STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Complete Care at Voorhees, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interviews, medical record review, and review of other pertinent facility documents on 02/17/2026 and 02/19/2026, it was determined that the facility failed to promptly notify the Physician about a resident's abnormal urine culture result. The facility also failed to follow its policy titled Physician, Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Lab Notification. This deficient practice was identified for 1 of 6 residents (Resident #6) reviewed for laboratory results.This deficient practice was evidenced by the following: According to the admission Record (AR), Resident #6 was admitted to the facility with diagnoses which included but were not limited to: Acute Kidney Failure (a rapid loss of kidney function), Diabetes (high blood sugar levels), and Urinary Tract Infection (bacteria infection in the bladder, kidneys).A review of Resident #6's most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 11/16/2025, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated the resident's cognition was severely impaired.A review of Resident #6's urine culture report revealed a collection date of 11/12/2025 at 09:08 AM, and a received date of 11/14/2025 at 10:14 AM. The urine culture report further revealed a reported date of 11/14/2025 at 1:49 PM, indicating the facility was notified that Resident #6 had an abnormal urine culture result on 11/14/25. A review of Resident #6's Progress Notes (PNs) revealed that on 11/18/2025 the Nurse Practitioner (NP) came in to see the resident (Resident #6), reviewed the urine culture results and ordered antibiotic therapy.During an interview with the surveyor on 02/19/2026 at 10:52 AM, the Unit Manager/Licensed Practical Nurse (UM/LPN) stated that abnormal urine culture results are usually received from the lab in about two to three days. She further stated that the expectation is for the nurse to notify the provider with the results as soon as possible. The UM/LPN stated, if the provider is not notified of an abnormal lab result until four days later, it would be considered a delay in care and if antibiotic is not started on time, there is a possibility of the infection becoming worse. The UM/LPN acknowledged the facility policy was not followed for R#6.During an interview with the surveyor on 02/19/2026 at 1:05 PM, the Director of Nursing (DON) in the presence of the Regional Nurse (RN), stated that the nurse is responsible for collecting the specimen. The DON further stated that the urine culture result usually came back within three to four days, and that once the results were received, the expectation was for the nurse to communicate the results with the Clinician as soon as possible for further orders. The DON stated that lab results are entered into the Point click Care (PCC) system and that Clinicians have access to review them on the PCC but the expectation is for the nurse to alert the Clinician once the lab results were received. The Regional Nurse (RN) stated, if the Medical Doctor (MD) was not made aware of a lab result and there is no documentation to show the MD was notified, then the facility policy was not followed.During an interview with the surveyor on 02/19/2026 at 1:32PM, the Nurse Practitioner (NP #1) caring for Resident #6 stated, if there is an abnormal lab result and it is after hours, the nurse is expected to call the on-call service for orders. She stated (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

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 was seen by a different NP (NP #2) on 11/17/2025 and that there was no documentation that NP #2 reviewed the abnormal lab results. NP #1 stated that the lab should have been reviewed by NP #2 on 11/17/2025. NP #1 further stated that when she saw Resident #6 11/18/2025, there was a change in the resident's baseline. She stated that she assessed the resident, reviewed the lab results and noticed the resident had severe UTI based on the lab results; and that she started the resident on antibiotic therapy. The NP #1 further stated that the expectation is for the nurse to call the provider once an abnormal lab result was received and that the provider should had been notified on 11/14/2025 about the abnormal results. When asked if there was a delay in care, the NP #1 stated, yes, that would be considered as a delay in care. Review of the facility policy titled Physician, Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Lab Notification dated 02/10/2026, under Policy revealed: It is the policy of this facility to timely notify the physician, physician assistant, nurse practitioner or clinical nurse specialist of lab results. Under Policy Explanation and Compliance Guideline, 1. The facility must promptly notify the attending physician, physician assistant, nurse practitioner or clinical nurse specialist of lab results that fall outside of clinical reference ranges in accordance with the facility policies and procedures for notification of a practitioner or per ordering physician orders. Delayed notification may contribute to delays in changing the course of treatment or care plan. NJAC 8:39-13.1 (d)