

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2025
NAME OF PROVIDER OR SUPPLIER Voorhees Pediatric Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 Laurel Oak 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Complaint: 2642805Based on interviews, review of the medical records, and review of other pertinent facility documents, it was determined that the facility failed to protect a severely cognitively impaired resident (Resident #1) from abuse a.) when the Certified Nursing Aide (CNA #1) alleged that she heard CNA #2 smacking Resident #1 and CNA #1 did not report the alleged abuse immediately and b.) when the Registered Nurse (RN #1) was made aware that Resident #1 was visibly upset from CNA #2 yelling at them and RN #1 left the resident in CNA #2's care and did not immediately report it. This deficient practice was identified for 1 of 3 residents reviewed for abuse.On 10/09/25 at approximately 1:45 PM, CNA #1 alleged while attending to Resident #2, she heard CNA #2, who was attending to Resident #1's bowel movement, smack Resident #1 who was touching their feces. CNA #1 stated that she was unable to report the incident at the time to the Unit Manager (UM), and reported the incident around 3:00 PM that day, to the Director of Nursing (DON). CNA #2 continued to care for Resident #1, and on 10/09/25, at approximately 2:00 PM, CNA #2 asked RN #1 to assist her in transferring Resident #1 onto the shower stretcher. At that time, RN #1 observed that Resident #1 looked sad and had a tear in [their] eye. RN #1 questioned CNA #2 why Resident #1 was sad, and CNA #2 reported that she had yelled at the resident. RN #1 did not report that allegation to her supervisor. During interviews on 10/20/25, with both RN #1 and CNA #2, they both confirmed Resident #1 was yelled at on 10/09/25, by CNA #2.The facility's failure to implement their abuse policy including protecting Resident #1 from abuse by CNA #1 not immediately reporting CNA #2 for the alleged physical abuse and for RN #1 not reporting CNA #2 after CNA #2 indicated that Resident #1 was visibly upset because she yelled at the resident, placed Resident #1 and all residents at risk for abuse. This posed the likelihood of serious physical harm and psychological, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation.The IJ began 10/09/25 at 1:45 PM, when CNA #1 alleged she heard CNA #2 smack Resident #1 and did not immediately report it. The facility was notified of the IJ on 10/20/25 at 3:22 PM. The facility submitted an acceptable Removal Plan (RP) on 10/20/25 at 7:38 PM. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 10/21/25 at 12:21 PM.The evidence was as follows:A review of the facility's policy titled Safety: Abuse, Neglect and Exploitation updated 5/21/25, included Policy: [name redacted] has an obligation to protect the welfare of its residents and to fully investigate and correct any circumstances bearing upon that welfare. The approach should be as proactive as possible. As such, all new employees shall be in-serviced about abuse and neglect as part of orientation, and all current employees shall review this information at least annually thereafter [.] VI. Protection of the Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. If alone, do not leave the resident and pull the code bell for immediate help.A review of the Facility Reported Event (FRE) dated 10/09/25, submitted to the New Jersey Department of Health (NJDOH) revealed the following:On 10/09/25, at approximately 1:45 PM, a staff member (CNA #1) providing care to Resident #1's roommate heard a slapping sound. When she turned to investigate, she observed a nursing aide (CNA #2) raising her hand, appearing to slap Resident #1's hand. At the time, Resident #1 had a bowel movement and feces on their hands. The event was reported to the DON after the staff was unable to notify her immediate supervisor. The nursing aide [CNA #2] involved in the allegation was immediately removed from the unit and from all patient.The FRE included a summary of the investigation created by the DON, which indicated that Resident #1 is incontinent and fully dependent on staff for medical and clinical needs which results in CNA #2 being immediately removed from the unit and suspended.A further review of the FRE included a written statement from CNA #1, which indicated CNA #1, who was 3-4 feet away from Resident #1, heard a loud slapping sound, and when CNA #1 turned her head and saw CNA #2 repeatedly raising her hand and it appeared she was slapping [Resident #1] on the arm. CNA #1 asked CNA #2 what she was doing, and CNA #2 replied she was going to get Resident #1 in the shower. The written statement also included CNA #1 was unable to notify her immediate supervisor and waited around an hour before reporting the incident to the DON.According to the admission Record (AR), Resident #1 was admitted to the facility with diagnoses which included but were not limited to: localization related (focal: seizures that originate in a specific area of the brain) (partial: seizures that cause a loss of awareness) symptomatic epilepsy (a chronic neurological condition characterized by recurrent unprovoked seizures) and epileptic syndromes with complex partial</p>		