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	01/13/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41072 Based on observation and interview, it was determined that the facility failed to ensure that the residents' dining experience was provided in a manner to promote dignity and respect of the residents. This deficient practice was identified in 1 of 5 units observed (the 100 unit) and was evidenced by the following: 1.) On 1/9/25 at 10:00 AM, during the surveyor-conducted resident council meeting, 4 of 4 residents (Resident #6, #60, #71 and #98) who attended the meeting stated that roommates did not get served their meal trays at the same time. 2.) On 1/7/25 at 9:27 AM, the surveyor observed the breakfast meal on the high end of the 100 unit and Resident #71 was delivered his/her breakfast tray. Resident #71 stated we don't get our meal trays delivered at the same time. At that time, the surveyor observed Resident #117 (Resident #71's roommate) standing at his/her doorway of their room and stated, I'm waiting for my breakfast tray. At 9:38 AM, the surveyor observed several residents on the unit had not received their breakfast trays. The Certified Nursing Assistant (CNA #4) confirmed with the surveyor that the following residents had not received their breakfast trays and that she had called the kitchen for the following seven (7) breakfast trays: Resident #20, #56, #80, #88, #112, #113, and #117. At 9:57 AM, the surveyor observed a food truck delivered to the 100 unit with the missing breakfast trays. The nursing staff delivered the breakfast trays to the residents. At that time, the surveyor observed that Resident #20's tray contained only oatmeal and not toast, which was listed on the meal ticket. At 10:02 AM, CNA #4 called the kitchen to obtain a new tray for Resident #20 that included the toast. At that time, CNA #4 stated that Resident #11 had not recieved a breakfast tray yet and then called the kitchen to obtain Resident #111's breakfast tray. The CNA did not give Resident #20 his/her tray with the missing item. (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: 315219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Voorhees, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 Evesham Road Voorhees, NJ 08043	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:14 AM, the surveyor observed the Food Service Director (FSD) deliver a breakfast tray to Resident #111. At 10:15 AM, the surveyor showed the FSD Residents #20's breakfast tray, that was still in the food truck, was missing the toast. The FSD stated she will get the resident a new breakfast tray. The FSD stated she was trying to find out what happened that all the breakfast trays were not delivered at the same time. At 10:25 AM, the surveyor observed Resident #20's breakfast tray delivered to the unit. On 1/8/25 at 1:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), in the presence of the Regional Director of Nursing (RDON), the Regional Director of Operations, the Regional Nurse Quality Assurance Nurse Specialist, and the survey team, who stated that her expectation would be that meal trays would not be missing from the food trucks. The LNHA further stated that unit 100 was the last unit to be served breakfast, usually around 9:15 AM, and that residents in the same room should be served their trays at the same time. The LNHA further stated that it was important that residents are served meals at the same time because it was their resident's right. A review of the facility's Promoting/Maintaining Resident Dignity policy, dated 9/1/24, included that all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident's rights. A review of the facility's Meal Distribution policy, revised September 2017, included that the nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents. NJAC 8:39-4.1(a)12

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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** 40041 Complaint #: NJ180809 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident environment, equipment and living areas in a safe, sanitary, and homelike manner for 3 of 35 residents (Resident #106, #107, and #126) and air temperature log for 5 of 5 units observed during environmental rounds. This deficient practice was evidenced by the following: 1.) On 1/3/2025 at 12:13 PM, the surveyor toured the 500 Unit, which was noted to be chilly in the hallway near room [ROOM NUMBER]. The hatch door leading to the attic was observed to be partially open. The Director of Maintenance (DM) took the air temperature, which registered at 65 degrees. A review of the Air Temperature audit logs from 12/1 2024 to 1/8/25 revealed the following: On 12/3/2024: The 100 Unit shower room was documented as 70 degrees. The 300 Unit shower room was documented as 70 degrees. The 400 Unit shower room was documented as 69 degrees. On 12/18/2024: The 100 Unit, resident's room [ROOM NUMBER] was documented as 69 degrees. The 200 Unit resident's room [ROOM NUMBER] was documented as 69 degrees. On 12/31/2024: The 200 Unit shower room was documented as 70 degrees. The 500 Unit shower room was documented as 69 degrees. On 1/7/2025: The 100 Unit shower room was documented as 69 degrees. The 200 Unit shower room was documented as 67 degrees. The 300 Unit shower room was documented as 68 degrees. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/2025 at 11:47 AM, the Account Manager of Environmental Services ([NAME]) stated in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, that the temperature should be comfortable and should not go below 65 degrees. He further stated the residents usually like it warmer. At that time, the LNHA stated she was unaware that the air temperature should be maintained between 71 to 81 degrees. 41260 2.) On 1/2/25 at 10:07 AM, the surveyor observed Resident #126 sitting on the edge of the bed. The resident stated their main concern with the facility was the cleanliness of the bathroom. The resident stated their roommate would often leave feces on the toilet and floor, and that the housekeeping staff did not come to clean the bathroom until hours later. The resident then asked the surveyor to look at their bathroom because there had been feces on the toilet since approximately 2:00 AM that morning. When the surveyor opened the resident's bathroom door, there was a strong, foul odor noted and feces on the toilet seat. The surveyor reviewed the medical record for Resident #126. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 10/7/24, included the resident had a Brief Interview for Mental Status (BIMS)score of 15 out of 15, which indicated the resident's cognition was intact. 41072 3.) On 1/2/25 10:25 AM, during the initial tour of the 200 Unit, the surveyor observed Resident # 106's bathroom and the toilet had a black substance dripping down the outside of the white toilet bowl. The white toilet seat was in a up position with yellow stains that were visible to the resident. The surveyor observed yellow liquid and black substance on the floor at the base of the toilet. At that time, the surveyor interviewed Resident #106 who stated that they uses the bathroom and was not sure when it was last cleaned. On 1/3/25 at 8:16 AM, the surveyor observed Resident #106's bathroom and observed the white toilet seat was in the up position with yellow stains, and yellow stains were also on the floor at the base of the toilet. A review of Resident #106's Admission record, an admission summary, revealed the resident had diagnoses which included, dementia, retention of urine, and constipation. A review of the resident's quarterly MDS, dated [DATE], included the resident had a BIMS score of 11 out of 15, which indicated that the resident's cognition was moderately impaired. Further review of the MDS revealed the resident was continent of both bowel and bladder. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/3/25 at 12:40 PM, the surveyor interviewed the [NAME] who stated the housekeepers cleaned the residents' rooms three times during their 7:00 AM to 3:00 PM shift. The [NAME] further explained that the housekeepers were expected to make morning rounds at 7:00 AM to empty resident room trash cans and inspect the room for any immediate need for cleaning. The [NAME] stated after the housekeepers' first break, they cleaned resident rooms until the end of their shift when they made their final rounds in each resident room. The [NAME] also stated there was a porter from 2:00 PM to 10:00 PM, but no housekeeping staff from 10:00 PM to 7:00 AM. At that time, the surveyor informed the [NAME] of Resident #126's dirty toilet that had been soiled at 2:00 AM and not yet cleaned by 10:00 AM during the surveyor's observation. The [NAME] stated the housekeeper should have seen the dirty toilet during their 7:00 AM rounds and cleaned the toilet for infection control reasons. The [NAME] further stated that Resident #106s bathroom should have been addressed on the 7:00 AM rounds. 37547 4.) On 1/3/25 at 11:47 AM, during a tour of the 200 Unit, the surveyor interviewed Resident #107 who stated that they had spoken the Licensed Nursing Home Administrator (LNHA) and the Director of Maintenance (DM) about their toilet seat being discolored with yellow on top of the seat and the inner side of the toilet seat. The resident stated that the LNHA indicated that at the very least they would replace the toilet seat. Resident #107 further stated that the bathroom was cleaned on Wednesday 1/1/25. A review of Resident #107's Admission Record revealed that the resident had diagnosis which included, Achalasia of cardia (a swallowing disorder), dementia, unspecified severity, with other behavioral disturbance, and dysphagia (difficulty swallowing). A review of Resident #107's quarterly MDS, dated [DATE], included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was fully intact. On 1/3/25 at 12:06 PM, the surveyor interviewed Housekeeper (HK) #1 who stated that resident rooms were cleaned daily. HK #1 stated that she did not know when Resident #107's room was cleaned last because she worked on a different unit. At that time, HK #1 accompanied the surveyor into Resident #107's bathroom. The surveyor showed HK #1 two areas of yellow staining and HK #1 stated these could come off. HK #1 then proceeded to spray the toilet seat and the surrounding area of the toilet with disinfectant cleaner and wiped it with a rag and both the yellow and black debris was removed. HK #1 stated, that was not discoloration. Resident #107 was present at that time and stated that we thought the yellow substance was staining, but it was urine. Resident #107 stated that the toilet was so much cleaner now. On 1/3/25 at 12:32 PM, the surveyor interviewed the [NAME] who stated that he had spoken with Resident #107 and the toilet seat should have been replaced after 12/5/24, and he referred the task to a Maintenance Aide verbally but had not documented it. The [NAME] stated that it was an infection control situation, and it should have been done. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/3/25 at 1:04 PM, the surveyor interviewed the DM who stated that he spoke with Resident #107 in the hall a couple of weeks ago and told the resident that he would get him/her a new toilet seat but then the resident requested a new toilet instead. The DM stated that he could have replaced the toilet seat right away. On 1/3/25 at 1:12 PM, the surveyor observed the DM outside of Resident #107's room with a new toilet seat after surveyor inquiry. On 1/8/25 at 1:22 PM, the surveyor interviewed the LNHA who stated that any staff member who sees a dirty toilet could notify housekeeping to clean the bathroom. The LNHA further stated it was important to ensure a resident's toilet was cleaned promptly for infection control reasons and because it was the resident's environment. A review of the facility's Routine Cleaning and Disinfection policy, dated 9/1/24, included that the facility is to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Routine cleaning and disinfection of frequently touched or visible soiled surfaces will be performed in common area, residents' rooms and at time of discharge. NJAC 8:39-31.4(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 43308 Complaint NJ #'s:168726, 168827, and 175632 Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure medications were administered within the physician's order scheduled time in accordance with professional standards of practice for 2 of 35 residents (Resident #86 and #160) reviewed for professional standards of practice. This deficient practice 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 and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens 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. 1.) On 1/2/25 at 10:27 AM, during the initial tour, the surveyor observed Resident #86 lying in bed sleeping. On 1/3/25 at 10:22 AM, the surveyor reviewed the medical record for Resident #86. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, Diabetes Mellitus (DM- high blood glucose), high blood pressure, pain in the right hip, and Alzheimer's disease. A review of the Medication Administration (Admin) Audit Report from 6/1/24 to 8/31/24 revealed the following: Metoprolol extended release (ER) 25 milligrams (mg), give one (1) tablet (tab) by mouth: scheduled for 8:00 AM. Ferrous Sulfate (iron) 325mg, give 1 tab by mouth: scheduled for 9:00 AM. Fluticasone (nasal spray) 50 micrograms (mcg) 1 spray in each nostril: scheduled for 9:00 AM. Aspirin 81 mg, give 1 tab by mouth: scheduled for 9:00 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Buspirone (for anxiety) 7.5mg, give 1 tab by mouth: scheduled for 9:00 AM. Lactobacillius (probiotic) 1 capsule by mouth: scheduled for 9:00 AM. Breo Ellipta (inhaler) 200/25 mcg, 1 puff: scheduled for 9:00 AM. Cholecalciferol (for calcium) 1000 unit, give 1 tab by mouth: scheduled for 9:00 AM. Hydralazine (for blood pressure) 50 mg, give 1 tab by mouth: scheduled for 9:00 AM. Amlodipine 10 mg, give 1 tab by mouth: scheduled for 9:00 AM, Oxycodone 5 mg, give 1 tab by mouth: scheduled for 8:00 AM was changed to Oxycontin 10 mg, give 1 tab by mouth: scheduled for 8:00 AM. In June 2024, medications were documented as administered late (not within the 60 minutes prior to or after the scheduled timeframe) a total of 47 times. In July 2024, medications were documented as administered late a total of 58 times. In August 2024, medications were documented as administered late a total of 34 times. A review of the Progress Notes (PN) from June 2024 to August 2024 did not reveal the physician was notified of the late administration of the medications. On 1/7/25 at 10:51 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #3) who stated that medications should be administered one (1) hour before or 1 hour after the scheduled time. LPN/UM #3 stated that it was important for medications (meds) to be administered within the timeframe because some medications needed to be taken with food, or pain meds taken before wound care. She further stated that if not administered within the timeframe the medications could interfere with one another. LPN/UM #3 stated that it was a medication error if the meds were not administered as scheduled and it should be reported to the supervisor. On 1/7/25 at 10:58 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that medications should be administered 1 hour before or 1 hour after the scheduled time. She stated that it was important to administer within those timeframes because the resident's blood pressure or blood glucose could be affected. She then stated it was also important to administer meds during the scheduled time to prevent the resident from being double dosed. LPN #1 stated that it was considered a medication error, and the physician should be notified to see if they still wanted the medication to be administered. On 1/7/25 at 12:20 PM, the Regional Director of Nursing (RDON) stated that nurses had an hour window which was one hour before or one hour after to administer the medications. She further stated that meds should be administered within the one-hour window as it may interfere with the next dosage. The RDON stated if the meds are not administered within the one-hour window the expectation would be that the nurse notify the physician. At that time, the surveyor and the RDON reviewed the Medication Audit report which revealed there were 13 nurses that did not administer medications within the one-hour window. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 at 8:43 AM, the surveyor interviewed the Regional Director of Nursing (RDON) who stated she spoke with some of the nurses regarding the times and they indicated that the medications were not administered late but that they documented late because the unit was busy. On 1/9/25 at 9:55 AM, the RDON stated in the presence of the Licensed Nursing Home Administrator (LNHA), the Regional Director of Operations (RDO), and the survey team that she attempted to contact the 13 nurses and six (6) nurses responded they administered the medications on time but documented late. The RDON acknowledged the nurses should document once the medications were administered. 41072 2.) On 1/3/25 at 10:22 AM, during medication pass observation, the surveyor observed a Licensed Practical Nurse (LPN #3) administer medications to Resident #160. At that time, Resident #160 stated he/she had pain patches to both his/her knees. LPN #3 and the surveyor observed Resident #160 pull up his/her pant legs and observed undated and unidentified white patches to both knees. LPN #3 removed the white patches from both knees. Resident #160 stated he/she had pain to both knees and it has been worse since the weather has changed. At that time, LPN #3 and the surveyor reviewed the active physician's orders (PO) which revealed there was not a physician order for patches to both knees. LPN # stated she will call the doctor to inform them of the patches to the knees. On 1/3/25 at 9:18 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated that she was made aware of the patches that were on Resident #160's knees without a PO and would start an investigation. On 1/3/24 at 9:23 AM, the surveyor reviewed the medical record for Resident #160. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, primary osteoarthritis of the left hip, muscle weakness, unspecified osteoarthritis, and unspecified dementia. A review of the admission Minimum Data Set (MDS), an assessment tool, dated 10/29/24, included 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. Further review of the MDS revealed that the resident had occasional pain at a moderate pain level. A review of the individual comprehensive care plan (ICCP) included focus area, dated 10/22/24, that the resident had chronic pain related to arthritis. Interventions included: monitor/record/report to nurse resident complaints of pain or requests for pain treatment. A review with Order Summary Report (OSR), dated as of 1/8/25, included the following PO: A PO, dated 1/3/25, for Lidocaine External Patch 4% apply to B/L(bilateral) knee topically one time a day for chronic pain and remove per scheduled with a start date of 1/4/25. The OSR did not reveal a PO for pain patches to both knees prior to surveyor inquiry. A review of the January 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reveal a PO for pain patches to bilateral knees prior to 1/3/25 at 11:21 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the December 2024 and January 2025 progress notes did not reveal any documentation of pain patches being applied to Resident #160's bilateral knees prior to the observation on 1/3/25. On 1/6/24 at 1:43 PM, the surveyor conducted a follow up interview with LPN/UM #1 who stated that the Nurse Practitioner was notified and a PO for Lidocaine pain patches to both knees was obtained. LPN/UM#1 stated that patches to both knees should not have been applied without a PO. On 1/7/25 at 8:47 AM, the Regional Director of Nursing (RDON) provided the surveyor an incident report for a medication error regarding applying pain patches without a PO. On 1/8/25 at 9:50 AM, the surveyor interviewed the RDON who stated that the patches should not have been applied to Resident #160's knees without a physician's order. The RDON stated that she would have expected the nurses to call the physician to obtain a PO before applying the patches. A review of the facility's Medication Administration policy, dated 9/1/24, included the following: 10. Ensure the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, and right documentation. 11. Review the MAR to identify medication to be administered. 12. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. A review of the facility's Medication Orders policy, dated 9/1/24, included that medication should be administered only upon a signed order of a person lawfully authorized to prescribe. The policy further revealed that the facility shall ensure medications will be administered as follows: a) according to physician's orders, b) per manufactures specifications and c), in accordance with accepted standards and principles which apply to professional providing services. A review of the facility's Medication Errors policy, dated 9/1/24, included, Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber 's order . a. Medications administration not in accordance with the prescriber's order. Examples include, but not limited to: i. incorrect dose, route of administration, dosage form, time of administration . c. Medications administered not in accordance with professional standards and principles . 7. If a medication error occurs . c. Document actions taken in the medical record. NJAC 8:39-29.2(d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40041 Complaint #: NJ00174162 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) provide nail care to a resident who required assistance with the activities of daily living (ADL) and b.) implement the comprehensive care plan. This deficient practice was identified for 1 of 8 residents (Resident #118) reviewed for activities of daily living. This deficient practice was evidenced as follows: 1.) On 1/7/25 at 11:07 AM, during an incontinence tour, while accompanied by Licensed Practical Nurse/Unit Manager (LPN) #1 and Certified Nurse Assistant (CNA) #2, the surveyor observed Resident #118 bilateral (b/l) lower legs with multiple blister-like areas containing some dried blood. The LPN/UM#1 stated that the resident scratches themselves. Resident #118's fingernails were observed to be medium in length and contained reddish-brown blood-like residue under multiple fingernails and thick brown fecal-like matter under their right thumb. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, hemiplegia and hemiparesis (partial paralysis on one side if the body) following cerebral infarction (a stroke) affecting the left non dominant side, dysarthria (weakness in the muscles used for speech) following cerebral infarction, chronic kidney disease and depression. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 9/11/24, included 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. Further review of the MDS revealed the resident had an upper extremity impairment on one side, required moderate assistance with personal hygiene, toileting hygiene, oral hygiene, and required substantial assistance with showers and lower body dressing. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 12/8/23, that the resident has a potential impairment to skin integrity. The interventions included: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Assist resident with general hygiene, skin will be assessed on a weekly basis and findings documented, monitor/document location, size and treatment of skin injury. On 1/8/2025 at 8:43 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1, who stated that the Certified Nursing Assistant (CNA) was responsible for cleaning the resident's fingernails as needed and trimming them to prevent scratching. The surveyor and LPN/UM#1 made a follow-up visit with the resident. At that time, Resident #118's fingernails still contained residue and were still the same length as the previous day (1/7/25). LPN/UM #1 confirmed that the resident's nails were medium in length and needed to be trimmed and cleaned. (continued on next page)

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 01/13/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/2025 at 9:56 AM, the surveyor interviewed the Regional Director of Nursing (RDON), who stated that the CNAs should check the residents' fingernails when they are performing care and clean them when they are soiled. She further stated that the resident's fingernails should be kept short and clean to prevent an infection. The RDON stated that the care plan should be followed. A review of the facility's Activities of Daily Living (ADLs) policy, dated 9/1/2024, included Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. A review of the facility's Comprehensive Care Plans policy, date 9/1/2024, included The policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. NJAC 8:39-27.2 (g)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. 43308 Complaint #: NJ175632 Based on observation, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to provide foot care and services for 1 of 1 resident (Resident #86) reviewed for foot care. This deficient practice was evidenced by the following: On 1/2/25 at 10:27 AM, during the initial tour the surveyor observed Resident #86 lying in bed sleeping. On 1/3/25 at 10:22 AM, the surveyor reviewed the medical record for Resident #86. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, Diabetes Mellitus (DM- high blood glucose), abnormalities of gait (a person's manner in walking) and mobility, and Alzheimer's disease. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 11/10/23, that the resident had DM. Interventions included: inspect feet daily, wash feet daily, dry thoroughly, and may use a light dusting powder or lotion. On 1/7/25 at 10:32 AM, the surveyor observed the resident lying in bed, dressed and their fingernails were trimmed. At that time, the surveyor was unable to observe the resident's feet. On 1/7/25 at 10:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that she was an agency nurse but that the Hospice Aide (HA) came and performed morning (AM) care. At that time, the surveyor and LPN #1 entered Resident #86's room. LPN #1 removed the resident's socks and their feet appeared dry and the toenails appeared they needed to be trimmed and groomed. She stated that she was unsure when the last time the resident's toenails were trimmed by the Podiatrist. LPN #1 stated that the HA and the Certified Nursing Assistant (CNA) should have applied lotion to the resident's feet during care and as needed. On 1/7/25 at 10:40 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #3) who stated that the Podiatrist came every other month. She further stated that the Podiatrist trimmed the residents' toenails, and the CNAs performed daily foot care. LPN/UM #3 stated that the resident was very feisty during care especially if he/she did not know the person. On 1/8/25 at 8:43 AM, the surveyor interviewed the Regional Director of Nursing (RDON) who stated that the resident was last seen by the Podiatrist in May of 2024. She further stated that since the resident was combative three (3) times the Podiatrist's office put the resident on the do not return list unless the facility called for the resident to be seen. The RDON stated that the facility was unaware that the resident was on that list. When asked who was responsible for performing daily foot care to the resident, the RDON stated the CNAs. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 at 8:58 AM, the surveyor interviewed LPN #2 who stated she was an agency nurse but that the CNAs should perform foot care and the nurse should assess the resident's feet during the skin assessment. On 1/8/25 at 9:02 AM, the surveyor interviewed the HA who stated that she came Monday to Friday and was with her residents for one (1) to two (2) hours. She stated that she performed AM care by washing the resident from head to toe. The HA stated that she performed fingernail care once but was then advised that the nurses trimmed the fingernails. The HA then stated that during AM care, she also provided foot care. When asked did she perform foot care yesterday (1/7/25), the HA replied yes around 8:30 AM. At that time, the surveyor informed the HA of the appearance of the resident's feet yesterday around 10:30 AM. When asked did she perform foot care today (1/8/25), the HA stated no, someone else applied lotion to the resident's feet. On 1/8/25 at 9:10 AM, the Resident's Representative (RR) was present in the room and stated the resident's feet were dry, so she asked a CNA to lotion them. The RR stated that the resident's feet were dry and flaky, and she always had to tell an aide to provide foot care for the resident. On 1/8/25 at 1:09 PM, the RDON provided an email confirming the resident was last seen by the Podiatrist on 5/16/24 and would not be placed back on the list to be seen unless requested by the facility. On 1/8/25 at 2:30 PM, the RDON stated in the presence of the Licensed Nursing Home Administrator (LNHA), the Regional Director of Operations (RDO), the Regional Nurse Quality Assurance Nurse Specialist and the survey team that the CNAs were responsible for performing foot care and that the HA and the CNAs should be looking at the resident's feet and inform the nurse if the resident's nails needed to be trimmed. On 1/9/25 at 9:55 AM, the RDON stated in the presence of the LNHA, the RDO, and the survey team that the resident was scheduled to be seen by the Podiatrist after surveyor inquiry. The RDON acknowledged that foot care should be performed daily during care. A review of the facility's Activities of Daily Living (ADLs) policy dated 9/1/24, included, Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. A review of the facility's Skin Integrity - Foot Care policy dated 9/1/24, included, 1. The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical conditions. 2. Assessment Risk c. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task. NJAC 8:39-27.1(a);27.2 (g)

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F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe, appropriate dialysis care/services for a resident who requires such services.

41072

Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to adjust medication administration times to accommodate for scheduled dialysis times.

This deficient practice was identified for 1 of 1 resident (Resident # 33) reviewed for dialysis and was evidenced by the following:

On 1/2/24 at 10:15 AM, the surveyor observed that Resident #33 was not in his/her room. Per the staff, Resident #33 was at dialysis.

On 1/7/24 at 10:18 AM, the surveyor interviewed Resident #33 who stated that his/her Midodrine medication (used to treat low blood pressure) was ordered three (3) times a day and he/she did not receive the medication at noon on his/her dialysis days. The resident stated the midodrine medication was scheduled for 6 am, 12 noon and 6pm, and the nurses were supposed to send the medication with him/her to dialysis for the noon dose. Resident #33 further stated that he/she had low blood pressure and was dizzy at dialysis the day before. Resident #33 stated that the medication was not adjusted around her dialysis times or sent with her to dialysis to be taken on her dialysis days at noon.

On 1/3/25 at 11:32 AM, the surveyor reviewed the medical record for Resident #33.

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to end stage renal (kidney) disease, chronic kidney diseases and dependence on other enabling machines and devices.

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/14/24, included the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident received dialysis while a resident at the facility.

A review of the individual comprehensive care plan (ICCP) included a focus area, dated 2/9/24, that the resident needed dialysis related to renal failure and that the resident went to dialysis on Mondays, Wednesdays, and Fridays with a 10:00 AM pick up time. The ICCP did not include any interventions to schedule medications around the resident's scheduled dialysis times.

A review of the Order Summary Report (OSR), dated as of 1/8/25, included the following physician orders (PO):

A PO, dated 12/30/24, for dialysis on Mondays, Wednesdays, and Fridays with a chair time of 10:00 AM and a pickup time of 9:00 AM.

A PO, dated 11/30/24, for Midodrine HCL oral tablet 10 mg (milligrams) one tablet by mouth three times a day for hypotension (low blood pressure). Hold for SBP (systolic blood pressure) greater than 140.

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NAME OF PROVIDER OR SUPPLIER: Complete Care at Voorhees, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 3001 Evesham Road Voorhees, NJ 08043	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the November and December 2024 Medication Administration Record (MAR) included the following PO: A PO, dated 11/22/24, for Midodrine HCL oral tablet 10 mg one tablet by mouth three times a day for hypotension. Hold for SBP greater than 140. The medication was scheduled to be administered at 6:00 AM, 12:00 PM, and 6:00 PM. A review of the January 2025 MAR included the following PO: A PO, dated 11/22/24, for Midodrine HCL oral tablet 10 mg one tablet by mouth three times a day for hypotension. Hold for SBP greater than 140. The medication was scheduled to be administered at 6:00 AM, 1:00 PM and 5:00 PM. On 1/8/25 at 9:23 AM, the surveyor interviewed Licensed Practical Nurse (LPN #5) who stated that if a medication was scheduled during the time the resident was at dialysis, then the nurse would not administer that medication. On 1/8/25 at 9:40 PM, the surveyor interviewed the LPN # 4 who stated dialysis residents' medication administration times were scheduled around their dialysis times and that the medication was scheduled during the dialysis time, the nurse should reach out to the physician to adjust the medication times. LPN#4 further stated that medication could not be sent with the resident to dialysis because we are not a pharmacy and cannot dispense medication. On 1/8/25 at 9:40 AM, the surveyor interviewed LPN/Unit Manager (LPN/UM #1) who stated that dialysis residents' medications should not be scheduled during dialysis times and that the nurse should have called the doctor to get the medication times changed. The LPN/UM #1 further stated that medication could not be sent with the resident to dialysis. On 1/8/24 at 9:44 AM, the surveyor interviewed the Regional Director of Nursing (RDON) who stated that medication should not be scheduled during dialysis times when the residents is not at the facility and nurses should have called the doctor to get the medication times changed on dialysis days. The RDON further stated that medication could not be sent with the resident to dialysis. The RDON stated that she had spoken with Resident #33 prior, and that the resident wanted to take the medication at 12 noon and for the facility to send the medication with her for the 12-noon dose on dialysis days. The RDON stated that she had informed the resident that the facility could not send medication to dialysis. On 01/08/25 at 1:19 PM, the Licensed Nursing Home Administrator (LNHA) in the presence of the RDON, the Regional Director of Operations, the Regional Nurse QA Specialist and survey team was made aware that the PO for midodrine medication was scheduled at noon on dialysis days. A review of the facility's Medication Administration policy, dated 9/1/2024, included that the six rights of medications were administered as followed: right resident, right drug, right dosage, right route, right time, and right documentation. A review of the facility's Hemodialysis policy, dated 9/1/2024, included the licensed nurse will communicate to the dialysis facility via telephonic communication or written communication, to include timely medication administration (initiated, held, or discontinued) by the nursing home. (continued on next page)

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	315219	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37547 Complaint #: NJ175632, 176860 Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to ensure appetizing and palatable temperature of food for 1 of 1 lunch meal on 1 of 5 nursing units (300 Unit). This deficient practice was evidenced by the following: 1. On 1/3/25 at 9:21 AM, the surveyor conducted a Resident Council meeting which included four residents (Resident #6, #60, #71 and #98). All four residents informed the surveyor that the food was served cold and was not appetizing or recognizable. On 1/7/25 at 11:17 AM, the surveyor informed the Food Service Director (FSD) and the District Food Service Manager (DFSM) that they wanted to observe a lunch meal service for the day including food temperatures. The DFSM stated that all hot foods should be above 135 F on the food service line. The surveyor asked the FSD to calibrate a thin probe thermometer in their presence, which the FSD completed using an ice bath, and the thermometer reached 32 F (degrees Fahrenheit). On 1/7/25 at 11:46 AM, the surveyor observed the DFSM who took the following food temperatures from the steam table: Swedish meatballs 184 F Rice 191 F Green beans 178 F Beets 163 Mashed potatoes 159 F Ground meatballs 171 F Puree green beans 148 F Turkey patties 178 F Turkey patty puree 145 F Gravy 193 F Sauce 189 F Meatballs without sauce 158 F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pasta 170 F. On 1/7/25 at 11:56 AM, the [NAME] began serving the lunch meal on the tray line. The [NAME] utilized plastic insulated domes and bases, heated plate liners, and heated plates to maintain temperature. On 1/7/25 at 12:02 PM, the Dietary Aide (DA) #2 left the kitchen with meal cart for the 300 Unit Day Room. At this time, the surveyor, the FSD and the District Food Service Manager In Training (DFSMIT) accompanied DA #2 with a thin probed thermometer that was calibrated to 32 F. On 1/7/25 at 12:04 PM, DA #2 arrived at the 300 Unit with the meal cart and left the meal cart on the nursing unit. On 1/7/25 at 12:05 PM, Nursing signed receipt for the meal cart delivery and began to distribute the meal trays to the residents in the day room and to those residents who dined in their rooms. On 1/7/25 at 12:22 PM, the FSD informed the surveyor that all the residents' meal trays had been served. At that time, the FSD stated that hot items should be 135 F and cold items should be less than 40 F. The FSD then served the surveyor the puree test tray and poured coffee into the mug located on the tray. On 1/7/25 at 12:22 PM, the surveyor observed the FSD obtain the following temperatures from the puree sample tray: Puree green beans 116 F Puree meat balls 112 F Puree mashed potatoes 118 F Puree apple sauce 68 F At that time, the FSD stated that the hot food items should be maintained at 135 F to ensure that they do not fall into the danger zone. The FSD stated that the canned apple sauce was not refrigerated and should have been chilled first and served below 40 F or below to remain out of the food temperature danger zone. The FSD explained that if food temperatures were in the danger zone it meant that they were not at the proper temperature. On 1/7/25 at 12:28 PM, the surveyor observed the FSD obtain the following temperatures from the regular sample tray: Green beans 120 F Rice 128 F Meatballs 126 F Mandarin oranges 64 F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coffee 128 F Hot water 140 F At that time, the FSD stated that hot beverages were served from carafes on the unit and should be served between 170 F and 180 F. The FSD further stated that the Mandarin oranges were canned fruit and were not refrigerated prior to the meal service and should be served at less than 40 F. 2. On 1/8/25 at 08:55 AM, The surveyor requested and was served both a regular and puree breakfast test tray for palatability. Both of the meal trays were provided without a meal ticket to indicate what food items were served. The surveyors sampled scrambled eggs with red and green peppers, wheat toast, and a slice of ham that were of regular consistency. The scrambled eggs with red and green peppers on both the regular and puree tray lacked both seasoning and taste. On the pureed tray, there was a brown pureed substance that had a brown liquid around it that was not identifiable and had a pasty taste and texture. A review of the facility's Meal Distribution policy dated September 2017, revealed the following: .Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining. A review of the facility's Food Preparation policy dated September 2017, revealed the following: .The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time food items are exposed to temperatures greater than 41 F and/or less than 135 F, or per state regulations . On 1/9/25 at 10:19 AM, in the presence of the Regional Director of Nursing (RDON) the Licensed Nursing Home Administrator (LNHA) stated that she was surprised that the food temperatures were a Resident Council concern because they had improved. NJAC 8:39-17.4(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 37547 Complaint #: NJ172440 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that resident dietary preferences were accurately identified and implemented for 4 of 21 residents (Resident #20, #39, #107, and #275) reviewed for dining and was evidenced by the following: On 1/3/25 at 10:00 AM, during a surveyor-conducted resident council meeting, 4 out of 4 residents (Residents #6, #60, #71 and #98) stated that condiments such as cream, sugar, mustard, and mayonnaise would not be on the meal trays and that the facility did not honor food preferences on their meal tickets. The residents also stated that when they ask for a substitute food item than what was on their meal ticket, it can take a long time for another meal tray, or they don't get it at all. 1. On 1/3/25 at 11:36 AM, the surveyor observed Resident #107 seated in a wheelchair in his/her room. The resident stated that his/her meal ticket listed no bread, no citrus, and no tomato, but received bread on his/her meal tray. On 1/3/25 at 1:02 PM, the surveyor reviewed the medical record for Resident #107. A review of the Admission Record revealed that the resident had diagnosis which included but were not limited to: Achalasia of cardia (a swallowing disorder), dementia, unspecified severity, with other behavioral disturbance, and dysphagia (difficulty swallowing). A review of the resident's quarterly Minimum Data Set (MDS), and assessment tool used to facilitate the management of care, dated 12/14/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was fully intact. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 3/8/24, that the resident had a need for a mechanically altered diet. Interventions included: Provide diet as ordered-Encourage diet compliance and educate family members on maintaining correct diet texture when eating outside facility or bringing in snacks. A review of the Order Summary Report revealed an order dated 5/20/24 for a Regular diet ground texture, thin liquids. On 1/6/25 at 1:02 PM, the surveyor received a Grievance Form that was completed by the facility's Director of Social Services (DSS) on 6/26/24 and indicated that the resident's family member reported a problem with tray accuracy and alleged that the resident received a biscuit on his/her tray. The DSS documented that the meal ticket was verified and indicated no bread. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the progress notes included a Health Status Note (HSN), dated 06/27/24 at 11:14 AM, which indicated that the resident had a cinnamon bun [trade name redacted] in a napkin and was educated that he/she was not allowed to have bread, and he/she responded, I only ate half. Further review of the progress notes revealed that there was no documentation that detailed that the resident was served a biscuit on 6/26/24 as indicated on the grievance form. On 1/6/25 at 1:37 PM, the surveyor observed the resident's meal tray and confirmed tray accuracy. The surveyor confirmed that the resident had no bread, no citrus, and no tomato listed on their meal ticket as preferences. On 1/7/25 at 11:00 AM, the surveyor interviewed the DSS who stated that on 6/26/24 the resident's family member called her to the resident's room and showed her the resident's meal tray with a meal ticket that indicated no bread products, and the resident was given a biscuit. The DSS stated that she went to the kitchen and verified that going forward no other bread products would be on the tray. On 1/7/25 at 12:21 PM, the surveyor interviewed Regional Director of Nursing (RDON) who stated that the meal ticket should match what is on the tray. The RDON further stated that a dry biscuit should not have been served to the resident and should match what was on the meal ticket. On 1/8/25 at 10:09 AM, the surveyor interviewed the Registered Dietician (RD) who stated that the resident's current diet was a ground consistency. The RD stated that there was a concern for aspiration (when food or liquid enter the airway) if the resident was served a biscuit. The Regional Registered Dietician (RRD) was present and stated that if bread were served it should have had gravy on it to ensure that it was moistened and soft. On 1/8/25 at 2:02 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the surveyor team who stated that it was her expectation for staff to follow the resident's dietary preferences and diet orders. 2.) On 1/3/25 at 11:56 AM, the surveyor observed Resident #275 seated alone at a table in the dining room. The resident stated that he/she had not yet received his/her meal tray. On 1/3/25 at 11:58 AM, the surveyor observed Licensed Practical Nurse/Unit Manager (LPN/UM) #4 serve Resident #275 his/her meal tray. The resident stated that he/she had not received margarine that was listed as meal preference on his/her meal ticket, or salt and pepper. LPN/UM #4 provided the surveyor with margarine, salt and pepper when requested. When the surveyor asked LPN/UM #4 why the resident had not received margarine or salt and pepper on his/her tray, he stated that he was unsure why the resident had not received margarine as indicated on his/her meal ticket, or salt and pepper. 41072 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Complete Care at Voorhees, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 Evesham Road Voorhees, NJ 08043	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) On 01/06/25 at 01:38 PM, the surveyor observed Resident #39's lunch meal tray ticket that included a chicken pot pie, dinner roll, ham and cheese sandwich with lettuce, tomato, and mayonnaise, tossed salad with dressing, deluxe fruit salad, hot coffee, and apple juice. The surveyor observed that Resident #39's lunch tray did not include the ham and cheese sandwich with lettuce, tomato, and mayonnaise. At that time, Certified Nursing Assistant (CNA # 4) stated that there was a ham and cheese sandwich on top of the meal cart and gave the sandwich to the resident. Resident #39 stated, my meal ticket has that I'm supposed to get lettuce and tomato on my sandwich. The sandwich did not have lettuce and tomato. On 1/6/25 at 1:41 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #6) who stated that it was every day that items were missing from residents' meal trays. LPN #6 stated that she would call the kitchen and let them know when items would be missing from the meal trays. On 1/8/25 at 11:14 AM, the surveyor interviewed the Registered Dietician (RD) in the presence of the Regional Registered Dietitian, who confirmed that Resident #39 had a food preference of a ham and cheese sandwich with lettuce, tomato, and mayonnaise on his/her meal ticket. 4.) On 1/7/25 at 9:35 AM, the surveyor observed breakfast meal delivery on the 100 Unit. The surveyor observed CNA #3 stated she had called the kitchen and requested a new breakfast tray for Resident # 20 because the tray was missing toast. On 1/7/25 at 9:57 AM, Resident #20's breakfast tray was delivered to the 100 unit. The surveyor observed Resident # 20's meal ticket on the tray that included oatmeal, toast, diet jelly, margarine, hot tea, and orange juice. The surveyor observed the meal tray did not include the toast, the diet jelly, or the margarine. At 10:15 AM, the surveyor and the Food Service Director (FSD) confirmed that the toast, diet jelly, and margarine were missing from the tray. The FSD stated I will get the resident a new tray. I am trying to find out what happened to the breakfast trays this morning. At 10:25 AM, Resident # 20 received the breakfast tray that included the toast, diet jelly, and margarine. On 1/8/25 at 1:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), in the presence of the Regional Director of Nursing, the Regional Director of Operations, the Regional Nurse QA Nurse Specialist, and the survey team, who stated that she would expect the kitchen would have someone checking that everything on the meal tray matches the meal ticket. The LNHA further stated that it was important that the facility followed the meal ticket, the diet order, and the residents' preferences because it is the residents right. A review of the facility Meal Distribution policy, dated September 2017, revealed that the nursing staff will be responsible for verifying meal accuracy and timely delivery of meals to residents/patients. The policy further included: All meals will be assembled in accordance with the individualized diet order, plan of care, and preferences . NJAC 8:39-17.4(a)1, e

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37547 Based on observations, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 1/2/25 from 10:00 AM until 10:51 AM, the surveyor observed the following in the presence of the Food Service Director (FSD): 1. There was no trash can at the handwashing sink at the entrance to the galley of the kitchen. The nearest trash can was covered with a lid and failed to contain a foot pedal. The FSD stated that the lid was normally removed during food service. 2. The oven in the galley of the kitchen was heavily soiled. The FSD stated that it was cleaned two weeks ago. 3. The lower double convection oven in the galley of the kitchen was soiled with a thick, black substance. The FSD stated that it was recently cleaned. The FSD failed to provide the surveyor with documented evidence to account for when the ovens were cleaned at that time. 4. Dietary Aide (DA) #1 who operated the dish machine wore a beard guard beneath his chin which left both his mustache and beard exposed. The FSD stated that the beard guard should have fully covered his beard. The FSD then instructed DA #1 to donn (put on) an alternative facial covering that covered both his beard and mustache. On 1/6/25 from 11:53 AM until 12:39 PM, the surveyor observed the following in the Nursing Unit Pantries: 1. In the 100 Unit Pantry in the presence of Licensed Practical Nurse (LPN) #4, the surveyor observed that there was no temperature log on the refrigerator and freezer. LPN #4 stated that we are supposed to have a temperature log and staff were required to check the temperatures and sign the log on every shift. 2. A forty-six (46) ounce carton of thickened water was opened and was not dated. LPN #4 stated that it was supposed to be dated when opened. 3. There was no thermometer in the freezer. A container of ice cream that was stored in the freezer was hard to the touch. LPN #4 stated that a thermometer was required to be in the freezer to ensure that food items were maintained at the proper temperature. 4. In the 200 Unit Pantry in the presence of Certified Nursing Assistant (CNA) #1, the refrigerator temperature was 30 degrees Fahrenheit (F). The temperature log indicated that the refrigerator minimum/maximum range was 34 F to 40 F. Further review of the temperature log revealed that the last recorded refrigerator temperature on 1/6/25 was 42 F. CNA #1 stated that she would notify maintenance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. A forty-six (46) ounce carton of orange juice was opened and was not dated. CNA #1 stated that she would throw it out because it could only be in the refrigerator for 48 to 72 hours. 6. In the freezer, there was a clear plastic cup with a convenience store logo that contained ice and was not labeled or dated. CNA #1 stated that the cup belonged to an unsampled resident and was usually stored in the resident's room. CNA #4 stated that it was an infection control issue if the cup was brought to the freezer from the resident's room. During a follow-up visit to the kitchen on 1/7/25 from 11:17 AM until 12:02 PM, the surveyor observed the following in the presence of the FSD: 1. The District Food Service Manager (DFSM) washed his hands for eleven seconds outside of the stream of running water and then proceeded to rub his hands together under the stream of running water before he dried his hands and donned gloves. The DFSM then proceeded to obtain food temperatures from the steam table. 2. The DFSM then doffed (removed) his gloves and failed to perform hand hygiene before he opened the chef's refrigerator and removed a bag of cheese and placed it on a cutting board. The DFSM then proceeded to assemble and prepare grilled cheese sandwiches. On 1/7/25 at 12:45 PM, in a later interview with the DFSM, he stated that he stated that the whole process of handwashing was twenty seconds and included the time that it took to rinse the hands in water. The DFSM further stated that there was no policy that directed a specific amount of time to lather the hands outside of the stream of running water. The DFSM stated that hand washing was required after gloves were doffed (removed) only if touching ready to eat food. On 1/8/25 at 10:39 AM, during an interview with the Regional Director of Operations (RDO) #2, in the presence of the FSD and the survey team, RDO #2 stated that it was a top priority to maintain a temperature log for the refrigerator and freezer because we want to know what the temperatures were to ensure that the refrigerator and freezer were working properly. RDO #2 stated that a thermometer was required in both the refrigerator and freezer to ensure that the temperature was maintained below 41 F in the refrigerator and close to zero for the freezer. RDO #2 stated that staff should notify maintenance to adjust it. RDO #2 further stated that once opened, thickened liquids should be refrigerated and used within seven days so that nursing would know when to discard it. On 1/8/25 at 11:25 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that the process for hand washing was to turn on the water, wet the hands, apply soap, lather the hands scrubbing vigorously under the nails and the tops of the hands for twenty seconds or more, rinse the hands under water with the hands pointed downward, then dry the hands with a paper towel and discard it and use additional paper towels to turn off the faucet and discard them. The IP stated that you were supposed to scrub with soap for twenty seconds out of the stream of running water to loosen up the dirt and germs and then rinse the hands under the stream of water. The IP further stated that her expectation was for everyone to sanitize their hands before donning and doffing gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/8/24 at 12:13 PM, the surveyor interviewed the Director of Nursing (DON) who stated that all facial hair should be covered, and beard guards should not be worn beneath the chin in order to keep hair from getting into the dishes. On 1/8/25 at 2:21 PM, the Licensed Nursing Home Administrator (LNHA) stated that hands should be washed for twenty seconds with friction prior to rinsing them. A review of a facility Staff Attire policy dated September 2017, revealed the following: All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. A review of a facility Food Preparation policy dated September 2017, revealed the following: All staff will practice proper hand washing techniques and glove use. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. A review of a facility, Food Storage: Cold Foods policy dated April 2018, revealed the following: All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated will be appropriately stored in accordance with the FDA (Food and Drug Administration) Food Code. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A review of a facility, Hand Hygiene policy dated 9/1/24, revealed the following: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene technique when using soap and water: Wet hands with water . Apply to hands the amount of soap recommended by the manufacturer. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse hands with water. Dry thoroughly with a single-use towel. Use a clean towel to turn off the faucet. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. NJAC 8:39-17.2 (g); 19.4