STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315219	A. BUILDING _____ B. WING _____	06/07/2022

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
F 000	INITIAL COMMENTS Survey Date: 06/07/22 CENSUS: 104 SAMPLE SIZE: 27 An Onsite Revisit Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documents, it was determined that the facility failed to obtain a physician's order for the use of bed [redacted]. This deficient practice was observed for 1 of 2 residents (Resident #14) reviewed for position/mobility and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching,	F 658	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law F-658: SCOPE and SEVERITY = "D": Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS	7/11/22

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

Electronically Signed | 07/01/2022

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F 658	Continued From page 1 health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 05/23/2022 at 10:23 AM, the surveyor observed Resident #14 lying in bed. A half bed [redacted] was attached to the [redacted] (window side) of the bed and the [redacted] of the bed was observed to be against the wall. According to the Admission Record, Resident #14 was admitted to the facility with diagnoses that included, but were not limited to, [redacted]. Review of the Annual Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted], reflected that Resident #14 had a Brief Interview for Mental Status score of [redacted] indicating [redacted]	F 658	FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ On 5/27/22, a physician's order for Resident #14 was obtained for [redacted] Resident has not been adversely affected by the deficient practice upon assessment by the DON. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents with side rails have the potential to be affected by the same deficient practice. The DON and Unit Managers completed a comprehensive audit of residents who were deemed appropriate for use of Ex.Order 26.4(b)(1). Records of these residents were reviewed to ensure that Physician's Orders for [redacted] was in place for these residents. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ Facility Policy was updated to include obtaining a Physician's Order for [redacted]. All Nurses and the Interdisciplinary Team members were in-serviced on the new policy. Any new hired licensed nursing/IDT staff will be educated by the Assistant Director of Nursing (ADON) and/or designee on the facility's updated policy titled: Proper Use of Ex.Order 26.4(b)(1). IV. MONITORING OF CORRECTIVE ACTIONS	

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F 658	Continued From page 2 On 05/24/2022 at 1:16 PM, the surveyor interviewed the Physical Therapy Assistant (PTA) regarding a Ex Order 26. 4B1 assessment completed by physical therapy on Ex Order 26. 4B1 for Resident #14. The PTA provided the following information, Ex Order 26. 4 [redacted] On 06/01/2022 at 12:09 PM, the surveyor reviewed the medical record. The following order was observed and dated Ex Order 26. 4B1 : Ex Order 26. 4B1 [redacted] On 06/02/2022 at 1:12 PM, the surveyor conducted an interview with the Administrator concerning Resident #14's Ex Order 26. 4B1 usage. The surveyor questioned the Administrator whether the use of bed Ex Order 26. 4B1 required a physician's order. The Administrator explained, "Bed Ex Order 26. 4B1 require a physician's order." On 06/03/2022 at 10:14 AM, the surveyor interviewed the Director of Nursing (DON) and Administrator. The surveyor explained that the physical Ex Order 26. 4B1 assessment conducted on Ex Order 26. 4B1 revealed that Resident #14 had a Ex Order 26. 4B1 in place, however there was no physician order for the Ex Order 26. 4B1 use until Ex Order 26. 4B1. The surveyor requested the staff to find a physician's order for Ex Order 26. 4B1 use prior to Ex Order 26. 4B1. The	F 658	¿ The Unit Managers or designee will conduct Medical Record Review audits of 5 residents per Unit per month x 3 months, to ensure that residents who have Ex.Order 26.4(b)(1) have proper Physician's Orders for the Ex.Order 2. Any identified issues will be rectified immediately and reported to the Director of Nursing. Audit Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program x 3 months for on-going compliance.	

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F 658	Continued From page 3 DON responded, "I was not able to locate an order for the timeframe you asked yesterday. There was an assessment completed on 03/30/2022 in addition to the consent form. We have not been able to locate a previous physician order for Ex.Order 26.4(b)(1)." The surveyor questioned the DON if Resident #14 should have had a physician's order for the Ex.Order 26.4B1 The DON replied, "Yes, there should have been a physicians order for the Ex.Order 26.4(b)(1). We only know that he/she had the Ex.Order 26.4(b)(1) in place since the Ex.Order 26.4(b)(1) conducted on 02/10/2022." Review of the facility's policy titled, Proper Use of Side Rails, updated 03/2022, did not include any documentation requiring a physician's order for Ex.Order 26.4B1 use.	F 658		
F 686 SS=D	NJAC 8:39-27.1 (a) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		7/11/22

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F 686	Continued From page 4 Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed to follow a physician's order to offload a resident's [redacted]. The deficient practice was observed for 1 of 3 residents (Resident #6) investigated for [redacted] and was evidenced by the following: On 05/19/22 at 11:03 AM, during the initial tour, the surveyor observed Resident #6 in bed. Resident #6's [redacted] appeared to be [redacted]. At this time, the surveyor observed a [redacted] on the nightstand. On the same date at 11:20 AM, the surveyor observed no off-loading support was in place on Resident #6's [redacted]. On 05/23/22 at 8:39 AM, the surveyor observed Resident #6 in bed. The resident did not have [redacted] on or off-loading support for his/her [redacted]. On 5/24/22 at 11:23 AM, the surveyor observed Resident #6 in bed. The resident did not have [redacted] on or off-loading support for his/her [redacted]. A [redacted] was observed on the nightstand. On 5/25/22 at 8:59 AM, in the presence of the surveyor, Licensed Practical Nurse #4 (LPN) removed Resident #6's bed sheet from his/her [redacted]. The surveyor observed that Resident #6 did not have [redacted] on or off-loading support in place for resident's [redacted]. On the same date at 10:26 AM in Resident #6's	F 686	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The involved staff were in-serviced and counseled regarding their failure to follow physician's order to offload Resident #6□s [redacted]. Upon physical examination, Resident #6 was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents who have a physician's order to offload resident's [redacted] are at risk for the deficient practice. The DON and/or designee generated a list of all residents with physician□s orders to offload resident's [redacted] from the Clinical Software. These residents were checked to ensure that staff is compliant in following physician□s orders to off-load their [redacted]. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ The DON (Director of Nursing) and/or designee in-serviced nursing staff re: facility□s policy on Prevention of [redacted]. Emphasis was made on ensuring that nursing staff follow physician□s orders to properly off-load the [redacted] of appropriate residents. IV. MONITORING OF CORRECTIVE	

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F 686	Continued From page 5 room, during an interview with the surveyor, Registered Nurse #5 (RN) stated that Resident #6 had a physician's order to support his/her [redacted]. RN #5 further stated that a pillow or rolled blanket would be used to support Resident #6's [redacted]. At this time, in the presence of the surveyor, RN #5 confirmed that Resident #6 did not have any [redacted] supports currently on and confirmed that the comprehensive care plan included preventative measures to offload or float resident's [redacted] while in bed. On the same date at 10:41 AM, during an interview with the surveyor, Licensed Practical Nurse/Unit Manager #1 (LPN/UM) stated that Resident #6 did not have a *Ex Order 26. 4B1* [redacted] or *Ex Order 26. 4B1* [redacted]. She stated that she thinks Resident #6 used [redacted]. She further stated that staff should float resident's [redacted] while resident was in bed. LPN/UM #1 affirmed that the nurse and CNA were responsible that Resident #6 had *Ex Order 26. 4B1* on. On 05/25/22 at 11:59 AM, during an interview with the surveyor, LPN/UM #1 revealed that she could not say why Resident #6 did not wear *Ex Order 26. 4B1* because she usually had "something." On 06/01/22 09:45 AM, during an interview with the surveyor, Certified Nursing Assistant #2 (CNA) revealed that Resident #6 did wear [redacted] but sometimes *Ex Order 26. 4B1* them off. Review of the Admission Record revealed that resident had a diagnoses that included, but were not limited to, *Ex Order 26. 4B1* [redacted]	F 686	ACTIONS ¿ The Assistant Director of Nursing or designee will conduct observation audits of residents with physician orders to off-load [redacted] to ensure that nursing staff is compliant with the MD Order. Audits will be conducted on 3 residents weekly x 1 month, then monthly x 3 months thereafter. Findings will be reported to the QAPI Committee monthly. Any identified issues will be rectified immediately and reported to the Director of Nursing. Audit Findings will be submitted to the QAPI Committee monthly to ensure on-going compliance.	

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F 686	Continued From page 6	F 686		

Ex Order 26. 4B1 [redacted]

Review of the Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated 05/17/22, and a Significant Change MDS, dated 02/14/22, reflected that Resident #6 did not have Ex Order 26. 4B1 [redacted] and was at risk for Ex Order 26. 4B1 [redacted]. Each MDS further revealed that resident utilized a Ex Order 26. 4B1 [redacted] in bed. The MDSs revealed Resident #6 was receiving Ex Order 26. 4B1 [redacted]

Review of Resident #6's physician orders located in the Electronic Medical Record (EMAR), revealed the following orders:
- an order dated Ex Order 26. 4B1 [redacted] reflected Ex Order 26. 4B1 [redacted] as of Ex Order 26. 4B1 [redacted], and
- an order started on Ex Order 26. 4B1 [redacted] to float resident's Ex Order 26. 4 [redacted] while in bed.

Review of Resident #6's Comprehensive Care Plan located in the EMAR, revealed a focus initiated on Ex Order 26. 4B1 [redacted] that resident is at risk or has actual Ex Order 2 [redacted] breakdown with an intervention initiated on Ex Order 26. 4B1 [redacted] to off load or float his/her Ex Order 26. 4 [redacted] while in bed.

Review of Resident #6's Treatment Administration Record for Ex Order 26. 4B1 [redacted] revealed the order to float

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F 686	Continued From page 7 Ex Order 26. 4 while in bed. On 06/02/22 at 12:46 PM, during an interview with the surveyor, the Director of Nursing (DON) stated that her expectation of off-loading Ex Order 26. 4 was using Ex Order 26. 4B1 or Ex Order 26. 4B1. Review of the facility policy titled, "Prevention of Ex Order 26. 4B1 updated on 10/19, under the heading, Support Surfaces and Pressure Redistribution, reflected to Ex Order 26. 4B1 [redacted]	F 686		
F 688 SS=D	NJAC 8:39-27.2(a) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited Ex Order 26. 4B1 does not experience Ex Order 26. 4B1 unless the resident's clinical condition demonstrates that a reduction in Ex Order 26. 4B [redacted] is unavoidable; and §483.25(c)(2) A resident with limited Ex Order 26. 4B1 [redacted] receives appropriate treatment and services to increase Ex Order 26. 4B1 and/or to prevent further decrease in Ex Order 26. 4B1. §483.25(c)(3) A resident with limited Ex Order 26. 4B1 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		7/11/22

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F 688	Continued From page 8 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to follow a physician's order for the application of a Ex Order 26. [redacted] for one resident. This deficient practice was identified for Resident #9, 1 of 2 residents reviewed for limited Ex Order 26. 4B1 [redacted] and was evidenced by the following: On 05/23/22 at 11:59 AM and 1:06 PM, on 05/24/22 at 10:27 AM and 1:17 PM, on 05/25/22 at 8:05 AM, on 06/01/22 at 8:30 AM and 11:15 AM, and on 06/02/22 at 10:46 AM, the surveyor observed Resident #9 lying in bed with the head of the bed elevated. The surveyor observed the resident's Ex Order 26. 4B1 was closed with the fingertips touching the resident's palm with no Ex Order 26. [redacted] in place. The surveyor further observed the resident was Ex.Order 26.4(b)(1) [redacted]. According to the Admission Record, Resident #9 was admitted to the facility with diagnoses that included, but were not limited to, Ex Order 26. 4B1 [redacted]. Review of the Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated 02/17/22, reflected that Resident #9 was unable to speak, identified as Ex Order 26. 4B1 [redacted], totally staff dependent for Ex Order 26. 4B1 [redacted], and had functional Ex Order 26. 4B1 [redacted] of the Ex Order 26. 4B1 [redacted] on both sides of the body.	F 688	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The order for Ex Order 26. 4B1 [redacted] for Resident #9 was moved by the Unit Manager from Other Orders to General orders to require a nurse□s signature once the task is completed. Resident□s Plan of Care Kardex was updated to include a task to apply Ex Order 26. 4B1 [redacted], q-shift, to ensure resident #9□s Ex Order 26. [redacted] remains intact and that the resident□s Ex Order 26. 4B1 [redacted] does not worsen. Resident #9 was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents with physician□s orders for Ex Order 26. 4B1 [redacted] have the potential to be affected by the deficient practice. The Director of Nursing and Unit Managers generated a list of all residents with physician□s orders for Ex Order 26. 4B1 [redacted] from the Clinical Software. These residents were checked to ensure that staff is compliant in following physician□s orders for in the proper application of the Ex Order 26. 4B1 [redacted] as ordered. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ The DON (Director of Nursing) and/or	

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F 688	Continued From page 9 Review of the Resident #9's current Care Plan, reflected a focus that resident cannot apply and remove the Ex Order 26. 4B1 due to Ex Order 26. 4B1 with the goal to prevent Ex Order 26. 4B1 and maintain Ex Order 26. 4B1 times 120 days. The Order Summary Report for the Active Orders as of 05/31/22 revealed an order dated Ex Order 26. 4B1 for resident to wear a Ex Order 26. 4B1 at all times, and to remove for Ex Order 26. 4B1 check only. Review of the March, April, and May 2022 Medication Administration Records (MAR) did not reflect the physician order for a Ex Order 26. 4B1 for the nurse to sign when applied. Review of the March, April, and May 2022 Treatment Administration Records (TAR) did not reflect the physician order for a Ex Order 26. 4B1 for the nurse to sign when applied. The March, April, and May 2022 TARs did reflect an undated notation under "Unscheduled 'Other' Orders" for resident to wear a Ex Order 26. 4B1 at all times, remove for Ex Order 26. 4B1 check only. The surveyor observed that this notation did not require nurse signatures. During an interview with the surveyor on 06/01/22 at 11:25 AM, the Certified Nursing Assistant #1 (CNA) stated that she had Resident #9 on her assignment and was familiar with the resident. CNA #1 stated that the resident was Ex.Order 26.4(b)(1) and required Ex.Order 26.4(b)(1) CNA #1 further stated that she was unaware that the resident was ordered a Ex Order 26. 4B1 to his/her Ex Orde hand. During an interview with the surveyor on Ex Order 26. 4B1 at 11:31 AM, the Licensed Practical Nurse #1	F 688	designee re-educated nursing staff and the Inter Disciplinary Team (IDT) on the importance of following Physician□s Orders to properly apply assistive devices to prevent the development or worsening of Ex Order 26. 4B1 . Any new hired licensed nursing/IDT staff will be educated by the ADON and/or designee re: following Physician□s Orders to properly apply Ex Order 26. 4B1 to prevent the development /worsening of Ex Order 26. 4B1 IV. MONITORING OF CORRECTIVE ACTIONS ¿ The Assistant Director of Nursing or designee will conduct observation audits of residents with physician□s orders for Ex Order 26. 4B1 or other Ex Order 26. 4B1 to prevent the development /worsening of Ex Order 26. 4B1 Audits will be conducted on 3 residents weekly x 1 month, then monthly x 3 months thereafter. Findings will be reported to the QAPI Committee monthly. Any identified issues will be rectified immediately and reported to the Director of Nursing. Audit Findings will be submitted to the QAPI Committee monthly to ensure on-going compliance.	

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F 688	Continued From page 10	F 688		

(LPN) stated that she was an agency nurse and had Resident #9 on her assignment. In the presence of the surveyor, LPN #1 reviewed the resident's current orders and confirmed there was an order for a Ex Order 26. 4B1 to resident's Ex Orde hand at all times dated Ex Order 26. 4B1. LPN #1 further reviewed the May 2022 MAR and TAR in the electronic medical record and confirmed that the MAR and TAR did not reflect the order. LPN #1 stated that she was unaware of this order, as it was not reflected in the MAR or the TAR for her to sign. LPN #1 further stated that it was important to know what Ex Order 26. 4B1 the resident required, and it was also important that the Ex Order 26. 4B1 were in place, so that the Ex.Order 26.4(b)(1) .

During an interview with the surveyor on 06/02/22 at 10:57 AM, the LPN/Unit Manager #1 (LPN/UM) reviewed the physician orders and confirmed that Resident #9 had an order for a Ex Order 26. 4B1 dated Ex Order 26. 4B1. LPN/UM #1 further confirmed that the order was not scheduled for nurse signatures on the May 2022 MAR or TAR. LPN/UM #1 acknowledged that the Ex Order 26. 4B1 was noted in the May 2022 TAR under "Other" orders, which did not require nurse signatures. LPN/UM #1 stated that it was important that the Ex Order 26. 4B1 was in place, as ordered, so that the resident's Ex Order 2 remained intact and the resident's Ex Order 26. 4B1 did not worsen.

During an interview with the surveyor on Ex Order 26. 4B1 at 1:20 PM, the Director of Nursing (DON) reviewed the physician orders and confirmed that Resident #9 had an order for a Ex Order 26. 4B1 dated Ex Order 26. 4B1. The DON further acknowledged that the May 2022 TAR reflected the Ex Order 26. 4B1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315219	A. BUILDING _____ B. WING _____	06/07/2022

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F 688	Continued From page 11 Ex Order 26. 4B1 order under "Other" orders, which did not require nurse signatures. The DON stated that she expected that the nurse would apply the Ex Order 26. 4B1, according to the physician's order, and monitor the resident's Ex Order 26. 4B1. The facility failed to provide a policy concerning Ex Order 26. 4B1.	F 688		
F 689 SS=D	NJAC 8:39-27.1 (a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) follow a physician's order for floor mats to the floor while in bed and b.) follow fall prevention interventions as written on the resident's plan of care for a resident that was identified as a higher risk for Ex Order 2. The deficient practice was identified for 1 of 4 residents reviewed for accidents (Resident #100) and was evidenced by the following: 1. During a tour of the facility on 05/19/22 at 12:10 PM, the surveyor observed Resident #100 with his/her eyes closed in bed, with the head of	F 689	F689: Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) (A) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice ¿ The involved staff who were assigned to Resident #100 were counseled and re-in-serviced on the facility's Ex Order 26. 4B1 Emphasized the need for them to (a) Follow a physician's order for floor mats to the floor while	7/11/22

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F 689	Continued From page 12 the bed slightly elevated. The surveyor further observed a blue mattress propped against the wall under the window. The surveyor did not observe floor mats on either side of the resident's bed. According to the Face Sheet, Resident #100 was admitted to the facility with diagnoses that included: Ex Order 26. 4B1 [redacted] Review of a Significant Change in Status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, reflected that staff assessed the resident as Ex Order 26. 4B1 and required Ex.Order 26.4(b)(1) [redacted]. Review of Resident #100's Fall Risk Assessment (an assessment tool used to score a resident's likelihood of falling), dated Ex Order 26. 4B1, revealed that staff calculated a score of [redacted], which identified Resident #100 as a higher risk for [redacted]. Review of Resident #100's Ex Order 26. 4B1 recommendations, dated Ex Order 26. 4B1, included a recommendation for Ex.Order 26.4(b)(1) to Ex Order 26. 4B1 sides of bed for Ex Order 26. 4B1 risk. Review of Resident #100's Progress Notes (PN) revealed a Ex Order 26. 4B1 "Health Status Note" that indicated the resident was admitted to Ex Order 26. 4B1 care on Ex Order 26. 4B1, had recommendations that included Ex.Order 26.4(b)(1) to Ex Order 26. 4B1 of bed for safety [redacted] risk, and that the NP [nurse practitioner] was notified.	F 689	resident is in bed, and b.) Follow [redacted] prevention interventions as written on the resident's plan of care for a resident that was identified as a higher risk for [redacted]. Resident #100 did not sustain any injury as a result of the deficient practice. (B) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken ¿ All residents who are high risk for [redacted] have the potential to be affected by the same deficient practice. A list of these residents was generated from the Clinical Software to ensure that interventions to prevent [redacted] or risk for injury are in place. (C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur ¿ The DON and/or designee re-educated nursing staff on the facility's policy titled: [redacted]- Clinical Protocol, with focus on the need for staff to follow physician's orders and to ensure that interventions in the care plan to prevent [redacted] or risk for injury are properly implemented. Any new hired licensed nursing staff will be educated by the ADON and/or designee on the facility's [redacted], Clinical Protocol. (D) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place ¿ The Director of Nursing and/or designee will conduct a random audit of 3	

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F 689	Continued From page 13 Review of Resident #100's Order Summary Report for Active Physician Orders (orders), on 05/20/22 at 2:06 PM, revealed a Ex Order 26. 4B1 order for Ex.Order 26.4(b)(1) to Ex Order 26. 4B1 of bed for safety Ex Orde risk." Review of the April 2022 and May 2022 Treatment Administration Record (TAR) did not include the aforementioned order. Review of Resident #100's Care Plan (CP), on 05/23/22 at 9:30 AM, reflected that Resident #100 had a "Focus" of high risk for Ex Order 2 related to Ex Order 26. 4B1 awareness. Review of the interventions did not include the use of floor mats to Ex Order 26. 4B1 of bed for safety Ex Order risk. On 05/23/22 at 9:04 AM, the surveyor observed Resident #100 in bed having his/her breakfast meal. The surveyor did not observe floor mats on either side of the resident's bed. The surveyor further observed a blue mattress propped against the wall under the window. On 05/25/22 9:05 AM, the surveyor observed Resident #100 in bed watching television. The surveyor did not observe floor mats on either side of the resident's bed. During an interview with the surveyor on 05/26/22 at 1:20 PM, the Licensed Practical Nurse #2 (LPN) stated that Resident #100 was on Ex Order 26. 4B1 and required Ex Order 26. 4B1 with transfers. LPN #2 further stated the resident was a Ex Orde risk and had interventions that included a floor mat to one side of the bed. LPN #2 reviewed Resident #100's orders, in the presence of the surveyor, and stated the resident's floor mat order was updated today, 05/26/22. LPN #2	F 689	residents identified as high risk for Ex Order 2 to ensure that physician's orders care plan interventions to prevent Ex Order 2 or risk for injury are properly implemented. This will be done weekly x 1 month, then monthly x 3 months thereafter. Audit Findings will be submitted to the QAPI Committee monthly to ensure on-going compliance	

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F 689	Continued From page 14 added that the new order was updated to floor mats to be positioned on both sides of the bed while in bed. During an interview with the surveyor on 05/26/22 at 1:24 PM, the Licensed Practical Nurse/Unit Manager #2 (LPN/UM) stated the resident was on Ex Order 26. 4B1, and had interventions that included the use of floor mats to Ex Order 26. 4B1 of bed. LPN/UM #2 added that the resident's Ex Order 26. 4B1 floor mat order was inputted into the electronic medical record under "Ancillary" and that the nurses were not signing off or accounting for the floor mat placement. LPN/UM #2 explained that orders inputted as "Ancillary" did not carry over to the TAR and that she updated the resident's order and care plan that day to capture the floor mat order. Review of the facility's "Medication and Treatment Orders" policy, updated 10/2019, revealed that orders for medications and treatments would be consistent with principles of safe and effective order writing. 2. Review of Resident #100's PN revealed a 02/09/22 PN that Resident #100 sustained a [redacted] while attempting to get up off the couch. The PN further revealed that Resident #100 had on socks at the time of the [redacted] and that staff was educated to ensure that Resident #100 had on non-skid socks or proper shoes. Review of Resident #100's [redacted], initiated on 10/13/21, reflected that Resident #100 had a "Focus" of Ex Order 26. 4B1 related to Ex Order 26. 4B1 [redacted] awareness. The [redacted] included an intervention, initiated on Ex Order 26. 4B1, to ensure the	F 689		

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F 689	Continued From page 15 resident wore Ex Order 26. 4B1 [redacted] Review of Resident #100's 02/10/22 Fall Investigation Report, under the "Notes" section, revealed that the Interdisciplinary Team discussed Resident #100's Ex Order 26. 4B1 and to prevent the potential for future occurrences, staff was to ensure non-skid socks or proper shoes were placed on resident. During an interview with the surveyor on 06/03/22 at 10:15 AM, the Director of Nursing (DON) stated Resident #100's Ex.Order 26.4(b)(1) should Ex.Order 26. should have been in place when the resident was in bed. The DON further stated that Resident #100 should have had the appropriate footwear at the time of the Ex Order 26. 4B1. The DON added that appropriate footwear included sneaker, shoes, or non-skid socks. Review of the facility's "Falls-Clinical Protocol," updated 10/2019, reflected that staff and physician would identify pertinent interventions to try to prevent subsequent [redacted] and to address the risks of clinically significant consequences of [redacted].	F 689		
F 756 SS=E	NJAC 8:39-27.1(a) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		7/11/22

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	315219	A. BUILDING _____ B. WING _____	06/07/2022

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F 756	Continued From page 16 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documents, it was determined that the consultant pharmacist failed to respond to a medication-related irregularity in a timely and	F 756	I. CORRECTIVE ACTION S ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	

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F 756	Continued From page 17 complete manner. This deficient practice was identified for 1 of 5 residents (Resident #55) reviewed for unnecessary medications and was evidenced by the following: On 05/27/22, the surveyor obtained and reviewed copies of the Consultant Pharmacist's (CP) Monthly Report. (A CP's note is a report of any medication-related irregularity or recommendation that needs to be addressed by the physician.) Review of the Consultant Pharmacist's Monthly Report, dated Ex Order 26. 4B1, revealed a recommendation to, *Ex Order 26. 4B1* [redacted] The surveyor reviewed the Physician's Order Form (POF) and Medication Administration Record (MAR), a recording document, for Resident #55. Review of the documents revealed diagnoses that included, but were not limited, to *Ex Order 26. 4B1* [redacted] The surveyor reviewed the POFs and MARs for the months of January, February, March, and April of 2022. The POF and MAR for the referenced months revealed an order for *Ex Order 26. 4B1* [redacted]	F 756	¿ The Attending Physician for Resident #55 was notified of the deficient practice that was corrected on 4/28/2022 when the Pharmacy Consultant Pharmacist gave a recommendation for physician to, Ex Order 26. 4B1 [redacted] Physician□s Order for Ex Order 26. 4B1 has been modified to include *Ex Order 26. 4B1* [redacted] for when to administer Ex Order 26. 4B1 for resident #55. Resident #55 was not adversely affected by this deficient practice. ¿ The Director of Nursing and Administrator notified the Pharmacy Consultant Company of the deficiency. The Pharmacy Consultant□s was in-serviced by his/her supervisor re: ensuring that he/she responds to a medication-related irregularity in a timely and complete manner, with emphasis on ensuring that Physician□s orders for *Ex Order 26. 4B1* [redacted]. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents with orders for Ex Order 26. 4B1 have the potential to be affected by this deficient practice. A list of these residents was obtained from the Pharmacy Vendor. The Physician□s Order s for these residents were checked to ensure that Physician□s orders for Ex Order 26. 4B1 include *Ex Order 26. 4B1* [redacted] for when to administer Ex Order 26. 4B1. No additional residents were identified.	

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	315219	A. BUILDING _____ B. WING _____	06/07/2022

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F 756	Continued From page 18 *Ex Order 26. 4B1* [redacted]. The surveyor reviewed the POFs and MARs for Resident #55 for the months of May and June of 2022. The POF and MAR for the referenced months revealed an order for *Ex Order 26. 4B1* [redacted]. During an interview on 06/01/22 at 12:55 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) reviewed the orders for Resident #55 with the surveyor and confirmed that the order for *Ex Order 26. 4B1* began on *Ex Order 26. 4B1* and was then rewritten on *Ex Order 26. 4B1*. She confirmed that the order during the referenced period had no parameter instructing the nurse when to give the medication with respect to *Ex Order 26. 4B1*. The LPN/UM acknowledged that the order should have had a parameter, and this was important so the nurse would know how and when to	F 756	III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ Pharmacy Consultant and Nurses were in-serviced on the facility□s Policy on Drug Regimen Review, with emphasis on ensuring that Physician□s orders for *Ex Order 26. 4B1* [redacted]. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Director of Nursing or Designee will conduct Record Review audits monthly x 6 months on 5 residents with Orders for *Ex Order 26. 4B1* to make sure that the orders for *Ex Order 26. 4B1* [redacted] for when to administer the medication. Any identified issues will be rectified and addressed immediately. Audit Findings will be reported to the Administrator on a monthly basis and reported in the QAPI Meeting on a Quarterly Basis. The QAPI Committee will determine the need for further audits and or action plans on a quarterly basis.	

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F 756	Continued From page 19	F 756		

administer the medication appropriately. She further stated that the lack of a parameter on the order should have been detected before April of 2022, since the order was written in January of 2022.

During the same interview, the LPN/UM acknowledged that the most recent order for the Ex Order 26. 4B1 was written and implemented on Ex Order 26. 4B1 and, in this case, there was a parameter present on the order. The LPN/UM stated that the updated order should have been more specific, indicating to administer the *Ex Order 26. 4B1* [redacted]. The LPN/UM further stated that the order, as written, could lead to ambiguous situations and potential medication administration errors. The order, according to the LPN/UM, would have only been given for a Ex Order 26. 4B1 level equal to Ex Order 26. 4B1 as written and reiterated that this could potentially be problematic.

During an interview with the survey team and facility administration on 06/02/22 at 12:50 PM, the Director of Nursing (DON) stated that it would be her expectation for a lack of a Ex Order 26. 4B1 [redacted] on a Ex Order 26. 4B1 order to be addressed before April of 2022, if written in January of 2022. It should have been addressed in January or at least during the review period following January, after the order was written. In addition, the DON acknowledged that administering Ex Order 26. 4B1 for a *Ex Order 26. 4B1* [redacted] was incomplete and the order should have been more specific, referencing a Ex.Order 26.4(b)(1) less than or equal to [redacted].

Review of the facility's policy titled, "Medication

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F 756	Continued From page 20 and Treatment Orders," updated 03/2022, revealed that medications and treatments will be consistent with principles of safe and effective order writing. The policy did not address the use of parameters in conjunction with medication administration. Review of the facility's policy titled, "Administering Medications" updated 03/2022, revealed that medications shall be administered in a safe and timely manner, and as prescribed. The policy did not address the use of parameters in conjunction with medication administration.	F 756		
F 760 SS=E	NJAC 8:39-29.3(a)(1) Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documents, it was determined that the facility failed to a.) accurately transcribe a physician's order and b.) ensure that the resident received the [redacted] medication in accordance with the [redacted] recommendation. This deficient practice was identified for 1 of 5 residents (Resident #87) reviewed for unnecessary medications and was evidenced by the following: According to the Admission Record, Resident #87 was admitted to the facility with diagnoses that included, but were not limited to, [redacted]	F 760	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The involved nurse who failed to transcribe the physician□s order for [redacted] completely with an end date was counseled and re-educated regarding facility's "Medication Therapy" policy. This is to ensure that the resident receives [redacted] medication in accordance with the [redacted] recommendation and physician□s order. ¿ The facility's Attending physician and [redacted] were notified of the	7/11/22

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F 760	Continued From page 21 Disorder. 1. Review of the [redacted] Evaluation dated [redacted] revealed Resident #87's current mediation orders for [redacted] every six hours PRN (as needed) times 14 days for diagnosis [redacted]. After the [redacted] evaluated the resident, the [redacted] was to "Extend PRN [redacted] order for an additional 30 days as a bridge [redacted], while [redacted] takes effect." Review of the electronic medical record Order Details revealed an order for [redacted] by mouth PRN every six hours for [redacted] with a start date of [redacted] and an end date of [redacted] The "Admin [Administration] Note" reflected [redacted] by mouth as needed for 30 days as bridge [redacted] while [redacted] takes effect. The surveyor observed the order did not include the end date of 30 days. Review of the Order Summary Report for the order date range of [redacted] reflected an order dated [redacted] for [redacted], give one tablet by mouth every six hours as needed for [redacted]. The surveyor observed the order did not include an end date of 30 days. Review of the March, April, and May 2022 Medication Administration Records (MAR) revealed the physician's order dated [redacted] for [redacted], give one tablet by mouth every six hours as needed for [redacted]. The surveyor observed that the order did not include an end date of 30 days.	F 760	medication error for Residents #87. Resident was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents who have Physician□s orders for PRN (as needed) [redacted] medications have the potential to be affected by the same deficient practice. The MARs (Medication Administration Records) of these residents were immediately audited to ensure that orders were accurately transcribed and to ensure that the residents received the [redacted] medication in accordance with the [redacted] recommendations and physician□s orders. No other medication errors were found. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All nurses were in-serviced on the Facility□s Policy regarding facility's "Medication Therapy" policy. Emphasis was made on ensuring that (a) Physician□s orders are accurately and completely transcribed, and (b) residents who have orders for PRN [redacted] medication will receive their medications in accordance with the [redacted] recommendation and physician□s order. IV. MONITORING OF CORRECTIVE ACTIONS:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315219	A. BUILDING _____ B. WING _____	06/07/2022

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

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F 760	Continued From page 22 2. Review of Resident #87's Order Summary Report for the order date range of Ex Order 26. 4B1 reflected an order dated Ex Order 26. 4B1 for Ex Order 26. 4B1, give one tablet by mouth every six hours as needed for Ex Order 26. 4B1. The surveyor observed the order did not include an end date of 30 days. Review of the March, April, and May 2022 MARs revealed the physician's order dated Ex Order 26. 4B1 for Ex Order 26. 4B1, give one tablet by mouth every six hours as needed for Ex Order 26. 4B1. The surveyor observed that the order did not include an end date of 30 days. Review of the March, April, and May 2022 MARs revealed that Resident #87 received the as needed Ex Order 26. 4B1, after the 30-day end date of Ex Order 26. 4B1, on the following dates and times: Ex Order 26. 4B1 at 8:42 AM and 8:56 PM, Ex Order 26. 4B1 at 12:57 PM, Ex Order 26. 4B1 and 5:00 AM, Ex Order 26. 4B1 at 8:49 AM, Ex Order 26. 4B1 at 11:50 AM and 6:41 PM, Ex Order 26. 4B1 at 9:43 AM, Ex Order 26. 4B1 at 8:54 AM, Ex Order 26. 4B1 at 6:23 PM, Ex Order 26. 4B1 at 7:57 AM and 5:00 PM, Ex Order 26. 4B1 at 5:45 PM, and Ex Order 26. 4B1 at 5:33 PM. During an interview with the surveyor on 05/27/22 at 10:27 AM, the Licensed Practical Nurse/Unit Manager #2 stated that the end date for the Ex Order 26. 4B1 order dated Ex Order 26. 4B1 should have been Ex Order 26. 4B1 and acknowledged that Resident #87 received the as needed Ex Order 26. 4B1 after Ex Order 26. 4B1.	F 760	¿ Pharmacy Consultant or designee will review the MARs (Medication Administration Records) of 5 residents on PRN Ex Order 26. 4B1 medications to ensure that (a) Physician□s orders are accurately and completely transcribed, and (b) residents who have orders for PRN Ex Order 26. 4B1 medication receive their medications in accordance with the Ex Order 26. 4B1 recommendation and physician□s order. This will be done monthly x 6 months. Findings will be reported to the Director of Nursing and Administrator monthly and presented in the QAPI Meeting quarterly. The QAPI Committee will determine the need for further audits and/or action plans on a quarterly basis.	

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	315219	A. BUILDING _____ B. WING _____	06/07/2022

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

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F 760	Continued From page 23 During an interview with the surveyor on 06/01/22 at 12:57 PM, the Director of Nursing (DON) stated that when the nurse transcribed the [Ex Order 26. 48] order, she did not include the end date. The DON further stated that when the facility staff reviewed the [Ex Order 26. 48] order, the order should have included an end date. Review of the facility's "Medication Therapy" policy, updated in March 2022, indicated that periodically, the staff and practitioner will review the medication regimen for proper dosage and duration. NJAC 8:39- 29.2(d)	F 760		
F 812 SS=E	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.	F 812		7/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner. This deficient practice was evidenced by the following: On 05/19/22 from 11:00 AM to 11:22 AM, the surveyor, accompanied by the Food Service Director (FSD), Executive Chef (EC), and District Manager in Training observed the following in the kitchen: 1. A stand up mixer on top of a wheeled cart was covered with a clear plastic bag. The mixer was cleaned and sanitized. Upon removal of the plastic cover, the surveyor observed unidentified debris and dead flies in the base of the bowl, which is a food contact surface. On 06/03/22 during a follow up interview, the EC stated, "We haven't used this in two years. We put plastic wrap over the bowl to protect it." 2. The surveyor opened the lid to the bulk ice machine. The surveyor observed unidentified black debris on the white drip plate which was above the ice supply. The surveyor then obtained a paper towel and wiped the drip plate. The paper towel was soiled with the unidentified black debris. On interview the FSD stated, "The ice machine was cleaned on 04/27/2022." On 06/01/2022 from 10:14 AM to 10:26 AM the surveyor, accompanied by the Licensed Practical Nurse #3 (LPN), observed the following on 200/300 unit pantry: 1. In the refrigerator on a middle shelf, a	F 812	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The following corrective actions were immediately implemented: ¿ The Food Service Director removed the stand-up mixer from the wheeled cart and discarded it immediately. ¿ The Food Service Director cleaned the white drip plate which was above the ice supply and ensured that the black debris on the white drip plate was removed. ¿ The refrigerator in the 200/300 Unit Pantry was thoroughly cleaned and all containers with food that were unlabeled and undated were immediately thrown out. The LPN and Staff in the Unit were in-serviced regarding the facility policy for monitoring of pantry refrigerators and on the facility□s policy re: Foods Brought by Family/Visitors. ¿ The facility Cook cleaned the meat slicer by re-washing and sanitizing the slicer parts and air-dried all the slice parts before reassembling and covering the slicer. No residents were affected by the deficient practice. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be	

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F 812	Continued From page 25 plastic-sealed container contained a garden salad. The salad had no dates and the lettuce was observed to be turning brown. LPN #3 stated, "Usually the aides check the refrigerator." A tan plastic bag contained previously opened containers of tuna salad and a container of chicken salad. The containers had no dates. In addition, a plastic zip lock type bag contained what appeared to be Habanero peppers. The peppers were observed to be slimy and had a brownish liquid in the bag. LPN #3 stated, "I don't know what they are and I don't want to know." On the side of the refrigerator door, two peanut butter and jelly sandwiches were wrapped with plastic wrap. When interviewed, LPN #3 stated, "I'm not sure who checks the refrigerators. Usually the aides check the refrigerator." The surveyor questioned LPN #3 whether the facility had provided in-service training in regard to the facility policy for monitoring of pantry refrigerators. LPN #3 responded, "No." A green sign on the freezer door revealed the following under Pantry Rules: "All food must be labeled with date/name" "After 48 hours anything will be thrown out" On 06/02/2022 from 10:24 AM to 10:36 AM, the surveyor, accompanied by the Executive Chef (EC) observed the following in the kitchen: 1. A cleaned and sanitized meat slicer was observed to be bagged on top of a metal counter. The surveyor lifted the plastic bag that was covering the meat slicer and observed a clear, wet, water-like substance on the base of the meat slicer and the slicing surface adjacent to the blade that would be a food contact surface. The	F 812	affected by the same deficient practice. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ All Dietary Staff and Nursing Staff were in-serviced on the regulations and facility□s policies and protocols on the importance of handling potentially hazardous foods and maintaining sanitation in a safe and consistent manner. ¿ Nursing Staff were in-serviced by the Director of Nursing or designee on the facility□s policy related to Dating and Labeling Food Storage containers in the refrigerator and on the facility□s policy re: Foods Brought by Family/Visitors. MONITORING OF CORRECTIVE ACTIONS ¿ Dietary Account Manager or designee will conduct Kitchen Observation Audits weekly x 1 month; then monthly thereafter x 6 months. Emphasis will be made on properly cleaning and sanitizing Equipment in the kitchen. Any issues identified in the audits will be rectified immediately. Unit Managers or designee will conduct Observation Audits of the Pantry Refrigerator weekly x 1 month; then monthly thereafter x 6 months. Emphasis will be made on properly Dating and Labeling Food Storage Containers and discarding potentially hazardous foods. ¿ Audit Findings will be reported to the QAPI Committee on a monthly basis. The QAPI Committee will determine the need	

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F 812	Continued From page 26 EC stated, "We are gonna re-wash and sanitize the slicer parts. We will completely air dry them before reassembling and covering the slicer. The parts should be completely air dried prior to reassembly." The surveyor reviewed the facility policy titled Foods Brought by Family/Visitors, updated 10/2019. The policy revealed the following under the heading Policy Interpretation and Implementation: 7. Food brought by the family/visitors that is left with the resident to consume later would be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. b. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. 8. The nursing staff will discard perishable foods on or before the "use by" date. 9. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates.) NJAC 8:39-17.2(g)	F 812	for further audits and or action plans on a quarterly basis ensuring on-going compliance.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060414	A. BUILDING: _____ B. WING _____	06/07/2022

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

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident for 5 of 14 day shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse,	S 560	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls being made by the shift supervisor to fill the shift. Facility has documented evidence to reflect facility□s Recruitment and Retention Efforts in its relentless attempts to comply with the staffing ratios. No residents have been adversely affected. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE	7/11/22

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

Electronically Signed — 07/01/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 05/1/22-05/7/22 and 05/8/22-05/14/22, the staffing-to-resident ratios that did not meet the minimum requirement of one CNA to eight residents for the day shift are documented below: The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: 05/01/22 had 10 CNAs for 107 residents on the day shift, required 14 CNAs. 05/02/22 had 13 CNAs for 107 residents on the day shift, required 14 CNAs. 05/03/22 had 13 CNAs for 106 residents on the day shift, required 14 CNAs. 05/04/22 had 13 CNAs for 105 residents on the	S 560	AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by this situation. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ Facility□s Recruitment and Retention Strategies and Efforts to comply with the State□s Staffing Ratios have been in progress, which include but are not limited to the following: o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage referrals from current staff o Offering daily and weekend bonuses to attract overtime or PRN staff shifts o Aggressively running ads in various social media o Flexible shifts and schedules o Increased wages to be well above state minimum o Currently have contracts with multiple staffing agencies IV. MONITORING OF CORRECTIVE ACTIONS ¿ Staffing Coordinator or designee will provide weekly reports to the Director of Nursing and Administrator regarding all efforts made to try to comply with the State□s Staffing Ratios. Reports will be submitted to the QAPI Committee monthly X 3 months then quarterly thereafter. ¿ Director of HR will submit monthly reports to document status of all recruitment efforts to the Administrator. Director of HR will report monthly to the	

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S 560	Continued From page 2 day shift, required 14 CNAs. 05/10/22 had 11 CNAs for 104 residents on the day shift, required 14 CNAs. During an interview with the surveyor on 06/0/3/2022 at 11:42 AM, the administrator stated he was aware of the mandated CNA staffing ratios of 1:8, 1:10, and 1:14. NJAC 8:39-5.1(a)	S 560	QAPI Committee X 3 months then quarterly thereafter.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315219 Y1	A. Building B. Wing Y2	9/2/2022 Y3

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 F0658	Correction	ID Prefix F0686	Correction	ID Prefix F0688	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	07/11/2022	LSC	07/11/2022	LSC	07/11/2022
ID Prefix F0689	Correction	ID Prefix F0756	Correction	ID Prefix F0760	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(f)(2)	Completed
LSC	07/11/2022	LSC	07/11/2022	LSC	07/11/2022
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/11/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/7/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060414 Y1	A. Building B. Wing Y2	9/2/2022 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/11/2022	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
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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 6/7/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/06/22 and 06/07/22, and Complete Care at Voorhees, LLC 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 The facility is a 1-story building that was built in the 1980's. It is composed of Type II protected. The facility is divided into 9- smoke zones. The generator does approximately 35% of the building as per the Maintenance Director interview. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

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

Electronically Signed | 07/01/2022

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 _____	**06/07/2022**

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K 000	Continued From page 1 The facility has 190 certified beds. At the time of the survey the census was 104.	K 000		
K 222 SS=F	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 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	K 222		6/30/22

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K 222	Continued From page 2 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 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 on 06/06/22, in the presence of the Maintenance Director and Administrator, it was determined that the facility failed to a.) provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 2 of 4 sets of exterior egress doors observed and b.) to ensure that the 15-second delayed egress feature for 1 of 6 exit discharge doors (with this feature) observed	K 222	1. The delayed egress of Exit door by resident room 508-509 was adjusted and corrected on 6/6/2022. On 6/7/2022 facility maintenance director removed the thumb turn lock on the Exit door at the Main entrance. On 6/7/2022 facility maintenance director removed the thumb turn lock on the Transitional Care Unit exit door. The facility maintenance director was in-serviced on the requirements to ensure all exit doors in the means of egress are readily accessible and free of all	

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K 222	Continued From page 3 would activate when tested. This deficient practice was evidenced by the following: 1. a.) On 06/06/22 at 9:30 AM, the Maintenance Director and Administrator observed, at the main entrance, that 1 of 2 doors (outside set of doors) revealed a thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. b.) On 06/06/22 at 11:30 AM, the Maintenance Director and Administrator observed, at the Transitional Care Unit entrance, that 1 of 2 doors (outside set of doors) revealed a thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. 2. a.) On 06/06/22 at 12:50 PM, the Maintenance Director and Administrator observed that the exit/egress door by resident rooms 508 and 509, when activated with the delayed 15-second egress feature, was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's egress feature did not function. The door had a keypad that opened the door; and according to the Maintenance Director, the fire alarm would release the device if it is activated. An interview was conducted with the Maintenance Director and Administrator, who confirmed the findings during the observations. The Administrator was notified of the findings at the Life Safety Code exit conference on 06/07/22.	K 222	obstructions to full instant use in case of fire or emergencies and to ensure all delayed egress to all exit doors are properly functioning as intended. 2. All residents have the potential to be affected by this deficient practice. 3. Thumb turn locks were never in use at the facility but were part of the door hardware and removed. All exit doors were inspected on 6/7/2022 for thumb turn locks and no other doors had them. All exit doors were inspected on 6/7/2022 to ensure proper delayed egress were functioning and all were in proper working condition. 4. Maintenance Director will audit all exit doors weekly x6months to ensure proper delayed egress function. Maintenance Director will audit all exit doors weekly x6 months to ensure any new doors that may need to be installed will not have the thumb turn locks. Any concerns will be brought to the attention of the Administrator immediately and corrected inhouse or by facility door alarm vendor. Audits findings will be reported to the QA Committee at the quarterly QA meeting x3 quarters.	

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K 222	Continued From page 4 NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/06/22, in the presence of the Maintenance Director and Administrator, it was determined that the facility failed to provide automatic emergency illumination that would operate automatically along the means of egress, and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.8, 7.8.1.1, 7.8.1.2, 7.8.1.4. The deficient practice was observed for 2 of 2 exterior enclosed courtyards and was evidenced by the following: At 10:38 AM, the surveyor, Maintenance Director and Administrator observed, in the two side-by-side enclosed exterior courtyards, that the exterior courtyard lighting was controlled by two separate interior corridor wall switches. It was observed that when the wall switches were in the off position, no lighting was observed. In the	K 281	1. Facility Electrical Vendor was contacted to provide a quote to fix the enclosed courtyard lighting. Facility maintenance director was in-serviced on the requirement to provide automatic emergency lights that would operate automatically during emergencies. 2. All residents can potentially be affected by this deficient practice. 3. Facility has no other enclosed courtyards. 4. Maintenance Director will audit the enclosed courtyard weekly x 3months and then monthly x6months to ensure all light bulbs are operating. Any bulbs that are out will be immediately corrected and if any electrical concerns will be immediately brought to the Administrators attention and facility electrical vendor will be contacted as necessary. All findings will be reported to the QA	6/30/22

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K 281	Continued From page 5 event of an emergency and/or fire, if anyone was in the courtyards someone could accidentally shut-off all the lights from the interior wall switches. The finding was verified by the Maintenance Director and Administrator, at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 06/07/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition: Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	K 281	Committee at the quarterly QA meeting x12 months or until it is determined that compliance has been met.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor	K 363		6/30/22

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K 363	Continued From page 6 covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/06/22, in the presence of the Maintenance Director and Administrator, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 2 of 30 corridor doors and was evidenced by the following: 1. At 11:50 AM, the surveyor, Maintenance Director and Administrator observed that the door to resident room 114, when closed, left a gap at the top edge of the door, approximately 1/2 inch from the closing edge due to the door not being	K 363	1. On 6/7/2022 facility maintenance director strengthened the alignment of the door and affixed a fire protection strip to the door frame of room 114 to eliminate the 1/2inch gap. On 6/6/2022 the facility maintenance director placed a doorknob/hardware on the door to room 508 to eliminate the 3 gap in the door. Maintenance Director was in-serviced on the requirements that all corridor doors need to be able to resist the passage of smoke in accordance with the NFPA guidelines. 2. All residents have the potential to be	

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K 363	Continued From page 7 aligned properly within the frame. 2. At 12:15 PM, the surveyor, Maintenance Director and Administrator observed that the door to unoccupied resident room 508, was observed to have no door hardware, leaving an approximately 3" hole in the door. The Maintenance Director and Administrator confirmed the findings during the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 06/07/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	affected by this deficient practice. 3. All doors were audited to ensure no gaps or openings, and none were found. Room 508 is in an unoccupied unit. 4. Maintenance Director will audit 5 resident room doors weekly x3months and then 2 doors weekly x3 months to ensure all doors are in good working condition with no gaps or holes. Any concerns will be addressed immediately upon finding. Maintenance Director will report all findings to the QA Committee at the quarterly QA meeting x3 quarters.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 06/06/22, in the	K 374	1. The smoke door was realigned,	6/30/22

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K 374	Continued From page 8 presence of the Maintenance Director and Administrator, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 8 sets of smoke barrier doors observed and was evidenced by the following: At 10:32 AM, the surveyor, Maintenance Director and Administrator observed the set of double smoke doors, by resident rooms 304 and 305, that when released from the electro-magnetic hold open device, 1 of 2 doors did not meet fully closed, due to the door hitting the edge of the 1st door closed, now leaving a gap approximately 1/4 to 1/2 inch. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The findings were verified and confirmed by the Maintenance Director and Administrator during the observations. The surveyor informed the Administrator of the findings at the Life Safety Code survey exit on 06/07/22. NFPA 101- 2012 edition Life Safety Code 19.3.7.6, 19.3.7.8, 19.3.7.9 NJAC 8:39-31.1(c), 31.2(e)	K 374	adjusted, and fixed immediately on 6/6/2022. Maintenance Director was in-serviced on the requirement to have all smoke barrier doors in working condition to be able to resist the transfer of smoke when completely closed for fire protection. 2. All residents have the potential to be affected by this deficient practice. 3. All smoke doors were inspected on 6/6/2022 and all were in good working condition. 4. Maintenance Director will inspect all smoke barrier doors monthly x6months and correct any problems immediately. Should a door be unable to be fixed the Administrator will be notified. Maintenance Director will report audit findings to the QA Committee at the quarterly QA meeting x3 quarters.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but	K 911		6/30/22

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K 911	Continued From page 9 are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/06/22, in the presence of the Maintenance Director, it was determined that the facility did not maintain the required clearance around electrical panels, electrical equipment and controls in accordance with NFPA 101, 2012 LSC Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26. This deficient practice was observed in 1 of 4 electrical rooms, of not ensuring 36" in front of the electrical panels will prevent staff and emergency personnel from disconnecting the electrical power quickly and was evidenced by the following: At 12:58 PM, the surveyor and Maintenance Director observed a housekeeping cart, stored in front of 4-electrical panels, marked PC2, PC1, CPC and CLC. The room was identified as "soiled utility and electrical room" located in Unit 3 by the nurses station. The observations were confirmed by the Maintenance Director during the tour of the electrical room. The Administrator was informed of the observations at the Life Safety Code exit conference on 06/07/22. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	1. The Housekeeping cart was removed immediately. An Inservice was done for all maintenance, housekeeping, and CNA staff on the requirement to a 36 clearance in front of any electrical panel in order to ensure that staff and emergency personnel can quickly disconnect the electrical power in case of emergency. 2. All residents have the potential to be affected by this deficient practice. 3. All electrical rooms were inspected on 6/6/2022 and again on 6/7/2022 and no electrical panels were blocked. 4. Facility Housekeeping Director or designee will inspect all soiled utility rooms that have electrical panels daily x60 days and then weekly x3 months to ensure no housekeeping carts are blocking the electrical panels. Any deficient practice will result in continued education for the staff member and immediate removal of the cart. Facility Housekeeping director will report to the QA Committee at the quarterly QA Meetings x 3 quarters.	

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K 918	Continued From page 10	K 918		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		8/10/22

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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
K 918	Continued From page 11 Based on observation and interview on 06/06/22, in the presence of the Maintenance Director and Administrator, it was determined that the facility did not ensure a remote manual stop station for 1 of 1 generator, which was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 2:00 PM, the surveyor, Maintenance Director and Administrator, observed the exterior diesel generator. There was no remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed outside the enclosure housing the prime mover. An interview was conducted during the observation with the Maintenance Director and Administrator, where they stated that at the time of observation, the exterior generator was observed to not have a remote manual stop station to prevent inadvertent or unintentional operation located outside the enclosure housing the prime mover. The Administrator was informed of the finding at the Life Safety Code exit conference on 06/07/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	1. On 6/6/2022 the facility reached out to the facility generator service vendor to get a quote to install a remote manual stop station. On 8/10/22, Facility generator service vendor installed remote manual stop station. 2. All residents have the potential to be affected by this deficient practice. 3. Facility only has one generator. 4. The remote manual stop station will be maintained by the facility generator vendor. All reports from the generator vendor are sent to the maintenance director and facility administrator and reviewed. Generator is maintained by vendor every six months, but is exercised weekly for 30 mins and under full load 1 time per month by the Maintenance staff. Maintenance Director will report to the QA Committee at their next quarterly meeting about the status of the remote manual stop station install and report to the administrator as needed of any concerns with the installation and/or operation.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315219 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/2/2022 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	06/30/2022	LSC K0281	06/30/2022	LSC K0363	06/30/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	06/30/2022	LSC K0911	06/30/2022	LSC K0918	08/10/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/7/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO