provided with means to indicate the extinguishers' location. Identify those individuals who could be affected by the deficient practice: 145 residents had the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: 9/26/2023 □ Proper signage was re-installed above the cabinet where the fire extinguisher on Unit 5, and adjacent to the Therapy Gym, is located. 9/26/2023 □ Proper signage was re-installed above the cabinet where the fire extinguisher in the front lobby is located. 9/29/2023 – Education provided to the Maintenance Department regarding the requirements to ensure all fire extinguishers are maintained in accordance with NFPA 10, including proper signage with location, especially after signage has been removed during	10/28/23

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K 355	Continued From page 7	K 355	times of paint touch-up. Measures or systemic changes to ensure that the deficiencies will not recur: Maintenance Director/designee to conduct audit to ensure signage is above fire extinguisher locations with obstructed views, facility wide. The duration of all audits will consist of completion one-time weekly x 4 weeks then two times monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315219	A. Building 01 - MAIN BUILDING 01 B. Wing	11/9/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 10/28/2023	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 10/28/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 10/28/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO