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	315144	A. BUILDING _____ B. WING _____	02/25/2025

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F 000	INITIAL COMMENTS Survey Date: 02/25/2025 Census: 9 Sample: 7 + 1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		4/18/25

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

Electronically Signed | 03/14/2025

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 761	Continued From page 1 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to: a) ensure controlled drugs (narcotics) were stored in a permanently affixed compartment, and b) have a system in place to ensure that the emergency crash cart (a portable wheeled cabinet that contained emergency medical supplies and drugs) did not contain expired emergency supplies. This deficient practice was identified for 1 of 1 medication storage room, and for 1 of 1 emergency crash carts (ECC) reviewed for medication storage. The deficient practice was evidenced by the following: 1. On 2/21/25 at 9:30 AM, in the presence of the US FOIA (b)(6) the surveyor inspected the ECC and observed a mechanical suction machine and a Bag Valve Mask (BGM- a manual resuscitator device used in emergencies to provide breathing support to patients who are not breathing). The BGM had an expiration date of 7/2023. The surveyor asked the US FOIA for the Cardiopulmonary Resuscitation (CPR) board (a flat, rigid surface that was used to position a patient to perform CPR). The US FOIA was unable to locate the CPR board and at 9:37 AM, the RN opened a cabinet and observed the CPR Board, and an Emergency Bag (EB- a bag that contained emergency use items). The US FOIA opened the EB and the following expired items were observed: 1. 4 -Suction catheter kits with expiration dates of 4/2024. 2. 4- Suction tubing kits with expiration dates of	F 761	F761 Label/Store Drugs and Biologicals 1. To immediately correct this deficient practice, all expired supplies and equipment were removed from the Emergency Bag and Emergency Crash Cart and replaced with supplies and equipment within current expiration dates by the RN Unit Manager. The RN Unit Manager had the narcotic medication box in the medication room refrigerator permanently affixed by Maintenance. There are no other medication refrigerators on the unit. 2. An audit of all supplies and equipment was conducted by the RN Unit Manager and found no additional expired items on the unit. There was a potential for residents to be affected, but a review of resident incidents was completed and it was determined that the emergency bag was not used on any residents since the last SNF survey. Residents who were prescribed refrigerated narcotic medications since the last SNF survey had the potential to be affected. However, it was determined that no other residents were affected through accurate narcotics logs. 3. To ensure that there is not a recurrence of this deficient practice, RN Unit Manager, or designee will revise the weekly supply inventory logs and conduct weekly audits to ensure that medication carts and emergency supplies are monitored for expired supplies and equipment to maintain compliance with	

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F 761	Continued From page 2 7/2023. 3. 2- non-rebreather oxygen masks (a device that delivered high concentrations of oxygen) with a manufacture date of 5/2016 and expiration date of 5/30/20. The surveyor then asked the [US FOIA] what was the process was to verify when the emergency items were not expired, and was there a checklist? The [US FOIA] was unable to locate a checklist, and did not speak to a process that was in place to ensure that the emergency supplies were not expired. On 2/24/25 at 9:00 AM, the surveyor interviewed the [US FOIA (b)(6)] and inquired regarding the process for checking the emergency supplies. The [US FOIA (b)(6)] stated that the 11:00 PM- 7:00 AM staff were responsible to check the emergency supplies in the EB weekly, and would then remove all expired items from the EB. The surveyor asked for the emergency supplies checklist for January 2025 and February 2025. The [US FOIA (b)(6)] stated she did not have a checklist to provide. The surveyor then asked the [US FOIA (b)(6)] when was the last time that she had observed the checklist. The [US FOIA (b)(6)] stated, "To tell you the truth, I have not seen a checklist for a while." The [US FOIA (b)(6)] then confirmed that staff had not been checking the emergency items to ensure there were no expired supplies in the EB. On 2/24/25 at 9:55 AM, the above concerns were discussed with the [US FOIA (b)(6)]). The [US FOIA (b)] confirmed that staff failed to comply and based on the expired items that were observed inside the EB, and stated the emergency supplies "had not been checked in a while."	F 761	expiration dates. The Director of Nursing will review and revise the Medication Storage policy to include proper narcotics storage. The revised Medication Storage policy will be communicated to staff through a mandatory in-service. The medication refrigerator temperature log will be revised to include a daily review of the refrigerated narcotics storage drawer to ensure it is permanently affixed. These reviews will be included on the weekly audits done by the RN Unit Manager, or designee. 4. The RN Unit Manager will complete weekly audits for a period of no less than 90 days or until 100% compliance is attained for no less than a three-month consecutive period. The revised Medication Storage policy, as well as the medication refrigerator log audits, and signed in-service will be completed within 90 days. The Clinical Quality Manager will add a discussion of the requirements for narcotic medication storage (to be permanently affixed) to the agenda of the QAPI meetings until QAPI team determines compliance with the Plan of Correction.	

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F 761	Continued From page 3 2. On 2/21/25 at 10:20 AM, the surveyor observed the medication room refrigerator in the presence of the [US FOIA] and another surveyor. Both surveyors observed the narcotic box was locked, and was located on a shelf inside the refrigerator. The surveyor then asked the [US FOIA] to remove the narcotic box from the refrigerator. The [US FOIA] lifted the narcotic box and removed it from the interior of the refrigerator, and then stated, "that defeated the purpose." On 2/24/25 at 8:50 AM, both surveyors again, observed the medication room refrigerator with the US FOIA (b)(6)), and again observed that the narcotic box was not permanently affixed. The [US FOIA] was able to remove the narcotic box along with the shelf from the refrigerator. On 2/24/25 at 9:55 AM, both surveyors interviewed the US FOIA (b)(6)) regarding the narcotic box not being permanently affixed. The [US FOIA] stated that she was made aware the same day the surveyors identified it, and maintenance was supposed to address the issue. The [US FOIA] stated she was made aware that morning that the narcotic box was still not permanently affixed. On 2/24/25 at 11:43 AM, the [US FOIA] provided the surveyor with the facility policy titled, "Medication Storage" dated July 2022. The policy revealed: It is the facility policy to store all medications in a safe, secure and orderly manner. The policy did not address narcotic storage. The [U.S. FOIA] stated that the policy would be reviewed to reflect narcotic storage. Purpose of the Policy: to outline guidelines, in accordance with state and federal regulations, for storage of medications.	F 761		

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F 761	Continued From page 4	F 761		
F 812 SS=F	NJAC 8:39-29.4(a)(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to to maintain the kitchen environment and equipment in a sanitary manner and ensure all staff performed hand hygiene appropriately to prevent potential contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 02/20/25 at 12:01 PM, the surveyor conducted an initial tour of the kitchen with the US FOIA (b)(6)	F 812	1. To immediately correct this deficient practice, the Operations Manager will have all sprinkler heads cleaned. Additionally, a complete survey of all kitchen equipment and kitchen areas was completed by the Director for Dining Services and all kitchen equipment and kitchen environment has been cleaned and sanitized. 2. After review of the kitchen facilities, it was determined that all residents may have the potential to be affected by this	5/6/25

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F 812	Continued From page 5 US FOIA (b)(6) and observed debris affixed to the ceiling tiles in the pot washing area. On 02/24/25 at 10:08 AM, the surveyor conducted a follow-up tour of the kitchen with the US FOIA (b)(6) and observed the following: -In the presence of the US FOIA observed Dietary Staff (DS) come to the hand washing sink, turned the water on, applies soap to hands and rubbed hands together for less than 10 seconds before placing both hands under the running water and continued to rub hands together under the running water. The surveyor asked DS how many seconds she was supposed to wash hands together prior to rinsing and the DS stated 30 seconds. The US FOIA interjected and stated 20-30 seconds. The surveyor asked the US FOIA if the DS appropriately washed her hands and the US FOIA stated, "no, she needed education." -Debris was visible affixed to the ceiling tiles and fan in the pot area. -A large box of plastic wrap and a dispenser for labels was located on a metal table in the cooks area various food type debris on the exterior of the box and dispenser. -Two can openers that were affixed to tables had visibly dull blades, and one of the openers had various food debris affixed to the blade. The US FOIA observed the debris and stated, looks like it needs attention." -Multiple sprinkler heads throughout the kitchen had visible dust type debris affixed to them.	F 812	deficient practice. 3. All staff dining services staff involved in cleaning and sanitation of kitchen equipment and maintaining a clean and sanitary the kitchen environment received mandatory training on the facilitys policies. All dining services staff will receive mandatory training on proper handwashing techniques. All education was completed on or before May 6, 2025. 4. To ensure that there is not a recurrence of the deficient practices, the Director of Dining Services or designee will conduct observational competencies of proper handwashing techniques with all dining services staff, complete weekly inspections of kitchen equipment and the kitchen environment to ensure proper cleanliness and sanitation. All inspections will continue for a period of no less than six months and up to one year or until 100% inspection audit compliance is achieved for at least three consecutive months. The results of the audits will be reported on a quarterly basis to the facilitys QAPI Committee.	

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F 812	Continued From page 6 - The ice machine had debris in the channel by the opening. -The under counter freezer by cooks area with debris in channel of door. -The large grill had visible embedded grease in the lower drain and on the back of the grill. The [redacted] stated "it doesn't look like it was cleaned it over the weekend", and confirmed it was not clean. -There were four stacks of plate covers stored upright on top of the meal shelf where the resident meal trays were assembled and not protected from potential contamination. -A stack of resident meal trays was on a cart with visible debris under the cart. The Equipment Cleaning and Maintenance Guidelines effective September 2018 revealed under Procedure: 1. The Dining Services managers, supervisors and/or coordinators will develop, implement and manage protocols and schedules for cleaning equipment in their areas of responsibility. The Hand Washing Policy and Procedure Policy dated 3/2022 revealed: Procedure: ...3. Rub hands together for 15 to 30 seconds: use friction on all surfaces of th hands-backs, palms, between the fingers and under the nails. (most bacteria on the hands live under the fingernails.)... NJAC 8:39-17.2(g)	F 812		
F 838 SS=E	Facility Assessment	F 838		4/11/25

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F 838	Continued From page 7 CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that	F 838		

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F 838	Continued From page 8 may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the	F 838		

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F 838	Continued From page 9 governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident	F 838		

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F 838	Continued From page 10 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility did not address the resident population, identify the specific care related to the type of diseases or conditions that were present in the resident population and did not identify the staff competencies and skill sets that were necessary to provide care for the specific resident population to the specific resident population and was evidenced by the following: On 02/20/25 at 1:30 PM, the facility provided the survey team with a copy of the Facility Assessment (FA), Updated 2/2024. The surveyor reviewed the FA which revealed: Facility Assessment and Overview: ... There are three healthcare buildings ... containing nursing care. Sub-acute Rehabilitation/ [Long Term Care] ...Employee's licensure and certifications to manage resident care needs, physical, psychological, spiritual and social needs ... Under Dining: Religious, ethnic, cultural considerations and preferences that may affect delivery of care and services, related to end of life care, can be managed through nurse on duty, social worker, resident services, and or unit resident care manager. Under QAPI [Quality Assurance and Performance Improvement]: ...utilize the quality assurance performance improvement process (Reference QAPI written plan). The purpose of the quality assurance performance improvement program is	F 838	1. In order to immediately correct this deficient practice, facility assessment was reviewed by the Director of Nursing. Revisions were made to ensure compliance with the current regulation and to address the resident population, identify the care needs related to the specific diseases and conditions of the specific resident population. The Director of Nursing, or designee, will implement staff competencies as identified in the facility assessment to competently care for the resident population based on the identification of care needs related to specific disease and conditions. This will be done by using reports from case mix and clinical categories based on resident diagnosis. 2. To ensure that there is not a recurrence of this deficient practice, the Director of Nursing, or designee, will review the facility assessment monthly, and as needed, to address the resident population and identify care needs related to resident disease and or condition. Additionally, staff competencies and skill set will be initiated to provide care for the specific resident population served, based on case mix report and diagnosis. This will be for a period of no less than 90 days or until 100% compliance is attained for no less than a three- month consecutive period. In addition, the QAPI meetings will include discussion and evaluation of compliance with the completion of competencies required to care for the	

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F 838	Continued From page 11 designed to promote excellence in resident safety satisfaction choice, as well as high-quality programs and services in our facility ...This program is designed to improve the lives of our residents in the areas of ...skilled nursing. Under Admissions: ...subacute rehabilitation/skilled nursing is a short stay unit ...The facility serves residents who often have one or more chronic/co morbid conditions ... The facility provides care services based on the needs of our resident population including the following: assistance with activities of daily living, mobility assistance, incontinence care, medication and medication management, fluid replacement, psychosocial support, wound care, competencies, infection control, physical therapy services, therapeutic recreation, nutrition, and respiratory therapy needs. Under Staff Education: ...[Facility Name] currently utilizes in-house services and online training [online training company name redacted]. Prior to staff orienting there is a day one orientation in which the employee is trained on the following: assisted living in philosophy, resident rights, advanced directives, trauma informed care, risk and response, safe patient handling, hazardous wondering, an elopement, fire, safety, active shooters, abuse neglect exploitation, compliance code of mandatory reporting infection, control, workplace violence, attendance appearance, information system, social media, cell phone, substance free workplace, weapons, free workplace, smoke-free, workplace, infection, control practices, PPE (personal protective equipment] and respiratory protection plan. Under Infection Control: ...conduct and infection	F 838	resident population identified by the facility assessment by staff working in resident care area. 4. The facility assessment will be up to date to the most recent regulation and identified competencies and skill sets need for the care of the resident population within 90 days. The Director of Nursing, or designee, will report facility assessment findings to the QAPI committee.	

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F 838	Continued From page 12 control risk assessment, which is evaluated and determined potential vulnerabilities within the resident population and surrounding community, this process is integrated in the facility. It is part of the QAPI program. It is reviewed annually and or as needed. ... maintain a full-time infection preventionist on site. On 02/24/25 at 12:09 PM, the surveyor interviewed the US FOIA (b)(6)) regarding the Facility Assessment (FA). The US FOIA (b) stated it was her responsibility to complete the FA and the surveyor asked the US FOIA (b) if the needs for staff education and competencies related to the care that was required for the residents. The US FOIA (b) stated that the facility used an online education program, and when asked if there were any educational needs identified in the FA, the US FOIA (b) stated, "no." The surveyor asked the US FOIA (b) if the specific resident population was identified in the FA and the US FOIA (b) stated "no" that the specific types of residents were not identified in the FA. The US FOIA (b) stated, we have "elders" and there were no specifics included regarding the resident population. The surveyor asked the US FOIA (b) if there any competencies included in the FA regarding the competencies the staff would need to care for the residents. Upon inquiry, the US FOIA (b) confirmed that the facility has utilized mechanical lifts to transfer residents. The surveyor asked were competencies assessed to ensure the staff know how to use the mechanical lift. The US FOIA (b) stated, "no", the staff would be shown but there would be no competencies. The US FOIA (b) stated that she had been unaware that the FA regulations had been revised 8/2024. On 02/24/25 at 1:17 PM, during the exit conference, the US FOIA (b)(6)	F 838		

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F 838	Continued From page 13 US FOIA (b)(6) confirmed that they were not aware of the updated FA requirements. NJAC 8:39-13.4(b)	F 838		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F 865		4/14/25

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F 865	Continued From page 14 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.	F 865		

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F 865	Continued From page 15 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to identify and consistently implement an effective Quality Assurance and Performance Improvement (QAPI) program to: a)ensure medication carts and emergency carts	F 865	1. To immediately correct this deficient practice, all expired supplies and equipment were removed from the Emergency Bag and Emergency Crash Cart and replaced with supplies and equipment within current expiration dates	

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F 865	Continued From page 16 for identified and monitored for expired supplies and medications, b) ensure secure storage of all narcotic medications, and c) ensure that competencies required for all staff who worked in resident care areas were identified and addressed. This deficient practice was evidenced by the following: 1. On 2/21/25 at 10:30 AM, two surveyors conducted an inspection of the nursing unit emergency cart and observed that the bag valve mask (an instrument to force air into the lungs) was expired in 7/2023; four suction catheters expired 4/2024; four suction tubing marked with an expiration date of 7/2023; and a non-rebreather mask (a device to provide oxygen) manufacturers date 5/2016 and expired 5/30/20. There was no emergency cart inspection check list. On 2/24/25 at 9:00 AM, the US FOIA (b)(6) [redacted] stated the process was for the 11:00 PM to 7:00 AM shift to inspect the emergency cart, "but it was not being done." The US FOIA (b)(6) was unable to locate January 2025 and February 2025 emergency cart checklist. The RN/UM stated that the presence of expired items meant that the staff were signing off that the emergency cart had been inspected, but they were not actually inspecting it. 2. On 2/21/25 at 10:20 AM, the US FOI [redacted] in the presence of two surveyors observed the medication refrigerator on the nursing unit. There was a locked narcotics box that was not permanently affixed and was easily removed from the refrigerator. At that time, the US FOI [redacted] removed the	F 865	by the RN Unit Manager. The RN Unit Manager had the narcotic medication box in the medication room refrigerator permanently affixed by Maintenance. There are no other medication refrigerators on the unit. In addition, the facility assessment has been reviewed by the Director of Nursing. Revisions will be made to ensure compliance with the current regulation and to address the resident population, identify the care needs related to the specific diseases and conditions of the specific resident population. The Director of Nursing, or designee, will implement staff competencies as identified in the facility assessment to competently care for the resident population based on the identification of care needs related to specific disease and conditions. This will be done by using reports from case mix and clinical categories based on resident diagnosis. 2. After a review of the deficient practices, including expired supplies, improperly stored narcotic medications, and noncompliance with facility assessment regulations and the required staff competencies identified in the facility assessment it was determined that the failure of the QAPI program to both identify and implement performance improvement plans to remedy these deficient practices all residents had the potential to be affected by the deficient practice. 3. To ensure that there is not a recurrence of this deficient practice, performance improvement plans will be	

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F 865	Continued From page 17 narcotic box and stated, "it defeated the purpose" for being secured narcotic storage. On 2/24/25 at 8:50 AM, the US FOIA (b)(6)) and two surveyors again inspected the nursing unit medication refrigerator and observed that the locked narcotic box was still not permanently affixed and was easily removed. 3. On 2/24/25 at 10:24 AM, a surveyor entered the kitchen for a follow-up inspection. During the inspection, a dietary staff member approached the sink next to the surveyor, turned on the water, applied soap, rub their hands together and placed both hands under the running water while applying friction. The surveyor requested a copy of the dietary staff members hand washing return demonstration competency. On 2/24/25 at 11:39 AM, the facility was unable to provide any return demonstration hand hygiene competencies. The US FOIA (b)(6) provided the hand hygiene policy, but acknowledged there were no documented return demonstration hand washing competencies for all the staff. On 2/24/25 at 12:09 PM, the US FOIA (b)(6) in the presence of two surveyors, stated that she was responsible for the Facility Assessment (FA) which included staff education. She stated the facility would use an outside service to provide online education, and that the facility would choose what topics were included from a database. The US FOIA (b) added there were no return demonstration competencies regarding staff education needs including the use of a mechanical lift, which the US FOIA (b) stated the facility utilized to transfer residents. The US FOIA (b) stated, it	F 865	implemented via the QAPI process to include; RN Unit Manager, or designee will revise the weekly supply inventory logs and conduct weekly audits to ensure that medication carts and emergency supplies are monitored for expired supplies and equipment to maintain compliance with expiration dates. The Director of Nursing will review and revise the Medication Storage policy to include proper narcotics storage. The revised Medication Storage policy will be communicated to staff through a mandatory in-service The medication refrigerator temperature log will be revised to include a daily review of the refrigerated narcotics storage drawer to ensure it is permanently affixed. These reviews will be included on the weekly audits done by the RN Unit Manager, or designee. Also, the Director of Nursing, or designee, will review the facility assessment monthly to address the resident population and identify care needs related to resident disease and or condition. Additionally, staff competencies and skill set will be initiated to provide care for the specific resident population served, based on case mix report and diagnosis. This will be for a period of no less than 90 days or until 100% compliance is attained for no less than a three- month consecutive period. The facility assessment and the determination of the population of residents that are served by this facility will be included in QAPI meetings going forward. The Director of Nursing, or designee, will report facility assessment findings to the QAPI committee. In	

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F 865	Continued From page 18 was the responsibility of whoever was training the Certified Nursing Aide (CNA) and it would be demonstrated and confirmed there was no documented evidence of a completed competency for the staff. On 2/25/25 at 9:07 AM, the [redacted] who was responsible for the QAPI program, stated that he was aware of some of the concerns identified by the survey team. He stated in September 2024, the pharmacy consultant identified a trend of expired medications. The [redacted] stated that the facility was conducting audits on expired medications but did not inspect any supplies, or the emergency cart. He next stated that a compliance company was at the facility 2/11, 2/12, and 2/13/25, for a mock survey and the facility was verbally told about a concern with narcotic storage not being secured in the cabinet. He specified that the [redacted] and another nursing manager inspected the cabinet but did not inspect the narcotic storage in the medication refrigerator. The [redacted] revealed that the concern with performing competencies for the staff was identified, "the middle of last year", but was not brought to QAPI, and the facilities efforts to use a computer program were not working, and the concern had not been addressed since. A review of the facility provided Quality Assurance Performance Improvement Plan "Date: December 2023, next plan review due date December 2024", included but was not limited to; guiding values to improve the quality of care and quality of life of the residents, and focus on systems and processes. Scope included encompasses all areas of care and services that impact clinical care ... Goals included the staff	F 865	addition, the QAPI meeting will include discussion and evaluation of compliance with the completion of competencies required to care for the resident population identified by the facility assessment by staff working in resident care area. QAPI meetings will be held quarterly with the intention to identify any other potential deficient practices. If and when potential deficient practices are identified the QAPI team under the direction of the Clinical Quality Manger will implement performance improvement plans to correct those practices. 4. The completion and compliance with the corrective actions set forth by the above-mentioned performance improvement plans will be discussed and reviewed at the quarterly QAPI meetings. The Clinical Quality Manager, who oversees the QAPI program, will on a quarterly basis review performance improvement plan documentation to ensure that sufficient progress and compliance are being achieved and to ensure all identified potential deficient practices are being addressed.	

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F 865	Continued From page 19 will receive up-to-date education on the best practice and clinical guidelines to promote highest level of clinical care. Trainings will be conducted ... in multiple ways ... Monitoring included to put in place systems to monitor care and services, drawing data from multiple sources. The QAPI team will decide what data to monitor routinely ... areas may include ... medications and medication compliance reports from the pharmacist (e.g. narcotics). On 2/25/25 at 9:59 AM, the facility administration was in the conference room with the survey team. The QAPI concerns were addressed. In reference to the competencies identified the middle of last year, the [redacted] stated, "I'll be honest we just started yesterday." Regarding the emergency cart inspections, the [redacted] stated it "fell off" the kardex and had not been completed.	F 865		
F 867 SS=E	NJAC 8:39-33.1; 33.2; 33.4 QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867		4/11/25

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F 867	Continued From page 20 are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;	F 867		

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F 867	Continued From page 21 (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	F 867		

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F 867	Continued From page 22 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to ensure a system was in place, and consistently followed to incorporate feedback from all departments and direct care staff for their Quality Assurance Performance Improvement (QAPI) program. Refer to 761E, 812F This deficient practice was evidenced by the following: On 2/20/25 at 12:54 PM, during entrance conference the facility provided documentation which included their QAPI plan and three months of attendance sheets. A review of the attendance sheets documented no direct care staff or maintenance staff.	F 867	1. To immediately correct this deficient practice the QAPI plan was reviewed and updated to ensure that it includes the requirement of ensuring a system is in place and consistently followed to ensure direct care and maintenance staff attendance and allow for feedback from all staff members other relevant stakeholders. 2. A review of sign in logs for previous QAPI meetings since the prior recertification survey was conducted and there was noted to be a lack of regular attendance at meetings by frontline staff and/or maintenance staff, therefore all residents who have had stays during that period had the potential to be affected by this deficient practice. 3. To ensure that there is not a recurrence of this deficient practice,	

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F 867	Continued From page 23 On 2/21/25 between 9:30 AM to 10:20 AM, two surveyors identified concerns regarding expired supplies on the emergency cart, no inspections of the emergency cart, and a narcotic lock box which was not permanently affixed in the medication refrigerator. On 2/24/25 at 10:24 AM, a surveyor was inspecting the kitchen when a dietary aide approached the sink next to the surveyor. The dietary aide turned on the water, applied soap to their hands, rubbed their hands together, and then placed their hands under the running water while applying friction. On 2/20/25 during the Life Safety Code (LSC) inspection, the LSC surveyor identified concerns with the facility which included 14 of 14 resident rooms being accessible for instant use in case of emergencies; exit stair landings and handrails were not marked/identified; means of egress with no continuous illumination; emergency lighting not provided in various areas; areas with no protected self-closing doors; no automatic fire sprinkler protection to all areas of the facility; 12 of 14 resident rooms where the air conditioner was not maintained in a safe operating condition; and no inspection of the fire door assemblies. On 2/25/25 at 9:07 AM, the US FOIA (b)(6) stated he was responsible for managing the QAPI program. The US FOIA (b)(6) stated that the QAPI team met monthly and recently changed to quarterly and a smaller group met at a subcommittee. He stated the attendees were the US FOIA (b)(6), three nurse managers, the Minimum Data Set (MDS) nurse, admission staff, the US FOIA (b)(6), the compliance staff member, the US FOIA (b)(6)	F 867	delegates from both direct care staff (to include a selection from RN, LPN, CNA) and maintenance staff will be invited to attend each QAPI meeting going forward. In addition, the facility will include in resident admission packet that is given to residents and/or their representees upon admission to the facility the document titled Resident and Family Engagement in Nursing Home Quality. Transforming the lives of nursing home residents through continuous attention to quality of care and quality of life which can be found online at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPI-Consumer-Factsheet.pdf This document will also be posted on the unit for residents and family/representee viewing. The contents of the document encourage residents and their representees to bring concerns/suggestions to the attention of the nurse on duty, RN Unit Manager, director of nursing, and Licensed nursing home administrator (LNHA), in that order of escalation. Furthermore, contact information for the State Survey Agency and State Ombudsmen is provided. Any suggestions/concerns brought to the attention of a nurse on duty, RN Unit Manager, director of nursing, or LNHA will be brought to the attention of the QAPI committee and discussed at QAPI meetings to determine if a performance improvement plan (PIP) or other action is needed. Also, an email address will be created for all staff to utilize for communicating quality related concerns or suggestions. The quality	

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	315144	A. BUILDING _____ B. WING _____	02/25/2025

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

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F 867	Continued From page 24 US FOIA (b)(6) and the US FOIA (b)(6) When asked if the maintenance department, or any direct care staff such as a Certified Nursing Aide (CNA) were invited, the US FOIA (b)(6) replied that maintenance was not invited. When inquired if there was a system for staff to report issues to QAPI, the US FOIA (b)(6) stated there was an email address where staff could report safety concerns but "not necessarily" for other quality related concerns. When asked if he spoke to staff or family for their input, he stated, "Not really. We do not have an official way." On 2/25/25 at 9:31 AM, a CNA on the nursing unit stated she worked at the facility for 8 years and did not know what QAPI was but did know the facility had a safety meeting. She added she had never been to or invited to a QAPI meeting. On 2/25/25 at 9:59 AM, the facility administration was in the conference room with the survey team. The US FOIA (b)(6) acknowledged he was ultimately responsible for the QAPI program. The US FOIA (b)(6) stated that CNAs and direct care nurses were "only part of the falls QAPI committee." The US FOIA (b)(6) added that QAPI was "largely administrative". The surveyor asked if the falls committee was all encompassing such as the QAPI meeting, the US FOIA (b)(6) stated "no." When asked about a comprehensive QAPI meeting to include staff and family input, the US FOIA (b) stated there was not a meeting that included all staff departments or family. A review of the facility provided Quality Assurance Performance Improvement Plan "Date: December 2023, next plan review due date December 2024", included but was not limited to;	F 867	concerns/suggestions email will be monitored weekly by the Clinical Quality Manager who oversees the QAPI program or designee. Quality concerns/suggestions relayed by employees via this email will be discussed at scheduled QAPI meetings to determine if a PIP or other action is needed. Information regarding this email will be communicated to all staff. 4. The Clinical Quality Manager who is responsible for overseeing the QAPI meeting will monitor invitations, and sign in logs quarterly to ensure all necessary personnel, including front line resident care staff and maintenance are in attendance at each scheduled QAPI meeting. The requirements for QAPI meeting attendance along with the compliance with those requirements will be reported at the QAPI meeting by the Clinical Quality Manager or designee. The QAPI minutes will be monitored on a quarterly basis by the Clinical Quality Manager who oversees the QAPI program to ensure that any feedback, suggestions provided by stakeholders through reporting to staff or via the quality suggestions/concerns email are being discussed at scheduled QAPI meeting and included	

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F 867	Continued From page 25 Feedback, Data Systems and Monitoring: ... will put in place systems to monitor care and services, drawing from multiple sources. Feedback systems will incorporate input from staff, families, and others as appropriate. NJAC 8:39-33.1(d); 33.2(b)(d); 33.3; 33.4; 34.1(a)(d)	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		4/11/25

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F 880	Continued From page 26 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 880	1. In order to immediately correct this	

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F 880	Continued From page 27 review, it was determined that the facility failed to follow appropriate hand hygiene during the meal service to prevent the potential spread of infection. This deficient practice was observed on 2/20/25 and 2/21/25, during the meal observation, as was evidenced by the following: On 2/20/25 at 12:40 PM, the surveyor observed Certified Nursing Aide (CNA #1) assisted Resident #60 to the Dining Room with the [NJ Exec Order] [redacted]. The resident sat at the table and proceeded to read the newspaper. At 12:48 the lunch cart arrived on the floor. The surveyor observed another resident along with Resident #60 at the table. The staff did not provide the residents with hand hygiene prior to the lunch meal. On 2/21/25 at 12:40 PM, the surveyor observed CNA #2 deliver the lunch tray to the a resident room, assisted the resident with the tray table, set the resident up for the meal and exited the room without performing hand hygiene. CNA #2 then returned to the cart picked up another meal tray, then delivered the tray to the room and exited without first performing hand hygiene. On 2/21/25 at 12:45 PM, the surveyor observed a [US FOIA (b)(6)] [redacted]) picked up a tray on the meal cart, went to the room, assisted the resident [NJ Exec Order 26.4b1] [redacted] in the chair, set up the meal, then exited the room without first performing hand hygiene. On 2/21/25 at 12:52 PM, the [US FOIA (b)] [redacted] then went to the meal cart picked up another tray, went to another resident's room and assisted the resident with the lunch tray. The [US FOIA (b)] [redacted] then exited the room without first performing hand hygiene. The [US FOIA (b)] [redacted]	F 880	deficient practice, the RN Unit Manager immediately re-educated direct care staff on duty at the time and also the oncoming shift on proper staff/resident hand hygiene practices related to mealtimes via in-service which included the deficient practices that were observed. Also, the RN Unit Manager notified the Clinical Quality Manager, who oversees the infection prevention and control program, of the deficient practice. 2. A review of education provided to employees since the previous recertification survey was conducted and it was noted while audits of handwashing practices had been conducted there had not been any recent competency-based hand washing education including return demonstration. Therefore all residents who had stays during that period had the potential to be affected by this deficient practice. 3. To ensure there is not a recurrence of this deficient practice hand hygiene education and competencies that will include a knowledge check of hand hygiene practices, a return demonstration of proper hand hygiene, and knowledge check of when hand hygiene is required for staff and residents. This will be completed by all staff upon hire and at least annually. In addition, a minimum of thirty hand hygiene practice audits will be conducted monthly by the Clinical Quality Manager who oversees the infection prevention and control program or designee. 4. The compliance with the completion of hand hygiene education/competencies	

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F 880	Continued From page 28 was about to return to the cart when the surveyor inquired regarding hand hygiene not being observed after assisting each resident. The US FOIA (b) stated to the surveyor, "I was not aware that I must wash my hands after passing each tray". On 2/24/25 at 9:55 AM, the surveyor met with the US FOIA (b)(6)) and informed her of the above-mentioned concerns. The US FOIA (b) stated that staff should wash their hands prior to meal tray delivery and perform hand hygiene after delivering each tray. The US FOIA (b) stated all residents should be provided with opportunity to wash their hands prior to their meals. On 2/24/25 at 12:15 PM, during an interview with the surveyor, the US FOIA (b)(6) stated hand washing would be performed for 20-30 seconds with soap and warm water. The US FO further stated hand hygiene was the best way to prevent infections. The US FO confirmed that the staff should have performed hand hygiene during the meal delivery, and assisted residents with hand hygiene prior to their meals. On 2/24/25 at 1:10 PM, the survey team met with the US FOIA (b)(6) and notified of the above-mentioned concerns. On 2/25/25 at 9:59 AM, the survey team met with the facility administration team for responses and no additional information was provided. A review of the facility's policy titled, "Hand Washing Policy and Procedure" dated 3/2022 revealed the following: Policy: It is a facility's policy to educate, promote, and enforce proper hand washing techniques throughout the facility in order to prevent and reduce the spread of	F 880	along with monthly hand hygiene audit results will be reviewed at quarterly QAPI meetings.	

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F 880	Continued From page 29 infections. Purpose: All employees will receive proper hand washing technique education upon hiring, on an annual basis, and as needed to promote increased infection prevention and control. All residents will be encouraged and given opportunities to wash their hands. Hand washing should occur before and after eating meals, after using the bathroom ... etc. NJAC 8:39-19.4 (a)(m)	F 880		

New Jersey Department of Health

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	060308	A. BUILDING: _____ B. WING _____	02/25/2025

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S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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

Electronically Signed | 03/14/25

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 B. Wing Y2	6/6/2025 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 F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0838	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.71(a)(1)(3)(b)(1)(c)(1)-(5)	Completed
LSC	04/18/2025	LSC	05/06/2025	LSC	04/11/2025
ID Prefix F0865	Correction	ID Prefix F0867	Correction	ID Prefix F0880	Correction
Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/14/2025	LSC	04/11/2025	LSC	04/11/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
2/25/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315144	A. BUILDING 01 B. WING	02/25/2025

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E 000	Initial Comments This facility is NOT 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		
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 02/21/2025 in the presence in the presence of the [redacted] it was determined that the facility failed to ensure that the Emergency Preparedness Communication Plan was reviewed and updated annually in accordance with Title 42 Code of Federal Regulations (CFR) at 483.73 LTC facilities. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 02/21/2025 of the facility's Emergency Preparedness Plan and Program	E 029	1. To immediately correct this deficient practice the annual review of the emergency preparedness plan was completed 2. After review of the plan, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of the annual review of the emergency preparedness plan from was provided to the survey team on 02/24/25 and is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will conduct a	3/17/25

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

Electronically Signed | 03/14/2025

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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	315144	A. BUILDING **01** B. WING _____	**02/25/2025**

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E 029	Continued From page 1 (EPP), revealed the emergency preparedness communication plan was last reviewed on 10/17/2023. In an interview at 2:41 PM, the US FOIA (b)(6) acknowledged the finding. The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. NJAC 8:39-31.6	E 029	compliance review for all required Life Safety inspections, including the annual review of the emergency preparedness plan on a quarterly basis. The results of the compliance reviews will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 02/20/2025 to 02/21/2025 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 221 SS=F	Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5.	K 221		3/17/25

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K 221	Continued From page 2 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/20/2025 in the presence of the [redacted] it was determined that the facility failed to ensure that patient sleeping room doors were readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA 101:2012 Edition, Section 19.2.2.2. This deficient practice had the potential to affect all 9 residents and was evidenced by the following: Observations in the presence of the [redacted] 12:08 PM to 4:10 PM revealed all 14 of 14 resident room doors were provide with a key-locking device that restricted egress access from the resident rooms. In an interview at 4:10 PM, both the [redacted] acknowledged and confirmed the findings. The [redacted] were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM.	K 221	1. To immediately correct this deficient practice, the locks on the patient room doors were removed by a licensed locksmith. In March 2025, the Operations Manager conducted a survey of all other rooms in the nursing facility to ensure that this condition is not present in any other locations. 2. After review of the plan, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of this work is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager or designee will conduct compliance rounds on a quarterly basis for a period of no less than 1 year to ensure that locks are not present on patient room doors. Results of the compliance rounds will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	
K 225 SS=F	N.J.A.C. 8:39-31.2(e) Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		3/14/25

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	315144	A. BUILDING **01** B. WING _____	**02/25/2025**

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 225	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/20/2025 in the presence of the US FOIA (b)(6) , it was determined that the facility failed to ensure that exit stair landings and exit stair handrails was marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2 and 7.2.2.5.5.3. This deficient practice had the potential to affect all 9 residents and was evidenced by the following: An observation at 1:00 PM revealed the exit stairway by physical fitness had no marking stripes on the steps and the upper surface of the handrails as required by the Code. In an interview at the time, the US FOIA (b)(6) confirmed the findings. The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM NJAC 8:39 31.2 (e)	K 225	1. To immediately correct this deficient practice, marking stripes on the steps and the upper surface of the handrails of the exit stairway by physical fitness have been added as required. In March 2025, the Operations Manager conducted a survey of all other exits in the nursing facility to ensure that this condition is not present in any other locations. 1. After review, it was determined that all residents may have the potential to be affected by this deficient practice 2. Documentation of this work is attached to this POC 3. To ensure that there is not a recurrence of this deficient practice, the Operations Manager or designee will conduct compliance rounds on the on a quarterly basis for a period of no less than 1 year to ensure that marking stripes are present in all exit stairwells. Results of the compliance rounds will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual	K 281		3/14/25

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K 281	Continued From page 4 intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/20/2025 in the presence of the [redacted], it was determined that the facility failed to provide illumination of the means of egress that was either continuously in operation or capable of automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all 9 residents and was evidence by the following: An observation at 1:55 PM revealed that all the lights in the Oak room were controlled by a light switch on the wall and were turned off. An observation at 2:14 PM revealed that all the lights in the main kitchen were controlled by a light switch on the wall and were turned off. In an interview at the time, the [redacted] confirmed the findings. The [redacted] were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM.	K 281	1. To immediately correct this deficient practice, the Operations manager confirmed with the community's electrical enginerr that the emergency lights on generator power at Medford Leas are controlled via UL924 devices, which allow for override of the control system in the case of power loss. In March 2025, the Operations Manager conducted a survey of all other means of egress in the nursing facility all other locations are similarly code compliant. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of the presence of the UL924 devices is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will confirm that the UL924 devices are continuing to operate as designed during the next load test for the nursing facility. Results of these tests will be reported to the facility's QAPI Committee for a period of not less than 1 year.	
K 291 SS=F	N.J.A.C 8:39-31.2(e) Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.	K 291		4/18/25

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K 291	Continued From page 5 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 02/20/2025 and 02/21/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to A) ensure battery powered emergency lighting was provided at the emergency power generator transfer switch and B) conduct functional testing of the emergency lighting system in accordance with NFPA 101:2012 Edition, Section 7.9, 19.2.9.1 and NFPA 110:2010 Edition, Section 7.3. This deficient practice had the potential to affect all 9 residents and was evidenced by: An observation with the US FOIA (b)(6) on 02/20/2025 revealed that battery back-up emergency lighting was provided in various locations of the facility. An observation at 1:14 PM revealed no evidence of a battery back-up emergency light for the generator transfer switch, independent of the emergency generator, in the basement where the emergency generator transfer switch was located. In an interview at the time, the US FOIA (b)(6) confirmed the findings. A documentation review on 02/21/2025 at 2:10 PM revealed that the annual battery back-up emergency lighting testing was due on 01/02/2024. The required detailed current test records on annual and monthly emergency lighting functional testing was not provided. In an interview at the time, the US FOIA (b)(6)	K 291	1. To immediately correct this deficient practice, battery-powered emergency lighting was installed at the emergency power generator transfer switch. In March 2025, the Operations Manager conducted a survey of all other transfer switch rooms in the nursing facility to ensure that this condition is not present in any other locations. 4. After review, it was determined that all residents may have the potential to be affected by this deficient practice 5. Documentation of this work is attached to this POC 6. To ensure that there is not a recurrence of this deficient practice, the Operations Manager or designee will conduct functional testing of the emergency lighting system on a quarterly basis for a period of no less than 1 year to ensure that the equipment if functional. Results of the compliance rounds will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	

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K 291	Continued From page 6 confirmed the findings The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM.	K 291		
K 321 SS=F	NJAC 8:39-31.2(e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		4/18/25

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K 321	Continued From page 7 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/20/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that hazardous areas were protected with doors that had self-closing devices in accordance with NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.5.9 and 8.4. This deficient practice had the potential to affect all 9 residents and was evidenced by the following: An observation at 11:31 AM revealed the soil linen room #157C was not provided with a self-closing device. An observation at 12:44 PM revealed the basement storage room #1 measuring approximately 100 by 214 feet was not provided with self-closing device and contained combustible storage. An observation at 1:20 PM revealed the basement storage room #2 was not provided with self-closing device and contained combustible storage. In an interview at the time, the US FOIA (b)(6) confirmed the findings. The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM	K 321	1. To immediately correct this deficient practice, self-closing devices were installed on the doors to the soiled linen room #157C, the basement storage room #1 and the basement storage room #2. In March 2025, the Operations Manager conducted a survey of the nursing facility to ensure that this condition is not present in any other locations. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of this work is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will conduct compliance rounds on a quarterly basis for a period of no less than 1 year to ensure that all rooms that contain combustible material has functional self-closing devices. Results of the compliance rounds will be reported to the facilitys QAPI Committee for a period of not less than 1 year.	
K 324 SS=F	NJAC 8:39-31.2(e) Cooking Facilities	K 324		3/28/25

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K 324	Continued From page 8 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/20/2025 in the presence of the [redacted], it was determined that the facility failed to conduct monthly inspections for 2 of 2 kitchen hood fire suppression systems in accordance with NFPA 101:2012 edition, Section 19.3.2.5.3*(10), NFPA 17 and NFPA 96. This deficient practice had the potential to affect all 9	K 324	1. To immediately correct this deficient practice, staff were educated on how to conduct monthly visual inspections of the fire suppression systems. Monthly inspections of the systems began in May 2025 will continue monthly thereafter. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice	

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K 324	Continued From page 9 residents and was evidenced by the following: An observation at 2:18 PM revealed the monthly inspection tag to the main kitchen fire suppression system lacked documentation of a monthly visual inspection. An observation at 2:20 PM revealed the monthly inspection tag to the cafe kitchen fire suppression system lacked documentation of a monthly visual inspection. In an interview at the time, the US FOIA (b)(6) confirmed the findings. The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96	K 324	3. Documentation of this work is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager or designee will conduct compliance rounds on a quarterly basis for a period of no less than 1 year to ensure that all fire suppression systems inspections have been completed. Results of the compliance rounds will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	
K 345 SS=F	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 observations, documentation review and interviews on 02/20/2025 and 02/21/2025 in the presence of the US FOIA (b)(6)	K 345	1. To immediately correct this deficient practice, the tape was immediately removed from the smoke detector and	2/25/25

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K 345	Continued From page 10 ([redacted], it was determined that the facility failed to ensure that the fire alarm system was tested annually and smoke detectors were maintained in accordance with NFPA 72, National Fire Alarm and Signaling Code (2010 Edition) Section 14.5.6.2. This deficient practice had the potential to affect all 9 residents and was evidenced by the following: An observation on 02/20/25 at 1:14PM revealed the smoke detector in the laundry area was covered with white tape. In an interview at the time, the [redacted] confirmed the findings. An observation on 02/25/25 the survey team revealed the same smoke detector in the laundry area was covered with white tape, 5 days later. A documentation review on 02/21/2025 at 1:35 PM revealed the last annual fire alarm system test was conducted on 07/11/2023. No current documentation for an annual fire system test was provided to the surveyor. In an interview at the time, the [redacted] confirmed the findings. The [redacted] were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	annual test was completed and documentation was provided to the survey team on 02/24/25. In March 2025, the Operations Manager conducted a survey of the nursing facility to ensure that this condition is not present in any other locations. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will conduct a quarterly compliance review for all required Life Safety inspections, including the annual test of the fire alarm system and visual inspection of all fire detection equipment. Results of the compliance surveys will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101	K 351		4/25/25

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K 351	Continued From page 11 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/20/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012 Edition, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 9 residents and was evidenced by the following: Observation at 1:39 PM revealed the storage closet in the Oak room was not provided with fire sprinkler coverage. In an interview at the time, the US FOIA (b)(6) confirmed the findings.	K 351	1. To immediately correct this deficient practice, a sprinkler was added to the storage closet in the Oak Room. In March 2025, the Operations Manager conducted a survey of the nursing facility to ensure that this condition is not present in any other locations. 5. After review, it was determined that all residents may have the potential to be affected by this deficient practice 6. Documentation of this work is attached to this POC 7. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will conduct compliance rounds on a quarterly basis for a period of no less than 1 year to	

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K 351	Continued From page 12 The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	ensure to ensure continued compliance. Results of the compliance rounds will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/20/2025 and 02/21/2025 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to (A) maintain the fire sprinkler system by ensuring that the ceiling was smoke resistant and sprinkler	K 353	1. To immediately correct this deficient practice, a sprinkler escutcheon was installed and the 3 holes in the ceiling of the Alcove lift storage area were be filled. The six ceiling tiles were replaced in the fitness room. The 2 sprinkler heads with buildup were cleaned and the missing an	3/28/25

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K 353	Continued From page 13 head were free from buildup and (B) ensure the fire hydrants were repaired/replaced, tested annually and documented in accordance with NFPA 101:2012 Edition, Section 9.7.5 and NFPA 25: 2011 Edition, Section 5.2.1.1. This deficient practice had the potential to affect all 9 residents and was evidenced by the following: An observation on 02/20/2025 revealed the following: At 12:02 PM, the Alcove lift storage area had a sprinkler escutcheon plate not in place and 3 holes in the ceiling. At 12:50 PM, the physical fitness room had six, 4-foot by 4-foot ceiling tiles not in place. At 2:18 PM, the main kitchen area had 2 sprinkler heads with buildup and 1 sprinkler head missing an escutcheon plate. In an interview at the time, the US FOIA (b)(6) confirmed the findings. A documentation review on 02/21/2025 revealed the following: At 9:10 AM, the private fire service mains inspection, testing and maintenance report dated 08/04/2023 provided by the US FOIA (b) vendor indicated the location of 7 fire hydrants that were out-of-service needed to be replaced. No further documentation was provided indicating that replacement or repair had been conducted. At 10:15 AM, the sprinkler report dated 08/09/2024 had no reference to annual fire hydrant testing for 15 of 15 dry fire hydrants.	K 353	escutcheon plate was installed in the main kitchen area. The fire hydrant was repaired and annual fire hydrant testing for all fire hydrants was completed. All work as completed in March 2025. In March, the Operations Manager conducted a survey of the nursing facility to ensure that this condition is not present in any other locations. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of this work is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager or designee will conduct compliance rounds on a quarterly basis for a period of no less than 1 year to ensure that all areas of the nursing facility and kitchen remain in compliance. Results of the compliance rounds will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	

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	315144	A. BUILDING **01** B. WING _____	**02/25/2025**

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K 353	Continued From page 14 In an interview at the time, the [redacted] confirmed the findings. The [redacted] were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 20, 25	K 353		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/20/2025 in the presence of the [redacted] it was determined that the facility failed to ensure that resident room air conditioner (AC) units were maintained in safe operating condition in accordance with the National Fire Protection Association (NFPA) 90A. This deficient practice was identified for 12 of 14 units observed, had the potential to affect all 9 residents and was evidenced by the following: Observations in the presence of the [redacted] and the	K 521	1. To immediately correct this deficient practice, all resident room air filters were replaced on 02/22/2025. Additionally, the schedule for replacing the filters was immediately increased from semi-annual to quarterly. In February 2025, the Operations Manager conducted a survey of the nursing facility to ensure that this condition is not present in any other locations. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice	2/25/25

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K 521	Continued From page 15 US FOIA (b) from 12:08 PM to 4:10 PM revealed rooms # 158, 159, 160, 161, 162, 163, 164, 165, 167, 169, 170 and 172 AC unit filters were clogged and dirty. In an interview at the time, the US FOIA (b)(6) confirmed the findings. The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. N.J.A.C 8:39-31.2(e) NFPA 90A	K 521	3. Documentation of this work is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will conduct compliance rounds on at least 25% of all filters on quarterly basis for a period of no less than 1 year to ensure that the new replacement cycle ensures that the filters to not have excessive build-up. Results of the compliance rounds will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced	K 531		2/25/25

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K 531	Continued From page 16 by: Based on documentation review and interview on 02/20/2025 and 02/21/2025 in the presence of the [redacted], it was determined that the facility failed to properly inspect, test and maintain 8 of 8 elevators in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B 44, Safety Code for Elevators and Escalators and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6 . This deficient practice had the potential to affect all 9 residents and was evidenced by the following: A record review on 02/21/2025 revealed the annual elevator certificate for 8 of 8 elevators were expired on 01/31/2024. At 12:45 PM, no documentation was provided for 8 of 8 elevators annual Fire Service Operations Phase 1 and Phase 2 testing. At 12:48 PM, documentation regarding regularly scheduled monthly preventive maintenance and testing of Fire Service Operation Phase 1 and Phase 2 were not provided. At 1:21 PM, Interface Component Test Results dated 9/28/2023 provided by the [redacted] from fire alarm vendor comments "Elevator functions did not operate properly - lower-level elevator recalled to fire floor, first and second floor elevators did not recall at all, also the shunt trip function did not work.". No further documentation was provided regarding correction or repair. In an interview at the time, the [redacted]	K 531	1. To immediately correct this deficient practice, inspections all elevators were completed and documentation provided to the survey team on 02/24/2025. Of the eight elevators noted in the survey, 2 travel more than 25 feet and are required to have annual Fire Service Operations Phase 1 and Phase 2 testing as well as monthly maintenance and testing. The first these two elevators has been undergoing replacement since the time of the survey and has not yet been placed back into service. The annual test will be completed before that elevator is placed back into service (estimated to be May 19, 2025) afterwhich monthly inspections shall commence. Staff began monthly inspections of the second elevator in May 2025 and will continue monthly thereafter. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of this work is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will review all required Life Safety inspections on a quarterly basis, including the monthly and annual elevator inspections, documentation and certificates for all elevators. The results of these reviews will be reported to the facilitys QAPI Committee on a quarterly basis for no less than 1 year.	

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K 531	Continued From page 17 confirmed the observations. The [US FOIA (b)(6)] were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM.	K 531		
K 712 SS=F	N.J.A.C 8:39-31.2(e) Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 02/21/2025 in the presence of the [US FOIA (b)(6)] [redacted], it was determined that the facility failed to conduct fire drills with varying activation types in accordance with NFPA 101: 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 8 of 13 fire drills, had the potential to affect all 9 residents and was evidenced by the following: A review of the facility's fire drill reports at 1:38 PM revealed that records provided for 8 of 13 months had no indication the fire drills were	K 712	1. To immediately correct this deficient practice, the Director of Nursing reviewed the previous months Fire Drill Response Evaluation Form that were requested in the recertification survey and noted that the drill scenarios did not consistently indicate the drill activation type. To immediately correct this deficient practice for current residents, the Director of Nursing revised the Monthly Fire Drill Response Evaluation form to include drill activation types (pull station, smoke simulation or paged). 2. It was determined that all residents	3/28/25

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K 712	Continued From page 18 conducted with an activation or the type of alarm transmission signal: Pull, Smoke or Page. The findings were verified by the [US FOIA (b)(6)] at the time of record review. The [US FOIA (b)(6)] confirmed that the fire drills were not descriptive as to the type of device used to activate the fire alarm system, (pull, page, and smoke). The [US FOIA (b)(6)] were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. NJAC 8:39-31.2(e)	K 712	had the potential to be affected by this deficient practice because it was noted that eight out of thirteen monthly fire drills conducted did not indicate the type of alarm transmission signal: Pull, Smoke or Page. 3. Documentation of this work is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Monthly Fire Drill Response Form has been revised to include drill activation types (pull station, smoke simulation or paged). The Director of Nursing, or designee, will perform monthly audits of Fire Drill Response Form to ensure that the appropriate activation is recorded. Education has been provided to maintenance employee who assists with monthly drills. 5. The Director of Nursing will complete the Fire Drill Response Form monthly audits for a period of no less than 90 days or until 100% compliance is attained for no less than a three-month consecutive period. The results will be reported to the facilitys QAPI Committee on a quarterly basis for a period of no less than 1 year.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility	K 761		3/28/25

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K 761	Continued From page 19 maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/20/2025 and 02/21/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that the fire doors assemblies were inspected, tested and documented annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101:2012 Edition, Section 19.7.6, 8.3.3.1, NFPA 80, 2010 Edition, Section 5.2,5.2.3. This deficient practice had the potential to affect all 9 residents and was evidenced by the following: An observation during the tour on 02/20/2025 from 12:18 PM to 4:10 PM revealed fire rated doors at various locations including the elevator machine room, horizontal exits, hazardous area enclosures and exits. A documentation review on 02/21/2025 at 1:23 PM revealed that the documentation provided indicated that the annual fire /smoke door inspection/testing was due on 01/02/2024. The required detailed current annual fire/smoke doors test/inspection documentation was not provided by the US FOIA (b)(6) [redacted]	K 761	1. To immediately correct this deficient practice, the Operations Manager and developed a policy to address the proper door inspection and completed the initial annual inspection, testing and documentation in March 2025. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will conduct a quarterly review of all required Life Safety inspections, including the door inspections. The results of these reviews will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	

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K 761	Continued From page 20 In an interview at the time, the US FOIA (b)(6) confirmed the findings. The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 80	K 761		
K 918 SS=F	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	K 918		2/25/25

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K 918	Continued From page 21 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 documentation review and interview on 02/21/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to A) exercise the emergency generator under load for 4 continuous hours every 36 months and B) conduct a load bank test on the emergency generator annually where the generator uses less in accordance with NFPA 101: 2012 Edition, NFPA 99: 2012 Edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, 8.4.9.1 and 8.4.9.7. These deficient practices had the potential to affect all 9 residents and were evidenced by the following: A documentation review at 12:30 PM revealed the facility had no documentation of an annual load bank test on the emergency generator. No further documentation was provided by the US FOIA (b) to the surveyor at the time of observation. The facility provided follow-up documentation from the inspection vendor at 1:15 PM stating the building only used 12% of the generator's capability, requiring this load bank test. In an interview at the time, the US FOIA (b)(6) confirmed the findings.	K 918	1. To immediately correct this deficient practice, the Emergency Generator Company completed the 36-month inspection, testing and documentation on 02/25/2025. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of this work is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will conduct a quarterly review of all required Life Safety inspections, including the emergency generator load inspections. The results of these reviews will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	

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K 918	Continued From page 22 The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 02/20/2025 and 02/21/2025 in	K 920	1. To immediately correct this deficient practice, the IT Manager removed all of	2/28/25

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K 920	Continued From page 23 the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with NFPA 101: 2012, Sections 19.5, 19.5.1,9.1 and 9.1.2, NFPA 70: 2011 Edition, Sections 400.8 and 590.3 (D), NFPA 99: 2012 Edition, Sections 10.2.3.6 and 10.2.4. This deficient practice was identified for 2 of 2 electrical wires observed, had the potential to affect all residents in the facility and was evidenced by the following: Observations on 02/21/2025 at 12:15 PM revealed non-UL listed power strip on the ground, unsecured and plugged into the wall outlet being used to energize a computer, a printer and a phone at the nurses' station. Observations in the physical fitness center at 12:48 PM revealed non-UL listed power strip on the ground, unsecured and plugged into wall outlet energizing a computer, a phone and a printer. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the observations. The surveyor requested policy on power strips. A documentation review on 02/21/2025 revealed no policy was provided for power strip use. The US FOIA (b)(6) [redacted] were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 920	the power cords and developed a policy to address the proper use of power cords. In March 2025, the IT Manager conducted a survey of all other rooms in the nursing facility to ensure that this condition is not present in any other locations. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of this work is attached to this POC 5. To ensure that there is not a recurrence of this deficient practice, the IT Manager will conduct compliance rounds on a quarterly basis for a period of no less than 1 year to ensure to ensure continued compliance. Results of the compliance rounds will be reported to the facilitys QAPI Committee on a quarterly basis for a period of not less than 1 year.	

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K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/20/2025 and 02/21/2025 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to provide	K 921	1. To immediately correct this deficient practice, the Operations Manager developed a policy and procedure for inspection, testing and maintenance of PCREE. All annual equipment inspection	4/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315144	A. BUILDING **01** B. WING _____	**02/25/2025**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 25 the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all 9 residents and was evidenced by the following: Observations from 12:08 PM to 4:10 PM revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers identifying an inspection throughout the facility. In an interview at the time, the US FOIA (b)(6) confirmed the observations. In an interview during documentation review on 02/21/2025 at 2:10 PM, the US FOIA (b)(6) stated they checked all PCREE equipment but could not provide a policy and procedure for testing of the equipment or evidence of an annual testing and maintenance program for PCREE. The US FOIA (b)(6) were notified of the deficient practice at the Life Safety Code survey exit conference on 02/21/2025 at 3:10 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	was completed and safety stickers were placed on all PCREE in March 2025. 2. After review, it was determined that all residents may have the potential to be affected by this deficient practice 3. Documentation of the annual inspection is attached to this POC 4. To ensure that there is not a recurrence of this deficient practice, the Operations Manager will conduct compliance rounds on a quarterly basis for a period of no less than 1 year to ensure to ensure continued compliance. Results of the compliance rounds will be reported to the facilitys QAPI Committee for a period of not less than 1 year.	

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 B. Wing (Y2)	6/6/2025 (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 E0029 Reg. # 483.73(c) LSC	Correction Completed 03/17/2025	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	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

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 2/25/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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	6/6/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0221	03/17/2025	LSC K0225	03/14/2025	LSC K0281	03/14/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	04/18/2025	LSC K0321	04/18/2025	LSC K0324	03/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	02/25/2025	LSC K0351	04/25/2025	LSC K0353	03/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	02/25/2025	LSC K0531	02/25/2025	LSC K0712	03/28/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0761	03/28/2025	LSC K0918	02/25/2025	LSC K0920	02/28/2025

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

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	6/6/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction				
Reg. # NFPA 101	Completed				
LSC K0921	04/11/2025				

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/25/2025	☐ YES ☐ NO