NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE YOORHEES CARE & REHABILITATION CENTER, THE TAGE OPROVIDER OR SUPPLIER TAGE OPROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH OREFICENCY MUST BE PRECEDED BY PULL REGULATORY OR USCI DENTIFYING INFORMATION) PROVIDER SPLAN OF CORRECTION (EACH OREFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR USCI DENTIFYING INFORMATION) F 000 INITIAL COMMENTS F 000 COMPLAINT#: NJ115081, NJ115142, NJ117798, NJ126519, NJ126468 CENSUS: 181 SAMPLE SIZE: 6 F 000 Reporting of Alleged Violations involving abuse, neglect, exploitation or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or resident property, are reported immediately, but not later than 2 hours after the allegation involve abuse or result in serious bodily injury, or not later than 2 hours after the allegation involve Abuse or result in serious bodily injury, or not later than 2 hours after the allegation involve Abuse or result in serious bodily injury, or not later than 2 hours after the allegation do not involve abuse and do not result in serious bodily injury, to the administrator or the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures	TE SURVEY MPLETED		CONSTRUCTION	· /	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OF DEFICIENCIES CORRECTION		
NAME OF PROVIDER OR SUPPLIER THEET ADDRESS. CITY. STATE. ZIP CODE 1302 LAUREL OAK ROAD 1302 LAUREL OAK ROAD VOORHEES CARE & REHABILITATION CENTER, THE THEET ADDRESS. CITY. STATE. ZIP CODE 1302 LAUREL OAK ROAD 1302 LAUREL OAK ROAD VOORHEES, NJ 08043 PROVIDER, NJ 08043 VORTES, NJ 08043 PROVIDER, NJ 08043	C 8/02/2019	01			315187			
VOORHEES CARE & REHABILITATION CENTER, THE VOORHEES, NJ 88043 (%1)0 PREFIX TAG Is SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID PREFIX TAG PROVIDENTS (EACH ORRECTION PRECIX TAG PROVIDENTS (EACH ORRECTION PRECIX TAG ID PREFIX TAG PROVIDENTS (EACH ORRECTION PRECIX TAG PROVIDENTS (EACH ORRECTION (EACH ORRE	0/02/2013		TREET ADDRESS, CITY, STATE, ZIP CODE	s		ROVIDER OR SUPPLIER	NAME OF PR	
Predirix TxG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) PRETX TxG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 COMPLAINT#: NJ115081, NJ115142, NJ117798, NJ126319, NJ126468 F 000 CENSUS: 181 SAMPLE SIZE: 6 F 609 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, the facility must: F 609 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation of mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 24 hours if the events that cause the allegation involve abuse and do not result in serious bodily injury, o the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or this or her designated representative and to other officials in					TION CENTER, THE	S CARE & REHABILITAT	VOORHEE	
COMPLAINT#: NJ115081, NJ115142, NJ117798, NJ126319, NJ126468 CENSUS: 181 SAMPLE SIZE: 6 Reporting of Alleged Violations SS=D CFR(s): 483.12(c)(1)(4) §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	(X5) COMPLETIO DATE	FION SHOULD BE THE APPROPRIATE	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	PREFIX	
NJ126319, NJ126468 CENSUS: 181 SAMPLE SIZE: 6 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation is not on to involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in				F 000		INITIAL COMMENTS	F 000	
SAMPLE SIZE: 6 F 609 Reporting of Alleged Violations F 609 SS=D CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: \$483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in								
F 609 SS=DReporting of Alleged Violations CFR(s): 483.12(c)(1)(4)F 609§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:F 609§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in						CENSUS: 181		
neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	10/2/19			F 609		Reporting of Alleged \		
involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in						neglect, exploitation, o		
investigations to the administrator or his or her designated representative and to other officials in					ect, exploitation or ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides -term care facilities) in	involving abuse, negle mistreatment, includin source and misapprop are reported immediat hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not resu the administrator of th officials (including to t adult protective servic for jurisdiction in long- accordance with State		
Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.					administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the eged violation is verified	investigations to the a designated representa accordance with State Survey Agency, within incident, and if the alle		

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.

	-	D HUMAN SERVICES				FORM	APPROVED		
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTI			(X3) DATE	0. 0938-0391		
	CORRECTION	IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			LETED		
			A. DOILDIN				c		
		315187	B. WING				02/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00,	02/2010		
				1302 LA	UREL OAK ROAD				
VOORHEE	S CARE & REHABILITA	FION CENTER, THE		VOORHEES, NJ 08043					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX			PREFIX	< l	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DEFICIENCY)	AIE			
F 609	Continued From page	1	F 60	00					
		is not met as evidenced	1.00	.03					
	by:	is not met as evidenced							
	C#: NJ115142			F60	09 Reporting of Alleged Violations				
		Medical Record (MR)			Resident #1 is no longer in the fac	-			
		other pertinent facility			incident was reported to NJDOH o	on			
		, it was determined that the)2/19 at 2:50 PM.				
	to the New Jersey De	an Injury of Unknown origin			Any resident with an injury of nown origin was at risk to be affect	be			
		follow the facility's own			he deficient practice. An audit was	eu			
	policy titled "Abuse, N	-			e of incidents within the past 3 mor	nths			
		sappropriation of Resident			lentify if any injuries of unknown or				
		ampled residents (Resident			e not reported. None were identifie				
		y of unknown origin. This			All Nurses and Nursing Superviso	rs			
	deficient practice was	evidenced by the following:			be re-educated on policy Abuse,	1			
					lect, Exploitation, Mistreatment, ar appropriation of Resident property,				
	1 According to Resid	dent #1's "Admission Record			e focus on the investigation and				
		as admitted to the facility on			orting of injuries of unknown origin	to			
		es which included but were			DOH.				
	not limited to:				DON or designee will perform an a	audit			
					ne shift reports and incident and				
					dent reports for 90 days to identify	any			
					ries of unknown origin that require the chart investigation and reporting to				
	According to Residen	t #1's Minimum Data Set		DOI					
	(MDS), an assessme				injury of unknown origin identified	will			
		ief Interview for Mental		-	nvestigated and reported immediat				
	Status (BIMS) score of	, which indicated the		to th	ne DOH.	-			
	Resident was	impaired. The			esults of the audits will be reported	l to			
		nat Resident #1 required		the	QAPI committee.				
	assistance with Activi	ties of Daily Living (ADLs).							
	Review of Resident #	1's Incident/Accident Report							
		:45 p.m., showed Resident							
	· · /	palance, which caused the							
	Resident to fall on the								
		revealed Resident #1							
	denied at the tim	e of the fall.							

If continuation sheet Page 2 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	
		315187	B. WING				C 102/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
VOORHEI	ES CARE & REHABILITA	TION CENTER, THE			1302 LAUREL OAK ROAD VOORHEES, NJ 08043		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page	2	F	609			
	Review of Resident # showed that the Resident # head on the floor. In a that Resident #1 was able with weakness on and Review of Resident # included the following is at high risk for falls safety needs Unde free of fall related inju- date. Under Interven the resident's needs Review of Resident # dated at 9:28 p 4:45 p.m., Resident # showed that the Resident #1 was to name with forgetfulness." The P Resident #1 was able with weakness on and Review of Resident # a.m., revealed "no co discomfort." The PN a #1 had no injury r/t fa Review of Resident # p.m., revealed that Re ito the	: Under Focus: The resident related to (r/t) unaware of r Goal: The resident will be wries through the review tions: "Anticipate and meet " 1's "Progress Notes (PN)" o.m., revealed that around 1 had a fall. The PN also dent denied hitting his/her addition, the PN revealed (and h periods of confusion and PN further revealed that to move all (and (and (and (and (and (and (and (and					

If continuation sheet Page 3 of 24

		ID HUMAN SERVICES				FORM	D: 03/26/2020
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		COMPLETED		
		315187	B. WING				02/2019
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
VOORHEE	S CARE & REHABILITA	TION CENTER, THE			1302 LAUREL OAK ROAD VOORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Resident was Review of Resident # 11:33 p.m., revealed and ordered to send I to rule out Review of Resident # (UTF) dated "reason for transfer" v reason for transfer" v Review of Resident # 11:18 p.m., revealed to the facility from the due to Review of Resident # documentation that the injury to the Review of Resident # documentation that the injury to the During an interview w (DON), who was new 2:46 p.m., the DON s injury of unknown orig also stated if a reside was seen and after a	with dressing. 1's PN dated at 11:02 ent #1 had from he PN also showed that the more swollen than the right. 1's PN dated at the hospital that the NP saw Resident #1 Resident #1 to the hospital). 1's Universal Transfer Form at 9:45 p.m., showed the was from and the right. 1's PN dated at the he Resident was readmitted hospital with from at the p the diagnosis of from at the set of the diagnosis of from at the hospital with from at the diagnosis of from at the hospital with from at the diagnosis of	F	609			
	injury of unknown orig also stated if a reside was seen and after a	gin to the NJDOH. The DON nt has a fall and no injury					

Facility ID: 60408

If continuation sheet Page 4 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		315187	B. WING				02/2019	
NAME OF P	ROVIDER OR SUPPLIER	L	I	:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
VOORHE	ES CARE & REHABILITA	TION CENTER, THE			1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ЗE	(X5) COMPLETION DATE	
F 609	and reported to the N indicated that he/she was reported to NJDC completed. During a post survey 8/5/19 at 2:31 p.m., th was not repo DON concluded the previous fall. In addit was no documentatio of the following Under g. Injuries of U should be classified a source when both of the met: i. The source of the ir any person or the sou be explained by the r ii. The injury is suspic of the injury or the loc injury is located in an trauma) or the number particular point in time over time. G. Reporting and Res Reporting, Initial repor incident or allegation Administrator or desig (immediate or within 2 Agency. A follow up in	JDOH. In addition, the DON was unaware if the DH or if an investigation was interview with the DON on he DON indicated the rted because the previous was from the ion, the DON indicated there n showing the investigation s policy titled "Abuse, t, and Misappropriation of 19, included but was not g: nknown Origin: An injury as an injury of unknown the following conditions are hjury was not observed by urce of the injury could not esident. ious because of the extent cation of the injury (e.g., the area not vulnerable to er of injuries observed at one e or the incidence of injuries sponse: Under External rrting of allegation: If an is considered reportable, the gnee will make an initial 24 hours) report to the State nvestigation will be	F	60\$				
	-	ency within five (5) working esults of all investigations to is or her designated						

Facility ID: 60408

If continuation sheet Page 5 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/26/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		315187	B. WING		08/02/2019
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
VOORHEE	S CARE & REHABILITA	TION CENTER, THE		02 LAUREL OAK ROAD OORHEES, NJ 08043	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 609	with State law, includ reporting to the State	other officials in accordance ing immediate or 24 hour Agency, law enforcement ort to the State Agency,	F 609		
F 610 SS=D	CFR(s): 483.12(c)(2) §483.12(c) In response	Correct Alleged Violation	F 610		10/2/19
	§483.12(c)(2) Have e violations are thoroug	evidence that all alleged ghly investigated.			
		t further potential abuse, or mistreatment while the gress.			
	designated represent accordance with Stat Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her rative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken.			
	C#: NJ115142 Based on interviews, review, and review of	Medical Record (MR) other pertinent facility , it was determined that the		 F610 Investigate/Prevent/Correct Alleg Violation 1. Resident #1 is no longer in the fac 2. All residents having an incident/accident/or injury of unknown origin are at risk for this deficient practic 	lity

Event ID: MY2311

Facility ID: 60408

If continuation sheet Page 6 of 24

CENTER STATEMENT	MENT OF HEALTH AN S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ΓIPLE	CONSTRUCTION		FORN OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG				LETED
		315187	B. WING				(08/	C 02/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
VOORHEI	ES CARE & REHABILITAT	TION CENTER, THE			302 LAUREL OAK ROAD OORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 610	Unknown origin, as w own policy titled "Abus Mistreatment, and Mis Property," for 1 of 6 sa #1), reviewed for injur deficient practice was 1. According to Resident w Mos anot limited to: According to Resident w Mos an assessmer Resident #1 had a Bri Status (BIMS) score of Resident was MDS also indicated th assistance with Activit Review of Resident # Mos also indicated the resident is at risk for f needs Under Goal: fall related injuries thr Under Interventions: " resident's needs"	ghly investigate an Injury of ell as follow the facility's se, Neglect, Exploitation, sappropriation of Resident ampled residents (Resident y of unknown origin. This evidenced by the following: dent #1's "Admission Record as admitted to the facility on es which included but were that tool dated 1 of 1 , which indicated the impaired. The nat Resident #1 required ties of Daily Living (ADLs). 1's Care Plan (CP) updated following: Under Focus: The alls, unaware of safety The Resident will be free of ough the review date. Anticipate and meet the 1 's Incident/Accident Report tion a.m., revealed that d lying on the right side next	F	610	A review of incident and accider from the prior 3 months were re ensure that thorough investigati completed. 3. All nurses and Supervisors re-educated on the policy Abuse Exploitation, Mistreatment, and Misappropriation of Resident pro focus on investigating all injuries injuries of unknown origin, that w un-witnessed and cannot be exp the resident, are suspicious due location, potential for possible a DON or designee are to be contain any injury of unknown origin. 4. DON or designee will audit report and incident and accident for 90 days to ensure that all inju- thoroughly investigated to identit Any injury of unknown origin wit causal factor identified will be re- the DOH. The results of this audit will be re- the QAPI committee monthly.	viewed ons were e, Negle operty v s and were plained to buse. T tacted for the shift t reports uries ar fy caus h no eported	to re ect, with by The or ft s e e. to	

Facility ID: 60408

If continuation sheet Page 7 of 24

					FORM	03/26/2020 APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			SURVEY
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING			
	315187	B. WING				02/2019
ROVIDER OR SUPPLIER						
ES CARE & REHABILITA	TION CENTER, THE					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE
Continued From page	97	F	610			
Review of Resident # (IR) dated at 4 Resident #1 stood up caused the Resident on the "left side lying showed that Resident at 9:28 p 4:45 p.m., Resident # dated at 9:28 p 4:45 p.m., Resident # showed that the Resident hitting his/her and PN revealed that Resident) to confusion and forgetfin revealed that Resident with and Review of Resident # a.m., revealed "no co and the PN a #1 had no injury r/t fa Review of Resident # p.m., revealed that Resident (c/o) motion. The PN also had and Review of Resident # p.m., revealed that Resident p.m., revealed that Resident and and and and and and and and and and	1's Incident/Accident Report :45 p.m. revealed that and lost balance, which to fall on the floor and land position." The IR also t #1 					
F	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ES CARE & REHABILITAT SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page Review of Resident # (IR) dated at 4 Resident #1 stood up caused the Resident on the "left side lying showed that Resident Review of Resident # dated at 9:28 p 4:45 p.m., Resident # confusion and forgetf revealed that Resident with a.m., revealed that Resident with a.m., revealed that Resident # 1 had no injury r/t fa Review of Resident # p.m., revealed that Resident # 1 had no injury r/t fa Review of Resident # p.m., revealed Resident # p.m., rev	CORRECTION IDENTIFICATION NUMBER: 315187 ROVIDER OR SUPPLIER S CARE & REHABILITATION CENTER, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 Review of Resident #1's Incident/Accident Report (IR) dated at 4:45 p.m. revealed that Resident #1 stood up and lost balance, which caused the Resident to fall on the floor and land on the "left side lying position." The IR also showed that Resident #1 Review of Resident #1's "Progress Notes (PN)" dated at 9:28 p.m., revealed that around 4:45 p.m., Resident #1 had a fall. The PN also showed that the Resident #1 mad fall. The PN also showed that the Resident #1 was #************************************	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 315187 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG Continued From page 7 F Review of Resident #1's Incident/Accident Report (IR) dated at 4:45 p.m. revealed that Resident #1 stood up and lost balance, which caused the Resident to fall on the floor and land on the "left side lying position." The IR also showed that Resident #1 Review of Resident #1's "Progress Notes (PN)" dated at 9:28 p.m., revealed that around 4:45 p.m., Resident #1 was able to move all mitting his/her for the floor. In addition, the PN revealed that Resident #1 was able to move all mitting his/her for the floor. In addition, the PN revealed that Resident #1 was able to move all mitting his/her for on the floor at 2:38 a.m., revealed that Resident #1 was able to move all mitting his/her for complaints of for confusion and forgetfulness." The PN further revealed that Resident #1's PN dated at 2:38 a.m., revealed that Resident #1 complained of (c/o) The PN also showed that Resident #1 had for the prove of the resident #1 son data at 2:53 p.m., revealed that Resident #1 son data for motion. The PN also showed that Resident #1 had for the prove of the resident #1 son data for motion. The PN also showed that Resident #1 had for the prove of the resident #1 had for mitting. Review of Resident #1's PN dated for (c/o) with passive range of motion. The PN also showed that the Review of Resident #1's PN dated for (c/o) with passive range of motion. The PN als	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING 315187 B. WING ROVIDER OR SUPPLIER 315187 ES CARE & REHABILITATION CENTER, THE 1 SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY WIST EE PRECEDED BY FULL (REACH DEFICIENCY WIST EE PRECEDED BY FULL (REACH DEFICIENCY WIST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 7 F 610 Review of Resident #1's Incident/Accident Report (IR) dated at 4:45 p.m. revealed that Resident #1 stood up and lost balance, which caused the Resident to fall on the floor and land on the "left side lying position." The IR also showed that Resident #1 Review of Resident #1's "Progress Notes (PN)" dated at 2:28 p.m., revealed that around 4:45 p.m., Resident #1 was able to move all (N) to name with periods of confusion and forgeffulness." The PN further revealed that Resident #1 was able to move all (N) to name with periods of confusion and forgeffulness." The PN further revealed that Resident #1 so showed that Resident #1 had no injury r/t falls. Review of Resident #1's PN dated at 2:38 a.m., revealed that Resident #1 complained of (c/o) (C/o) (With passive range of motion. The PN also showed that Resident #1 had () area to (with dressing. Review of Resident #1's PN dated () (at 11:02 p.m., revealed Resident #1 had () (with dressing. Review of Resident #1's PN dated () (c/o) () () () () () () () () () () () () ()	MENT OF HEALTH AND HUMAN SERVICES SFOR MEDICARE & MEDICALO SERVICES STREETADORESS.CITY.STATE.2P.CODE 315187 B. WING SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH OPENCIENCY MUTHER THE SUMMARY STATEMENT OF DEFICIENCIES (EACH OPENCIENCY MUTHER) CROSS-REFERENCE DIP VILL REGULATORY OR LSC DENTIFYING INFORMATION Continued From page 7 Continued From page 7 Continued From page 7 Review of Resident #1's Incident/Accident Report (IR) dated at 4.45 p.m. revealed that Resident #1 stood up and lost balance, which caused the Resident #1 ad fail. The PN also showed that Resident #1 mad fail. The PN also showed that Resident #1 ad fail. The PN also showed that Resident #1 mad fail. The PN also showed that Resident #1 was approximately. Review of Resident #1 SPN dated for or Hitting his/her for on the floor. In addition, the PN revealed that Resident #1 was approximately. Review of Resident #1 SPN dated for or Hitting his/her for on the floor. In addition, the PN revealed that Resident #1 was approximately. Review of Resident #1 SPN dated for or Hitting his/her for on the floor. In addition, the PN revealed that Resident #1 was approximately. Review of Resident #1 SPN dated for or Hitting his/her for on the floor. In addition, the PN revealed that Resident #1 was approximately. Review of Resident #1 SPN dated for or Hitting his/her for on the floor. In addition, the PN revealed that Resident #1 was approximately. Review of Resident #1 SPN dated for or Hitting his/her for onceptained of (comment #1 SPN dated for or Hitting his/her for onceptained of (comment #1 SPN dated for or Hitting his/her for onceptained of (comment #1 SPN dated for or HIT for No higher for onceptained of (comment #1 SPN dated for or HIT for No higher for onceptained for (comment #1 SPN dated for or HIT for No higher for onceptained for (comment #1 SPN dated for or HIT for No higher for onceptai	MENT OF HEALTH AND HUMAN SERVICES OMB NC SFOR MEDICARE & MEDICALD SERVICES OMB NC PERCIPACE & MEDICALD SERVICES OMB NC PERCIPACE & MEDICALD SERVICES OMB NC PERCIPACE & MEDICALD SERVICES OMB NC BUILDING 315187 B. WING STREET ADDRESS, CITV, STATE, 2P CODE 132 LAUREL CAX ROAD VOORHEES, NJ 08043 CORRECTION SUMMARY STATEMENT OF DEFICIENCES REACH DEFICIENCY WAST BE PRECEDED BY FULL RECHLARCHY OR LSC IDENTIFYING INFORMATION) Continued From page 7 Review of Resident #1's Incident/Accident Report (IR) dated at 4:45 p.m. revealed that Resident #1 stood up and lost balance, which caused the Resident #1's "Progress Notes (PN)" dated at 4:45 p.m., revealed that around 4:45 p.m., revealed that Resident #1 was able to move at with dimension 1 the floor, in addition, the PN revealed that Resident #1 was able to move at with dimension 1 the floor, in addition, the PN revealed that Resident #1 was able to move at with and company is able to move at with and company is able to move at with and company is able to move at with and that Resident #1 had motion. The PN also showed that Resident #1 had on injury it fails. Review of Resident #1 s PN dated at 2:53 p.m., revealed that Resident #1 had motion. The PN also showed that Resident #1 had company is and company is an of company is and company is an of company is an of company is an of company is anot company is an of company is

Event ID: MY2311

If continuation sheet Page 8 of 24

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		315187	B. WING			C 08/02/2019		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
VOORHEI	ES CARE & REHABILITA	TION CENTER, THE			I302 LAUREL OAK ROAD /OORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORREC (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APP DEFICIENCY) DEFICIENCY)					(X5) COMPLETION DATE	
F 610	Review of Resident # 11:33 p.m., revealed to 1 and ordered to send hospital to rule out). Review of Resident # (UTF) dated	1's PN dated at the NP saw Resident # d the Resident to the (a), (b), (c), (c), (c), (c), (c), (c), (c), (c	F	610				

If continuation sheet Page 9 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315187	B. WING				C 02/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
VOORHE	ES CARE & REHABILITA	TION CENTER, THE			1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
F 610	8/2/19 at 4:06 p.m., the believed the fail. In addition, the D could have had fail. In addition, the D could have had failed for the fail. In addition, the DON indicate concluded the failed failed for the failed failed for the facility's Neglect, Mistreatmen Property," dated 5/20 limited to the following Under g. Injuries of U should be classified a source when both of the met: i. The source of the in any person or the sou be explained by the re ii. The injury is suspice of the injury or the loce injury is located in an trauma) or the number particular point in time over time. Under E. Investigation of Injury of Unknown Injuries: must be imm out abuse: i. injuries in bruising of the inner the breast, bruises of an the	the DON stated that he/she boccurred from the previous iON stated the resident and had interview on 8/5/19 at 2:31 ed the previous DON was from the previous fall. ndicated there was no ing the investigation for the s policy titled "Abuse, t, and Misappropriation of 19, included but was not g: nknown Origin: An injury s an injury of unknown he following conditions are jury was not observed by wrce of the injury could not esident. ious because of the extent ation of the injury (e.g., the area not vulnerable to er of injuries observed at one e or the incidence of injuries an Procedure b. Investigation Origin or Suspicious ediately investigated to rule include, but not limited to, nigh, chest, face, and unusual size, multiple and/or bruising an area not	F	610				

If continuation sheet Page 10 of 24

		MEDICAID SERVICES			OMB NO. 0938-03		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315187	B. WING		C 08/02/2019		
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
VOORHE	ES CARE & REHABILITA	TION CENTER, THE		1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIC		
F 610	Continued From page	e 10	F 610				
F 800 SS=B	N.J.A.C: 8:39-13.4(c) Provided Diet Meets CFR(s): 483.60	2i-vi Needs of Each Resident	F 800		10/2/19		
	nourishing, palatable, meets his or her daily dietary needs, taking preferences of each r	ide each resident with a well-balanced diet that nutritional and special into consideration the		F800 Provided Diet Meets Needs of E Resident 1. Resident #2 no longer resides in			
	review, and review of documents on 8/2/19 facility failed to provic Resident's personal p the facility's own polic Management," for 1 c (Resident #2) reviewe	Medical Record (MR) other pertinent facility , it was determined that the le meals which met the preference, as well as follow cy titled "Food and Nutrition of 6 sampled residents ed for dietary preference. e was evidenced by the		 Resident #2 no longer resides in facility All Residents in the facility have t potential to be affected by the deficien practice. Registered dietitian will revie current Residents diet slips and diet o to ensure accuracy. Registered dietitians, Food Servi Director, Administrator, DON met to review, update and discussed the poli on food preferences. All Nursing will b re-educated on the food preferences policy. Nursing and dietitian staff will b 	he it w all rder ices cy ie		
	(AR)," the Resident w	t #2's "Admission Record, vas admitted to the facility on s which included but were		 educated on the updated policies and providing patient preferences. 4. Registered Dietitians will review a diet orders and food preferences upor admission/readmission and as needed update diet and preferences. Registe Dietitian will audit 10 Residents weekl 90 days to ensure correct diet orders, 	are all d to red y x		

Event ID: MY2311

Facility ID: 60408

If continuation sheet Page 11 of 24

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315187	B. WING				C 02/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
VOORHE	ES CARE & REHABILITA	TION CENTER, THE			302 LAUREL OAK ROAD /OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 800	According to Residen (MDS), an assessme Resident #2 had a Br Status (BIMS) score of Resident was cognitive indicated that Reside with Activities of Daily Review of Resident # 	t #2's Minimum Data Set Int tool dated, ief Interview for Mental of, which indicated the vely The MDS also Int #2 required assistance ' Living (ADLs). 2's Care Plan (CP) created oblowing: Under Focus: The The resident will consume meals without signs and difficulty 'Provide diet as ordered" heals, offer alternate choices food preferences/ update 2's Hospital Records dated oblowing: Under Hospital s: Diet: "You may return to Inder Daily Care Plan: Diet: " Under New Admission No Added Salt n Liquids. 2's Order Summary Report cumentation that the d a diet during	F	800	during QAPI		

Facility ID: 60408

If continuation sheet Page 12 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF		
		315187	B. WING				02/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
VOORHEI	ES CARE & REHABILITA	TION CENTER, THE			1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 800	family/relative contact encouragement" Review of Resident # documentation that R diet. During an interview w (DS) on 8/2/19 at 1:24 a Resident is on a spo on the Resident's diet dietary staff would no it is not written on the During an interview w (RD) on 8/2/19 at 1:33 a Resident is on a the Resident and ask mean" The RD als is now individualized. "if a resident is a on the diet slip for die Resident is a did not write the order and did no Review of the Facility Preference Policy" da was not limited to the the policy of this facili preferences to reside restrictions as ordered (MD)." Under procedu reviewed with the res member, if the reside Food preferences are Service Director Re	ted by nursing for 2's MR showed no esident #2 was on a with the Dietary Supervisor 5 p.m., the DS stated when ecial diet, it is usually written t slip. The DS further stated t know the Resident's diet if diet slip. with the Registered Dietician 5 p.m., the RD stated, "when diet, I always go to what they specifically to indicated, differentiated it would be written tary staff to know the " The RD stated he/she r that Resident #2 is a ot write it on the diet slip. 's policy titled "Food ted 11/2018 included but following: Under policy: "It is ty to provide food nts within their dietary d by the Medical Doctor ure: Food preferences are ident by a qualified staff nt is able to participate. e communicated to the Food esidents can change their desired based on verbal and	F	800				

Facility ID: 60408

If continuation sheet Page 13 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/26/20 FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		315187	B. WING		08/02/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	•		
VOORHEI	ES CARE & REHABILITA	TION CENTER, THE		1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLETIO TO THE APPROPRIATE DATE IENCY)		
F 800	and the MD, the Resi	dent would like food not recommended by the RD dent will be educated by the penefits of maintaining an	F	800			
F 835 SS=F	CFR(s): 483.70 §483.70 Administratic A facility must be adm	on. ninistered in a manner that esources effectively and	F	835	10/2/19		
	practicable physical, r well-being of each res This REQUIREMENT by: Based on observation facility provided docur 7/26/2019, and 8/02/1 the Administrator faile replace and/or repair Conditioning (PTAC) units located in variou Shower/Tub rooms ar rooms, as well ensure "Heat Emergency Res This failure to have a	mental, and psychosocial sident. is not met as evidenced n, interviews and review of mentation on 7/16/2019 and 19, it was determined that ed to implement a plan to Packaged Thermal Air units for 79 of 195 PTAC us Resident rooms, nd common Activity/ Dining that the facility's policy for sponse" was implemented. plan in place resulted with cuated on 7/21/2019, due to deficient practice is owing:		F-835 Administration. "What corrective ac accomplished for those by the deficient practice A shipment of the corre has been delivered to th been installed. "How the facility will residents having the po affected by the same de and what corrective act All residents are at risk by the deficient practice The director of mainten log of all areas in the fa replacement PTACH un	e residents affected e ct PTACH units he facility and has I identify other otential to be eficient practice ion will be taken of being affected e. ance has taken a ucility that need a		

Event ID: MY2311

Facility ID: 60408

If continuation sheet Page 14 of 24

		ID HUMAN SERVICES				FOF	ED: 03/26/2020 RM APPROVED 0. 0938-0391	
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315187	B. WING			08	C B/ 02/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1		
				130	02 LAUREL OAK ROAD			
VOORHEE	S CARE & REHABILITA	TION CENTER, THE		VC	DORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 835	Continued From page	e 14	F 8	35				
	During a tour of the fa a.m., with the Facility	acility on 7/16/19 at 9:24 Maintenance Worker observed 24 New PTAC stored			orders have been placed to replace th units. All rooms without a working PTA unit has a temporary AC unit. All temporary units were inspected for pro- function and setup.	ACH		
	At 9:27 a.m. the Adm surveyor in the baser PTACs were the wror asked the Admin., "H units been here and o the purchase order for getting the correct PT stated; that he had or weeks and that the un approximately May 20 give a date as to whe be at the facility. The units in the basement could not be used as Resident rooms. According to Adminis 11:15 a.m. a visitor ca excessive heat in the Department and Loca arrived. At 1:40 p.m., to excessive heat in t need to be evacuated On 7/26/2019 at 10:2	inistrator (Admin.) met the nent and stated that the ng units. The surveyor then ow long have these PTAC could you provide a copy of or them. When are you "AC units." The Admin. hly been Administrator for 3 nits had been there since 019. The Admin could not en the correct PTAC units will Admin. confirmed the PTAC t were the wrong type and replacements in the tration, on 7/21/2019 at alled the local police due to building. The Fire al Department of Health it was determined that due he building, the Residents d to a local High School. 4 a.m., the surveyor made a			" What measures will be put in place what systemic changes will you make ensure that the deficient practice does not recur; A preventative maintenance schedule the PTACH units is in place to ensure proper functionality of the units. All temporary units will be inspected wee to ensure proper placement and functionality. A maintenance book is located at eac nurse□s station where an issue with t PTACH unit can be logged. Nursing s will be educated on proper documents of malfunctioning PTACH units. Administrator or designee will educate maintenance staff on the deficient pra and ensure proper maintenance of PTACH units. GE HVAC company is i contract with the facility to ensure prop maintenance of the Roof Top Units (R The facility'□s policy for Heat Emerge Response has been reviewed, and updated to maintain resident safety ar remain in compliance.	to for kly h taff ation ctice n cer TU). ncy		
	request to the Admin - 1. A copy of the P that had occurred on building had to be eva - 2. A Work acknow	to provide; olice report for the incident 7/21/2019, where the			" How the corrective actions(s) will monitored to ensure deficient practice not recur, i.e. what quality assurance program will b put into practice. The date for correcti	will e		

Facility ID: 60408

If continuation sheet Page 15 of 24

	S FOR MEDICARE &					NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		TE SURVEY
		315187	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		08/02/2019
	NOVIDEIN ON SUIT LIEN			1302 LAUREL OAK ROAD		
VOORHEI	ES CARE & REHABILITA	TION CENTER, THE		VOORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE
F 835	Continued From page	e 15	F 8	35		
1 000	1.0		F O.	and the title		
	Conditioning system	mperatures that were		of the person responsible	e for correction of	
	recorded on 7/21/201	•		deficiency		
		acility's heat emergency plan.				
		, , , , , , , , , , , , , , , , , , , ,		Administrator and Direct	or of Maintenance	
	A review of the facility			will audit all maintenance		
		ket included: "7/21/19,		basis to identify issues o		
		ooke with Admin. about		PTACH units for 3 month		
		is hot and is being evacuated		monthly for the next 3 m		
	by the Fire Departme			Results of the audit will b		
	portable AC units, ins	tions. Next I inspected the		monthly by the VP of Clir VP of Operations, and at		
	-	ire it was operating properly.		quarterly QA meetings.		
	Inspected the			quarterly QA meetings.		
		sor that was previously		Compliance 10/2/19 and	ongoing.	
	written up. (Worker)s				0 0	
	(information) via text	to (Worker) for replacement				
	compressor for heat	pump. Next I troubleshot the				
	RTU (roof top unit) th					
		nd Nursing stations found the				
		vith only 2 of 3 compressors				
		oil was dirty. Found that the				
	-	off was defective. Worker				
	to help with replacem	ressor and remained onsite nent."				
	A review of the facility					
		ormed and reads in part: If				
	-	resident care area cannot be				
		degrees Fahrenheit, the oyee or their designee shall				
	following perform or e					
		epartment of Health.				
		cord to record dates, times				
	and actions taken , e					
	The Director of Maint	enance or authorized				
	delegate, in a heat er	mergency shall acts as				
	follows:					
		ies of the log record, every				

Facility ID: 60408

If continuation sheet Page 16 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		315187	B. WING				C 1 02/2019	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
VOORHEE	ES CARE & REHABILITA	TION CENTER, THE			1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE	
F 835	 A review of the facility performed. The follow - Nursing staff record 7/21/2019, in every R documented once and the sheet. The Maintenance dep following temperatures On 7/19/2019, or on the On 7/20/2019, or on the On 7/21/2019, or on the On 7/20/2019, or on the On 7/20/2019,	 v temperature log was ving was recorded: rded temperatures on vesident room. This was d had no times written on Deartment provided the e logs recorded: nce per shift (3 times daily) floors. floors. were recorded in common orded. The facility did not y for recording temperatures exit conference, after n-functioning PTAC units, ne Admin. what was the placement of non-functioning ne building. The Admin. did 	F	835				
	duty Officer.	AC not working. Request Fire Department Fire Department contacting						

Facility ID: 60408

If continuation sheet Page 17 of 24

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/26/2020 FORM APPROVED OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C		
		315187	B. WING		08/02/2019		
NAME OF PI	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
VOORHEE	ES CARE & REHABILITA	TION CENTER, THE		302 LAUREL OAK ROAD YOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 835	Department of Health - 7/21/2019, 12:31 J High School for possi - 7/21/2019, 13:09 - 7/21/2019, 13:09 - 7/21/2019, 13:40 - 7/21/2019 walking door B-15. - 7/21/2019, 14:29 press and family. The facility had identi several individual roo Units (RTU) since Jui purchased PTAC unit and have been sitting 2019. The facility did PTAC units and order replacement. The fac	n. Asked to contact Eastern ible evacuation site. no maintenance on location. DPW bus for evac. g PTS (patients) can use Officer at front door due to ified ongoing problems with om PTAC units and Roof Top ne 2019. The facility had ts which were the wrong type g un-used on-site since May not send back the wrong r the correct PTAC units for cility had no plan in place to ioning PTAC units, which led d to be evacuated on	F 835				
F 908 SS=F	CFR(s): 483.90(d)(2) §483.90(d)(2) Mainta and patient care equi condition. This REQUIREMENT by: Based on observatio	in all mechanical, electrical, pment in safe operating is not met as evidenced n, interview and review of n on 7/16/2019, 7/26/2019,	F 908	F-908 Essential Equipment.	10/2/19		

Event ID: MY2311

Facility ID: 60408

If continuation sheet Page 18 of 24

<u>CENTERS</u>	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-039	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315187	B. WING			C 08/02/2019		
NAME OF PF	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
				13	302 LAUREL OAK ROAD			
JOORHEE	S CARE & REHABILITA	ATION CENTER, THE		v	OORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 000	Continued From non	- 10						
F 908	Continued From page		F	908				
		ir Packaged Thermal Air			by the deficient practice			
	• • • •	units in a safe and optimal			Maintenance Dept. have taken logs to			
	u	r 79 of 195 PTAC units			identify areas that are at risk of getting			
		esident rooms, Shower/Tub Activity/ Dining rooms. This			excessive heat and provided tempora cooling.	ıу		
		s evidenced by the following:			coomig.			
	denoient practice was	s evidenced by the following.			" How the facility will identify other			
					residents having the potential to be			
					affected by the same deficient practic	е		
	During the survey en	trance on 7/16/2019 (day			and what corrective action will be take			
	one) at 8:58 a.m., a r				All residents are at risk of being affect	ed		
	Maintenance Directo	r #1 (MD#1) to provide a			by the deficient practice.			
	copy of the facility lay	y-out which identifies the			The director of maintenance has take	n a		
		building. A request was also			log of all areas in the facility that need	la		
	-	ntenance requests. The			replacement PTACH unit. Additional			
		maintenance request log			orders have been placed to replace the			
		5 floors. The surveyor made			units, and temporary cooling units have			
		the maintenance log books			been placed. Maintenance staff will be			
	for June and July 20	19.			educated on maintaining the PTACH	units		
	At 0.05 a m tha aum	vover started a tour of the			in an efficient and optimal working condition.			
	building on the	veyor started a tour of the . The surveyor observed						
		ns have PTAC units located						
		surveyor also observed the			" What measures will be put in place	ce or		
	•	ooms had Portable Air			what systemic changes will you make			
	-	nits that were venting out of			ensure that the			
		indows in the following			deficient practice does not recur;			
	locations:	-			A preventative maintenance schedule	for		
	Resident rooms #	#, #, #, #			the PTACH units is in place to ensure			
	# and floor D	ay/ Dining room had 2 PACs.			proper functionality of the units. A			
					maintenance book is located at each			
		cility Maintenance Worker			nurse station where an issue with t			
	. ,	ome of the PTAC units need			PTACH unit can be logged. Nursing s			
		ed. The surveyor then asked,			will be educated on proper documents	ation		
	-	PTAC units in some of the			of malfunctioning PTACH units.			
1			1		I ne tacility is policy for Heat Emerge	ncv	1	
		The FMW told the surveyor			The facility s policy for Heat Emerge	ncy		
		/W also told the surveyor			Response has been reviewed, and updated to maintain resident safety a	-		

Facility ID: 60408

If continuation sheet Page 19 of 24

PRINTED: 03/26/2020 FORM APPROVED

CENTER STATEMENT (AND PLAN OF NAME OF PI	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ES CARE & REHABILITAT SUMMARY ST/ (EACH DEFICIENCY	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315187 FION CENTER, THE TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILDING B. WING S 1:	CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP COL 302 LAUREL OAK ROAD OORHEES, NJ 08043 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	FOR OMB N (X3) DAT COM 08 DE DRRECTION N SHOULD BE	ED: 03/26/2020 MAPPROVED O. 0938-0391 E SURVEY IPLETED C 3/02/2019 (X5) COMPLETION DATE
F 908	9:24 a.m., the survey units model number on pallets. At 9:27 a.m. the Admi surveyor in the basen he/she had only been 3 weeks, and that the since approximately M not give a date as to W will be at the facility. T time, the PTAC units i wrong type and could replacements in the F Later at 9:46 a.m. the in the presence of the observed from the cou At 9:46 a.m., on the units venting out of th Resident rooms, # room, At 10:01 a.m., on the units venting out of w and Day/ Dining room At 10:27 a.m., on the rooms, # two (2). Later at 11:02 a.m. a provided maintenance	asement with the FMW at or observed 24 New PTAC stored nistrator (Admin.) met the nent. The Admin. stated that the Administrator there for units had been in the facility May 2019. The Admin could when the correct PTAC units The Admin. confirmed at that n the basement were the not be used as tesident rooms. surveyor continued the tour FMW and MD#1 and ridor the following; frooms with PAC e windows, , #,, floor Day/ Dining rooms with PAC ndows, Resident rooms, had two (2). 2nd. floor, PACs in resident _, Day/ Dining room had	F 908	DEFICIENCY) are inspected weekly to ensu- placement and function " How the corrective actio monitored to ensure deficient not recur, i.e. what quality assurance progr put into practice. The date for and the title of the person responsible for deficiency Administrator and Director of will audit all maintenance log basis to identify issues or cor PTACH units or temp cooling months and then monthly for months. Results of the audit will be wi monthly by the VP of Clinical VP of Operations, and at the quarterly QA meetings. Compliance 10/2/19 and ong	Ire proper Ins(s) will be t practice will ram will be r correction correction of Maintenance is on a weekly incerns with g units for 3 the next 3 ill reviewed Services and facility	

If continuation sheet Page 20 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		315187	B. WING				C / 02/2019	
NAME OF P	ROVIDER OR SUPPLIER		I	;	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
VOORHEI	ES CARE & REHABILITA	TION CENTER, THE			1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 908	AC unit not cold, 6/20 6/20/19, room A AC not working, 6/18/ window, 6/18/19, room 6/16/19, room A room AC needs working on system,) 6 need to be fixed (Con system)6/9/19, room hot in there, 6/5/19, ro broken (Comments: the unit from window) On the 4th. floor: - 7/12/19, room (we need more units) Conditioner broken, 7 (Comments: needs A notified when done- A no AC(Comments: no 6/27/19, room B 6/25/19, room B 6/25/19, room B 6/25/19, room B needs to be drained, 10 AC unit not working maybe cycling), 5/30/ working, 5/30/19, room 5/30/19, room AC not w Air not working in room	change AC filter, 7/2/19, g noise, 6/28/19, room /19, room AC FULL, G filter, 6/19/19, room /19, room AC out of m AC out of window, C not working, 6/13/19, to be fixed (Comments: 6/13/19, room AC ments: working on tubing off back of AC, com A Air Conditioner ubing disconnected from Portable AC not working , 7/12/19, room Air /7/19, room Ac C unit, Family must be /// No AC C unit, Family must be // No Units", 6/14/19, room // Comments: compressor 19, room AC not m AC not working, // C not working, 5/30/19, // Yorking, 5/29/19, room	F	309	3			

Event ID: MY2311

If continuation sheet Page 21 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315187	B. WING				C 6/ 02/2019	
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE			
VOORHEI	ES CARE & REHABILITA	TION CENTER, THE			1302 LAUREL OAK ROAD VOORHEES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 908	 7/10/17, room hot, 7/10/19, room warm air, 7/9/19, kitcl (Comments: pending), portable AC disconneneed AC it very hot, 6 portable not working, exhaust, 5/30/19, roo blowing only hot air, 5 conditioner blows only air conditioner blows only air conditioner blows only air conditioning, 7/15/19, room are working, 7/15/19, room from the from air conditioning (Comme units), 6/28/19, rooms from air, 6/26/19, room spewing water. At 11:01 a.m. a review Purchase order dated 25 item # 14501 Mod console." These were the New be sent back. During the exit on 7/1 the Admin. when the rand/or replace the no The Admin. did not are On 7/26/2019 (day 2) was made to the Admin. 	family states room is too air conditioner blowing hen AC not turning on), 6/7/19, room acted, 6/6/19, room AC 5/30/19, room air conditioner 5/30/19, room air conditioner air v hot air, 4/8/19, room not working. AC manufacture not manufacture no air not working. AC manufacture no air not working all came , Day room the left hand dition Vent came out from ms and AC hose w of the facility provided 15/16/2019, reads in part; " el PTAC units that needed to 6/2019, the surveyor asked facility planned to repair n-functioning PTAC units. hswer the surveyor. at 10:24 a.m., a request	F	908	3			

If continuation sheet Page 22 of 24

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315187	B. WING				C / 02/2019
NAME OF P	ROVIDER OR SUPPLIER	L	I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
VOORHE	ES CARE & REHABILITA	TION CENTER, THE			1302 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 908	PTAC units in the buil non-functioning and e replacement. The MD#2 provided a for all 5 floors marking non-functioning PTAC of the facility provided following areas as ha units: On the 1st. floor: - No PTAC unit inside room, Resident rooms the Day/Dini non-functioning PTAC Shower room and Exc PTAC units identified non-functioning on the On the 2nd. floor: - Nurses station, F Resident rooms, an units in the Day On the 3rd. floor: - Residents Bath/s rooms, and the floor Day	Iding that are either in need of repair or a copy of the facility lay-out g the areas where the C units are located. A review d lay-outs identify the ving non-functioning PTAC de the Residents family s and , and ing room has 5 C units and residents Bath/ am room. There are 11 of 27 by the facility as e . Resident Bath/ Shower room, d 2 non-functioning PTAC There are 20 of 42 PTAC facility as non-functioning Shower room, Resident , //Dining room has 3 C units. There are 18 of 42 by the facility as	F	908	3		

Event ID: MY2311

Facility ID: 60408

If continuation sheet Page 23 of 24

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315187	B. WING				C 02/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
VOORHEE	ES CARE & REHABILITA	TION CENTER, THE			I302 LAUREL OAK ROAD /OORHEES, NJ 08043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 908	Residents rooms floor Day/Dining room PTAC units. There are identified by the facilit third floor. On the 5th. floor: - Two (2) Residents Resident Day/Dining room has units. There are 14 of the facility as non-fun At 3:22 p.m., during a the surveyor asked w it gets hotter or other properly. The Admin s PAC units around the	Bath/ Shower rooms, , and the , and the 16 of 42 PTAC units ty as non-functioning on the Bath/ Shower rooms, and the 3 non-functioning PTAC 42 PTAC units identified by ctioning on the TAC units identified by ctions on the TAC units fail to function said they would get more rooms. I of 79 of 195 PTAC units ng.	F	908			

If continuation sheet Page 24 of 24

PRINTED: 03/26/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
	060408				0	08/02/2019
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
OORHEE	S CARE & REHABILITA	TION CENTER, THE	UREL OAK ROAD EES, NJ 08043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S1680	8:39-25.2(b)(1)&(2) N	landatory Nurse Staffing	S1680			10/2/19
	registered profession nurses, and nurse aid of nursing are not ince except for the direct of nursing in facilities will provides more than that at N.J.A.C. 8:39-25.1 1. Total number of hours/day; plus 2. Total number of service listed below, for corresponding not Wound care 0.75 hour/day Nasogastric gastrostomy Oxygen ther 0.75 hour/day Tracheostor 1.25 hours/day Intravenous 1.50 hours/day Use of respin 1.25 hours/day	umber of hours per day: tube feedings and/or 1.00 hour/day rapy ny therapy day rator day a stimulation/advanced				
	DIRECTOR'S OR PROVIDER/			TITLE		(X6) DATE

6899

If continuation sheet 1 of 2

PRINTED: 03/26/2020 FORM APPROVED

New Jers	sey Department of Hea	lth			I ORANIA I ROVEB							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		060408	B. WING		C 08/02/2019							
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE								
VOORHEES CARE & REHABILITATION CENTER, THE 1302 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE							
S1680	This REQUIREMENT by: Based on review of s by the facility for the y determined that the fa least the minimum sta staffing requirements deficient practice was For the week of 9/2/1 Required staffing hou Date Actual Staf 9/2/18 504 In a post survey ema the staffing coordinat are short, during the	is not met as evidenced taffing schedules provided week of 9/2/18, it was acility failed to provide at affing to meet the nursing for 1 of 7 days. This s evidenced by the following: 8 Irs: 550.50	S1680	 S1680 Failure to maintain mandatory Nurse staffing There were no Residents affected the deficient practice with mandatory nurse staffing. All Residents at the facility had th potential to be affected by the deficient practice with mandatory nurse staffing Facility will review and calculate and ensure mandatory nurse staffing Coordinator will be re-educated on pro documentation/ calculation of all acuit to assure mandatory nurse staffing is DON or Designee will ensure all to managers and Staffing Coordinator is re-educated on proper documentation/calculation of all acuitite Also, DON or Designee will review act and ensure required staffing is in place The results will be reviewed and presented during QAPI. 	e It It It It Sper ies met Jnit es. uities							

MY2311