STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315144	A. BUILDING _____ B. WING _____	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD LEAS	ONE MEDFORD LEAS WAY MEDFORD, NJ 08055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: CENSUS: 8 SAMPLE: 8 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. In addition, a COVID-19 Focused Infection Control Survey was conducted.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries,	F 640		2/28/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/31/2023

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.

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F 640	Continued From page 1 and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interviews, facility policy review, record review, and document review, it was determined that the facility failed to complete and transmit Minimum Data Set (MDS) assessments in a timely manner for 2 (Resident #6 and Resident #9) of 12 residents reviewed for MDS assessments. Findings included: Review of the facility's policy titled, "MDS/PPS	F 640	1. The Clinical Quality Manager/RNAC transmitted the Discharge MDS Assessments for Resident #6 and Resident #9 2. An audit of MDS submissions over the past calendar year was conducted by the Clinical Quality Manager/RNAC and no other residents were found to have been affected by the deficient practice. The MDS Coordinator will be re-educated on timely completion of Discharge MDS	

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F 640	Continued From page 2 [prospective payment system] RAI [resident assessment instrument] Process," dated 10/2019, specified, "RNAC [registered nurse assessment coordinator]/MDS Coordinator will transmit each resident's completed and signed MDS 3.0 within time frame required by OBRA [Omnibus Budget Reconciliation Act], MDS 3.0 and Medicare guidelines." The "Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual," dated 10/2019, specified, "5.2 Timeliness Criteria In accordance with the requirements at 42 CFR [code of federal regulation] § [section sign] 483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions: Completion Timing: - For all non-Admission OBRA and PPS assessments, the MDS Completion Date must be no later than 14 days after the Assessment Reference Date." 1. A review of a "Profile Face Sheet" indicated the facility admitted Resident #6 with diagnoses that included EX Order 26 § 4b1 [redacted] A review of Resident #6's discharge MDS, with an assessment reference date of 07/19/2022, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had EX Order 26 § 4b1 [redacted]. The MDS indicated the resident was discharged to the community on EX Order 26 § 4b1 [redacted]. Further review of the MDS, revealed the RNAC signed the MDS as being completed on 09/27/2022. 2. A review of a "Profile Face Sheet" indicated the	F 640	Assessments as per RAI Manual guidelines. 3. To ensure that there is not a recurrence of this deficient practice, the Clinical Quality Manager/RNAC, or designee, will perform weekly audits of current and previous month resident assessments to ensure timely transmission of assessments per RAI Manual guidelines. The Clinical Quality Manager/RNAC will complete these audits for a period of no less than 90 days or until 100% compliance is attained for no less than a consecutive three-month period. 4. The audit results will be reported to Medford Leas QAPI Committee which meets on a monthly basis.	

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F 640	Continued From page 3 facility admitted Resident #9 with diagnoses that included EX Order 26 § 4b1 [redacted] A review of Resident #9's discharge MDS, with an assessment reference date of 07/22/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was EX Order 26 § 4b1 [redacted]. The MDS indicated the resident was discharged to the community on EX Order 26 § 4b1 Further review of the MDS, revealed the RNAC signed the MDS as being completed on 09/26/2022. During an interview on 01/07/2023 at 9:23 AM, the Director of Nursing (DON) stated the MDS Supervisor had been out sick all week and was unavailable for an interview. During a follow-up interview on 01/07/2023 at 12:56 PM, the DON stated she had spoken with the MDS Supervisor and the MDS Supervisor stated he must have missed submitting the MDS assessments, but thought he had a year to submit. Per the DON, the MDS Supervisor oversaw all the facility's MDS process. During an interview on 01/07/2023 at 3:25 PM, the Administrator stated he was surprised that the MDS assessments had not been transmitted. He stated he thought it should have been caught during the facility's triple-check process. According to the Administrator, he expected MDS assessments to be transmitted in a timely manner according to the regulation. NJAC 8:39-11.1	F 640		

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F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		2/28/23

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F 655	Continued From page 5 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, it was determined that the facility failed to include pertinent information on the baseline care plan for 1 (Resident #22) of 8 residents reviewed for care plans. Specifically, the facility failed to include the diagnosis and treatment of EX Order 26 § 4b1 on Resident #22's baseline care plan. Findings included: Review of the facility's "Baseline Care Plan Policy," dated 11/2017, specified, "The purpose of the policy is to assure that the residents immediate care needs are met through completion and implementation of the baseline care plan within 48 hours of a resident's admission. It is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative participate in the initial plan for delivery of care and are provided a written summary of the baseline care plan." The policy further specified, "The baseline care plan will include conditions and risks affecting the resident's health and safety." A review of a "Profile Face Sheet" indicated the facility admitted Resident #22 on 01/02/2023, with a diagnosis that included NJ Exec. Order 26 4.b.1 due to	F 655	1. The SNF RN Resident Care Manager immediately developed and initiated a care plan for Resident #22 which addressed the resident□s diagnosis of NJ Exec. Order 26:4.b.1 2. An audit of current SNF Residents□ care plans was completed by the SNF RN Resident Care Manager and no other residents were found to have been affected by the deficient practice. All licensed nursing staff will receive mandatory training on the Baseline Care Plan Policy and Procedure, which will include care planning for all pertinent diagnoses. 3. To ensure that there is not a recurrence, of this deficient practice, the SNF RN Resident Care Manager, or designee, will complete audits of the baseline care plans for each new admission within 48 hours of the admission date to ensure that there are care plans in place for each pertinent diagnosis. The SNF RN Resident Care Manager will complete these audits for a period of no less than 90 days or until 100% compliance is attained for no less than a consecutive three-month period. 4. The audit results will be reported to Medford Leas QAPI Committeewhich meets on a monthly basis.	

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F 655	Continued From page 6 NJ Exec. Order 26:4.b.1). A review of Resident #22's baseline care plan, initiated 01/02/2023, revealed the resident did not have a care plan to address the resident's diagnosis of EX Order 26 § 4b1 . A review of Resident #22's physician orders indicated on 01/03/2023, the resident had orders for EX Order 26 § 4b1 During an interview on 01/07/2023 at 2:32 PM, Unit Manager (UM) #1 stated a resident that was being treated for EX Order 26 § 4b1 should have a care plan in place to guide the staff on how to care for the resident. UM #1 stated the admitting nurse should initiate the baseline care plan. Per UM #1, she did not realize Resident #22 did not have a care plan to address the diagnosis and treatment of EX Order 26 until being interviewed by the surveyor. During an interview on 01/07/2023 at 2:47 PM, the Director of Nursing (DON) stated a diagnosis of EX Order 26 with EX Order 26 § 4b1 treatment should be care planned, and the nurse who received the order from the physician was responsible for initiating the care plan. During an interview on 01/07/2023 at 3:25 PM, the Administrator stated the baseline care plan should include any pertinent diagnosis and treatment that the resident was to receive upon admission to the facility.	F 655		

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F 655	Continued From page 7 NJAC 8:39-11.2(d)	F 655		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315144	A. Building B. Wing	2/28/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD LEAS	ONE MEDFORD LEAS WAY MEDFORD, NJ 08055

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0640 Reg. # 483.20(f)(1)-(4) LSC	Correction Completed 02/28/2023	ID Prefix F0655 Reg. # 483.21(a)(1)-(3) LSC	Correction Completed 02/28/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/09/2023 and Medford Leas was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Medford Leas is a two-story Type II Protected building that was built in 1970.	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to maintain 1 of 1 fire alarm systems in accordance with the	K 345	1. The Operations Manager has completed and documented a visual inspection of the fire alarm system	2/10/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/31/2023

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K 345	Continued From page 1 National Fire Protection Association (NFPA) 72, as required by life safety code (LSC) 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 which indicated that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 specified that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. [Exempli gratia, for example] duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices. This deficient practice had the potential to affect 8 residents who resided in the facility, staff, and visitors. Findings included: A review of the "System Record of Inspection and Testing," dated 06/17/2022, revealed the fire alarm system was inspected by a licensed vendor on 06/17/2022. The facility was unable to provide documentation of semi-annual visual inspections of the fire alarm system within the past 12 months. During an interview on 01/09/2023 at 1:41 PM, the Plant Operations Manager (POM) revealed he was not aware of the semi-annual visual inspection requirements but expected the fire alarm system to be inspected, tested, and maintained per the life safety code requirements. The POM indicated he was responsible for the life safety code inspection, testing, and maintenance requirements.	K 345	2. A reoccurring work order has been entered into the facility□s electronic work order system for the Operations Manager, or his/her designee to complete and document a visual inspection of the fire alarm system every six months. 3. To ensure that there is not a recurrence, of this deficient practice, the Operations Manager, or designee, will complete a compliance audit every six months for no less than one year or until 100% compliance has been maintained for a one-year period 4. The audit results will be reported to Medford Leas QAPI Committee which meets on a monthly basis.	

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K 345	Continued From page 2 During an interview on 01/09/2023 at 2:00 PM, the Administrator revealed he was not aware the semi-annual inspections of the fire alarm system were not documented because the POM made rounds weekly looking at the life safety code systems. According to the Administrator, the POM was responsible for the inspection, testing, and maintenance of the fire alarm system. The Administrator stated he was aware of the fire alarm semi-annual visual inspection requirements and expected the fire alarm system to be inspected, tested, and maintained per the life safety code requirements. In a follow-up interview on 01/09/2023 at 2:43 PM, the Administrator stated the facility did not have a policy on inspecting the fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to ensure 2 of 2 portable Class K fire extinguishers were maintained in accordance with National Fire Protection Association (NFPA) 10, Standard for Portable Fire Extinguishers. This had the potential to affect 8 residents who resided in the	K 355	1. The Operations Manager has installed signs at each of the two Class K fire extinguishers in the kitchen the appropriate warning signage to indicate in the case of appliance fire, use the fire extinguisher after the fixed suppression system had been activated.	2/10/23

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K 355	Continued From page 3 facility. Findings included: A review of the "Fire Extinguisher Inspection Report," dated 10/25/2022, revealed two Class K fire extinguishers in the main kitchen. On 01/09/2023 at 1:25 PM, an observation in the kitchen revealed two Class K fire extinguishers did not contain the appropriate warning signage to indicate in the case of appliance fire, use the fire extinguisher after the fixed suppression system had been activated. During an interview on 01/09/2023 at 1:41 PM, the Plant Operations Manager (POM) revealed he was not aware of the required signage for the Class K fire extinguisher but expected the fire extinguishers to be inspected, tested, and maintained per the life safety code requirements. The POM indicated he was responsible for the life safety code inspection, testing, and maintenance requirements and acknowledged the findings. During an interview on 01/09/2023 at 2:00 PM, the Administrator revealed he was aware of the signage requirements for the Class K fire extinguisher. According to the Administrator, he did not know why the Class K fire extinguishers did not have the required signage. Per the Administrator, the POM was responsible for the inspection, testing, and maintenance of the life safety code systems. The Administrator stated he expected the life safety code requirements to be followed. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96	K 355	2. The checklist for the visual inspection of the fire alarm system (see above) which will be completed every six months includes a visual inspection to ensure that the appropriate warning signage is hung at each Class K fire extinguisher 3. To ensure that there is not a recurrence, of this deficient practice, the Operations Manager, or designee, will complete a compliance audit every six months for no less than one year or until 100% compliance has been maintained for a one-year period 4. The audit results will be reported to Medford Leas QAPI Committee which meets on a monthly basis.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315144	A. BUILDING **01** B. WING _____	**01/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD LEAS	**ONE MEDFORD LEAS WAY** **MEDFORD, NJ 08055**

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K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was	K 918	1. The Operations Manager ordered a	2/28/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315144	A. BUILDING **01** B. WING _____	**01/09/2023**

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K 918	Continued From page 5 determined the facility failed to conduct annual testing of diesel fuel in accordance with National Fire Protection Association (NFPA) 99, Health Care Facilities Code, 2012 Edition, Section 6.5.4 and NFPA 110 Standard for Emergency and Standby Power. This deficient practice had the potential to affect 8 residents who resided in the facility. Findings included: A review of a vendor service report dated 08/20/2021, indicated a fuel sample was completed. A review of an "Inspection Report," dated 10/11/2022, revealed the vendor did not conduct an annual fuel quality test. The facility was unable to provide documentation of the annual fuel quality test performed over the last 12 months. During an interview on 01/09/2023 at 1:41 PM, the Plant Operations Manager (POM) revealed he was not aware of the code requirement to complete an annual generator diesel fuel quality analysis. The POM acknowledged the findings and indicated he was responsible for all the life safety code inspection, testing, and maintenance requirements. Per the POM, he expected all life safety code requirements to be met and followed. During an interview on 01/09/2023 at 2:00 PM, the Administrator revealed he was aware of the requirement to complete an annual generator diesel fuel quality analysis. According to the Administrator, the POM was responsible for the inspection, testing, and maintenance of the life safety code systems. The Administrator indicated that when the facility changed over to a new	K 918	test of the emergency generator fuel which was completed on February 17, 2023 2. The contract with the outside generator testing company has been amended to include an annual test of the emergency generator fuel 3. To ensure that there is not a recurrence of this deficient practice, the Operations Manager, or designee, will complete a compliance audit every year for no less than one year or until 100% compliance has been maintained for a one-year period 4. The audit results will be reported to Medford Leas QAPI Committee which meets on a monthly basis.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315144	A. BUILDING **01** B. WING _____	**01/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD LEAS	**ONE MEDFORD LEAS WAY** **MEDFORD, NJ 08055**

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K 918	Continued From page 6 vendor contractor, the diesel fuel quality analysis was mistakenly not included with the new vendor. Per the Administrator, he expected the life safety code requirements to be followed. In a follow-up interview on 01/09/2023 at 2:43 PM, the Administrator stated the facility did not have a policy on conducting an annual diesel fuel quality analysis. NJAC 8:39-31.2(e)	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315144 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	2/28/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD LEAS	ONE MEDFORD LEAS WAY MEDFORD, NJ 08055

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 02/10/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 02/10/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 02/28/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO