STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315207	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kresson View, LLC	2601 Evesham Road Voorhees, NJ 08043

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to: (a) maintain a homelike environment that was clean, safe, and sanitary, and (b) ensure pantry ice machines were maintained in a sanitary condition. This deficient practice was identified for 4 of 4 units (100-unit, 200-unit, 300- unit, and 400 -unit) and was evidenced by the following: 1.) On 7/29/2025 at 10:39 AM, in room [ROOM NUMBER], the surveyor observed the following: Food in clear packaging on the floor next to the resident’s bed. Foil lid from a juice container on the floor near the radiator. An empty soda bottle, a fork, a used paper towel, and dried liquid spillage were found under the resident’s bed. Brown dried substance on the outer part of the footboard. An accumulation of dust and brown and black substances on the low-air-loss mattress (mattress used to prevent pressure ulcers) hose. On 7/29/25 at 10:51 AM, in room [ROOM NUMBER], the surveyor observed the following: Three (3) styrofoam cups and two (2) urinals sitting side by side, on the floor, between the resident’s bed and nightstand. A white fitted sheet with a brown discoloration. The bedframe contained multiple stains. A brown, rust-like radiator cover vent. Various dried, particle-like stains on the wall near the window and in the bathroom. A buildup of residue on the floor throughout the resident’s room and bathroom. Brown dried substance on the call bell in the bathroom. A strong urine-like odor in the bathroom. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/25 at 12:26 PM, the surveyor conducted a follow-up visit to room [ROOM NUMBER] and observed the room was still not cleaned. On 7/30/225 at 12:31 PM, the surveyor conducted a follow-up visit to room [ROOM NUMBER], and observed dried liquid spillage was still under the resident’s bed. On 7/30/25 at 11:29 AM, the surveyor interviewed the Housekeeper (HK), who stated that she cleaned the resident rooms daily. The HK stated that her daily cleaning included but were not limited to; high/low dusting, wiping down the exterior of the radiator, cleaning the walls and bedframe as needed, and sweeping and mopping the floor daily. On 7/31/25 at 10:38 AM, the surveyor interviewed the Director of Environmental Services (DEVS), who stated that the housekeepers cleaned each room daily and were responsible for emptying the trash, checking the supplies, high/low dusting, dusting and damp mopping the floors, cleaning the commode and sink, cleaning the exterior of the radiator, the bedframe and walls as needed. He further stated that each room was carbolized (disinfected) monthly. At that time, the surveyor requested a copy of the carbolization (the process of treating or disinfecting, primary used to kill microorganisms and prevent infection) schedule for July 2025. The surveyor reviewed the schedule, which did not include room [ROOM NUMBER]. On 8/4/2025 at 12:01 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the resident rooms should be kept clean and tidy. She also stated that each room was cleaned daily and disinfected monthly. She further stated that the daily cleaning consisted of, but was not limited to, sweeping, mopping, cleaning the bedframe and footboard, the exterior of the radiator, and walls as needed. The LNHA stated it was everyone’s responsibility to pick up items off the resident’s floor. A review of the facility’s “Cleaning and Disinfecting Residents’ Rooms,” policy, revised/reviewed January 2019 included, 1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. …4. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. 2.) On 7/29/25 at 10:34 AM, during the initial tour of the 300 unit, the surveyor observed a black substance on the top of the air conditioner unit (AC) located in room [ROOM NUMBER]. On 8/1/25 at 10:40 AM, the surveyor observed the black substance on the top of the AC unit in room [ROOM NUMBER]. On 8/1/25 at 10:45 AM, the surveyor interviewed a housekeeper who stated that the maintenance department cleaned the AC units. On 8/1/25 at 10:57AM, the surveyor interviewed a maintenance employee (ME) who stated that the maintenance department conducted daily rounds called “Room a day” rounds and explained during these rounds, the ME would check a different room every day and record their findings on a check list. The ME further stated that the maintenance department would change the AC unit filters monthly and would paint the outside the AC units if needed. At that time, the ME, in the presence of the surveyor, observed the black substance on top of the AC unit in room [ROOM (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NUMBER]. The ME stated that he did not observe the black substance when the “Room a Day” was conducted last month but the outside of the AC unit should be clean. On 8/1/25 at 11:37 AM, the surveyor interviewed the Director of Maintenance (DOM) who stated that housekeeping was responsible to clean the outside of the units and maintenance would change the filters and paint the AC units as needed. The DOM provided the surveyor the “Room a Day” checklist that was completed on 7/22/25 for room [ROOM NUMBER], which indicated that the AC unit was operable. On 8/1/25 at 12:54 PM, the surveyor, in the presence of the DON, interviewed the LNHA who stated that the maintenance department looked at the AC unit which encompassed the entire AC unit, and that the AC unit should be clean. On 8/5/2025 at 9:33 AM, in the presence of the survey team, the DON, the Regional LNHA and the Regional Clinical Director (RCD), the LNHA stated that the housekeeping department was responsible for cleaning the outside of the AC unit when cleaning the room and the Maintenance department was responsible to ensure the AC unit was operable. A review of the facility’s “safe and Homelike Environment” policy, dated 9/1/2024, included that housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 3.) On 8/1/25 at 8:58 AM, the surveyor toured the nursing units with the Food Service Director (FSD) and Regional (FSD). The surveyor observed 4 of 4 units ice machine interiors had white and black sediment on the interior of the ice dispensing shoot. On 8/1/25 at 9:25 AM the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #1) on the 400 unit who stated, if there was a concern for maintenance or housekeeping, all nursing staff was accountable to notify her, place a work order request in the electronic system, or they could call the department directly to report the concern. LPN/UM #1 acknowledged the black and white sediment on the interior of the ice shoot and stated it has the potential to cause an infection. On 8/1/25 at 10:13 AM, the surveyor interviewed the Director of Maintenance (DOM) who stated the unit ice machines were cleaned within the time frame suggested by the manufacturer and that the last cleaning was performed on 5/16/25. The DOM then acknowledged that the facility had a hard water issue and maybe the cleaning should be done more often. On 8/1/25 at 10:45 AM, the surveyor interviewed the Licensed Nursing Home Director (LNHA) who acknowledged that the ice machines were not clean and could cause a health issue for staff and residents. On 8/5/25 at 1:15 PM, in the presence of the survey team, the LNHA, the DON, the Regional Clinical Director, and the Regional LNHA acknowledged the surveyors concerns and had nothing else to provide. A review of the policy titled “Safe and Homelike Environment,” dated 9/1/24 revealed…#3) Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. #9e) Report any furniture in disrepair to maintenance promptly… #9f) Report any unresolved environmental concerns to the administrator. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the manufacture guidelines, dated reviewed 1/7/22, Part # 000015202, for the Nugget Ice machines on the units reads as follows: Preventative maintenance and descaling procedure…descale and sanitize the ice machine every 6 months for efficient operation…If the ice machine requires more frequent descaling and sanitizing consult a qualified service company to test the water quality and recommend appropriate treatment…sanitizing for exterior, remedial and detailed procedures can be performed independently and more frequently then descaling when needed…periodic descaling MUST be performed on adjacent surface areas not contacted by the water distribution system. NJAC 8:39-4.1 (a)11; 31.2(e)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and review of pertinent records, it was determined that the facility failed to accurately account for and document the administration of controlled medications. This deficient practice was identified on 1 of 5 medication carts (4th floor Cart #1) reviewed and was evidenced by the following:On 7/31/25 at 11:45 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN #1), reviewed the 4th floor nursing unit's medication cart #1. The following was observed when the declining inventory log was reviewed: Resident #123 should have had 29 tablets of tramadol HCL 50 milligram (mg) (a controlled medication used for pain management), but 28 tablets were on hand. LPN #1 at that time, stated she administered the medication during the morning medication pass (8 AM) and failed to sign it out. LPN #1 further stated that controlled medications should be signed out immediately for each dose administered so that the narcotics were accounted for. LPN #1 acknowledged that the narcotic bingo card (medication packaging method) had 28 doses of tramadol HCL 50 mg tablet, and the narcotic declining sheet revealed there should have been 29 tablets. LPN #1 further stated she did not sign it out when she administered the medication this morning. On 7/31/25 at 11:55 AM, the surveyor interviewed Licensed Practical Nurse/ Unit Manager (LPN/UM #1), who stated that the narcotic administration record declining sheet should be signed by the nurse immediately when administered. LPN/UM #1 acknowledged and confirmed that there were 28 doses of tramadol HCL 50 mg tablets and that the narcotic declining sheet revealed 29 tablets remaining. She further acknowledged that LPN #1 did not sign the narcotic declining sheet when she administered the medication. On 7/31/25 at 12:05 PM, the Director of Nursing (DON), in the presence of the Regional Director of Clinical Services, confirmed that a narcotic should be signed out by the nurse on the narcotic declining sheet when the medication was pulled from the bingo card. She further acknowledged that LPN #1 did not sign the declining narcotic sheet for the tramadol HCL 50 mg 8 AM dose when it was administered. A further review of the medication administration audit report indicated the tramadol HCL 50 mg tab 8 AM dose was administered on 7/31/25 at 8:28 AM and not signed out when compared to their corresponding Medication Administration Records (MAR). On 8/5/25 at 9:34 AM, the DON, in the presence of the Licensed Nursing Home Administrator (LNHA), the Regional Clinical Director, the Regional LNHA, and the survey team, confirmed that LPN #1 did not sign the narcotic declining sheet when she administered the medication to the resident. The DON further stated that the nurse should have signed the narcotic declining sheet when she removed it from the narcotic bingo card. A review of the facility's Medication Administration policy dated 9/1/24, included if a medication is a controlled substance, sign narcotic book upon removal from inventory. A review of the facility's Controlled Substance Administration and Accountability policy with a revised date of 3/17/25, included all controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided.in all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the medication administration record (MAR), controlled drug record, or other facility specified form and placed in the patient's medical record . NJAC 8:39-29.7(c)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that the resident's dietary preferences were accurately implemented for 1 of 10 residents (Resident #14) reviewed for nutrition, and was evidenced by the following:On 7/31/25 at 12:15 PM, the surveyor observed Resident #14 sitting upright in a geriatric chair (a specialized recliner designed to provide comfort, support, and positioning for individuals with mobility limitations) in the 400 Unit dining room being assisted by the Certified Nurse Assistant (CNA). The resident's diet slip indicated large portions of ground cheesy ham and macaroni casserole, poultry gravy, sauteed spinach with garlic, crustless bread, margarine, vanilla ice cream, chocolate milk, and apple juice. The meal ticket further indicated, No green vegetables. At that time, the surveyor observed Resident #14's tray included a large portion of sauteed spinach.On 7/31/25 at 12:30 PM, the surveyor reviewed the medical record for Resident #14.A review of the admission Record, an admission summary, revealed that the resident had a diagnosis that included but was not limited to intellectual disabilities. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/9/2025, included that the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident's cognition was severely impaired. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 11/9/2021, that the resident was at risk for malnutrition. Interventions included: provide food and beverage preferences, dislikes green vegetables.A review of the Order Summary Report (OSR) included a diet consisting of ground texture, thin liquids, and large portions.On 7/31/25 at 12:15 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1, who confirmed the resident's lunch contained sauteed spinach. She stated that meals were served according to the resident's likes and dislikes. LPN/UM #1 stated that she would provide the resident with a substitute for the green vegetables. On 8/1/25 at 9:03 AM, the surveyor interviewed the Food Service Director (FSD), who stated that the meals should be accurate. She further stated that the dietary team collaborated with the nursing team, and the trays are double-checked before being given to the resident. She also said that No green vegetables should not have been written on the meal ticket because the resident eats everything. On 8/1/25 at 10:02 AM, the surveyor interviewed the Registered Dietitian (RD), who stated that the food trays should be accurate as shown on the meal ticket. She further stated that food preferences could change, and they should be communicated to dietary services and honored. The RD also stated that if there was a discrepancy on the meal ticket, it should be clarified immediately.On 8/4/2025 at 11:50 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the dietician visited the resident upon admission and discussed the resident's likes and dislikes. She further noted that the person delivering the tray was supposed to check it for meal accuracy before giving it to the resident. The DON stated that if there was any discrepancy, the dietician should be notified, and the matter should be followed up.On 8/4/25 at 12:01 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who acknowledged that the meal tickets and trays should be accurate.A review of the facility's Dining and Food Preferences policy, revised September 2017, included: Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value. NJAC 8:39-17.4(e)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to follow appropriate infection control practices, specifically the use of Personal Protective Equipment (PPE) during incontinence tours to residents who required Enhanced Barrier Precautions (EBP)(an infection control strategy focused on reducing the spread of multidrug-resistant organisms in nursing homes), to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was identified for 2 of 2 residents (Resident #180 and Resident #188) and was evidenced by the following:According to the CDC Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, EBP are recommended for residents with indwelling devices or wounds . because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO (multidrug-resistant organisms) and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized. EBP expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. EBP are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) .https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html1. On 7/30/25 at 8:54 AM, during an incontinence tour with Registered Nurse/ Unit Manager #1 (RN/ UM #1), the surveyor observed an EBP sign on Resident #180's door and an orange dot on the resident's name posted outside the room. RN/ UM#1 sanitized their hands with an alcohol-based hand sanitizer (ABHS) and wore gloves but did not put on a gown. RN/ UM #1 pulled away the resident's bed linen and exposed the resident's green incontinence brief on the front side. The surveyor observed the incontinence brief to be wet with the bedsheet under the resident's buttocks also wet. Resident #180 stated that they just got wet. The surveyor asked RN/ UM#1 to expose the back of the brief. RN/ UM #1 turned the resident to the side and unfastened the incontinence brief to expose the back of the resident. The green incontinence brief was observed to be wet at the back. RN/ UM #1 fastened the brief and stated to the surveyor that the resident would get changed.On 7/30/25 at 12:06 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #180.A review of the admission Record revealed that the resident was admitted to the facility with diagnoses which included but not limited to displaced bimalleolar fracture of left lower leg (a type of ankle fracture where both bony sides of the ankle are broken) and difficulty of walking.A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 7/9/25, revealed that the resident had surgical wound.A review of the Clinical Physician Orders completed and active as of 7/30/25, revealed the following order: Resident requires Enhanced Barrier Precautions for a diagnosis of surgical incision w/soft cast left leg ordered on 7/3/25.A review of the resident's comprehensive care plan as of 7/30/25 indicated a focus for the resident requiring EBP related to left ankle surgical incision with soft cast in place. Interventions initiated on 7/7/2025 included the following: Clear signage must be posted on the door or wall outside of the resident room indicating the type of precautions and required PPE. For Enhanced Barrier Precautions, signage should also clearly indicate the high contact resident care activities that require the use of gown and gloves.2. On 7/30/2025 at 9:22 AM, during an incontinence tour with Registered Nurse/ Unit Manager #2 (RN/ UM) #2, the surveyor observed an EBP sign on Resident #188's door and an orange dot on the resident's name posted outside the room. RN/ UM #2 sanitized their hands with an ABHS and wore gloves. RN/ UM #2 asked the assistance of Certified Nursing Assistant #2 (CNA #2) for turning the resident. CNA #2 sanitized their hands with ABHS and put gloves on. Both RN/ UM #2 and CNA #2 did not put on a gown. RN/ UM #2 exposed the resident's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	white incontinence brief from the front side. The brief was observed to be damp. The surveyor asked RN/ UM #2 to expose the back side of the brief. RN/ UM #2 with the assistance of CNA #2 turned the resident to the side and exposed the brief from the back side which appeared damp. There was also a small amount of dry, brownish substance along the resident's buttocks. RN/ UM #2 stated that the resident would get changed.On 7/30/25 at 12:07 PM, the surveyor reviewed the EMR for Resident #188.A review of the admission Record revealed that the resident was admitted to the facility with diagnoses which included but not limited to carrier of Carbapenem-resistant Enterobacterales (CRE) (a group of bacteria that have developed resistance to carbapenem antibiotics) and peripheral vascular disease.A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 7/9/25, revealed that the resident had pressure ulcer stage 3, 2 venous arterial ulcers, infection of the foot, and moisture associated skin damage.A review of the Clinical Physician Orders completed and active as of 7/30/25, revealed the following order: Resident requires Enhanced Barrier Precautions for a Vascular Wounds to legs w/dressings, sacral wound; and history of CRE E.coli (urine), history of MRSA (Methicillin-resistant Staphylococcus aureus) (a group of bacteria resistant to methicillin antibiotics) to leg wounds every shift for EBP started on 7/14/25.A review of the resident's comprehensive care plan as of 7/30/2025 indicated a focus for the resident requiring EBP for wounds, history of CRE E. coli in urine, and history of MRSA to leg wounds. Interventions initiated on 7/14/25, included the following: Clear signage must be posted on the door or wall outside the resident's room indicating the type of precautions and required PPE. For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves.On 8/1/25 at 11:03 AM, during an interview with the survey team, the Infection Preventionist (IP) stated that high-contact activities requiring EBP include incontinence care, transferring, and wound care. The IP also stated that the PPEs required for EBP included gloves and gowns.On 8/1/25 at 11:39 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that high-contact activities requiring EBP include direct care and extended period activities with residents on EBP including opening and closing of incontinence briefs.A review of the facility-provided policy date implemented on 9/1/2024 titled Enhanced Barrier Precaution under Policy Explanation 1.b.) An order for enhanced barrier precautions will be obtained for residents with any of the following: i.) Wounds . ii.) Infection or colonization with CDC-targeted MDRO when contact precautions do not otherwise apply. N.J.A.C. 8:39 - 19.4 (a)