STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	**185 TUCKERTON ROAD MEDFORD, NJ 08055**

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F 000	INITIAL COMMENTS Complaint #: NJ166997 and NJ180357 Survey Date: 11/13/24 through 12/5/24 Census: 93 Sample: 22 + 2 Closed Records During a Recertification/LSC survey conducted at Medford Care Center from 11/13/24 through 12/5/24 to determine compliance with 43 CFR Part 483 requirements for Long Term Care Facilities. 1. During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR Part 483.12 (a)1 F 600 as the facility neglected to provide residents with acceptable water temperatures for bathing and showers after residents complained. Interviews on 11/13/24, with both residents and staff, revealed the facility had no hot water for resident showering and bathing for months, and the facility was aware of the complaints. Temperatures obtained on 11/13/24, in both resident rooms and shower rooms on all the nursing units registered between 66.8 degrees Fahrenheit (F) and 82 degrees F. Interviews with the U.S. FOIA (b)(6) confirmed water temperatures had been cold, that the water temperature should register at least 105 degrees F; residents and their families had complained; and the facility's boiler was "underrated" for the facility size. The facility failed to protect all residents from neglect by providing residents with the appropriate water temperature for bathing and	F 000		

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

Electronically Signed | 12/26/2024

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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showers on [redacted]. The facility failed to implement facility policies and procedures to ensure the residents' rights were protected which constituted an IJ identified under 42 CFR 483.70 F 835 as the [redacted] who was aware of the residents' concerns failed to implement facility policies.

The Administration was informed of the concerns for the F 600 IJ and the F 835 IJ and were provided the IJ templates on 11/13/24 at 4:19 PM.

Acceptable Removal Plans (RP) were received on 12/4/24 at 12:24 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented corrective action plans to remediate the deficient practice including; a licensed plumber repaired the hot water system; the [redacted]) was on-site fulltime; the [redacted] on facility policies and procedures and the importance of implementing them; a hot water management system was put in place to verify hot water was available; residents were offered a hot bath or shower two to three times a week; maintenance and nursing staff checked hot water temperatures twice on the day and evening shifts and once during the night shift to ensure acceptable temperatures; and if water temperatures were not acceptable, the [redacted] was notified to remedy the issue.

2. During the survey, a finding which constituted an IJ was identified under 42 CFR Part 483.25(d)(2) F 689 as the facility failed to ensure that hot water temperature was maintained at a safe level to protect residents from third degree burns and serious injury. Hot water temperatures obtained

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on [NJ Exec Order 26.4b], in both residents' rooms on all three nursing units and in resident shower rooms on the [NJ Exec Order 26.4b1] units, registered between 117 degrees F and 131.5 degrees F. Interviews with the [U.S. FOIA] revealed that the facility's boiler system was "undersized" for the facility size; provided inconsistent hot water temperatures; and the residents' water used should be between 95 degrees F through 115 degrees F.

The facility failed to protect all residents from excessive hot water temperatures that had the potential to cause third degree burns on [NJ Exec Order 26.4b1]

The Administration was informed of the concerns for the F 689 and was provided the IJ template on 11/16/24 at 5:38 PM.

An acceptable Removal Plan (RP) was received on 12/4/24 at 12:24 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; a plumber repaired the hot water system; the [U.S. FOIA (b)(6)] and maintenance department were educated on acceptable water temperatures, obtaining water temperatures several times a day, and notification to the [U.S. FOIA (b)(6)] of water temperatures outside parameters; maintenance and nursing staff monitored water temperatures daily; and if water temperature was not in acceptable range, nursing staff utilized rinse free body wipes for resident care.

3. During the survey, a finding which constituted an IJ was identified under 42 CFR Part 483.25(d)(2) F 689 as the facility failed to protect the

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residents by ensuring the facility's NJ Exec Order 26.4b area was maintained to NJ Exec Order 26.4b1 Observations and interview on 11/17/24, with both residents and staff, revealed that the facility did not have a system to ensure that there was a process for safe storage of NJ Exec Order 26 materials. Observations and interviews also confirmed that the dried leaves that surrounded the courtyard contained NJ Exec Order 26.4b1NJ Exec Order 26.4b1 and the residents utilized open NJ Exec Order 26.4b1 and dumped their discarded NJ Exec Order 26.4b1 and NJ Exec Order into four plastic lined garbage receptacles that were filled with combustibles. The residents also held onto [redacted] U.S. FOIA (b)(6) and NJ Exec Order 26.4b.

The facility failed to ensure that appropriate NJ Exec Order 26.4b1 were utilized and a process was followed to ensure the safe storage of NJ Exec Order 26.4b1 posed the likelihood of serious harm, injury, or death due to fire on NJ Exec Order 26.4b1

The Administration was informed of the concerns for the F 689 and was provided the IJ template on 11/17/24 at 12:26 PM.

An acceptable Removal Plan (RP) was received on 12/4/24 at 12:24 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; leaves around or near resident NJ Exec Order 26.4b1 area were removed; NJ Exec Order 26.4b1 were now held by the nursing staff; residents assessed as NJ Exec Order 26.4b1 were given their NJ Exec Order 26.4b1 prior to NJ Exec Order 26.4b and were educated to return upon entrance into the building; maintenance inspected the NJ Exec Order 26.4b area a minimum of twice a day to remove any

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F 000	Continued From page 4 debris; housekeeping staff emptied [NJ Exec Order 26.4b] twice on the day shift and once on the evening shift; additional [NJ Exec Order 26.4b1] were purchased; and the [NJ Exec Order 26.4b1] was reviewed with residents. The survey team verified the RPs on-site on 12/5/24, and determined that the IJs for F 600; F 689; and F 835 were removed as of 12/5/24 at 1:29 PM.	F 000		
F 550 SS=F	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		1/31/25

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F 550	Continued From page 5 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to serve meals in a dignified, home-like manner by using disposable containers to serve food and beverages for residents who resided on 3 of 3 resident units (Birch, Cedar and Dogwood). The deficient practice was evidenced by the following: On 11/17/24 at 9:06 AM, Surveyor #2 and #4 observed the breakfast meal on the Cedar unit and observed that all hot cereal was served in a 1/4 pound plastic disposable container with a lid, and all the beverages were served in Styrofoam cups. On 11/17/24 at 10:10 AM, the surveyor observed the kitchen with the U.S. FOIA (b)(6)), who was preparing a fruit cup and pudding for meal service. The fruit cups were being placed into plastic drinking type disposable cups. The U.S. FOIA stated that the facility had been using disposable diningware and confirmed that she did	F 550	1. An order for appropriate dishware was placed by the Dietary Director for dishware, beverage cups and lids. The order has been received and the appropriate dishware is being used by the residents. Disposable dishware will only be used in the event of an outbreak or emergency. 2. Current residents have the potential to be effected by the concern identified. 3. Food Service Department staff will be educated on the utilization of appropriate dishware including beverage containers, lids and utensils for meals by the Food Service Director or Dietitian by 01/31/2025. The importance of serving meals in a home-like and dignified manner will be emphasized. The Food Service Director will order dishware on a regular basis as necessary to verify an appropriate amount of product	

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F 550	Continued From page 6 not have lids for any of the washable insulated bowls. On 11/21/24 at 9:09 AM, the survey team informed the U.S. FOIA (b)(6) , in the presence of a U.S. FOIA (b)(6) , the concerns that the residents regularly received food and beverages in non-insulated, disposable cups and bowls. The U.S. FOIA (b)(6) stated, was "there some regulation that says they can't use Styrofoam?" A review of "The Resident Rights Policy" dated effective October 2021, included; Policy: The resident has the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, as described in the policy consistent with the principles of requirements of Federal, State and Local Laws and Regulation... NJAC 8:39-17.2 (e)	F 550	is available for use. 4.The Food Service Director/designee will complete an inventory of dishware on a weekly basis for 4 weeks, bi-weekly for a month and monthly for 1 month to verify there is a sufficient supply of appropriate dishware. The Food Service Director/designee will randomly audit the food service delivery areas (dining rooms, resident rooms) to verify appropriate dishware is utilized 3 times a week for a month, then bi-weekly for the next month and monthly for the next month. Areas of concern will be addressed. The outcome of the audits will be reported at the monthly QAPI committee meeting monthly for the next 3 months with follow up provided as needed.	
F 558 SS=F	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that the telephones	F 558	1. The facility cannot retroactively address the concern identified. Telephones have been repaired as of	1/31/25

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F 558	Continued From page 7 located in resident rooms were functional and residents were provided an alternate means of communication to accommodate their needs and ensure their well-being was maintained. This deficient practice was identified for 7 of 7 residents who attended a resident council meeting and on 2 of 3 nursing units NJ Exec Order 26.4b1 [redacted] The evidence was as follows: 1. On 11/14/24 at 11:06 AM, Surveyor #3 conducted the U.S. FOIA (b)(6) meeting with seven resident who were alert and oriented. During the meeting, seven of seven residents informed the surveyor that the phones had not been working. On 11/20/24 at 8:33 AM, Resident #61 informed Surveyor #3 that their phone had not been working. Resident #61 stated that the maintenance staff were unable to fix the phone. Resident #61 informed the nurse and the issue had not been resolved. Resident #61 stated,' NJ [redacted] On 11/20/24 at 8:59 AM, Surveyor #3 interviewed CNA #2 regarding the issue with the phone. CNA #2 stated, "It makes the residents really upset when the communication system was not working. The residents cannot communicate with their families and they do not have a cell phone." On 11/21/24 at 2:15 PM, Surveyor #3 informed facility administration of the concerns with the phone in the residents' rooms. On 11/22/24 at 8:30 AM, the U.S. FOIA (b) provided an in-service education form dated 11/21/24, that	F 558	12/11/2024 and the system is fully operational. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. Administration and Nursing Supervisory staff spoke to residents that were effected by the outage. The residents were directed to speak to a staff member should there be an issue with service or need to use a telephone. A private area and communication device will be provided as necessary. This procedure will be reviewed with residents at the January 2025 resident council meeting. Administrative and nursing staff will be re-educated by the LHNA by 01/31/2025 regarding the importance of providing a means of communication in the event of a phone outage. This re-education will include the availability of an emergency phone and emergency phone usage. Should an issue be identified with service, staff will notify supervisory personnel to initiate a resolution. Administrative and nursing supervisory staff will be responsible to notify responsible parties/family members via messaging and provide emergency contact information/method. 4. The telephone system will be audited by the Maintenance Director weekly for one month, bi-weekly for the following month and monthly for 1 month. Should an issue be identified it will be brought to the attention of the Administrator for	

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F 558	Continued From page 8 staff would inform residents to use the phone at the nurse's station to call their families. Surveyor #1: 2. On 11/14/24 at 9:15 AM, Surveyor #1 toured the [NJ Exec Order] unit of the facility. Resident #43 informed the surveyor that their phone in their room had not been working for the last two months, and stated they were "unable to speak with their family." The surveyor observed a telephone located on the bedside table. The surveyor attempted to use the phone by lifting the receiver, and verified there was no dial-tone. Resident #43 further added that they informed the facility that the phone had not been working. On 11/14/24 at 10:30 AM, Surveyor #1 reviewed the maintenance log for the [NJ Exec Order] unit which did not include any reported concerns related to the telephone that had not been working. On 11/15/24 at 9:30 AM, during an interview with a Certified Nursing Aide (CNA #3) on the [redacted] unit regarding the residents' phone system, CNA #3 stated that there were some issues with the telephone and the facility was aware. CNA #3 also stated that sometimes the telephone at the nurse's station did not work. On 11/15/24 at 12:30 PM, Surveyor #1 reviewed the electronic medical record (EMR) for Resident #13 which contained a document dated 11/03/24 at 6:20 PM. The document was an email sent by the[U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)] [redacted] that revealed the facility was experiencing intermittent phone	F 558	resolution. Results of the audits will be reported at the monthly QAPI committee meeting monthly for the next 3 months with follow up provided as needed.	

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outages; and that the phone lines may be intermittently unavailable. The facility provided an emergency number if needed.

On 11/15/24 at 1:30 PM, the surveyor reviewed Resident #13's EMR which contained a document dated 11/7/24 at 6:20 PM. The document was an email sent by the [U.S. FO redacted] that revealed the facility was experiencing intermittent phone outages; and that the phone line may be intermittently unavailable. The facility provided an emergency number if needed.

On 11/20/24 at 10:00 AM, Resident #36 approached Surveyor #1 in the hallway and reported that their phone had not been working for the last two months. The resident reported that they were [NJ Ex Order 26.4(b)(1) redacted] with the telephone issue.

On 11/20/24 at 10:29 AM, Resident #8 informed Surveyor #1 that their phone had been out of service for at least two months. Resident #8 stated it was [NJ Ex Order 26.4(b)(1) redacted] and sometimes they had to ask the CNA to use their cell phone.

On 11/20/24 at 11:15 AM, the Licensed Practical Nurse (LPN # 1) assigned to the [NJ Exec Orde redacted] unit, confirmed that the phones had not been working.

On 11/20/24 at 12:30 PM, the surveyor interviewed a Maintenance Staff employee (MS #1), who confirmed that the issues with the phone were "ongoing." When asked if the residents were provided with any other form of communication, he declined to comment.

On 11/21/24 at 8:52 AM, Surveyor #1 interviewed the [U.S. FOIA (b)(6) redacted] who stated that

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F 558	Continued From page 10 he was aware the phones had not been working; staff verbally informed him. When inquired if an alternative form of communication was provided to the residents, he stated, "No." A review of the facility's "Telephone Service and Access" policy dated last reviewed October 2024, included; Policy: All new admissions will be informed and given the opportunity to receive telephone services for while at the facility. Procedures: All residents will be informed of availability of phone service and cost involved. All residents may have a private telephone in their room at their own expense... NJAC 8:39-4.1(a)20	F 558		
F 569 SS=E	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those	F 569		1/31/25

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F 569	Continued From page 11 funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility provided documents it was determined that the facility failed to a) ensure that within 30 days of a resident's [NJ Ex Order 26] the resident's [NJ Ex Order 26] and a final accounting of those [NJ Ex Order 2] were conveyed to the resident's responsible party for 1 of 1 [NJ Ex Order 26.4(] unsampled resident (UR #1) NJ Ex Order 26.4(b)(1) ; and b) notify the resident or resident's responsible party that the funds in their [NJ Ex Order 26.4(b)(1)] reached the NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) which could jeopardize their eligibility for [NJ Ex Or] or [NJ Ex Order 26.4(b)(1)] This was identified for 5 of 56 (UR #2, UR #3, Resident # 5, Resident # 24, and Resident #53) [NJ Ex Order 26.4(b)(1)] reviewed and was evidenced as follows: A review of the facility's "Personal Needs Accounts" policy last reviewed 10/2023, included; Purpose: to provide protection and maintenance of resident funds in accordance with policies set forth by federal and state governing bodies... 6.3 ... the Business Office must notify the resident and/or responsible party when his/her account reaches $200.00 less than the resource limit for the resident for financial eligibility to participate in the [name redacted] program...6.8 resident fund balances must be refunded on a timely basis (30 days) upon the death or discharge of the resident... On 11/18/24 at 10:23 AM, the facility provided the	F 569	1. The facility cannot retroactively address the concern identified. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. The LNHA will review the PNA policy and procedure with the Business Office Manager. The Business Office Manager will audit current residents having a PNA account in the Facility by 01/31/2025. Balances will be reviewed. Notification will be made to current Medicaid residents who are near or within $200.00 of the $2000.00 Medicaid maximum allowable. The notification will be documented in a log/form. A log will be implemented to track any resident that have discharged or expired. The resident/responsible party will be notified by the Business Office Manager/ designee of the funds remaining on account and advise they will be reimbursed within 30 days of discharge. A record/log will be kept and discharge date, disbursement date, amount, party to receive will be reflected. 4. The Business Office Manager will audit the PNA account and respective balances 2 times a month for one month and then	

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F 569	Continued From page 12 surveyor with the residents' quarterly PNA statements which ended 09/30/24. The surveyor identified the following concerns: A review of the quarterly statement for UR #1, who had expired at the facility in NJ Exec Order 26.4b1, the PNA reflected interest being paid and an ending balance dated NJ Exec Order 26.4b1. A review of the 56 facility provided PNA account statements, the surveyor noted that three of the statements reflected a NJ Ex Order 26.4(b) of over the NJ Ex Order 26.4 and two statements reflected a NJ Ex Order 26.4(b) of over the NJ Ex Order 26.4(which was NJ Ex Order 26.4(b) less than the NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b were as follows: UR #2 had an account balance of NJ Exec Order 26.4b1. Resident #53 had an account balance of NJ Exec Order 26.4b1 UR #3 had an account balance of NJ Exec Order 26.4b1. Resident #24 had an account balance of NJ Exec Order 26.4b1. Resident #5 had an account balance of NJ Exec Order 26.4b1 On 11/18/24 at 11:28 AM, the surveyor inquired about the PNA statement for the NJ Ex Order 26.4(resident. The Business Office staff member stated that she had "forgot" to NJ Ex Order 26.4(b)(1). She stated the process was that the money should have been refunded within 30 days. On 11/19/24 at 9:15 AM, the Business Office staff member stated that she could not provide any documentation or verification that there was any communication between the facility to the resident or resident's representative of the accounts which could potentially jeopardize the	F 569	monthly for the next two months. Notifications will be made to Medicaid Residents/Responsible parties of overages or near overage of allowable funds. Residents who have discharged will be identified on the audit form and appropriate notification will be made regarding reimbursement. Payment will be made within 30 days of discharge. The Social Worker will be advised of residents nearing or reaching the maximum allowable Medicaid funds. The Social Worker will assist in counseling the resident to facilitate a spend-down to verify the resident does not jeopardize Medicaid eligibility. Social Work communication will be documented in the resident record. Outcomes of the audits and logs will be reported at the monthly QAPI meeting for the next 3 months with follow up as needed.	

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F 569	Continued From page 13 SSI or Medicaid eligibility. NJAC 8:39-9.5	F 569		
F 570 SS=F	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure a surety bond was in full force and effect to protect the residents' Personal Needs Accounts (PNA) funds (resident funds that is held by the facility in an interest bearing account). The deficient practice was evidenced as follows: On 11/13/2024 at 10:27 AM, an entrance conference was conducted with the facility administration U.S. FOIA (b)(6)). At that time the surveyor requested a copy of the current surety bond with the contact information, and a list of all residents with PNA holdings. On 11/13/2024 at 2:19 PM, the facility provided a document titled "Patient Trust Fund Bond" (Bond) with [name redacted] insurance company, along with four other documents. The Bond included but was not limited to; "sealed with our seals and dated this 20th day of February 2020". The second facility provided document was "Principal's Acknowledgement" which included	F 570	1.The Facility Surety Bond was located and is currently in place and in full effect. 2.The facility recognizes that current residents have the potential to be effected by the concern identified. 3. The Consultant LNHA counseled the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) on the importance and necessity for maintaining a Surety Bond to safe-guard resident funds. Documents related to the Surety Bond shall be placed in a dedicated file and placed in the LNHA's office. A copy of the documents will be placed in the facility Survey Book to verify it is accessible. The Surety Bond will be reviewed by the Business Office Manager and LNHA bi-annually. The review will be documented to verify on-going effectiveness and appropriate	1/31/25

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F 570	Continued From page 14 but was not limited to; "On 3/13/20" ... "witness my hand and official seal" was signed but did not include any seals. The third document was titled "Surety Disclosure Statement ..." and the documentation was dated 07/11/19. The fourth document was titled "P and C Balance Sheet," [name redacted insurance company] and dated 04/18/2019. The fifth document included a Power of Attorney for the [name redacted insurance company] signed and dated 2/20/2020, with an expiration dated 1/31/2023. On 11/20/2024 at 12:54 PM, the facility responded to the additional request for the complete surety bond information including the contact information to show the bond was in full force and effect. The response was that the U.S. FOIA (b)(6) replied the surety bond was not his "current focus. Does not have one and will not have one today". The survey team requested contact information to confirm the Bond was in full force and effect. The facility failed to provide documentation to ensure the Bond was currently in effect to protect the residents' PNA funds. A review of the facility provided, "Personal Needs Accounts" policy last reviewed 10/2023, included but was not limited to; "7. A surety bond will be in place following all applicable federal and state laws." NJAC 8:35-9.5	F 570	financial coverage based on the resident population and total of resident funds. Adjustments will be made as determined to be necessary. 4. The documented review of the Surety bond will be reported to the QAPI committee at the next monthly meeting and added to the QAPI calendar for bi-annual review to verify compliance is sustained with follow up provided as needed.	
F 600 SS=L	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		1/31/25

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F 600	Continued From page 15 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to protect the residents' right to be free from neglect by not addressing residents' complaints of cold water for bathing and showering. The deficient practice was identified on NJ Exec Order 26.4b1). Refer to F 835L Interviews on 11/13/24, with both residents and staff, revealed the facility had no hot water for resident showering and bathing for months, and the facility was aware of the complaints. Temperatures obtained on 11/13/24, in both resident rooms and shower rooms on all the nursing units registered between 66.8 degrees Fahrenheit (F) and 82 degrees F. Interviews with the U.S. FOIA (b)(6) confirmed water temperatures had been cold, that the water temperature should register at least 105 degrees F; residents and their families had complained; and the facility's boiler was "underrated" for the	F 600	1. The facility cannot retroactively address the issue identified. The facility has put in place a hot water management procedure to verify hot water will be available for residents□ needs. The LNHA initially contacted a licensed plumbing contractor on November 14, 2024 to come to the facility to assess the system and advise on/complete needed repairs. They were in contact several times, and the plumber was at the facility several times to work on the hot water system. Repairs were completed on 12/2/24. 2. The Facility recognizes that all current residents have the potential to be affected by the issue identified. Residents will be offered a hot bath or shower with comfortable water temperatures at least 2-3 times per week. This will be monitored by the Nursing Department and	

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F 600	Continued From page 16 facility size. The facility's failure to protect all residents from neglect by addressing the residents' complaints of cold water when showered or bathed posed a likelihood of serious harm to the residents' care and ability to achieve their highest practicable level of wellbeing. This resulted in an Immediate Jeopardy situation (IJ). The IJ began on 11/13/24, when the survey team was made aware of the cold water. The facility U.S. FOIA (b)(6) was notified of the IJ on 11/13/24 at 4:19 PM. The facility submitted and acceptable Removal Plan (RP) on 12/4/24. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. The evidence was as follows: Reference: "STATE OF NEW JERSEY DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT DIVISION OF PUBLIC SAFETY AND OCCUPATIONAL SAFETY AND HEALTH BUREAU OF BOILER AND PRESSURE VESSEL COMPLIANCE" included but was not limited to; boilers shall be inspected at 12-month intervals. A review of the facility provided "Freedom from Abuse, Neglect and Exploitation" policy dated effective October 2022, included: Purpose: To provide a proactive and systematic approach to the protection of the residents' rights and safeguarding residents from harm due to abuse, neglect and or misappropriation of property. This will be accomplished by incorporating the seven components of abuse prevention into the facility's procedural practices...	F 600	the Director of Nursing. 3. The facility engaged a licensed plumbing contractor to repair the hot water system. Repairs were made on 11/27 and 12/2 as of 12/2/24 the system is fully repaired and functional as evidenced by the water temp logs. To verify water temps are within acceptable range 24/7 and that residents receive showers/bed baths as required, the facility will do the following: - Water temps will be taken by Maintenance and/or a nurse twice on the day and evening shifts, and once on the night shift. - If water temps are found not to be within the required range, the following will occur: The LNHA will be notified and will notify the Director of Nursing. The Director of Nursing will notify her team that water temps are out of range. If a resident requests/requires a shower or bed bath during that time, disposable, rinse free body wipes will be used. Care staff was educated on the above by the RN Supervisors/RN Nurse Educator on 12/3/24 (on all three shifts). This education will be ongoing until the education of care staff has been completed (by 01/31/2025). 4.Facility Maintenance Department will	

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F 600	Continued From page 17 Definitions: g. "Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in physical harm, pain, mental anguish, or emotional distress." C. Prevention: Administration establishes a close rapport with residents and their representative at the time of admission. During this process, the residents and resident representatives are provided information regarding Resident's Rights, which includes discussion about who to speak to regarding any concerns, incidents, and grievances, without fear or retribution. A review of the facility provided "Resident Rights" policy, dated effective October 2021, included: Purpose: To inform, recognize, respect and safeguard the individual rights of all residents provided under law. Policy: The resident has the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, as described in the policy consistent with the principles of requirements of Federal, State and Local Laws and Regulation. b. Planning and implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: 5ii. The right to participate in establishing the expected goals and	F 600	continue to check water temperatures daily on resident units, dietary and laundry daily to verify temperatures are within required range and take corrective action as needed. (This will be reflected on a daily log/audit sheet). Water temperature checks will continue and be a routine daily job task to be performed by the maintenance department. If a water temperature appears to be not within acceptable range for facility and/or resident use, the LNHA will be notified to address the issue. Water temperature checks will continue daily with results being reviewed with the QAPI team by the Maintenance Director monthly for the next 3 months. Follow up will be provided as needed.	

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outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

d. Respect and Dignity. The resident has a right to be treated with respect and dignity, including:
3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

e. Self-Determination. The resident has the right to self-determination, including but not limited to the right to:
1. Choose activities, schedules (including sleeping and waking times), health car and providers of health care services consistent with his or her interests, assessments, and plan of care.

i. ii. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment in accordance with 483.11(g), including but not limited to receiving treatment and supports for daily living safely.

Surveyor #1:

On 11/13/24 at 9:28 AM, Resident #43 stated to Surveyor #1 that they had a complaint and asked if it was okay to get washed by staff with cold water.

On 11/13/24 at 10:04 AM, on the [redacted] Unit, Surveyor #1 interviewed a Certified Nurse Aide (CNA #1) about the water temperatures, and CNA #1 stated she was unable to shower residents because the water temperature was "too cold"

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F 600	Continued From page 19 and that the facility had been aware of the cold water problem. On 11/13/24 at 11:32 AM, Surveyor #1 interviewed the U.S. FOIA (b)(6) about the laundry process and the hot water temperatures. The U.S. FO stated that they needed to stop using the washing machines at 10:00 AM to preserve the hot water. Surveyor #1 then asked the U.S. FO if she had been aware that there was a problem with the hot water and she stated, "yes", three months ago, and stated "I never in my life worked in such a condition." Surveyor #2: On 11/13/24 at 11:12 AM, Surveyor #2 toured the NJ Exec Order 26.4b1 Unit, and in the presence of CNA #2 took the bathroom water temperature for Room #74 (unoccupied resident room) which registered 68.1 degrees F. At that time, Surveyor #2 asked if that was the hot water knob and CNA #2 confirmed it was and that the facility had not had hot water "in a while" and they provided cold showers. On 11/13/24 at 11:22 AM, Surveyor #2 interviewed Resident #240, who stated that they could not take a shower, but their NJ Ex Order 26.4(b)(was also NJ Ex Orde On 11/13/24 at 11:25 AM, Surveyor #2 interviewed Resident #23, who stated "I won't NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1)." On 11/13/24 at 11:25 AM, Surveyor #2 interviewed Resident #241, who stated they have not been at the facility long, but that the water	F 600		

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was cold.

Surveyor #3:

On 11/13/24 at 11:19 AM, Surveyor #3 entered the [redacted] Unit and in the presence of CNA #4, obtained the following water temperatures: Shower #1 the hot water from the sink and shower was 78 degrees F, and in Resident #72 and #74's room the bathroom sink was 78 degrees F. At the time of the observation, Surveyor #3 interviewed CNA #4, who stated that in the "morning the water was hot when we gave their baths, it's usually around 10:30 AM and sometimes during the day that it got cold but not all the time."

On 11/13/24 at 12:13 PM, Surveyor #3 interviewed Resident #79 about the water temperatures in the room, and the resident stated "the water used to be hot but lately it's been cold; [redacted]. [The facility] fixes it and it got cold again." The resident had reported that the issue had been going on in the last few days.

On 11/13/24 at 12:17 PM, Surveyor #3 interviewed Resident #46 in their room who stated, "I've been here for [redacted] due to a [redacted] and had [redacted]. I'm a [redacted]. My major issue was there was no hot water for a year now. My [redacted], I took [redacted] that were ice cold. I got a [redacted] but it's ice cold. I've told everyone, the nurses, Director of Nursing, Unit Managers, CNAs and Social Worker."

Surveyor #4:

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On 11/13/24 at 11:13 AM, Surveyor #4, in the presence of CNA #5, entered Resident #82's room and tested the hot water in the resident's bathroom which registered at 80 degrees F. CNA #5 stated that residents complained of cold water "all the time" and CNA #5 stated he worked on all of the units. CNA #5 then accompanied Surveyor #4 to the shower room and held the shower head hose; the water felt cold and registered 69 degrees F.

On 11/13/24 at 12:04 PM, Surveyor #4 entered the kitchen and observed the Kitchen Staff employee (KS #1) washing large stainless steel type pans in the three-compartment sink. The surveyor felt the wash water which felt cool and the wash temperature registered 92 degrees F, the sanitizer temperature registered 79 degrees F. Surveyor #4 asked KS #1 if there was hot water and he stated, depends if it was on and hot water was "not always on."

Surveyor #5:

On 11/13/24 at 11:16 AM, Surveyor #5, in the presence of the U.S. FOIA (b)(6) tested the hot water on the NJ Exec Orde Unit bathroom of Room #5 (unoccupied resident room) which registered 66 degrees F.

On 11/13/24 at 11:22 AM, Surveyor #5, in the presence of the U.S. FOIA, tested the hot water on the NJ Exec Orde Unit bathroom of Room #26 (unoccupied resident room) which registered 66 degrees F.

On 11/13/24 at 11:25 AM, Surveyor #5 interviewed the U.S. FOIA about the water temperatures in the boiler room. Surveyor #5 observed and counted that there were 12 boilers. There were

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six boiler certificates posted that indicated six boilers were inspected in 2023. The [U.S. FOIA] stated that the boilers observed were only used to heat the resident rooms and "not for hot water." The [U.S. FOIA] stated that there were only six certificates because "only six boilers were working." The [U.S. FOIA] stated that the hot water boiler was recently replaced. Surveyor #5 asked for the annual inspection certificate of the recently replaced hot water boiler and the [U.S. FOIA] stated that he was not sure if there was one because the boiler was changed prior to [U.S. FOIA]'s date of hire. The [U.S. FOIA] stated that he believed that the boiler ran well but was "undersized" for the facility and he believed at one point the facility used to have two bigger boilers in use, telling from the empty space next to the smaller boiler. There were also two boiler venting pipes, one of them did not have a boiler hooked up to it, and the other pipe was connected to the current boiler. The other had the venting pipes reduced in size to accommodate the smaller boiler and appeared as though it was retrofitted per the [U.S. FOIA], to accommodate a smaller boiler. Surveyor #5 then noticed old inspection stickers on the boiler and asked the [U.S. FOIA] if the unit was recently replaced, and why did it have an inspection sticker from January of 2016 on it? The [U.S. FOIA] stated that he was unsure since the boiler was already installed prior to his employment, and stated that the boiler could have been taken from somewhere else and then was installed at the facility. The [U.S. FOIA] stated, "This was how it was when I got here, I inherited this".

At that time the [U.S. FOIA] explained the facility boilers to Surveyor #5 which included the following:

- (1) boiler that provided hot water for the entire building. Kitchen, laundry, and resident areas.

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F 600	Continued From page 23 - (12) boilers that were used for heating. Only (6) of those boilers were inspected because only (6) of them were working according to the [U.S. FOIA], and the [U.S. FOIA] stated he got that information from the maintenance staff that worked there prior to his date of hire. On 11/13/24 at 12:31 PM, the survey team interviewed the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)(6)]) regarding the lack of hot water. The [U.S. FOIA (b)] stated that she had only been at the facility for two months and had been told by the facility that they were "working on it, and some units get it sometimes and some don't." The [U.S. FOIA (b)] stated she "didn't know what was happening, I do not know of anything" and that the [U.S. FOIA (b)(6)]) had been aware of the problem. The [U.S. FOIA (b)(6)] stated that she had worked at the facility for 16 years and "occasionally the hot water doesn't work, and they '[U.S. FOIA (b)(6)]) don't share with us." The [U.S. FOIA (b)(6)] confirmed that residents and their families have complained about the lack of hot water. On 11/13/24 at 12:37 PM, the survey team interviewed the [U.S. FOIA] regarding the hot water temperature concerns, who stated he had worked at the building for five months. The [U.S. FOIA] continued that his staff informed him that there was an issue with the hot water. The [U.S. FOIA] stated the boiler was not fit for the property and the use, and was "underrated for the facility size." The [U.S. FOIA] stated, "the boiler only worked to produce enough hot water when the usage was low." The [U.S. FOIA] stated that the residents told him about the hot water not working and that not having hot water was "unacceptable." The [U.S. FOIA] stated hot water should be available 24-7 (24 hours per day and seven	F 600		

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days per week), and "occasionally it doesn't work." The [redacted] again confirmed that residents and their families have complained about the lack of hot water, and the [redacted] and [redacted] were aware. Surveyor #4 asked the [redacted] if he had ever met the [redacted], and the [redacted] stated, "no, never saw him in the building." The [redacted] stated, "honest truth, I only spoke to him through her [redacted]" and stated he "cannot call him." Surveyor #4 then asked about the discussion that occurred through the [redacted]. The [redacted] stated that his staff told him that the facility used to have a bigger system, and the [redacted] stated that the hot water temperature needed to be at least 105 F. The [redacted] stated, "we only talked to him [the [redacted]] through [the [redacted]]." The MD stated about four months ago, he was on a conference phone call that the [redacted] set-up between the [redacted] and the [redacted] (neither was present at the facility). The MD stated he informed the [redacted] that the hot water system needed to be replaced sometime soon. The [redacted] had "no response" regarding the MD's concerns, and nothing from the [redacted] either, and he had not heard anything since.

On 11/13/24 at 1:11 PM, Surveyor #4 interviewed the [redacted] and asked if she had ever met the [redacted]. She stated she had been there for six months and had never met him. The surveyor asked if the washing machine needed to be at a certain temperature to wash clothing and she stated, "yes", 130 F. The surveyor asked how would you know, and she stated, "I don't." The [redacted] confirmed the facility did all linen and laundry in house.

On 11/14/24 at 8:44 AM, the [redacted] came to the conference room to show the survey team a cellular phone picture of a thermometer reading of 113 F. The surveyor asked the [redacted] if the hot

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water was fixed and the water temperature was now consistent, and the [redacted] confirmed that the hot water temperature was not consistent.

On 11/14/24 at 10:14 AM, the [redacted] met with the survey team to review the concerns with the lack of hot water and the IJ Situation that was presented to the facility on 11/13/24 at 4:19 PM. The [redacted] stated that he looked at the IJs "last night, but it was on his phone and he could not read them." The [redacted] then stated "I just got the printout this morning", and he now wanted to discuss how the facility was going to respond. The [redacted] stated "it [the hot water] was on and off these days", and if they [staff] adhered to the schedule "they would get hot water, and yesterday they did not adhere to the schedule." The [redacted] stated he knew there was an issue with the hot water and we implemented a schedule when they should be using the water and "that the [residents] don't remember if they had a shower or not."

Surveyor #1:

On 11/14/24 at 12:39 PM, Survey #1 interviewed CNA #5, who stated the water was sometimes cold. CNA #5 stated that the resident showers could only be scheduled at 8:00 PM or after because that would be the only way they would have hot water. CNA #5 stated he could not give anyone a shower when they wanted it because of the cold water, and the nurses were aware of the hot water concerns. Surveyor #1 asked how CNA #5 knew the nurses were aware of it, and he stated because we reported it.

On 11/14/24 at 12:45 PM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN

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#1) on the [NJ Exec Orde] unit, who stated that the concern with the hot water had been reported by staff and the staff had reported that during resident care the water being used was cold, and the water for hand hygiene was cold. LPN #1 stated that Management was already aware, and that they entered documentation regarding the water in the maintenance log.

On 11/14/24 at 1:41 PM, Surveyor #1 interviewed a Maintenance Staff employee (MS #1), who stated he was aware of the issue with the hot water and that there was one pipe for the hot water that was smaller.

On 11/14/24 at 2:24 PM, Surveyor #1 interviewed the 3:00-11:00 PM CNA (CNA #6), on the [NJ Exec Orde] unit, who stated they did not document the resident's refusal of a shower; they informed the nurse.

On 11/15/24 at 10:55 AM, Surveyor #1 interviewed Resident #36 and Resident #8 in their room, and they both stated they had not received a shower for two months because of cold water. They both stated the [U.S. FOIA (b)] and [U.S. FOIA (b)(6)] were aware of the problem. Surveyor #1 asked how not receiving a shower made them feel and they both stated, "very sad", and they do not know what was going on and they cannot shower because of cold water.

On 11/14/24 at 2:28 PM, Surveyor #2 interviewed Resident #22, who stated that the showers were "terrible." Resident #22 continued that this morning they "got all stripped down" and the staff used a NJ Exec Order 26.4b1 and went to shower at 9:30 AM and "the water was so cold I didn't take one. We came back and I got a bed-bath

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F 600	Continued From page 27 with cold water." Resident #22 then stated they "refused showers often because it was a struggle to get in because of the [NJ Exec Order 26.4b1] and the "water was freezing." Resident #22 stated shower days were on Monday and Thursday but unfortunately they had to wait a week, and the "wipes were cold." Resident #22 stated "would like to take a warm shower but [expletive redacted]." On 11/14/24 at 12:45 PM, Surveyor #5 obtained water temperatures from Room #79's (unoccupied resident room) sink which registered a hot water temperature of 98.6 degrees F. Surveyor #1: On 11/15/24 at 8:18 AM, Surveyor #1 checked the hot water with MS #1 on the [NJ Exec Orde] unit and the hot water temperature in the first shower registered 73.9 degrees F, and the sink registered 73.5 degrees F. On 11/15/24 at 8:35 AM, Surveyor #1 checked the hot water with the Maintenance Staff (MS #2) in the [NJ Exec Orde] unit second shower which registered 63.3 degrees F. On 11/15/24 at 8:37 AM, Surveyor #1 interviewed a Hospice Staff employee (HS #1), who revealed that she did not give showers because the water was cold, so she was only able to give sponge baths. On 11/15/24 at 8:39 AM, Surveyor #1 interviewed CNA #4, who stated she did not give showers because the water was cold. On 11/15/24 at 10:47 AM, Surveyor #1	F 600		

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interviewed MS #2, who revealed that residents could not be showered because of the cold water, and the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)] had been informed. At that time, the shower log for [NJ Exec Orde] was reviewed and there was no documentation if residents received showers on their scheduled days.

Surveyor #3:

On 11/15/24 at 8:35 AM, Surveyor #3 observed Resident #46 lying in bed, who stated "I've been NJ Ex Order 26.4(b)(1) for about [NJ Ex Order 26.4(b)(1)] because it was cold; it made me feel NJ Ex Order 26.4(b)(1)] because there was no NJ Ex Order 26.4(b)(1) anymore."

On 11/15/24 at 9:33 AM, Surveyor #3 interviewed CNA #5, who stated I gave Resident #46 a NJ Ex Order 26.4(b)(1) the other day. The CNA continued that the resident had not [NJ Ex Order 26.4(b)(1)] for some time because the water was cold. The CNA reported for the past three months, all the units had cold water; that the water was usually hot from 8:30 PM to about 7:00 AM. The CNA stated the water temperature was very inconsistent, and the residents wanted a hot shower.

On 11/15/24, Surveyor #5 obtained the following hot water temperatures:

At 9:59 AM, Room #5 (unoccupied resident room) - 65.5 degrees F
At 10:30 AM, Resident #21 and #47's room - 64 degrees F
At 10:47 AM, Resident #2 and #42's room - 67 degrees F

An acceptable Removal Plan (RP) was received

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F 600	Continued From page 29 on 12/4/24 at 12:24 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; a licensed plumber repaired the hot water system; a hot water management system was put in place to verify hot water was available; residents were offered a hot bath or shower two to three times a week; maintenance and nursing staff checked hot water temperatures twice on the day and evening shifts and once during the night shift to ensure acceptable temperatures; if water temperatures were not acceptable, the [redacted] was notified to remedy the issue; and nursing staff utilized rinse free wipes for resident care if water was not within acceptable range and the resident requested care. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. NJAC 8:39- 4.1(a)(3)(5)(12); 5.1 (a); 27.1 (a); 27.2(i); 27.5e; 31.2(e); 31.6 (j), 31.7(h)	F 600		
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,	F 607		1/31/25

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F 607	Continued From page 30 neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy by ensuring all newly hired employees were appropriately screened by conducting a criminal background checks prior to date of hire. This deficient practice was identified for 10 of 10 newly hired employees reviewed, and was evidenced by the following: A review of the facility's "Freedom from Abuse, Neglect, and Exploitation" policy with a reviewed	F 607	1. No residents were specified in the 2567 to have been effected by the concern identified. 2. The facility recognizes that current and future residents have the potential to be effected by the concern identified. 3. Education will be provided to hiring staff by the Human Resource Director/Designee by 01/31/2025 regarding documents and checks required	

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F 607	Continued From page 31 date of October 2024, included...the organization will protect the resident right to be free from verbal, sexual, physical, and mental abuse. Resident must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, or volunteers...1. Screening of potential staff... A review of the facility's "Hiring" policy with a reviewed date of November 2023, included facility provides equal employment opportunity to all persons qualified to perform essential functions of the position and an organized process for hiring...8. Prior to hiring the following must be completed...h. Background Investigation-following organizational policy... On 11/18/24 at 8:50 AM, the surveyor reviewed ten facility provided employee files, Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. All ten staff were hired between April 2023 through November 2024. All ten employee files reviewed had a document titled, "Personal History Questionnaire." The questions asked the employees if they had ever been convicted of a felony that included fraud, violence, abuse, or sexual misconduct. The employee answered yes or no and signed the form. The surveyor was unable to locate criminal background checks in the staff files for the ten employees hired. On 11/18/24 at 10:20 AM, the surveyor conducted an interview with the U.S. FOIA (b)(6)) regarding the criminal background check process. The [redacted] stated that the facility "did not run a formal background check." The surveyor verified that the self-screening form was the only	F 607	for the new hire process, specifically background check attestation. A background check attestation will be completed by new employee hires prior to the start of their employment. The Human Resources Director will review new employee files to verify a background check attestation has been completed. Current policy will be revised to reflect this change by 01/31/2025. 4. The LNHA will check new hire files weekly for the next 3 months to verify proper documentation is in place and background check attestations have been completed. Areas of concern will be addressed. The Human Resources Director will audit new employee files to verify a background check attestation has been done and that the checklist of documents required has been completed to verify the hiring process has been finalized as required. Outcomes of the audits will be reported to the monthly QAPI committee for review. The report will be submitted every month for the next three months with follow up provided as needed.	

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F 607	Continued From page 32 background check completed by the facility for employees upon hire. When asked if that form would provide an accurate and reliable information regarding criminal background, the PC confirmed "it would not." NJAC 8:39-4.1(a)(5)	F 607		
F 689 SS=L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Part A Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to maintain hot water temperatures at a safe level to protect residents from third degree burns and serious injury on 3 of 3 units (Birch, Cedar, and Dogwood). Refer F 835L Hot water temperatures obtained on 11/16/24, in both residents' rooms on all three nursing units and in resident shower rooms on the Cedar and Dogwood units, registered between 117 degrees Fahrenheit (F) and 131.5 degrees F. Interviews with the U.S. FOIA (b) (6) revealed that the facility's boiler system was "undersized" for	F 689	1. Leaves around or near the NJ Exec Order 26.4b area were removed. NJ Exec Order 26.4b1 are now retained by the NJ Exec Order 26.4b1 who are responsible to NJ Exec Order 26.4b1 for residents. The hot water system was repaired as of 12/2/24. CNA #2 was disciplined for not having a second staff member assist with the Resident transfer via NJ Exec Order 26.4b1 The staff member was re-educated on the proper procedure and safety precautions when using a lift. 2. Current residents have the potential to be effected by the issues identified. There are presently NJ Ex Order 26.4(b)(1) patients who	1/31/25

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F 689	Continued From page 33 the facility size; provided inconsistent hot water temperatures; and the residents' water used should be between 95 degrees F through 115 degrees F. The facility's failure to ensure the residents were protected from excessive hot water temperatures posed the likelihood of serious harm and injury from third degree burns. This resulted in an Immediate Jeopardy situation (IJ). The IJ began on 11/16/24 at 1:25 PM, when the survey team identified water temperatures on the resident units in excess of 120 degrees F. The facility Administration was notified of the IJ on 11/16/24 at 5:38 PM. The facility submitted and acceptable Removal Plan (RP) on 12/4/24. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. The evidence was as follows: Reference: State Operation Manual; Guidance to Surveyors for Long Term Care Facilities; 483.25 (d)(1); Water Temperature - Water may reach hazardous temperatures in hand sinks, showers, tubs, and any other source or location where hot water is accessible to a resident. Burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate.	F 689	have smoking privileges. Upon admission, smoking assessments are completed by licensed nurses for residents wishing to smoke. Re-assessments are completed by licensed nurse yearly or when a residents condition indicates a change. Upon assessment, it is determined whether a resident may smoke independently or requires supervision with smoking. Residents deemed capable of smoking independently (by full smoking assessment) will be required to sign a smoking agreement indicating that they are aware of the facility policies as related to smoking. The facility recognizes that current residents have the potential to be effected by the temperature of the water. A licensed plumbing contractor met with the LNHA and Maintenance Director on November 18, 2024. The system was inspected and repairs needed were identified. The licensed plumbing contractor sourced materials and repairs were completed on 12/2/24. Residents requiring a mechanical lift transfer have the potential to be effected by the concern identified. 3. Maintenance Coordinator/Designee will inspect the smoking area minimum of twice daily and remove accumulated debris and leaves to mitigate fire hazard. An additional Smoking Post receptacle was purchased and effective November 29, 2024,	

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F 689	Continued From page 34 Time and Temperature Relationship to Serious Burns Water Temperature and Time Required for Third degree Burn (Penetrate the entire thickness of the skin and permanently destroy tissue). Water temperature and time required for a third degree burn to occur: 148 F - 2 Seconds 140 F - 5 Seconds 133 F - 15 Seconds 127 F - 1 Minutes 124 F - 3 Minutes 120 F - 5 Minutes On 11/13/24 at 11:25 AM, Surveyor #5 interviewed the [redacted] who stated that the facility's boiler was "undersized" for the facility. The [redacted] continued that the facility had one boiler that provided hot water for the entire building with six working boilers used for heating. On 11/14/24 at 8:44 AM, the [redacted] came to the conference room to show the survey team a cellular phone picture of a thermometer reading of 113 degrees F. The surveyor asked the [redacted] if the hot water was consistent, and the [redacted] confirmed that the hot water temperature was not consistent. On 11/16/24 at 10:42 AM, Surveyor #6 interviewed the [redacted] who stated that the hot water temperatures were higher in the afternoon when laundry and the kitchen were not utilizing hot water. The [redacted] continued that the boiler ran continuously so the water when not in use, was held in a holding tank where it increased in	F 689	both doors that are used to access and exit the designated smoking courtyard have a post in place for disposal of cigarette butts. Housekeeping staff will empty ashtrays into the Smoking Posts twice on the day shift and once on the evening shift. In addition, the Smoking Post receptacles will be emptied by housekeeping staff a minimum of once daily. The smoking policy final revision was completed on 12/18/2024. Staff was educated on the revision by Nursing Administration on 12/18/2024 and 12/19/2024. The smoking policy will be reviewed at the next Resident Council Meeting and will be reviewed 2x a year with the Resident Council and if/when changes to the smoking policy occur. The LNHA re-educated the Maintenance Department on November 21, 2024 regarding water temperature ranges, taking and recording of water temperatures several times/day and notification of the LNHA immediately should the water temperatures not be within the required range. If the LNHA is advised of an issue with water temperatures, the LNHA/designee will immediately contact a licensed plumber for service and notify the Director of Nursing. In the event that water temperatures are not within the required range, the Director of Nursing will direct nursing staff to utilize rinse-less body wipes for resident care	

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F 689	Continued From page 35 temperature until use. The U.S. FOIA stated the water the residents used should be within 95 degrees F to 115 degrees F for safety. On 11/16/24 at 12:02 PM, Surveyor #5 and Surveyor #6 interviewed the U.S. FOIA about the hot water readings. The U.S. FOIA stated that "currently the hot water boiler could not be controlled and when no hot water was being utilized throughout the facility, it produced these hot temperatures." The U.S. FOIA continued and stated he had "no control of the boiler and he did not know enough about the system to adjust it." On 11/16/24 beginning at 1:25 PM, the survey team in the presence of the U.S. FOIA obtained the following water temperatures on all three nursing units that registered over 120 degrees F: NJ Exec Order 26.4b1 Unit: Unoccupied Resident Room #70 - 127.9 degrees F Unoccupied Resident Room #72 - 128.8 degrees F Unoccupied Resident Room #79 - 121.5 degrees F Unoccupied Resident Room #80 - 129.7 degrees F Resident #239's Room - 131.5 degrees F Shower Room #2 - 127 degrees F Pantry - 128.6 degrees F Bathroom by NJ Exec Order 26.4b1 Nurses' Station - 127 degrees F NJ Exec Order 2 Unit: Unoccupied Resident Room #34 - 124.1 degrees F	F 689	until correct water temperatures can be restored. The facility smoking policy was revised on 12/18/2024 as follows: a. residents may not possess lighters or matches b. smoking times will be established, smoking monitors will monitor resident smoking including smoking monitors to light cigarettes and verify that cigarette butts are properly extinguished in designated receptacles. This policy revision was individually communicated to residents who smoke on 12/19/24 by the Consultant Administrator and the conversation was documented in the individual resident's medical record. Residents who smoke were and will continue to be required to acknowledge the policy with acknowledgement documented in the resident medical records. The facility staff were educated on the smoking policy changes by administration on 12/19/24. Designated smoking times were established and put into effect following staff and resident education on 12/19/24. The DON/designee will re-educate nursing staff by 01/31/2025 regarding the proper use/procedure for use of mechanical lifts to include 2 staff members must be present to use the lift. 4. The DON/designee will randomly observe three residents every week x4,then every	

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F 689	Continued From page 36 Unoccupied Resident Room #38 - 123.3 degrees F Resident #29's Room - 120.6 degrees F Resident #80's Room - 121.9 degrees F Shower room #1 - 122.7 degrees F Pantry - 121.3 degrees F Resident #24 and #35's Room - 121.2 degrees F Resident #79 and #84's Room - 120.2 degrees F [redacted] Unit: Unoccupied Resident Room #5 - 120.2 degrees F Unoccupied Resident Room #27 - 120.2 degrees F A review of the facility's "Weekly Water [Temperature] Reading 2024" log provided by the [redacted], revealed that the last weekly temperature obtained was on 11/11/24. The log reflected that the water temperatures were within normal range, but the log did not include at what time the temperatures were obtained. An acceptable removal plan was received on 12/4/24, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; a plumber repaired the hot water system; the [redacted] and maintenance department were educated on acceptable water temperatures, obtaining water temperatures several times a day, and notification to the [redacted] of water temperatures outside parameters; maintenance and nursing staff monitored water temperatures daily; and if water temperature was not in acceptable range, nursing staff utilized rinse free body wipes for resident care.	F 689	other week x2, then monthly x1, who require mechanical lift transfers being transferred by staff to verify proper device, sling and technique is conducted by staff members. Results of the observation will be logged on an audit form. The DON/RN Nurse Educator will address any concern with re-education, counseling and disciplinary action as deemed necessary. The facility smoking policies will be reviewed at resident council twice per year of if a change in the policy occurs. Residents who smoke will be required to sign a new smoking agreement with each review. The policy was reviewed at the next Resident Council Meeting. The Smoking Agreements and the list of residents who smoke shall be reviewed by the QAPI committee on a quarterly basis. Areas of concern will be addressed with follow up as needed. The LNHA/designee will randomly observe three smoking times per week of the next twelve weeks to verify staff and residents are adhering to the revised policy. Areas of concern will be addressed. Maintenance and Nursing will monitor water temperatures in resident care areas daily and report any concerns to the LNHA at the time of discovery to be addressed. Water temperature checks will continue daily and be a routine job task performed by the maintenance department. Outcomes for water temperature, mechanical lift audits and smoking observations shall be reviewed at the	

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F 689	Continued From page 37 The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. NJAC 8:39-31.7(h) Part B Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to protect the residents by ensuring the facility's [NJ Exec Order 26.4b] area was maintained to prevent [NJ Ex Order 26.4(b)(1)]. The deficient practice was identified in the [NJ Exec Order 26.4b] and affected 3 of 3 units [NJ Exec Order 26.4b1]). Refer F 835 Observations and interview on 11/17/24, with both residents and staff, revealed that the facility did not have a system to ensure that a safe [NJ Exec Order 26.4b] environment for residents who [NJ Ex Order 26.4(b)] was maintained and to ensure there was a process for the safe storage of [NJ Exec Order 26.4b] materials. Observations and interviews also confirmed that the dried leaves that surrounded the courtyard contained extinguished [NJ Exec Order 26.4b1] and the residents utilized [NJ Exec Order 26.4b1] and dumped their [NJ Exec Order 26.4b1] into four plastic lined garbage receptacles that were filled with combustibles. The residents also held onto their own [NJ Exec Order 26.4] materials which included [NJ Exec Order 26.4b] and [NJ Exec Order 26]. The facility's failure to ensure that appropriate [NJ Exec Order 26.4b1] were utilized and a process	F 689	monthly QAPI meeting for 3 months. Areas of concern will be addressed with follow up provided as needed.	

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F 689	Continued From page 38 was followed to ensure the safe storage of NJ Exec Order 26.4b1 posed the likelihood of serious harm, injury, or death due to fire. This resulted in an Immediate Jeopardy situation (IJ). The IJ began on 11/17/24 at 10:52 AM, when the survey team identified NJ Exec Order 26.4b1 in the dried leaves. The facility Administration was notified of the IJ on 11/17/24 at 1:26 PM. The facility submitted and acceptable Removal Plan (RP) on 12/4/24. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. The evidence was as follows: Reference: 11/17/24: The New Jersey Forest Fire Services: Advisory: STAGE 3 FIRE RESTRICTIONS IN EFFECT: In response to prolonged dry conditions and increased wildfire activity until further notice... Current Fire Danger (for facility county) RED: EXTREME. A review of the "Smoking Policy for Residents" dated effective October 2022, included the purpose: to verify that residents that choose to smoke will be properly assessed and be able to smoke outdoors in a "safe environment." Policy: the organization is non-smoking facility and will permit residents to smoke in designated outside areas only. Procedure: 1. Any resident who is a smoker will be informed at the time of admission of the facility smoking policy. Residents admitted will be required to acknowledge the policy and adhere to it...4. Cigarettes may be kept by residents in their locked drawer. 5. Matches and lighters, will be kept in a locked box or in a locked drawer in the medication room/on each unit or in the	F 689		

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medication cart. Lighters and/or matches may be taken out to the smoking area by residents but must be turned to staff upon the resident re-entering the facility. 6. Residents "are strictly prohibited from having matches/lighters in their possession inside of the facility." Smoking is strictly prohibited inside the facility. 7. Cigarettes must be extinguished in the ashtrays provided in the smoking area. "Butts" cannot be retained by any resident and taken inside the facility...

On 11/17/24 at 10:52 AM, Surveyor #2 and #4 entered the designated NJ Exec Order 26.4b1 and immediately upon entrance observed approximately one foot from the automatic door opener to the courtyard, multiple areas o[redacted] directly on the red brick wall; spread on four bricks. There were multiple NJ Exec Order 26.4b1 on the ground located in the rocks and mixed in the leaves in the same area of the NJ Exec Order 26.4b1 [redacted]. There were no observed covered [redacted] receptacles located in that area. The landscaping beds were observed throughout the entire courtyard to be covered with dried leaves, pine needles, and other debris.

At the time of the observation, Resident #71 greeted the surveyors and confirmed that they [redacted] and held onto their NJ Exec Order 26.4b1 and [redacted] and brought them into the facility. The surveyor asked about the condition of the courtyard including the debris and leaves, and Resident #71 stated that the landscapers had not been at the facility for months, that "he U.S. FOIA (b)(6) [redacted] isn't paying the bill." When asked how Resident #71 knew that the [redacted] did not pay the bills, the resident stated, [redacted]

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F 689	Continued From page 40 On 11/17/24 at 10:55 AM, Surveyor #2 and #4 then observed Resident #34, #85, and #66 at a table outside with two black plastic-like open [redacted] in front of Resident #66 and Resident #34 while they were [redacted] At that time, the surveyors observed no staff were present in the courtyard. The surveyor asked Resident #34 what was done with the [redacted] when they were finished [redacted]? Resident #34 stated that they had to '[redacted]." When asked if anyone ever helped them, all four residents stated there was "never" anyone out there to help them. On 11/17/24 at 10:59 AM, Resident #190 joined the other residents and stated that the facility never kept their [redacted] and did not provide a locked box. The resident continued that they stored their [redacted] and [redacted] in their jacket pocket which the resident left on their wheelchair. On 11/17/24 11:00 AM, Resident #66 pulled a [redacted] out of their pocket and [redacted] in front of the surveyors and stated, "I don't have a locked box." The resident continued that staff were aware since they knew that the resident stored their [redacted] and [redacted] in a bag on the back of their wheelchair. When asked if it was accessible to other residents, Resident #66 stated "anyone can take it ([redacted] On 11/17/24 at 11:01 AM, Resident #67 stated their [redacted] was kept in an unlocked drawer in their room. On 11/17/24 at 11:06 AM, Resident #79	F 689		

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F 689	Continued From page 41 confirmed there was no locked box in their room. On 11/17/24 at 11:16 AM, Surveyor #5 and Surveyor #6 joined the observation. The surveyors observed that there were [NJ Exec Order 26.4b1] in front of Resident #34. The surveyor asked Resident #34 where they discarded their [NJ Exec Order 26.4b1] and the [NJ Exec Order 26.4b1], Resident #34 stated, "we dump them in the trash." At that time, all four surveyors observed four trash cans in the courtyard and lifted the lids which revealed plastic lined cans filled with debris including [NJ Exec Order 26.4b1] paper, a cardboard pizza box, and other combustible debris inside the plastic liners. There was one fire extinguisher in the opposite corner of the courtyard with a sticker attached that it was last inspected in June 2024. Two additional black plastic-like open [NJ Exec Order 26.4b] were observed on two other tables located in the [NJ Exec Order 26.4b1] On 11/17/24 at 2:00 PM, the [U.S. FOIA (b)(6)]) informed the survey team that he tried to contact the [U.S. FOIA (b)(6)] regarding the IJ, and the phone went to voicemail. The [U.S. FOIA] stated that he checked all four garbage cans in the [NJ Exec Order 26.4b] , and confirmed that he observed the [NJ Exec Order 26.4b1], papers, and [NJ Exec Order 26] inside. The [U.S. FOIA] acknowledged he understood the concerns shared by the survey team and he discarded all the garbage in all four receptacles located in the courtyard. An acceptable removal plan was received on 12/4/24 at 12:24 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient	F 689		

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F 689	Continued From page 42 practice including leaves around or near resident [NJ Exec Order 26.4b] area were removed; [NJ Exec Order 26.4b1] were now held by the nursing staff; residents assessed as [NJ Exec Order 26.4b1] were given their [NJ Exec Order 26.4b1] prior to [NJ Exec Order 26.4b] and were educated to return upon entrance into the building; maintenance inspected the [NJ Exec Order 26.4b] area a minimum of twice a day to remove any debris; housekeeping staff [NJ Exec Order 26.4b1] twice on the day shift and once on the evening shift; additional [NJ Exec Order 26.4b1] receptacles were purchased; and the [NJ Exec Order 26.4b1] was reviewed with residents. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. NJAC 8:39-31.6(e) Part C Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident was [NJ Ex Order 26.4(b)(1)] in a safe manner to prevent potential injury. The deficient practice occurred for 1 of 5 residents reviewed for accidents (Resident #43) and was evidenced by the following: On 11/14/24 at 2:00 PM, the surveyor entered Resident #43's room. Upon entrance, the surveyor observed that the bed was [NJ Ex Order 26.4(b)(] with Resident #43 lifted by a [NJ Exec Order 26.4b1] resident's bed. The surveyor observed one Certified Nurse Aide (CNA #2) in the room operating the [NJ Exec Order 26.4b1]	F 689		

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The surveyor then exited the room, notified the Licensed Practical Nurse (LPN #1), and the surveyor and LPN #1 returned to the room. CNA #2 was in the process of completing the NJ Exec Order 26.4b1 when the LPN #1 informed the surveyor that the facility policy was to have NJ Ex Order 26.4(b)(1) when operating the NJ Exec Order 26.4b1

On 11/14/24 at 2:15 PM, during an interview with CNA #2, he stated, that "I forgot, I usually asked another CNA to assist with the NJ Exec Order 26.4b1

On 11/14/24 at 2:50 PM, the surveyor re-interviewed CNA #2 about the NJ Exec Order 26.4b1 NJ Ex Order 26.4(b and how CNA #2 knew how Resident #43 needed to be NJ Ex Order 26.4(b)(1) CNA #2 provided the surveyor with a form titled "Nursing Care Log" initiated on NJ Exec Order 26.4b1, which indicated the following: NJ Ex Order 26.4(b) NJ Exec Order 26.4b1

On 11/15/24 at 9:41 AM, the surveyor observed Resident #43 in bed and interviewed the resident regarding how they were two people who NJ Ex Order 26.4(b)(1) them with the NJ Ex The resident continued when female staff NJ Ex Order 26.4(b)(1), there were two people, but when a male CNA cared for them, they NJ Ex Order 26.4(b)(1) by themselves.

On 11/15/24 at 10:00 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #43 which revealed the following:

A review of the Admission Record face sheet (an admission summary) reflected the resident had diagnoses which included but were not limited to;

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NJ Exec Order 26.4b1

A review of the most recent quarterly Minimum Data Set, an assessment tool dated NJ Exec Order 26.4b1, indicated that the resident was NJ Exec Order 26.4b1. Resident #43 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident had a NJ Exec Order 26.4b1.

A review of the individualized comprehensive care plan (ICCP) dated NJ Exec Order 26.4b1 revealed that Resident #43 had a NJ Exec Order 26.4b1. The interventions included: to provide the resident with a safe environment and NJ Exec Order 26.4b1.

On 11/20/24 at 1:03 PM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated that she was aware of the incident of U.S. FOIA (b)(6), and the U.S. FOIA (b)(6)) was going to address the concern with the NJ Exec Order 26.4b1

On 11/21/24 at 10:55 AM, during an interview with the U.S. FOIA (b)(6), she revealed that she was informed on 11/20/24, that CNA #2 did not execute the transfer of Resident #43 properly while using the NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) stated that Resident #43 should have been NJ Ex Order 26.4(b)(1) with NJ Exec Order 26.4b1 The surveyor then asked what the protocol was and the U.S. FOIA (b)(6) stated, that a NJ Exec Order 26.4b1 at all times for NJ Ex Order 26.4(b) using the NJ Exec Order 26.4b1];" that one person took care of the NJ Ex Order and the other person directed

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F 689	Continued From page 45 the NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) stated that "if the resident NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1), we needed another person to prevent injury." On 11/20/24 at 12:50 PM, the U.S. FOIA (b) provided Resident #43's statement which the resident confirmed that CNA #2 used the NJ Exec Order 26.4b1 alone. On 11/20/24 at 1:00 PM, the U.S. FOIA (b) provided CNA #2's statement dated NJ Ex Order 26.4(b)(, which the CNA indicated that they "just forgot" and lifted the resident with the NJ Exec Order 26.4b1 by themselves. A review of the facility's "Mechanical Lift and Stand Policy" dated October 2023, included; policy: the mechanical lift or stand lift will be used for those residents who cannot be transferred comfortably and/or safely by other normal transfer technique. Procedure: all appropriative staff will receive training on hire and as needed for proper use of the mechanical lift. Prior to use of the mechanical lift/stand the employee will ensure that: there is a second person to assist with transfer...	F 689		
F 761 SS=D	NJAC 8:39-27.1(a) 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	F 761		1/31/25

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F 761	Continued From page 46 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 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, dispose, and store medication in 1 of 2 medication carts reviewed. The deficient practice was evidenced by the following: On 11/15/24 at 9:15 AM, the surveyor inspected the [NJ Exec Order] Unit Medication Cart #1 in the presence of the Licensed Practical Nurse (LPN #2). The following were observed: 1. One Lantus insulin pen (prescription medication used to treat diabetes) that was opened and not dated. At that time, the [U.S. FOIA (b)] stated that all insulin pens should be dated with an opened date and expiration date and then discarded after 28 days. 2. One NJ Exec Order 26.4b1 with an expiration	F 761	1. The Lantus, [NJ Ex Order 26.4(b)(1)] and Xalatan medications that were not labeled with open, expired or dated containers were immediately destroyed and new medications were ordered as needed. Medication carts were audited on 11/20/2024 to verify drugs were appropriately labeled and dated and that any expired drugs were removed from the med carts. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. Re-Education was provided to licensed	

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F 761	Continued From page 47 date of 11/02/24. A review of the Medication Administration Record (MAR) dated NJ Exec Order 26.4b1 , revealed that the resident received the NJ Exec Order 26.4b1 . 3. One bottle of Xalatan (prescription medication to treat high eye pressure) was opened and not dated. The NJ Exec Or sated that the eye drop should have been dated with an opened and expiration date. On 11/20/24 at 12:51 AM, the U.S. FOIA (b)(6) provided the Health Company (name redacted) "Insulin Storage Recommendations" dated 3/2020 which revealed the following: 1. NJ Ex Order 26.4(b)(1) insulin pen when opened had a 28-day expiration date. 2. Lantus insulin pen when opened had a 28-day expiration date. 3. Xalatan ophthalmic solution should be dated when opened and discard after six weeks. On 11/20/24 at 1:30 PM, the U.S. FOIA (b) acknowledged that all NJ Exec Order 2 should be dated when they were opened. A review of the the facility's "Medication Dating and Storage Policy" dated last reviewed October 2024, included the following: Purpose: It is the policy of this facility that medications will be dated and stored based on the guidelines below...To ensure the proper management and storage of medication. Procedure: The facility will utilize the (name redacted) "Medication Storage Parameters" guideline for dating and storage of medications...Expiration dates need to be checked prior to administer medications...Nursing supervisors will check all expiration dates on shift to shift count...	F 761	nurses by the RN Nurse Educator on 11/20/2024. The education included a review of the Labeling and Dating procedure and disposal of medications for discharged and expired residents. 4. Med carts will be audited by the Nursing Supervisors weekly for the next 12 weeks to verify that medications are properly labeled and dated. Expired medication and those medications for discharged or expired residents will be properly addressed. The RN Nursing Supervisors will conduct audits of med carts weekly for four weeks, then every other week for two months. Areas of concern will be addressed. Audit outcomes will be reported to the QAPI committee monthly for the next three months with follow up provided as needed.	

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F 761	Continued From page 48 NJAC 8:39-29.4(a)(b);2(g)	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of food and drink served to the residents. This deficient practice was identified during the lunch time meal service on 11/18/24, on [NJ Exec Order] nursing units [U.S. FOIA (b)(6)] food temperatures were tested in the presence of the [U.S. FOIA (b)(6)]) ,and was evidenced by the following: On 11/18/24 at 12:23 PM, in the presence of the [U.S. FOIA], the surveyor conducted a test tray with a calibrated (calibration ensures that the thermometer is accurate and precise for the	F 804	1. The Dietitian is reviewing all food orders and comparing them to the menu to verify the items needed are available. Food orders are being delivered consistently. The Dietitian is auditing food service to verify it matches the menu. The Dietitian/Food Service Director will verify Food Temperatures during meal service daily to substantiate safe and appetizing temperatures of food and drink for residents. The pellet warmer will be repaired and metal plates will be supplied to enhance warm	1/31/25

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F 804	Continued From page 49 measurement of food temperatures) thermometer. The meal tray cart arrived to the unit at 12:10 PM. It was an open, not an enclosed cart. The surveyor tagged the bottom tray for temperature testing. When all the meal trays were delivered to the residents from that truck at 12:15 PM, the temperatures were checked for a regular consistency meal. The temperatures were as follows: Chicken a la king: 150 degrees Fahrenheit (F) Buttered egg noodles: 118 degrees F Spinach: 140 degrees F Black coffee: 121 degrees F 4-ounce milk carton: 45 degrees F The plates did not have metal plates warmers (pellets) underneath the plates to help maintain heat. The [redacted] stated that one of the pellets warmers was out of service and the working one was unable to be used due to the device needed to extract the pellets from the warmer was on back order. A review of the facility policy "Food Temperature Control," with a last reviewed date of November 2024, included that food temperatures would be monitored to ensure that resident's food is safe for consumption and is "served at the proper temperature." It also included, "Hot foods are served hot = minimum 140 degrees F when served to resident;" and "Cold foods are served cold = maximum 41 degrees F when served to resident." NJAC 8:39-17.4(a)	F 804	meals exit the kitchen for service by 01/31/2025. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. The Dietary staff will be in-serviced by the Consultant Dietitian/Dietitian by 01/31/2025 related to food preferences, palatability, nutritive value, appearance and appropriate temperature. Grievances related to food will be forwarded to the Food Service Director/Dietitian for resolution when submitted. The Food committee will meet monthly to address food concerns and capture resident feedback. Food preferences and recommendations will be considered as possible. Meeting notes shall reflect the areas of concern and subsequent resolution. The pellet warmer will be repaired by 01/31/2025. 4. The Food Service Director will audit food temperatures daily x 4 weeks, then 2x week for 4 weeks, then conduct random audits for 3 trays per week for the next month. Areas of concern will be addressed. The outcome of the audits and meetings will be reported to the monthly QAPI meeting for he next 3 months with follow up provided as needed.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		1/31/25

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F 812	Continued From page 50 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, record review, and policy review, it was determined that the facility failed to; a) store food in a manner to prevent food-borne illness, b) maintain the kitchen environment and equipment in a sanitary manner, and c) ensure the water temperature was appropriate when utilizing the three-compartment sink to wash food preparation equipment to prevent potential for food borne illness. This deficient practice was evidenced by the following: 1. On 11/13/24 at 9:08 AM, the surveyor conducted an initial tour of the kitchen with the U.S. FOIA (b)(6)) and observed the following:	F 812	1.A daily and weekly sanitation and food storage procedure has been re-implemented by the Consultant Dietitian to address identified areas of sanitation and food storage concerns and to substantiate that food is stored in a manner to prevent food-borne illness; to maintain kitchen environment and equipment in a sanitary manner; to verify water temperature is appropriate when utilizing the three compartment sink to wash food and prep equipment to prevent potential food borne illness. In addition, the following areas will be addressed:	

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F 812	Continued From page 51 - The door gasket and the door curtain on the walk-in refrigerator was torn. - The floor to the walk-in refrigerator was rusted and lifted. - The dish drying rack was rusted in appearance. On 11/13/24 at 12:04 PM, the surveyor observed the kitchen staff (KS #1) washing large pans in the three-compartment sink. The surveyor tested the wash water which felt cool, and registered 92 degrees Fahrenheit (F). The surveyor asked KS #1 if the water should be hotter, and KS #1 stated the water was not always hot and it depended on if "it was on." 2. On 11/13/24 at 1:19 PM, the surveyor conducted a follow-up kitchen tour with the [redacted] and observed the following: - The walk-in freezer had a ripped gasket, there was ice on the floor and the floor appeared visibly rusted. - The wall behind the cooking battery had splatters, and underneath the equipment there was various debris and crumbs. - There were cobwebs on the fire suppression system nozzle located above the cooking area. - The fryer that was not in use was visibly soiled with splatters on the exterior. - There were knives stored in a rack with a plastic type of cover and there was debris inside the rack by the knives. - There were dark stains and splatters on several areas on the ceiling tiles. - A walk-in refrigeration box was not in service and was used to store nonperishable items and the floor was soft underfoot and appeared visibly rusted.	F 812	a) Dish drying rack rusted in appearance b) Wall behind cooking battery was splattered; debris and crumbs found beneath equipment c) Cobwebs on the fire suppression system nozzle located above the cooking area d) Fryer that not in use was visibly soiled with splatters on exterior e) Knives stored in rack with plastic cover-debris inside rack. f) Dark stains and splatters on several areas of ceiling tiles g)) Meat slicer had food debris on blade and base h) Dry storage room had debris on the floor under the racks and a disposable cup was stored in the flour bin as a scoop. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. Food Service staff will be educated by the Consultant Dietitian/Food Service Director by 01/31/2025 regarding sanitation of the department and proper food storage to limit the potential of food borne illness. The following identified issues will be addressed: a) Door gasket torn on the walk in fridge. b) Floor to walk-in is rusted and lifted. c) Walk-in freezer has ripped gasket, ice on floor and floor is rusted d)Walk-in refrigerator, not in use- non	

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F 812	Continued From page 52 - The meat slicer had food debris on the blade and the base; there were splatters on the wall behind the meat slicer. - The dry food storage room had debris on the floor under the racks and there was a disposable cup stored in the flour bin used as a scoop. A review of the "Three Compartment Sink" policy dated effective November 2021, included Purpose: The organization will properly utilize, clean and sanitize the the three compartment sink when completing manual warewashing. Purpose: To prevent food borne illness...Procedure:..4. In the first sink, scrub all surfaces of the dishes in warm, soapy water. Wash them in detergent solution at least 110 degrees F... NJAC-8:39-17.2(g)	F 812	perishables stored here. Floor soft and visibly rusted. Maintenance concerns/issues will be logged into a repair log and reviewed daily by the Maintenance Director. Completed concerns will be signed off when completed. The Food Service Director/Dietitian will conduct daily sanitation and food storage rounds for the next 12 weeks to include verifying proper labeling and dating of product. A rounding sheet will be utilized and retained. 4. The outcome of the audits will be reported at the monthly QAPI meeting for the next 3 months with follow up provided as needed.	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure garbage and recycling was managed in an appropriate manner to limit the potential for vermin and the spread of bacteria. This deficient practice had the potential to affect all residents who resided on 3 of 3 units and was evidenced by: On 11/13/24 at 9:08 AM, upon entrance to the kitchen, and in the presence of the U.S. FOIA (b)(6) [redacted] it was observed that cardboard	F 814	1.Trash and Recycling materials are now being removed regularly by the waste management company 3 days per week with extra pickups as needed to verify the potential for vermin and the spread of bacteria is limited. Dumpsters have covers and the lids to control potential exposure to vermin and the elements. 2. The facility recognizes that current residents have the potential to be effected	1/31/25

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F 814	Continued From page 53 boxes were piled up the length of a door opening by the [redacted]'s office to the wall and were stacked in egg creates, on the floor and in a bin and the pile was at least four or more feet high. The surveyor asked the [redacted] why it was piled up in the kitchen and the [redacted] stated she did not know why because it was usually picked up 1-2 times per week. The surveyor then exited the kitchen with the [redacted] to view the dumpster area in the rear of the building and the following was observed: -Two garbage dumpsters did not have lids covering the garbage bags that were visible and observed various debris strewn on the ramp leading to the garbage dumpsters and around the exterior of the garbage dumpsters. The cardboard dumpster was observed uncovered and overflowing with cardboard, and cardboard was also stored on the ground on the side of the dumpster. -At the time of the observation the [redacted] stated she went into the dumpster to try and pack the cardboard down to make room since she did not know why it was not getting picked up. On 11/1324 at 9:28 AM, the surveyor interviewed the [redacted]) regarding the cardboard stacked in the kitchen and the cardboard dumpster that was overflowing. The [redacted] stated he was unaware that the cardboard was piled up. On 11/17/24 at 7:30 AM, the surveyor observed the recycling dumpster which remained fully filled, uncovered and cardboard boxes were stored outside of the dumpster on the ground. On 11/17/24 at 8:45 AM, the surveyor observed	F 814	by the concern identified. 3. The [redacted], [redacted] and [redacted] will be educated by the LNHA by 01/31/2025 regarding waste removal and sanitation. Based on observation and compliance, the Administrator will determine if additional waste removal is necessary to maintain a safe and sanitary environment. The Administrator will assign the Maintenance Director/Food Service Director or Housekeeping Director to monitor and clean these areas on a daily basis as needed. The daily findings will be documented in an audit form. 4, The Administrator/designee will observe the outside dumpsters, surrounding area and kitchen 3x a week for the next moth then weekly for 2 months to verify the trash and recycling has been removed and the adjacent areas are free of debris. The audits will be submitted to the QAPI committee monthly meeting for review for the next 3 months to verify continued compliance with follow up provided as needed.	

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F 814	Continued From page 54 the kitchen with the [U.S. FOIA], and the cardboard boxes remained stacked up in the kitchen against a wall. The [U.S. FOIA] was not aware of why the garbage company had not picked up the recycling. NJAC 8:39-31.4(b)	F 814		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Part A Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that there was a [U.S. FOIA (b)(6)] who was physically present and actively involved by providing daily oversight to ensure all policies and procedures were implemented including consistently providing hot water for all residents' bathing and care needs. This deficient practice affected all residents who resided on [NJ Exec Order 26.4b1] units ([NJ Exec Order 26.4b1]). Refer to F 600L, F 689L Interviews on 11/13/24, with both residents and staff, revealed that the facility neglected residents' complaints of no hot water for showering and bathing for months, and that the [U.S. FOIA (b)(6)] had not	F 835	1. The LNHA has been on site full time since [U.S. FOIA (b)(6)]. A LNHA will remain on site full time to meet licensure requirements and the needs of facility, residents, families and staff. 2. The facility recognizes that current residents have the potential to be affected by the concern identified. As per the DPOC, effective 11/20/24, A Consultant LNHA has been working full time at the facility. This will continue until the DOH discontinues the requirement. 3. The current LNHA will be on site full-time as required by licensure to meet the needs of the facility and its□ residents.	1/31/25

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F 835	Continued From page 55 been present at the facility in six months was aware. Temperatures obtained on 11/13/24, in both resident rooms and shower rooms on all three nursing units registered between 66.8 degrees Fahrenheit (F) and 82 degrees F. Interviews with the U.S. FOIA (b)(6) confirmed water temperatures had been cold, that hot water should be at least 105 degrees F; residents' and their families had complained; and the facility's boiler was "underrated" for the facility size. The facility's failure to ensure the U.S. FOIA (b)(6) was present at the facility to implement all facility policies including the residents' rights to hot water for bathing and personal care needs posed a likelihood of serious harm to the residents' care and ability to achieve their highest practicable level of wellbeing. This resulted in an Immediate Jeopardy situation (IJ). The IJ began on 11/13/24, when the survey team entered the facility and became aware that the U.S. FOIA (b)(6) had not been present at the facility for six months and that the U.S. FOIA (b)(6) had neglected the residents' complaints including water temperatures. The facility Administration was notified of the IJ on 11/13/24 at 4:19 PM. The facility submitted and acceptable Removal Plan (RP) on 12/4/24. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. The evidence was as follows: A review of the "Administrator Job Description", signed as the "Employee" and "Supervisor" on 03/15/24, by the U.S. FOIA (b)(6) revealed: The Administrator	F 835	The LNHA re-educated the U.S. FOIA (b)(6) on 11/21/24 regarding water temperature ranges, taking and recording of water temperatures daily and notification of the LNHA immediately should the water temperatures not be in the required range. If the LNHA is advised of an issue with water temperatures, the LNHA will immediately contact a licensed plumber for service. In the event that water temperatures are not within the required range, the Director of Nursing will direct nursing staff to utilize, rinse less body wipes for resident care until correct water temperatures can be restored. The Consultant LNHA educated the LNHA on the following: 11/20/24: Regulation 8:39-9.2- The requirement for an onsite full-time Licensed Nursing Home Administrator and their responsibility to ensure all policies and procedures are implemented and to be actively involved in daily oversight of the facility. 11/29/24: the facility Smoking Policy and its revision to include scheduled emptying of ashtrays and smoker post receptacles. 11/20/2024: Regulations regarding hot water requirements-Specifically, hot water temps within required range and available 24/7. 11/27/24: The facility policy on taking water temps and its revision which includes immediate notification of the Administrator if temps are outside of the required	

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F 835	Continued From page 56 is responsible for planning and directing the overall operation of the facility; budgetary development; expense control; supervisory oversight; and ensuring federal and state licensure requirements are met. Job responsibilities: 1. Assists Department Managers in the development and use of facility policies and procedures ... 2. Overseeing all department facility operations. 3. Maintaining and meeting federal and state regulations governing nursing facility operations. 4. Plans, submits and reviews financial data and develops budget for operations, revenue and expenses for all departments ... 6. Reasonable for facilitating positive resident outcomes and addressing and grievance or concerns in a timely manner following regulatory and organizational policy. 8. Actively participates in facility committees' and community programs. 9. Conducts thorough investigation of occurrences. Participated in and/or conducts Root Cause Analysis (RCA) for precursor/serious safety events. Tracks, analyzes, reports, and oversees plan of correction for occurrences in compliance with organizational policies and procedures. Reports results to the Quality Assurance Performance Improvement (QAPI) Committee. 12. Completes payroll in an accurate and timely manner. 13. Promotes the professional growth and development of all employees. Monitors plans for educational needs of the employees and ensuring compliance for mandatory education as governed by state, federal and accrediting agencies. j) Grievances: 1. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances to the facility without discrimination or reprisal. Such grievances include those with respect to care and discrimination or reprisal. Such grievances	F 835	guidelines. 4. The facility will maintain a log which shows the presence of the Administrator and the Executive Director. The log will be maintained by the Payroll Coordinator. Areas of concern will be addressed and corrected if identified. LNHA/designee will audit water temperature logs daily to verify water temperature are checked and within the required temperature range for facility and resident use. Areas of concern will be immediately addressed by LNHA arranging for service and repairs as needed by licensed plumbers. The Consultant Administrator will work with the Administrator to verify the delegations of authority and succession plans for an emergency are completed with progress reported weekly in the DOH report.	

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include those with respect to care and treatment which has been furnished as well as that which has not been furnished. 2. The resident has the right to prompt efforts by the facility to resolve grievances in accordance with 483.11 (h).

A review of the facility's "Resident Rights" policy dated effective October 2021, included the resident has the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside of the facility. The facility must protect and promote rights of each resident, as described in the policy consistent with the principles of requirements of Federal, State and Local Laws and Regulation...

On 11/13/24 at 8:10 AM, the survey team entered the facility and the surveyor asked the U.S. FOIA (b)(6) if the U.S. FOIA (b)(6) was available. The U.S. FOIA (b) (6) stated, "he [the U.S. FOIA (b)(6)] worked up north [northern New Jersey]"; that he [the U.S. FOIA (b)(6)] was the owner and was not in the building. The surveyor then asked the U.S. FOIA (b)(6) if he was expected at the facility, and the U.S. FOIA (b)(6) stated he did not "physically" work in the facility. The surveyor observed the U.S. FOIA (b)(6) framed New Jersey Department of Health (NJDOH) U.S. FOIA (b)(6) license hanging behind the U.S. FOIA (b)(6) on the wall. The U.S. FOIA (b)(6) again stated to the survey team that "he works up north", and she did not know where, and informed the survey team that the U.S. FOIA (b)(6)) was "in charge." The survey team then observed, affixed to the wall opposite of the reception desk, a plastic holder that contained copies of a document titled: [Facility Name] "Below is a list of the Department Heads at Our Facility, Please Feel Free To Call If

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You Have Any Questions of Concerns Regarding Yourself or a Family Member"; listed as the administrator was the [redacted] name and telephone number, which did not correspond with the facility's NJDOH [redacted] license on file.

On 11/13/24 at 8:15 AM, the surveyor interviewed the [redacted] who confirmed that the [redacted] was the person with the license hanging on the wall, but he was "up north [northern New Jersey]."

On 11/13/24 at 8:39 AM, the [redacted]) greeted the survey team, and when the survey team inquired about the [redacted], and asked if he would be expected at the facility for the survey, the [redacted] stated, "he doesn't work here", and she had "no idea where he works." The [redacted] stated she was employed by the facility as the [redacted] for two months, and she never met or communicated with the [redacted]. The [redacted] continued that the person she reported to, and who hired her was the [redacted]. The [redacted] stated the [redacted] was not available and was not coming to the facility today. The surveyor then inquired if the [redacted] was a [redacted], and the [redacted] stated "she was not", and the surveyor then requested a business card for the [redacted] and [redacted].

On 11/13/24 at 9:00 AM, the [redacted] provided a business card for the [redacted]. The card revealed the (ED's name), listed as a [redacted] with the title [redacted] for the [name redacted] Management Company in [town redacted], New Jersey. The surveyor conducted an Internet search for the company location which revealed it was located 96 miles north of the facility.

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F 835	Continued From page 59 Surveyor #1: On 11/13/24 at 9:28 AM, Resident #43 stated to Surveyor #1 that they had a complaint and asked if it was okay to get washed by staff with cold water. On 11/13/24 at 10:04 AM, on the [NJ Exec Orde] Unit, Surveyor #1 interviewed a Certified Nurse Aide (CNA #1) about the water temperatures, and CNA #1 who stated she was unable to shower residents because the water temperature was "too cold" and that the facility had been aware of the cold-water problem. On 11/13/24 at 11:32 AM, Surveyor #1 interviewed the [U.S. FOIA (b)(6)] about the laundry process and the hot water temperatures. The [U.S. FO] stated that they needed to stop using the washing machines at 10:00 AM to preserve the hot water. Surveyor #1 then asked the [U.S. FOI] if she had been aware that there was a problem with the hot water and she stated, "yes", three months ago, and stated "I never in my life worked in such a condition." Surveyor #2: On 11/13/24 at 11:12 AM, Surveyor #2 toured the [NJ Exec Order 26.4b1] Unit, and in the presence of a CNA #2 took the bathroom water temperature for Room #74 (unoccupied resident room) which registered 68.1 degrees F. At that time, Surveyor #2 asked if that was the hot water knob and CNA #2 confirmed it was and that the facility had not had hot water "in a while" and they provided cold showers. On 11/13/24 at 11:22 AM, Surveyor #2	F 835		

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interviewed Resident #240, who stated that they could not take a shower, but their bed bath was also cold.

On 11/13/24 at 11:25 AM, Surveyor #2 interviewed Resident #23, who stated "I won't shower with cold water and don't even ask me about washing my hair. It hasn't been pleasant."

On 11/13/24 at 11:25 AM, Surveyor #2 interviewed Resident #241, who stated that they had not been at the facility long but that the water was cold.

Surveyor #3:

On 11/13/24 at 11:19 AM, Surveyor #3 entered the [redacted] Unit, in the presence of CNA #4, obtained the following water temperatures: Shower #1 the hot water from the sink and shower was 78 degrees F, and in Resident #72 and #74's room bathroom sink was 78 degrees F. At the time of the observation, Surveyor #3 interviewed CNA #4, who stated "this morning the water was hot when we gave their baths, it's usually around 10:30 AM and sometimes during the day that it gets cold but not all the time."

On 11/13/24 at 12:13 PM, Surveyor #3 interviewed Resident #79 about the water temperatures in the room and the resident continued, "the water used to be hot but lately it's been cold; I don't take showers when the water was cold. [The facility] fixes it and it got cold again." The resident had reported that the issue had been going on in the last few days.

On 11/13/24 at 12:17 PM, Surveyor #3 interviewed Resident #46 in their room, who

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stated "I've been here for [NJ Exec Order] [NJ Ex Order 2] due to a NJ Exec Order 26.4b1 for [NJ Exec Order 26.4b1] I'm a [NJ Exec Order 26.4b1]. My major issue was there was no hot water for a year now. My last [NJ Ex Order 26.4(] was [NJ Ex O] ago, I took [NJ Ex Order 26.4(b)(1)] that were ice cold. I got a [NJ Ex Order 26.4(b)(1] but it's ice cold. I've told everyone, the nurses, U.S. FOIA (b) (6) ."

Surveyor #4:

On 11/13/24 at 11:13 AM, Surveyor #4, in the presence of CNA #5, entered Resident #82's room and tested the hot water in the resident's bathroom which registered at 80 degrees F. CNA #5 stated that residents complained of cold water all the time and CNA #5 stated he worked on all of the units. CNA #5 then accompanied Surveyor #4 to the shower room and held the shower head hose; the water felt cold and registered 69 degrees F.

On 11/13/24 at 12:04 PM, Surveyor #4 entered the kitchen and observed the Kitchen Staff employee (KS #1) washing large stainless steel type pans in the three-compartment sink. The surveyor felt the wash water which felt cool and the wash temperature registered 92 degrees F, the sanitizer temperature registered 79 degrees F. Surveyor #4 asked KS #1 if there was hot water and he stated, depends if it was on and hot water was "not always on."

Surveyor #5:

On 11/13/24 at 11:16 AM, Surveyor #5, in the presence of the U.S. FOIA (b)(6) tested the hot water on the [NJ Exec Orde] Unit bathroom in Room #5 (unoccupied resident room), which

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F 835	Continued From page 62 registered 66 degrees F. On 11/13/24 at 11:22 AM, Surveyor #5, in the presence of the [U.S. FOIA], tested the hot water on the [NJ Exec Orde] Unit bathroom in Room #26 (unoccupied resident room), which registered 66 degrees F. On 11/13/24 at 11:25 AM, Surveyor #5 interviewed the [U.S. FOIA] about the water temperatures in the boiler room. Surveyor #5 observed and counted that there were 12 boilers. There were six boiler certificates posted that indicated six boilers were inspected in 2023. The [U.S. FOIA] stated that the boilers observed were only used to heat the resident rooms and "not for hot water". The [U.S. FOIA] stated that there were only six certificates because "only six boilers were working." The [U.S. FOIA] stated that the hot water boiler was recently replaced. Surveyor #5 asked for the annual inspection certificate of the recently replaced hot water boiler and the [U.S. FOIA] stated that he was not sure if there was one because the boiler was changed prior to [U.S. FOIA (B)] date of hire. The [U.S. FOIA] stated that he believed that the boiler ran well but was "undersized" for the facility and he believed at one point the facility used to have two bigger boilers in use, telling from the empty space next to the smaller boiler. There were also two boiler venting pipes, one of them did not have a boiler hooked up to it. The other had the venting pipes reduced in size to accommodate the smaller boiler. Surveyor #5 then noticed old inspection stickers on the boiler and asked the [U.S. FOIA] if the unit was recently replaced, and why did it have an inspection sticker from January of 2016 on it? The [U.S. FOIA] stated that he was unsure since the boiler was already installed prior to his employment, and stated that the boiler may have been taken from somewhere else, and then was	F 835		

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installed at the facility. The U.S. FOIA stated, "This was how it was when I got here, I inherited this".

On 11/13/24 at 12:31 PM, the survey team interviewed the U.S. FOIA (b)(6) regarding the lack of hot water. The U.S. FOIA (b) stated that she had only been at the facility for two months and had been told by the facility that they were "working on it, and some units [nursing units] get it sometimes and some don't". The U.S. FOIA (b) stated she "didn't know what was happening, I do not know of anything" and that the U.S. FO had been aware of the problem. The U.S. FOIA (b)(6) stated that she had worked at the facility for 16 years and "occasionally the hot water doesn't work, and they 'U.S. FOIA (b)(6) don't share with us." The U.S. FOIA (b)(6) confirmed that residents and their families had complained about the lack of hot water.

On 11/13/24 at 12:37 PM, the survey team interviewed the U.S. FOIA regarding the hot water temperature concerns. The U.S. FOIA stated he had worked at the building for five months and stated that his staff informed him that there was an issue with the hot water. The U.S. FOIA stated the boiler was not fit for the property and the use, and was "underrated for the facility size." The U.S. FOIA stated, "the boiler only works to produce enough hot water when the usage was low." The U.S. FOIA stated that the residents tell him about the hot water not working and that not having hot water was "unacceptable." The U.S. FOIA stated hot water should be available 24-7 (24 hours per day and seven days per week), and "occasionally it doesn't work." The U.S. FOIA again confirmed that residents and their families complained about the lack of hot water, and the U.S. FOIA (b)(6) were aware. Surveyor #4 asked the U.S. FOIA if he had ever met the U.S. FOIA (b) (6) stated, "no, never saw him in

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the building." The [redacted] stated, "honest truth, I only spoke to him through her [redacted]" and stated he "cannot call him." Surveyor #4 then asked about the discussion that was had through the [redacted]. The [redacted] stated that his staff told him that the facility used to have a bigger system and the [redacted] then stated the hot water temperature needed to be at least 105 degrees F. The [redacted] stated, "we only talk to him [the [redacted] through [the [redacted]." The [redacted] stated about four months ago he was on a conference phone call that the [redacted] set up with her and the [redacted] (neither was present at the facility). The [redacted] stated he informed the [redacted] that the hot water system needed to be replaced sometime soon. The [redacted] had "no response" regarding the [redacted] concerns, and nothing from the [redacted] either, and he had not heard anything since.

On 11/13/24 at 1:11 PM, Surveyor #4 interviewed the [redacted] and asked if she had ever met the [redacted] She stated she had been there for six months and had never met him. The surveyor asked if the washing machine needed to be at a certain temperature to wash clothing and she stated yes, 130 degrees F. The surveyor asked how would you know, and she stated, "I don't." The [redacted] confirmed the facility did all linen and laundry in house.

On 11/13/24 at 1:48 PM, Surveyor #4 interviewed the [redacted] employee (PS) who provided the [redacted] job description. The [redacted] job description was signed and dated as Employee and Supervisor on 3/15/24. Surveyor #4 asked the PS about the date, and she stated that was when the other [redacted] left and "he took over." Surveyor #4 asked the PS where the [redacted] was since he was not at the facility, and the PS stated he was up north (northern New Jersey) in the

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corporate office. Surveyor #4 asked when the last time you physically saw the [U.S. FOIA (b)(6)] at the facility and she stated, "six months ago."

On 11/14/24 at 7:55 AM, the [U.S. FOIA (b)] informed the survey team that she forwarded the IJ templates to the [U.S. FO] yesterday when they were presented to her.

On 11/14/24 at 8:16 AM, the surveyor team observed through the opened door to the conference room, a male who introduced himself as the facility [U.S. FOIA (b)(6)] to the [U.S. FOIA (b)], and the [U.S. FOIA (b)(6)] then immediately entered the conference room. Upon entrance, the [U.S. FOIA (b)(6)] introduced himself as the [NJ Exec Order] and stated to the survey team that he had not yet read the IJ templates (provided to the [U.S. FOIA (b)] more than 12 hours prior). The surveyor informed the [U.S. FOIA (b)(6)] that the IJ templates were sent to the [U.S. FO] per the [U.S. FOIA (b)], and then asked the [U.S. FOIA (b)(6)] if the [U.S. FO] was a licensed nursing home administrator? The [U.S. FOIA (b)(6)] confirmed that the [U.S. FO] was not a a licensed nursing home administrator. The surveyor then informed the [U.S. FOIA (b)(6)] of the observation regarding the introduction that he made to the [U.S. FOIA (b)], and asked if he had met or interacted with her. The [U.S. FOIA (b)(6)] stated, he "spoke" with her before.

On 11/14/24 at 8:44 AM, the [U.S. FOIA] came to the conference room to show the survey team a cellular phone picture of a thermometer reading of 113 degrees F. The surveyor asked the [U.S. FOIA] if the hot water was fixed and the hot water temperature was now consistent, and the [U.S. FOIA] confirmed that the hot water temperature was not consistent.

On 11/14/24 at 10:14 AM, the [U.S. FOIA (b)(6)] met with the

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survey team to review the concerns with the lack of hot water and the two IJ Situations that were presented to the facility on 11/13/24 at 4:19 PM. The [redacted] stated he looked at the IJs "last night, but it was on his phone and he could not read them." The [redacted] then stated "I just got the printout this morning," and he now wanted to discuss how the facility was going to respond. The [redacted] stated "it [the hot water] was on and off these days," and if they [staff] adhered to the schedule "they would get hot water, and yesterday they did not adhere to the schedule." The [redacted] stated to the survey team, "I do not communicate with everyone, I am explaining that I communicate through the [redacted]." The [redacted] then stated the [redacted] would not be at the facility. The [redacted] provided a business card to the survey team that identified him as the President of the same company as the [redacted] and in the same location (the business card did not identify him as the facility [redacted]. The [redacted] stated he knew there was an issue with the hot water and we implemented a schedule when they should be using the water and "that the [residents] don't remember if they had a shower or not."

An acceptable removal plan was received on 12/4/24 at 12:24 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; a licensed plumber repaired the hot water system; the [redacted] was on-site fulltime; the facility maintained a log to track the [redacted] at the facility; the [redacted] in-serviced the [redacted] on facility policies and procedures and the importance of implementing them; a hot water management system was put in place to verify hot water was

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F 835	Continued From page 67 available; and the [U.S. FOIA (b)(6)] audited daily temperature logs and immediately addressed any temperatures outside parameters. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. NJAC 8:39-9.2(a)(2) Part B Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure the [U.S. FOIA (b)(6)] [redacted]) implemented all facility policies and procedures to function in a manner that ensures the resources were available for residents to attain or maintain their highest practicable level by ensuring: a) a system was in place to ensure consistent food and supplements were regularly purchased to coincide with the resident menu and therapeutic needs; b) residents were provided with an operational telephone system; c) a QAPI (Quality Assurance and Performance Improvement) program existed and involved facility staff and the U.S. FOIA (b) (6); d) waste services were consistently provided to ensure recycling was not stored in the facility due to lack of dumpster space; and e) residents' Personal Needs Account (PNA) funds were protected by having a current surety bond that was in full force and effect. The deficient practice affected all residents who resided on 3 of 3 resident units (Birch, Cedar, and Dogwood) and was evidenced by the following: A review of the "Administrator Job Description",	F 835		

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signed as the "Employee" and "Supervisor" on 03/15/24, by the U.S. FOIA (b)(6) [redacted] revealed: The Administrator is responsible for planning and directing the overall operation of the facility; budgetary development; expense control; supervisory oversight; and ensuring federal and state licensure requirements are met. Job responsibilities: 1. Assists Department Managers in the development and use of facility policies and procedures ... 2. Overseeing all department facility operations. 3. Maintaining and meeting federal and state regulations governing nursing facility operations. 4. Plans, submits and reviews financial data and develops budget for operations, revenue and expenses for all departments ... 6. Reasonable for facilitating positive resident outcomes and addressing and grievance or concerns in a timely manner following regulatory and organizational policy. 8. Actively participates in facility committees' and community programs. 9. Conducts thorough investigation of occurrences. Participated in and/or conducts Root Cause Analysis (RCA) for precursor/serious safety events. Tracks, analyzes, reports, and oversees plan of correction for occurrences in compliance with organizational policies and procedures. Reports results to the Quality Assurance Performance Improvement (QAPI) Committee. 12. Completes payroll in an accurate and timely manner. 13. Promotes the professional growth and development of all employees. Monitors plans for educational needs of the employees and ensuring compliance for mandatory education as governed by state, federal and accrediting agencies. j) Grievances: 1. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances to the facility without

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F 835	Continued From page 69 discrimination or reprisal. Such grievances include those with respect to care and discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished. 2. The resident has the right to prompt efforts by the facility to resolve grievances in accordance with 483.11 (h). A) On 11/13/24 at 9:08 AM, upon entrance to the kitchen, the surveyor asked the [redacted] if there have been any concerns regarding the ability to purchase food. The [redacted] stated that the representative from the food purveyor sent her a text last week, "within one hour of submitting order." The order was submitted 11/05/24, for delivery on 11/06/24, and the text informed her that food order "was on hold", and she stated that was the order, "that was never delivered last week." When the surveyor asked why that happened, the [redacted] stated, "no one (facility or purveyor) said any reason why and maybe the business office person would know." The [redacted] stated, it was not the first time it happened and the former [redacted] told her that happened before. The surveyor asked how the lack of ability to order food was affecting the foods served to the residents, and the [redacted] stated "not fully"; that she tried to stock up on items and usually made the main menu items but has had to substitute vegetables. The [redacted] confirmed that she has had no communication with the [redacted] regarding the reason why the food order was canceled. The surveyor requested substitution logs that were provided by the [redacted] at that time. A review of the substitution log revealed the following:	F 835		

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Date: 11/13/24, for lunch revealed original item: green beans and substitute (sub) given asparagus; Reason for Substitution: Vendor did not deliver.
Date: 11/13/24, for lunch revealed original item: stuffing and sub given mashed potato; Reason for Substitution: Vendor did not deliver.

On 11/13/24 at 3:00 PM, the U.S. FOIA provided the surveyor a copy of the food order that she stated was the ordered items that were submitted on 11/5/24, and was never delivered. The U.S. FOIA stated the order would not be saved in the system if it was not delivered, and that was why the order was dated 10/22/24, and she would have to re-enter the entire food order. The food order listed 90 items. The surveyor asked the U.S. FOIA if she was now able to order food, she stated that she "may be able to."

On 11/14/24 at 9:28 AM, the surveyor interviewed the U.S. FOIA regarding if the facility was able to order food. The U.S. FOIA stated that she was told by the payroll person that she could order food today for tomorrow, and the facility would scan a check to the food vendor after the food order was submitted.

On 11/14/24 at 1:12 PM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding her role at the facility. The U.S. FOIA stated she reported to the U.S. FOIA (b)(6) who was not a U.S. FOIA (b)(6). The U.S. FOIA stated, "this was the first time that she saw the U.S. FOIA (b)(6) since she had been back at the facility since NJ Exec Order 26.4b1. The surveyor asked the U.S. FOIA if she had ever had an issue with getting paid. The U.S. FOIA stated that she heard it had been an issue, but that she was directed by other

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department heads including the Business Office, to cash her paycheck quickly and deposit the cash into her account and to not directly deposit the paycheck. The surveyor asked the [redacted] if there were problems with the facility being able to order food. The [redacted] stated that she was aware that to order food, the facility had to "scan checks first" to pre-pay the vendor. The [redacted] stated that there were times they needed to personally go to the grocery store to purchase food items, including not having coffee for the residents and food for a resident who required a gluten free diet and they were unable to get the food. The [redacted] stated, the food order was "usually" delayed, and the residents were confused at times, because they ordered food and were getting substitutes. The [redacted] stated that they did not have the magic cup [fortified ice cream for extra calories and nutrition] and seven residents received it.

On 11/15/24 at 8:52 AM, the surveyor interviewed the [redacted] regarding the food order, and the [redacted] stated a "new order is supposed to be in today." The surveyor asked if magic cups were available for the residents? The [redacted] stated, "we do not have magic cups because the food order from last week, was not approved" and the facility has not had them since lunch yesterday (two meals were missed).

On 11/15/24/ at 11:00 AM, the surveyor observed the emergency food storage closet with the [redacted], and the "3 Day Menu" was posted on the wall. The [redacted] stated the supply was not full because when the food orders were not able to be ordered, she took food items from the emergency supply and used them for the regular menu which depleted the emergency supply. The [redacted] stated she did not have enough emergency water also

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F 835	Continued From page 72 and has not replenished either. On 11/15/24 at 12:21 PM, the surveyor interviewed the [U.S. FOIA (b)(6)]) regarding why food cannot be delivered at times. The [U.S. FOIA (b)] stated there were times that [U.S. FOIA (b)(6)] staff (AP) had to prepay for food before the food would be sent, and stated, "we are making payments" as the facility was over 60 days on payments for the food vendor. B) On 11/14/24 at 11:06 AM, Surveyor #3 conducted the Resident Council meeting with seven awake and alert residents. During the meeting, seven of seven residents informed the surveyor that the phones had not been working. On 11/20/24 at 8:33 AM, Resident #61 informed Surveyor #3 that their phone had not been working. Resident #61 stated that the maintenance staff could not fix the phone. They informed the nurse and the issue had not been addressed. Resident #61 stated," I feel like a motherless child, I feel horrible." On 11/20/24 at 8:59 AM, Surveyor #3 interviewed the Certified Nursing Aides (CNA #2) regarding the issue with the phone. CNA #2 stated, "It makes the residents really upset when the communication system is not working. The residents cannot communicate with their families and they do not have a cell phone." C) On 11/13/24 at 10:27 AM, during the entrance conference that was held with the facility administration, the surveyor requested: the QAPI plan, the QAPI program, the quality assessment and assurance (QAA) committee information, and the quarterly sign-in sheets for the QAPI	F 835		

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F 835	Continued From page 73 meetings since the last standard survey conducted on 04/21/23. On 11/14/24 at 12:28 PM, the surveyor requested from the U.S. FOIA (b)(6) the QAPI plan, the QAPI program, the QAA committee information, and the quarterly sign-in sheets for the QAPI meetings since the last standard survey conducted on 04/21/23. The U.S. FOIA (b)(6) stated, "I don't know where it is, but I will look for it." On 11/15/24 at 10:36 AM, the surveyor again, requested from the U.S. FOIA (b)(6) the QAPI plan, the QAPI program, the QAA committee information, and the quarterly sign-in sheets for the QAPI meetings since the last standard survey conducted on 04/21/23. On 11/15/24 at 12:38 PM, the surveyor reminded the U.S. FOIA (b)(6) that the QAPI documentation was requested on 11/13/24, during entrance conference. The U.S. FOIA (b)(6) confirmed that the documentation should have been readily available to the facility administration, but again stated he "did not know where it was." The surveyor then stated to the U.S. FOIA (b)(6) that he may have additional time to provide the documentation, and the U.S. FOIA (b)(6) stated, "don't bother, I won't have it." The U.S. FOIA (b)(6) stated the U.S. FOIA (b)(6) was in charge of the QAPI binder. On 11/15/24 at 12:44 PM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the survey team, regarding any involvement she had with QAPI. The U.S. FOIA (b) stated, "not here", but was aware of what QAPI was. The U.S. FOIA (b) stated that upon being hired, she requested	F 835		

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the QAPI documentation from the [U.S. FOIA] since that was her supervisor, but was "not provided anything." When asked if the facility's [U.S. FOIA (b)(6)] was a required attendee of the QAPI meetings, the [U.S. FOIA (b)] confirmed that the [U.S. FOIA] was required to attend.

On 11/15/24 at 1:37 PM, the surveyor conducted a telephone interview with the acting [U.S. FOIA]. The [U.S. FOIA] stated he had been the full-time [U.S. FOIA] for the facility for [NJ Exec Order 26.4b1]. The [U.S. FOIA] stated that he was involved in monthly QAPI meetings held by the facility until approximately six to nine months ago when the QAPI meetings stopped. The [U.S. FOIA] stated that the last QAPI meeting he was aware of was held in March 2024. The [U.S. FOIA] stated that the [U.S. FOIA (b)(6)] was responsible to ensure QAPI meetings were scheduled and held with all required attendees. The [U.S. FOIA] stated when the former [U.S. FOIA (b) (6)] resigned, there "were no more QAPI meetings" and he confirmed that he was not there, "because it wasn't scheduled." The [U.S. FOIA] stated that things changed, [not for the good], and he had since resigned his position as the [U.S. FOIA]. The [U.S. FOIA] stated he was presently helping the new medical director transition into the role. The [U.S. FOIA] stated, the old [U.S. FOIA (b)(6)] scheduled QAPI meetings, "like clockwork", and he knew to attend the last Wednesday of the month.

D) On 11/13/24 at 9:08 AM, upon entrance to the kitchen, and in the presence of the [U.S. FOIA (b) (6)]) it was observed that cardboard boxes were piled up the length of a door opening by the [U.S. FOIA (b)(6)] office to the wall and were stacked in egg creates, on the floor and in a bin and the pile was at least four or more feet high. The surveyor asked the [U.S. FOIA (b)] why it was piled up in the kitchen and the [U.S. FOIA] stated she did not know why

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because it was usually picked up 1-2 times per week. The surveyor then exited the kitchen with the [U.S. FOIA (b)] to view the dumpster area in the rear of the building where the following was observed:

-Two garbage dumpsters did not have lids covering the garbage bags that were visible and observed various debris strewn on the ramp leading to the garbage dumpsters and around the exterior of the garbage dumpsters. The cardboard dumpster was observed uncovered and overflowing with cardboard, and cardboard was also stored on the ground on the side of the dumpster.

-At the time of the observation the [U.S. FOIA] stated she went into the dumpster to try and pack the cardboard down to make room since she did not know why it was not getting picked up.

E) On 11/13/2024 at 10:27 AM, an entrance conference was conducted with the facility administration [U.S. FOIA (b)(6)]. At that time,the survey team requested a copy of the current surety bond with the contact information, and a list of all residents with PNA holdings.

On 11/13/2024 at 2:19 PM, the facility provided a document titled "Patient Trust Fund Bond" (Bond) with [name redacted] insurance company, along with four other documents. The Bond included but was not limited to; "sealed with our seals and dated this 20th day of February 2020." The second facility provided document was "Principal's Acknowledgement" which included but was not limited to; "On 3/13/20" ... "witness my hand and official seal" was signed but did not include any seals. The third document was titled "Surety Disclosure Statement ..." and the

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F 835	Continued From page 76 documentation was dated 07/11/19. The fourth document was titled "P and C Balance Sheet," [name redacted insurance company] and dated 04/18/2019. The fifth document included a Power of Attorney for the [name redacted insurance company] signed and dated 2/20/2020, with an expiration dated 1/31/2023. On 11/20/2024 at 12:54 PM, the facility responded to the additional request for the complete surety bond information including the contact information to show the bond was in full force and effect. The response was that the [redacted] replied the surety bond was not his "current focus. Does not have one and will not have one today".	F 835		
F 838 SS=F	NJAC 8:39-9.2(a)(2) Facility Assessment 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,	F 838		1/31/25

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F 838	Continued From page 77 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 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,	F 838		

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F 838	Continued From page 78 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 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	F 838		

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	315176	A. BUILDING _____ B. WING _____	C 12/05/2024

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F 838	Continued From page 79 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 care. This REQUIREMENT is not met as evidenced by: Based on interview, and review of facility documentation, it was determined that the facility failed to ensure that a facility wide assessment was reviewed and updated to identify: a) the required services and procedures necessary to protect the health, safety, and welfare of all residents; b) address staff competencies to provide resident care; c) review the facility environment to ensure safety; and d) ensure adequate facility resources to provide resident care and services. This deficient practice has the potential to affect 94 of the 94 residents at the facility during the time of survey. This deficient practice was evidenced as follows: On 11/13/24 at 10:27 AM, the survey team	F 838	1. The Consultant Administrator educated the [redacted] regarding the Facility Assessment. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3, The Facility Assessment will be reviewed and updated. It will be updated annually or when there are changes made to the Center resident population, staff or services. Copies of the Facility Assessment will be placed in the Survey and Emergency Plan binders.	

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F 838	Continued From page 80 conducted an entrance conference with the U.S. FOIA (b)(6) There were documents requested to complete the survey process which included but were not limited to; the Facility Assessment. The U.S. FOIA (b) was unaware of a facility assessment. On 11/14/24 at 8:16 AM, the U.S. FOIA (b)(6)) was present in the facility. The survey team made the U.S. FOIA (b)(6) aware of required documents requested upon entrance. The U.S. FOIA (b)(6) requested a list of outstanding documents via email which was sent on 11/14/24 at 12:28 PM. On 11/15/24 at 11:41 AM, the survey team asked the U.S. FOIA (b) for a copy of the Facility Assessment. The U.S. FOIA (b)(6) informed the survey team that the Facility Assessment was something the U.S. FOIA (b)(6) should have and stated, "Well, he doesn't know what that is, and doesn't have one." On 11/19/24 at 9:37 AM, Surveyor #2 questioned the U.S. FOIA (b)(6) regarding the Facility Assessment not being provided. The U.S. FOIA (b)(6) stated, "we do have a Facility Assessment, but it was not updated." On 11/20/24 at 10:58 AM, the U.S. FOIA (b) was in the conference room with Surveyor #1 and Surveyor #2. The U.S. FOIA (b) provided additional documents that were still outstanding, but the Facility Assessment was not provided. On 11/20/24 at 1:46 PM, the facility provided a "Facility Wide Staffing and Resource Assessment" dated 1/26/2023, which explained the "following goals: to assess and analyze the resident population including census, case mix and overall plan of care for each resident to	F 838	4. The updated Facility Assessment will be reviewed and approved at the monthly the QAPI committee meeting. The Facility Assessment will be updated through the course of the year as a result of a change in resident population, staff or services. Updated Facility Assessment will be presented at the next available scheduled QAPI meeting.	

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F 838	Continued From page 81 competently determine the resources needed to care for residents. To determine the resources the organization has and the resources that may be needed. Ensuring adequacy of training based on resident case mix and needs." Policies and Procedures "The organization reviews all policies and procedures annually and are approved by [redacted]." NJAC 8:39-9.2 (a); 27.1	F 838		
F 843 SS=F	Transfer Agreement CFR(s): 483.70(i)(1)(2) §483.70(i) Transfer agreement. §483.70(i)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii).	F 843		1/31/25

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F 843	Continued From page 82 §483.70(i)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation, it was determined that the facility failed to have in effect written transfer agreements with other Medicare and Medicaid participating facilities to ensure resident care during an emergency situation. This deficient practice had the potential to affect all residents and was evidenced by the following: On 11/13/24 at 10:27 AM, during the entrance conference with the facility administration, the facility was informed of documentation the survey team would need to review. On 11/14/24 at 12:00 PM, the surveyor asked the U.S. FOIA (b)(6)) to view the written transfer agreement that the facility had with one or more hospitals. The U.S. FOIA (b)(6) was unable to provide the surveyor a written transfer agreement. On 11/15/24, the U.S. FOIA (b)(6)) provided the survey team with the facility's emergency preparedness book for review. The surveyors reviewed the book in the presence of the U.S. FOIA. The emergency preparedness book failed to contain any arrangements with other facilities in case of an emergency situation where the residents needed to be evacuated. The U.S. FOIA was present and acknowledged there were no agreements in the book.	F 843	1 Two Agreements have been secured with other Long Term Care Facilities to allow transfer of residents in the event of an emergency. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. Contracts and/or Agreements will be placed in a dedicated file and retained in the LNHA's office. Transfer agreements will be reviewed annually to verify contract dates remain effective. Licensed nurses will be educated by the Director of Nursing by 01/31/2025 regarding valid transfer agreements and contact information will be readily available at the nurses stations. 4. The names and any particulars related to agreements for long term care providers will be reviewed at the monthly QAPI committee meeting with follow up provided as needed.	

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F 843	Continued From page 83 NJAC 8:39-27.1(a); 31.6(f)(g)	F 843		
F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her	F 847		1/31/25

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F 847	Continued From page 84 representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility failed to ensure that a process was in place for explaining the NJ Ex Order 26.4(b)(1) agreement that was included in the Admission Agreement, to residents prior to having the residents sign the agreement. This deficient practice occurred for 3 of 3 residents reviewed for NJ Ex Order 26.4(b)(1) agreements (Resident #23, #89, and #240) and was evidenced by the following: On 11/19/24 at 10:10 AM, the U.S. FOIA (b)(6) provided Surveyor #9 with a list of residents who signed into a NJ Ex Order 26.4(b)(1) Agreement (NJ Ex Ord The U.S. FOIA (b)(6) stated the U.S. FOIA (b)(6) was responsible for having the residents sign the agreements. On 11/19/24 at 11:00 AM, the surveyor reviewed the facility's Admission Agreement. Under section J of the agreement titled "Quality of Service Disputes" which indicated if any dispute arises concerning the services or quality rendered to the	F 847	1. A facility policy will be developed regarding NJ Ex Order 26.4(b)(1) agreements. Residents 23, 89, and 240 allege they were not informed and/or recall signing acceptance of a NJ Ex Order 26.4(b)(1) Agreement at Admission. LNHA will follow up with the 3 residents identified/responsible parties related to the signed NJ Ex Order 26.4(b)(1) agreements. 2. The facility recognizes that current and future residents have the potential to be effected by the concern identified. Current residents signed arbitration agreements will be reviewed. 3, Department Directors and Management staff will be educated regarding Arbitration Agreements and facility policy by the LNHA by 01/31/2025. 4. LHNA/designee will review current residents signed arbitration agreements to	

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F 847	Continued From page 85 resident, under this agreement the resident agrees to submit to NJ Ex Order 26.4(b)(1) to resolve all matters. On 11/19/24 at 11:30 AM, the surveyor reviewed Resident #23's signed Admission Agreement dated NJ Ex Order 26.4(b)(1). The surveyor then conducted an interview with Resident #23 regarding signing into a NJ Ex Order 26.4(b)(1) agreement. The resident who had a Brief Interview of Mental Status (BIMS) score of NJ Exec meaning the resident was U.S. FOIA (b)(6) told the surveyor that they signed an admission agreement but did not remember the word NJ Ex Order 26.4(b)(1) being explained to them. Resident #23 told the surveyor they did not know what that was. On 11/19/24 at 12:21 PM, the surveyor reviewed the Admission Agreement which included arbitration for Resident #89 which was signed on NJ Ex Order 26.4(b)(. Two surveyors then interviewed Resident #89 regarding signing into an NJ Ex Order 26.4(b)(1) agreement. The resident had a BIMS score of NJ Exec meaning the resident was NJ Exec Order 26.4b1. The resident told the surveyors that they did not remember signing anything on admission and did not know anything about an NJ Ex Order 26.4(b)(1) agreement. On 11/19/24 at 12:24 PM, the surveyor reviewed the Admission Agreement signed by Resident #240 on NJ Ex Order 26.4(, which included NJ Ex Order 26.4(b)(1). The surveyor then conducted an interview with Resident #240 in the room in the presence of their significant other. Resident #240 had a BIMS score of NJ Exe, meaning the resident was NJ Exec Order 26.4b1 Both denied being explained NJ Ex Order 26.4(b)(1) and do not recall if they were asked to sign NJ Ex Order 26.4(b)(1) documents. Both stated they were	F 847	verify that they coincide with facility policy. Results of this review will be presented at the next QAPI meeting with follow up provided as needed. .	

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F 847	Continued From page 86 never explained arbitration. On 11/19/24 at 1:08 PM, Surveyor #9 conducted an interview the U.S. FOIA (b)(6) regarding NJ Ex Order 26.4(b)(1) agreements. The U.S. FOIA told the surveyor that it was her responsibility to have residents sign the Admission Agreement. The surveyor asked what her role was when having the resident or resident representatives sign the agreement. The U.S. FOIA told the surveyor that she explained the care they would receive, and they may be responsible for certain fees. The U.S. FOIA said she also gave the residents the Ombudsman information. The surveyor asked about the arbitration section of the Admissions Agreement, which was part of the admissions agreement. The U.S. FOIA told the surveyor that she was not the best at it. The U.S. FOIA stated, "I have explained it in the past, but I don't know how." The surveyor asked the U.S. FOIA how much time a resident had to opt out of an agreement and the U.S. FOIA said, "I don't think there is an opt out, no one has ever asked." The surveyor asked the U.S. FOIA if she was familiar with the arbitration agreement and the U.S. FOIA responded, "No." On 11/20/24 at 9:01 AM, the surveyor conducted an interview with the facility's U.S. FOIA (b)(6) regarding NJ Ex Order 26.4(b)(1) The U.S. FOIA responded, "NJ Ex Order 26.4(b)(1) I have only done it twice." The surveyor asked the U.S. FOIA if she was familiar with an NJ Ex Order 26.4(b)(1) Agreement and she stated, "No, I'm not familiar with NJ Ex Order 26.4(b)(1) On 11/20/24 at 10:00 AM, the surveyor requested a policy on NJ Ex Order 26.4(b)(1) Agreements and Admission Agreements from the U.S. FOIA (b)(6) On 11/20/24 at 11:01 AM, the U.S. FOIA (b) told the	F 847		

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F 847	Continued From page 87 surveyor the facility did not have policies on Admissions or [NJ Ex Order 26.4(b)(1)] Agreements. NJAC 8:39- 13.1(a)	F 847		
F 865 SS=F	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 §483.75(a)(4) Present documentation and	F 865		1/31/25

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F 865	Continued From page 88 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 89 §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 record review, it was determined that the facility failed to maintain a comprehensive data driven Quality Assurance and Performance Improvement (QAPI) program with demonstrated evidence of a program to improve the quality of life of all residents. This deficient practice affected all	F 865	1. The facility will develop a comprehensive data driven QAPI program to identify quality issues and develop appropriate plans of action to correct the concerns identified through an interdisciplinary approach. A QAPI Plan will be developed	

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F 865	Continued From page 90 residents who resided on [NJ Exec Orde] units [NJ Exec Order 2] [redacted]), and was evidenced by the following: On 11/13/24 at 10:27 AM, during the entrance conference was held with the facility administration, the surveyor requested: the QAPI plan, the QAPI program, the quality assessment and assurance (QAA) committee information, and the quarterly sign-in sheets for the QAPI meetings since the last standard survey conducted on 04/21/23. On 11/14/24 at 12:28 PM, the surveyor requested from the U.S. FOIA (b)(6) [redacted]) the QAPI plan, the QAPI program, the QAA committee information, and the quarterly sign-in sheets for the QAPI meetings since the last standard survey conducted on 04/21/23. The [U.S. FOIA (b)(6)] stated, "I don't know where it is, but I will look for it." On 11/15/24 at 10:36 AM, the surveyor again, requested from the [U.S. FOIA (b)(6)] the QAPI plan, the QAPI program, the QAA committee information, and the quarterly sign-in sheets for the QAPI meetings since the last standard survey conducted on 04/21/23. On 11/15/24 at 12:38 PM, the surveyor reminded the [U.S. FOIA (b)(6)] that the QAPI documentation was requested on 11/13/24, during entrance conference. The [U.S. FOIA (b)(6)] confirmed that this documentation should have been readily available to the facility administration, but again stated he "did not know where it was." The surveyor provided the [U.S. FOIA (b)(6)] an opportunity to provide the documents, and the [U.S. FOIA (b)(6)] stated, "don't bother, I won't have it." The [U.S. FOIA (b)(6)] stated	F 865	by the LNHA/designee. The Consultant Administrator conducted a QAPI meeting on 12/12/2024. The next meeting is scheduled for January 16, 2025. Identified areas of Survey concern will be reflected in the QAPI Plan and Program. Education related to QAPI and relevant associated materials, (i.e. calendar, topics, list of committee members, Performance Improvement templates, forms, sign in sheets) will be made available to all staff and committee members by the LNHA/designee. Staff members will prepare areas of focus for the January meeting. 2. The facility recognizes that current and future residents have the potential to be effected by the concern identified. 3. Evidence of meeting attendance and meeting minutes will be documented and retained in a separate binder or folder. Meetings will be held on a monthly basis or more-often as deemed necessary to address identified areas for needed improvement, corrective actions or documented opportunities to enrich and enhance quality of life for residents and facility service. 4. The LNHA, Executive Director and Medical Director will review information presented and discussed at the Quality Assurance Performance Program to verify quality concerns are reviewed, corrective	

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F 865	Continued From page 91 the U.S. FOIA (b)(6) - not a U.S. FOIA (b) (6)) was in charge of the QAPI binder. On 11/15/24 at 12:44 PM, the surveyor interviewed the U.S. FOIA (b)(6)), in the presence of the survey team, regarding any involvement she had with QAPI. The U.S. FOIA (b)(6) stated, "not here", but was aware of what QAPI was. The U.S. FOIA (b) stated that upon being hired she requested the QAPI documentation from the U.S. FOIA since that was her supervisor, but was "not provided anything." When asked if the facility's U.S. FOIA (b)(6) was a required attendee at the QAPI meetings, the U.S. FOIA (b) confirmed that the U.S. FOIA was required to attend. On 11/15/24 at 1:37 PM, the surveyor conducted a telephone interview with the acting U.S. FOIA (b)(6)). The U.S. FOIA stated he had been the full-time U.S. FOIA for the facility for seven years. The U.S. FOIA stated that he was involved in monthly QAPI meetings held by the facility until approximately six to nine months ago when the QAPI meetings stopped. The U.S. FOIA stated that the last QAPI meeting he was aware of was held in March 2024. The U.S. FOIA stated that the U.S. FOIA (b)(6) was responsible to ensure QAPI meetings were scheduled and held with all required attendees. The U.S. FOIA stated when the former U.S. FOIA (b)(6) resigned, there "were no more QAPI meetings" and he confirmed that he was not there, because the QAPI meeting wasn't scheduled." The U.S. FOIA stated that things "fell apart", and he has since resigned his position of U.S. FOIA. The U.S. FOIA stated he was presently helping the new medical director transition into the role. The U.S. FOIA stated, the old U.S. FOIA (b)(6) scheduled QAPI meetings, "like clockwork", and he knew to attend of the last	F 865	actions are developed and there is monitoring for adverse events. A QAPI for development of the program will be implemented to verify required elements of the program are addressed. The LNHA , Medical Director and Executive Director will monitor the program development and assess the continued development for the next four quarters. They will report on the status and make any recommendations and/or provide additional education as necessary. Status of the program will be reported at the monthly QAPI committee meeting with follow up provided as needed.	

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F 865	Continued From page 92 Wednesday of the month. A Review of the facility's "Quality Assurance Performance Improvement Program" policy with a last reviewed and approved date of 4/2024, included but was not limited to "It is the policy of the organization to maintain, demonstrate and document a planned, ongoing, organization wide Quality Assurance Performance Improvement (QAPI) program that systematically and regularly monitors and evaluates the effectiveness, appropriateness, accessibility, continuity and efficiency of the delivery of resident care and services, pursuing opportunities for improvement and resolving problems." The policy further included, "the implementation of the QAPI program is the responsibility of the Administrator and QAPI Committee. The QAPI Committee will meet monthly to review and act upon data collection reports and activities as carried out by all departments, services, committees and improvement teams." NJAC 8:39-33.1; 33.2; 33.3; 33.4; 34.1	F 865		
F 867 SS=F	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	F 867		1/31/25

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F 867	Continued From page 93	F 867		

from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that 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:

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F 867	Continued From page 94 (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (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	F 867		

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F 867	Continued From page 95 identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §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 implement a system to identify and initiate, a comprehensive Quality Assurance Performance Improvement (QAPI) program, that developed and monitored corrective action by failing to ensure: a) hot water was available consistently for all resident care, services and facility needs; b) water temperatures did not exceed safe standards to limit the potential for 3rd degree burns; and c) a safe [redacted] process was in place. The deficient practice affected residents who resided on 3 of 3 units (Birch, Cedar, and Dogwood). The evidence was as follows:	F 867	1. No specific residents were identified as having been affected in the 2567. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. Education will be provided to facility staff defining QAPI, the program and the need for continuous improvement action to verify the highest level of care and services for the residents. This education will be provided by the Staff Educator by 01/31/2025. The facility will initiate a comprehensive Quality Assurance Performance Improvement Program that identifies	

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F 867	Continued From page 96 Refer to F600L, F689L, F835L On 11/13/24 at 10:27 AM, during the entrance conference held with the facility administration, the surveyor requested: the QAPI plan, the QAPI program, the quality assessment and assurance (QAA) committee information, and the quarterly sign-in sheets for the QAPI meetings since the last standard survey conducted on 04/21/23. Interviews on 11/13/24, with both residents and staff, revealed that the facility neglected residents' complaints of no hot water for showering and bathing for months, and that the [redacted] who had not been present at the facility in six months was aware. Temperatures obtained on 11/13/24, in both resident rooms and shower rooms on all three nursing units registered between 66.8 degrees Fahrenheit (F) and 82 degrees F. On 11/13/24 at 12:37 PM, the survey team interviewed the [redacted] regarding the hot water temperature concerns, who stated he had worked at the building for five months. The [redacted] continued that his staff informed him that there was an issue with the hot water. The [redacted] stated the boiler was not fit for the property and the use and was "underrated for the facility size." The [redacted] stated, "the boiler only worked to produce enough hot water when the usage was low." The [redacted] stated that the residents told him about the hot water not working and that not having hot water was "unacceptable." The [redacted] stated hot water should be available 24-7 (24 hours per day and seven days per week), and "occasionally it doesn't work." The [redacted] again confirmed that residents and their families have complained about the lack of hot water, and the	F 867	quality concerns, development of corrective actions and monitoring for adverse events. The program will address: - Hot water that is consistently available for resident care, services and facility needs -water temperatures do not exceed safe standards to limit the potential for 3rd degree burns -the revised smoking program is in place with consistent supervision and resident compliance -other deficient practices as identified in the recent survey and those concerns and opportunities identified by the Facility team. Regular, monthly meetings will be held and documented to verify on-going program participation and development. 4. The LNHA, Executive Director and Medical Director will review information presented and discussed at the Quality Assurance Performance Program meetings to verify quality concerns are reviewed, corrective actions are developed and there is monitoring for adverse events. A QAPI for development of the program will be implemented to verify required elements of the program are addressed. The LNHA , Medical Director and Executive Director will monitor the program development and assess the continued development for the next four quarters. They will report on the status and make any recommendations	

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F 867	Continued From page 97 U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) were aware. Surveyor #4 asked the U.S. FOIA if he had ever met the U.S. FOIA (b)(6), and the U.S. FOIA stated, "no, never saw him in the building." The U.S. FOIA stated, "honest truth, I only spoke to him through her U.S. FOIA]" and stated he "cannot call him." Surveyor #4 then asked about the discussion that occurred through the U.S. FO. The U.S. FOIA stated that his staff told him that the facility used to have a bigger system, and the U.S. FOIA stated that the hot water temperature needed to be at least 105 degrees F. The U.S. FOIA stated, "we only talked to him [the U.S. FOIA (b)(6)] through [the U.S. FO]." The U.S. FOIA stated about four months ago, he was on a conference phone call that the U.S. FO set-up between the U.S. FO and the U.S. FOIA (b)(6) (neither was present at the facility). The U.S. FOIA stated he informed the U.S. FOIA (b)(6) that the hot water system needed to be replaced sometime soon. The U.S. FOIA (b)(6) had "no response" regarding the U.S. FOIA (b) concerns, and nothing from the U.S. FOIA either, and he had not heard anything since. On 11/14/24 at 8:44 AM, the U.S. FOIA came to the conference room to show the survey team a cellular phone picture of a thermometer reading of 113 degrees F. The surveyor asked the U.S. FOIA if the hot water was fixed and was now consistent, and the U.S. FOIA confirmed that the hot water temperature was not consistent. On 11/14/24 at 10:14 AM, the U.S. FOIA (b)(6) met with the survey team to review the concerns with the lack of hot water and the two Immediate Jeopardy (IJ) Situations that were presented to the facility on 11/13/24 at 4:19 PM. The U.S. FOIA (b)(6) stated that he looked at the IJs "last night, but it was on his phone and he could not read them." The U.S. FOIA (b)(6) then stated, "I just got the printout this morning", and he now wanted to discuss how the facility	F 867	and/or provide additional education as necessary. Status of the program will be reported at the monthly QAPI committee meeting with follow up provided as needed.	

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was going to respond. The [redacted] stated "it [the hot water] was on an off these days", and if they [staff] adhered to the schedule "they would get hot water, and yesterday they did not adhere to the schedule." The [redacted] stated he "knew there was an issue with the hot water" and we implemented a schedule when they should be using the water and "that the [residents] don't remember if they had a shower or not."

On 11/14/24 at 11:05 AM, a surveyor conducted a resident council meeting with seven alert and oriented residents. When the surveyor inquired if there were any concerns related to water temperatures. Five of seven residents stated, "sometimes it's hot and sometimes it's cold". The residents confirmed that "they [administration] all know about it."

On 11/14/24/at 12:28 PM, the surveyor requested from the [redacted] the QAPI plan, the QAPI program, the QAA committee information, and the quarterly sign-in sheets for the QAPI meetings since the last standard survey conducted on 04/21/23. The [redacted] stated, "I don't know where it is, but I will look for it."

On 11/15/24 at 10:36 AM, the surveyor again, requested from the [redacted] the QAPI plan, the QAPI program, the QAA committee information, and the quarterly sign-in sheets for the QAPI meetings since the last standard survey conducted on 04/21/23.

On 11/15/24 at 12:38 PM, the surveyor reminded the [redacted] that the QAPI documentation was requested on 11/13/24, during entrance conference. The [redacted] confirmed that this documentation should have been readily

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available to the facility administration, but again stated he "did not know where it was." The surveyor provided the [redacted] an opportunity to provide the documents, and the [redacted] stated, "don't bother, I won't have it."

On 11/15/24 at 12:44 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that the facility's U.S. FOIA (b)(6) was a required attendee to QAPI meetings, and further stated that she has not been at a QAPI meeting since she was hired two months prior. The [redacted] stated that upon her hiring, she requested to review QAPI documentation but was "not provided anything."

On 11/15/24 at 1:37 PM, the surveyor conducted a telephone interview with the acting [redacted] The [redacted] stated he had been the full-time medical director for the facility for seven years. The [redacted] stated that he was involved in monthly QAPI meetings held by the facility until approximately six to nine months ago when the QAPI meetings stopped. The [redacted] stated that the last QAPI meeting he was aware of was held in March 2024. The [redacted] stated that the [redacted] was responsible to ensure QAPI meetings were scheduled and held with all required attendees. The [redacted] stated when the former [redacted] resigned, there "were no more QAPI meetings" and he confirmed that he was not there, "because it wasn't scheduled." The [redacted] stated that things changed, [not for the good], and he has since resigned his position as the U.S. FOIA (b)(6). The [redacted] stated he was presently helping the new medical director transition into the role. The [redacted] stated, the old [redacted] scheduled QAPI meetings, "like clockwork", and he knew to attend the last Wednesday of the month.

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Temperatures obtained on 11/16/24, in both residents' rooms on all three nursing units and in resident shower rooms on the [NJ Exec Order 2] and [NJ Exec Order 26.4b1] units, the hot water temperatures registered between 117 degrees F and 131.5 degrees F. Interviews with the [U.S. FOIA] revealed that the facility's boiler system was "undersized" for the facility size; provided inconsistent hot water temperatures; and the residents' water used should be between 95 F through 115 degrees F.

On 11/16/24 at 10:42 AM, Surveyor #6 interviewed the [U.S. FOIA], who stated that the hot water temperatures were higher in the afternoon when laundry and the kitchen were not utilizing hot water. The [U.S. FOIA] continued that the boiler ran continuously so the water when not in use, was held in a holding tank where it increased in temperature until use. The [U.S. FOIA] stated the water the residents used should be within 95 F to 115 degrees F for safety.

On 11/16/24 at 12:02 PM, Surveyor #5 and Surveyor #6 interviewed the [U.S. FOIA] about the hot water readings. The [U.S. FOIA] stated that "currently the hot water boiler could not be controlled and when no hot water was being utilized throughout the facility, it produced these hot temperatures." The [U.S. FOIA] continued and stated he had "no control of the boiler and he did not know enough about the system to adjust it."

A Review of the facility's "Quality Assurance Performance Improvement Program" policy with a last reviewed and approved date of 4/2024, included but was not limited to; "It is the policy of the organization to maintain, demonstrate and document a planned, ongoing, organization wide

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F 867	Continued From page 101 Quality Assurance Performance Improvement (QAPI) program that systematically and regularly monitors and evaluates the effectiveness, appropriateness, accessibility, continuity and efficiency of the delivery of resident care and services, pursuing opportunities for improvement and resolving problems." The policy further included, "the implementation of the QAPI program is the responsibility of the Administrator and QAPI Committee. The QAPI Committee will meet monthly to review and act upon data collection reports and activities as carried out by all departments, services, committees and improvement teams." NJAC 8:39-34.1(a)(b)(c)(d)	F 867		
F 880 SS=F	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	F 880		1/31/25

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	315176	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	**185 TUCKERTON ROAD MEDFORD, NJ 08055**

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F 880	Continued From page 102 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 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	F 880		

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F 880	Continued From page 103 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, record review, and review of pertinent documentation, it was determined that the facility failed to ensure: a) a system was in place to monitor and minimize the risk of NJ Exec Order 26.4b1 [redacted] for the facility per the Center for Medicare and Medicaid Services (CMS) guidelines; b) staff performed hand hygiene (hh) in between assisting residents in the dining room; c) staff donned (put on) a Personal Protective Equipment (PPE) gown when assisting a resident on NJ Ex Order 26.4(b)(1) [redacted]) (for 1 of 2 residents (Resident #83) reviewed who was on NJ Ex Order 2[redacted] and d) the potential spread of infection was minimized by storing dirty meal trays away from other resident meal trays. This deficient practice was evidenced by the following: Reference: CMS https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO17-30-HospitalCAH-NH-REVISED-.pdf, revised 7/6/2018, included but was not limited to; "42 CFR §483.80 for skilled nursing facilities and nursing facilities: "The facility must establish and maintain an infection prevention	F 880	1. A risk assessment and policy and procedure for water management developed to reduce the risk of the growth of NJ Ex Order 26.4(b)(1) and other NJ Ex Order 26.4(b)(1) [redacted] in the water system will respectively by the facility Infection Preventionist and Maintenance Director. Staff received education regarding the implementation of hand hygiene in between assisting residents in the dining room on 11/25/2024. Nursing staff received education regarding the donning of PPE when assisting a resident on NJ Ex Order 26.4(b)(1) [redacted] on 11/20/2024. Staff was educated regarding the potential to spread infection by storing dirty meal trays away from clean trays. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. A water management program will be implemented that will reflect testing protocol, acceptable ranges for control measures and documentation to include results and corrective actions as deemed	

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F 880	Continued From page 104 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." CMS's expectation for long-term care facilities was to have water management policies and procedures to reduce the risk of the growth and the spread of Legionella and other opportunistic pathogens in the water system. At a minimum, the facility must: conduct a facility risk assessment to identify where water borne pathogens may harbor; develop and implement a water management program; and to specify testing protocol with acceptable ranges for control measures which would be documented to include results and any corrective actions necessary. a) On 11/13/24, upon entrance to the facility, the survey team requested the infection control documentation which included the [NJ Exec Order 26.4b1] monitoring for the facility. On 11/15/24 at 9:54 AM, the surveyor met with the [U.S. FOIA (b)(6)]). The [U.S. FOIA (b)(6)] stated that she was not responsible for any part of the facility [NJ Exec Order 26.4b1] monitoring, and that the maintenance department would handle that tracking. On 11/18/24 at 9:37 AM, the surveyor asked the [U.S. FOIA (b)(6)]), in the Maintenance Department, about the [NJ Ex Order 26.4(b)(1)] monitoring. The [U.S. FOIA] then asked a [U.S. FOIA (b)(6)] where the monitoring log was, but the [U.S. FOIA] replied he did not know. The [U.S. FOIA] stated, "I never checked for [NJ Ex Order 26.4(b)(1)]. The surveyor inquired if he knew the process to test for [NJ Exec Order 26.4b1] in the facility. The [U.S. FOI] replied the "testing was not being done but, should be done." The [U.S. FOIA] further stated	F 880	necessary. The Legionella risk assessment will be conducted. Results will be documented and assessments will be routinely completed per CMS guidelines. Staff will be educated with regard to Legionella, hand hygiene, proper donning and doffing of PPE, and the storage of potentially contaminated materials near those that are clean by the Infection Preventionist by 01/31/2025. 4. Audits will be developed to record observations of hand hygiene, utilization of PPE and proper storage of potentially contaminated materials by the DON/Infection Preventionist. Audits will be conducted weekly for 4 weeks, every 2 weeks for 1 month and monthly for 1 month. Areas of concern will be addressed The results of the Legionella risk assessment and audits for hand hygiene, use of PPE and proper storage of potentially contaminated materials will be presented by the Infection Preventionist at the monthly QAPI meeting for the next meeting and following three months with follow up provided as needed.	

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F 880	Continued From page 105 that he was not aware of any policy for checking the water for [NJ Exec Order 26.4b1], but he knew if was important because it was a [NJ Ex Order 26.4(b)(1)] The surveyor asked if there was any monitoring in place not just testing. The [U.S. FOIA] stated, "No". On 11/19/24 at 9:40 AM, the [U.S. FOI] stated he found, "an old policy in a book regarding [NJ Exec Order 26.4b1]" and provided it to the surveyor. A review of the facility provided, "Prevention and Control of [NJ Exec Order 26.4b1] Control Guidance for General Hospitals; Surveillance, Investigation, and Control" undated, did not address a policy or procedure for monitoring the water system in a long-term care facility for [NJ Exec Order 26.4b1] b) On 11/14/24, in the main dining room, the surveyor observed the following: -At 12:23 PM, an activity staff (AS) #1 delivered a plate of food to Table #10. AS #1 next returned to the steam table line without first performing hand hygiene (hh). -At 12:24 PM, the [U.S. FOIA (b)(6)] delivered a scoop dish to Table #19. The [U.S. FOIA (b) (6)] was observed providing a plate of food to table #19. Both staff members returned to the steam table line without first performing hh. -At 12:26 PM, the [U.S. FOIA (b)(6)] delivered food to table 20, adjusted her pants, and returned to the steam table line without performing any hh. The [U.S. FO] delivered food to table 12. She next went to exit the dining room without performing hh.	F 880		

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F 880	Continued From page 106	F 880		

-At 12:27 PM, the [redacted] held the hand of a resident and walked the resident to table 19. The [redacted] returned to the steam table line without performing any hh.

-At 12:28 PM, the U.S. FOIA (b)(6) delivered a tray to Table #2 and adjusted the utensils with her bare hands. She returned to the steam table line without performing any hh.

-At 12:29 PM, the AS #2 delivered food to Table #5 and returned to the steam table line without first performing hh.

-At 12:30 PM, AS #1 delivered a plat with a sandwich at the same time the [redacted] delivered food to Table #9. The [redacted] next adjusted her watch. Both staff members returned to the steam table line without first performing hh.

-At 12:31 PM, the U.S. FOIA (b)(6) delivered a wrapped sandwich and a plate of food to Table #6. She returned to the steam table line without first performing hh.

-At 12:33 PM, the [redacted] delivered a plat to Table #11, fixed her hair, and returned to the steam table line without first performing hh.

On 11/14/2024, the surveyor conducted the following interviews:

At 12:40 PM, the [redacted] stated that she always helped to distribute lunch in the dining room. She stated the process was to deliver a meal and return to the line for the next meal. When asked if there was anything to be done between residents, the [redacted] stated, "we only have to get another

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F 880	Continued From page 107 tray." At 12:41 PM, the [redacted] stated that she would help distribute lunch a lot, and stated that she would distribute the food, ask the resident if they needed help, and cut up food if the resident requested. When asked if there was anything to be done between residents, the [redacted] stated, "after we help that person we go for another tray." At 12:42 PM, AS #2 stated that she always passed out trays. AS #2 stated, "after we deliver a tray we help if they [the resident] needs it. When asked if there was anything to be done between residents, AS #2 stated, "When we are done with that resident, we go straight to the line for the next tray." At 12:44 PM, the U.S. FOIA (b)(6) stated that she always helped deliver trays. She stated she would check the meal ticket and cut up food if anyone needed help. When asked if there was anything to be done between residents, the [redacted] replied, "go back for next tray until all residents are served." At 12:46 PM, AS #1 stated that she would always pass out food for the residents. She stated she would also go to resident and assist them if they need help. When asked if there was anything to be done between residents, AS #1 stated, "Go back in line and wait for next order." On 11/14/24 at 1:31 PM, the [redacted] stated that any staff who were assisting with meals need to sanitize their hands upon entering the dining room and in between assisting each resident. The [redacted] stated it was important to perform hh in between resident to prevent the spread of	F 880		

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F 880	Continued From page 108 infection. On 11/14/24 at 2:30 PM, the [U.S. FOIA (b)(6)] provided Hand Hygiene competency validations for the five staff members. The competencies indicated that all 5 staff members met the critical elements on how to perform hh. A review of the facility provided policy, "Feeding and Meal Management Program" reviewed 10/2024, included but was not limited to; Process "1. Staff will follow all proper infection control guidelines during meals including feeding residents. This includes washing hands before and after assisting each resident." A review of the facility provided policy, "Hand Washing and Hand Hygiene" reviewed 10/2024, included but was not limited to; Policy: All personnel working in the facility are required to wash their hands ... before handling food ... Purpose: "to prevent the spread of infection ..." Procedure: A.2. Indications for hand washing and hand hygiene ... before preparing or serving food ... c) On 11/15/24 at 11:17 AM, on the [NJ Exec Order 26 4b1] unit, the surveyor observed LPN #3 assist Resident #83 to their room. Resident #83's door had a sign to stop and see the nurse. Upon inquiry, the surveyor was told that Resident #83 was on [NJ Ex Order]. There was a sign regarding [NJ Ex Orde] with the PPE outside of the resident's door. LPN #3 stopped and donned PPE gown and gloves. LPN #3 next assisted Resident #83 into the bathroom. From the open door, the surveyor observed that LPN #3 was bent over, and her PPE gown was not secure in the back allowing it to flow and come in contact with the floor.	F 880		

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F 880	Continued From page 109	F 880		

On 11/15/24 at 11:19 AM, LPN #3 stated that the process was to don the PPE gown first, next her mask, and third her gloves. When asked about securing the PPE gown, LPN #3 informed the surveyor that the tie to secure the PPE gown in the back had broken. LPN #3 stated she should have donned a new PPE gown and that it was important to prevent infection and cross contamination.

On 11/15/24 at 11:21 AM, the [redacted] stated to assist a resident in an [redacted] room, the staff needed to apply a PPE gown and gloves. The [redacted] stated it was important to secure the PPE gown in the back so, "nothing gets on them and they don't spread infection".

On 11/15/24 at 11:30 AM, The surveyor reviewed of the medical record for Resident #83 revealed that the resident was admitted with diagnoses which included but were not limited to: [redacted] Resident #83 had physician orders which included but were not limited to; dated NJ Exec Order 26.4b1 [redacted] every NJ Exec Order 26.4b1 hours; dated NJ Exec Order 26.4b1 [redacted].

A review of the facility provided policy, "Donning and Removing Personal Protective Equipment (PPE)" reviewed 03/2024, included but was not limited to; Purpose: " ... to protect the healthcare worker from potential and known exposure to pathogenic organisms". Procedure: "2. Apply the appropriate (one size fits all) size gown with the opening in the back. Secure at neck and waist".

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F 880	Continued From page 110	F 880		

d) On 11/19/24 at 9:10 AM, Surveyor #1 went to the [NJ Exec Order] Unit to observe the breakfast meal. The surveyor observed a Certified Nursing Assistant (CNA) #3 who exited Room [NJ Exec Order] with an uncovered dirty tray with the remaining of the food not eaten and placed the tray on the food cart with the other breakfast trays that had not yet being served. The surveyor remained in the hallway and observed LPN #1 removed the dirty tray from the food cart at 9:20 AM, and placed the tray on an empty cart in the hallway.

On 11/19/24 at 9:30 AM, the surveyor interviewed LPN #1 who removed the dirty tray from the cart. During the interview, the [U.S. FOIA] stated, "The tray is contaminated and should be separated from the other trays for infection control prevention."

On 11/19/24 at 10:15 AM, the surveyor interviewed CNA #3 who placed the dirty tray with the trays not being served yet. CNA #3 informed the surveyor that she was not paying attention. She confirmed that she placed the dirty tray on the food cart in the hallway. Surveyor #1 then asked the CNA what the process was when you removed a dirty tray from a resident room. CNA #3 stated, after you removed the tray, you have to dispose of the tray properly and washed your hands. The dirty tray should not be placed with other trays that had not been served.

On 11/20/24 at 2:15 PM, the surveyor discussed the above concern with the U.S. FOIA (b)(6) and requested the CNA's file for review.

On 11/22/24 at 10:52 AM, the [U.S. FOIA (b)] provided the CNA's file. The surveyor reviewed the employee's file and verified that the staff was educated on

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F 880	Continued From page 111 Infection Control. NJAC 8:39-19.4(a)(k); 19.6; 31.2(c)	F 880		
F 922 SS=F	Procedures to Ensure Water Availability CFR(s): 483.90(i)(1) The facility must-- §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and pertinent facility documents it was determined that the facility failed to maintain the designated emergency supply of water needed for residents in the event of a loss of normal water supply. This deficient practice was evidenced by the following: A review of the facility's "Emergency Water Management and Supply" policy dated last reviewed 10/2023, included: in order to maintain daily operations and resident care services, the facility has implemented an emergency water supply plan to prepare for, respond to, and recover from a total or partial interruption of the facility's normal water supply...The organization will be prepared with emergency water... one gallon per day for the total licensed beds in the facility for a total of three days... A review of the facility's "Emergency Water" policy dated last reviewed 10/2023, included: for drinking water, the U.S. FOIA (b)(6)] will contact [name redacted] for emergency delivery of bottled water (see attached letter)... The facility was unable to supply the attached letter to verify this statement and process.	F 922	1. The facility has ordered and received 540 gallons of water to be dedicated and stored for the mandatory three day Emergency water supply. Inventory shall be taken and documented weekly for 4 weeks, every other week for 4 weeks and monthly thereafter by the Food Service Director/designee. Stores will be replenished as needed. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3..The LNHA will review the emergency water policy and procedure with the U.S. FOIA (b) [redacted] A letter of commitment from a water supply source such as the contracted food vendor will be secured to verify provision for emergency water by 01/31/2025. The letter will be placed in the Survey and Emergency Plan binders.	1/31/25

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F 922	Continued From page 112 On 11/13/24 at 10:32 AM, Surveyor #4 conducted an entrance conference with the U.S. FOIA (b)(6) [redacted]. She stated that the facility was licensed for 180 beds (resident capacity) and the current facility census was 93 residents. On 11/15/24 at 11:00 AM, the surveyor observed the emergency food storage closet with the U.S. FOIA (b) [redacted], and the "3 Day Menu" was posted on the wall. The U.S. FOIA (b) stated she did not have enough emergency water; it had not been replenished. On 11/16/24 at 1:53 PM, Surveyor #2 entered the kitchen. The U.S. FOIA (b)(6) was present and stated the facility received 100 gallons of emergency water and 100 gallons was observed. She could not speak to that amount of emergency water the facility needed to have on hand. On 11/18/24 at 9:56 AM, Surveyor #2 entered the kitchen. The U.S. FOIA was present and reviewed the emergency water on hand. The U.S. FOIA and Surveyor #2 counted and observed 100 gallons of water on hand. The U.S. FOIA stated that 100 gallons was not enough emergency water. On 11/21/24 at 9:57 AM, Surveyor #7 and #10 observed and counted the facility's emergency water with the U.S. FOIA, which was in two locations. There were 340 gallons of water on hand. The U.S. FOIA stated that one gallon of water was needed per resident for three days which would have been 540 gallons. On 11/21/24 at 11:08 AM, Surveyor #10	F 922	4. The Food Service Director will provide a documented log of water inventory and report on the quantity of reserved water in the facility at the monthly QAPI committee meeting monthly and the next three months with follow up provided as needed.	

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(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
F 922	Continued From page 113 interviewed the [U.S. FOIA]. She stated the purpose of emergency water was to ensure residents could be hydrated. She again acknowledged that 540 gallons of water were required. The [U.S. FOIA] also stated that the 540 gallons of water was also enough to rehydrate powdered dry milk which was on the three-day emergency menu. To rehydrate powdered dry milk to eight-ounce portions for each resident per day would have required an additional 68 gallons of water. On 11/21/24 at 12:58 PM, Surveyor #7 reviewed the above concern with the [U.S. FOIA (b)(6)] and the consultant [U.S. FOIA (b)(6)] in the presence of the survey team. They could not speak to why the facility still did not have an adequate amount of emergency water on hand. On 11/18/24, there were 100 gallons of water on hand (enough for a census of 33.3 residents for three days). On 11/21/24, there were 340 gallons of water on hand (enough for a census of 113.3 residents for three days). A review of the facility's "Emergency Food and Nutrition" menu, with a revised date of 10/27/20, included "Emergency Supply Water = 1 gallon per day, per resident at full census and full staffing." A review of the facility's job description for the [U.S. FOIA (b)] with a revised date of 5/2022, included the following: the [U.S. FOIA (b)] was responsible to ensure proper and efficient service of food and drink in accordance with administrative policies... NJAC 8:39-31.6 (n)	F 922		

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S 000	Initial Comments Complaint # 166997 Survey Dates: 11/13/24 through 11/21/24 Survey Census: 93 Sample Size: 22 + 2 Closed Records The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 395	8:39-4.1(a)(5) Mandatory Resident Rights (a) Each resident shall be entitled to the following rights: 5. To be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to protect the residents' right to be free from neglect by not addressing residents'	S 395	1..The facility cannot retroactively address the issue identified. The facility has put in place a hot water management procedure to verify hot water will be available for	1/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/26/24

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S 395	Continued From page 1 complaints of cold water for bathing and showering. The deficient practice was identified on 3 of 3 units (Birch, Cedar, and Dogwood). Interviews on 11/13/24, with both residents and staff, revealed the facility had no hot water for resident showering and bathing for months, and the facility was aware of the complaints. Temperatures obtained on 11/13/24, in both resident rooms and shower rooms on all the nursing units registered between 66.8 degrees Fahrenheit (F) and 82 degrees F. Interviews with the Maintenance Director (MD) confirmed water temperatures had been cold, that the water temperature should register at least 105 degrees F; residents and their families had complained; and the facility's boiler was "underrated" for the facility size. The facility's failure to protect all residents from neglect by addressing the residents' complaints of cold water when showered or bathed posed a likelihood of serious harm to the residents' care and ability to achieve their highest practicable level of wellbeing. This resulted in an Immediate Jeopardy situation (IJ). The IJ began on 11/13/24, when the survey team was made aware of the cold water. The facility Administration was notified of the IJ on 11/13/24 at 4:19 PM. The facility submitted and acceptable Removal Plan (RP) on 12/4/24. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. The evidence was as follows: Reference: "STATE OF NEW JERSEY DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT DIVISION OF PUBLIC SAFETY	S 395	residents□ needs. The LNHA initially contacted a licensed plumbing contractor on November 14, 2024 to come to the facility to assess the system and advise on/complete needed repairs. They were in contact several times, and the plumber was at the facility several times to work on the hot water system. Repairs were completed on 12/2/24. 2. The facility recognizes that current residents have the potential to be effected by the issue identified. 3. The facility engaged a licensed plumbing contractor to repair the hot water system. Repairs were made on 11/27 and 12/2 as of 12/2/24 the system is fully repaired and functional as evidenced by the water temp logs. Residents will be offered a hot bath or shower with comfortable water temperatures at least 2-3 times per week. This will be monitored by the Nursing Department and the Director of Nursing. To verify water temps are within acceptable range 24/7 and that residents receive showers/bed baths as required, the facility will do the following: - Water temps will be taken by Maintenance and/or a nurse twice on the day and evening shifts, and once on the night shift. - If water temps are found not to be within the required range, the following will	

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S 395	Continued From page 2 AND OCCUPATIONAL SAFETY AND HEALTH BUREAU OF BOILER AND PRESSURE VESSEL COMPLIANCE" included but was not limited to; boilers shall be inspected at 12-month intervals. A review of the facility provided "Freedom from Abuse, Neglect and Exploitation" policy dated effective October 2022, included: Purpose: To provide a proactive and systematic approach to the protection of the residents' rights and safeguarding residents from harm due to abuse, neglect and or misappropriation of property. This will be accomplished by incorporating the seven components of abuse prevention into the facility's procedural practices... Definitions: g. "Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in physical harm, pain, mental anguish, or emotional distress." C. Prevention: Administration establishes a close rapport with residents and their representative at the time of admission. During this process, the residents and resident representatives are provided information regarding Resident's Rights, which includes discussion about who to speak to regarding any concerns, incidents, and grievances, without fear or retribution. A review of the facility provided "Resident Rights" policy, dated effective October 2021, included: Purpose: To inform, recognize, respect and safeguard the individual rights of all residents	S 395	occur: The LNHA will be notified and will notify the Director of Nursing. The Director of Nursing will notify her team that water temps are out of range. If a resident requests/requires a shower or bed bath during that time, disposable, rinse free body wipes will be used. Care staff was educated on the above by the RN Supervisors/RN Nurse Educator on 12/3/24 (on all three shifts). This education will be ongoing until the education of care staff has been completed. The Consultant Administrator will educate the LNHA regarding response to Resident, Family or Staff submitted complaints or concerns. Education will be provided to facility staff. The LNHA will review all concerns on a daily basis and oversee response and resolution. The Grievance Policy and Procedure will be reviewed and updated as necessary. The Social Worker will be responsible for maintaining a grievance binder with documentation reflecting the details of submitted complaints or concerns and the resulting resolution. The status of the water system and availability of hot water will be reviewed at the next scheduled Resident Council meeting. 4. Facility Maintenance Department will continue to check water temperatures daily on resident units, dietary and laundry	

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S 395	Continued From page 3 provided under law. Policy: The resident has the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, as described in the policy consistent with the principles of requirements of Federal, State and Local Laws and Regulation. b. Planning and implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: 5ii. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. d. Respect and Dignity. The resident has a right to be treated with respect and dignity, including: 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. e. Self-Determination. The resident has the right to self-determination, including but not limited to the right to: 1. Choose activities, schedules (including sleeping and waking times), health car and providers of health care services consistent with his or her interests, assessments, and plan of care. i. ii. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment in accordance with 483.11(g), including but not limited to receiving treatment	S 395	daily to verify temperatures are within required range and take corrective action as needed. Water temperatures will continue to be checked and be a routine job task performed by maintenance department. If a water temperature appears to be not within acceptable range for facility and/or resident use, the LNHA will be notified to address the issue. The outcome of water temperature checks will be reported to the QAPI committee monthly x 3 with follow up provided as needed. The Social Worker will report submitted grievances at the monthly QAPI meeting for review for the next 3 months. Patterns and or trends will be identified by the team and remedial Performance Improvement will be implemented as determined to be necessary.	

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S 395	Continued From page 4 and supports for daily living safely. Surveyor #1: On 11/13/24 at 9:28 AM, Resident #43 stated to Surveyor #1 that they had a complaint and asked if it was okay to NJ Ex Order 26.4(b)(1) with cold water. On 11/13/24 at 10:04 AM, on the NJ Exec Order Unit, Surveyor #1 interviewed a Certified Nurse Aide (CNA #1) about the water temperatures, and CNA #1 stated she was unable to shower residents because the water temperature was "too cold" and that the facility had been aware of the cold water problem. On 11/13/24 at 11:32 AM, Surveyor #1 interviewed the Housekeeping Director (HD) about the laundry process and the hot water temperatures. The HD stated that they needed to stop using the washing machines at 10:00 AM to preserve the hot water. Surveyor #1 then asked the HD if she had been aware that there was a problem with the hot water and she stated, "yes", three months ago, and stated "I never in my life worked in such a condition." Surveyor #2: On 11/13/24 at 11:12 AM, Surveyor #2 toured the NJ Exec Order 26.4b Unit, and in the presence of CNA #2 took the bathroom water temperature for Room #74 (unoccupied resident room) which registered 68.1 degrees F. At that time, Surveyor #2 asked if that was the hot water knob and CNA #2 confirmed it was and that the facility had not had hot water "in a while" and they provided cold showers.	S 395		

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S 395	Continued From page 5 On 11/13/24 at 11:22 AM, Surveyor #2 interviewed Resident #240, who stated that they could not [NJ Ex Order 26.4(b)(1)], but their [NJ Ex Order 26.4(b)(1)] was also cold. On 11/13/24 at 11:25 AM, Surveyor #2 interviewed Resident #23, who stated "I won't [NJ Ex Order 26.4(b)(1)] with cold water and don't even ask me about [NJ Ex Order 26.4(b)(1)]. It [NJ Ex Order 26.4(b)(1)]." On 11/13/24 at 11:25 AM, Surveyor #2 interviewed Resident #241, who stated they have not been at the facility long, but that the water was cold. Surveyor #3: On 11/13/24 at 11:19 AM, Surveyor #3 entered the [NJ Exec Order 2] Unit and in the presence of CNA #4, obtained the following water temperatures: Shower #1 the hot water from the sink and shower was 78 degrees F, and in Resident #72 and #74's room the bathroom sink was 78 degrees F. At the time of the observation, Surveyor #3 interviewed CNA #4, who stated that in the "morning the water was hot when we gave their baths, it's usually around 10:30 AM and sometimes during the day that it got cold but not all the time." On 11/13/24 at 12:13 PM, Surveyor #3 interviewed Resident #79 about the water temperatures in the room, and the resident stated "the water used to be hot but lately it's been cold; I [NJ Ex Order 26.4(b)(1)] when the water was cold. [The facility] fixes it and it got cold again." The resident had reported that the issue had been going on in the last few days. On 11/13/24 at 12:17 PM, Surveyor #3	S 395		

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interviewed Resident #46 in their room who stated, "I've been here for [redacted] due to a NJ Exec Order 26.4b1 [redacted]. I'm a [redacted]. My major issue was there was no hot water for a year now. My [redacted] was [redacted] ago, I took [redacted] that were ice cold. I got [redacted] but it's ice cold. I've told everyone, the nurses, Director of Nursing, Unit Managers, CNAs and Social Worker."

Surveyor #4:

On 11/13/24 at 11:13 AM, Surveyor #4, in the presence of CNA #5, entered Resident #82's room and tested the hot water in the resident's bathroom which registered at 80 degrees F. CNA #5 stated that residents complained of cold water "all the time" and CNA #5 stated he worked on all of the units. CNA #5 then accompanied Surveyor #4 to the shower room and held the shower head hose; the water felt cold and registered 69 degrees F.

On 11/13/24 at 12:04 PM, Surveyor #4 entered the kitchen and observed the Kitchen Staff employee (KS #1) washing large stainless steel type pans in the three-compartment sink. The surveyor felt the wash water which felt cool and the wash temperature registered 92 degrees F, the sanitizer temperature registered 79 degrees F. Surveyor #4 asked KS #1 if there was hot water and he stated, depends if it was on and hot water was "not always on."

Surveyor #5:

On 11/13/24 at 11:16 AM, Surveyor #5, in the presence of the Maintenance Director (MD), tested the hot water on the [redacted] Unit bathroom of Room #5 (unoccupied resident room) which

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S 395	Continued From page 7 registered 66 degrees F. On 11/13/24 at 11:22 AM, Surveyor #5, in the presence of the MD, tested the hot water on the [redacted] Unit bathroom of Room #26 (unoccupied resident room) which registered 66 degrees F. On 11/13/24 at 11:25 AM, Surveyor #5 interviewed the MD about the water temperatures in the boiler room. Surveyor #5 observed and counted that there were 12 boilers. There were six boiler certificates posted that indicated six boilers were inspected in 2023. The MD stated that the boilers observed were only used to heat the resident rooms and "not for hot water." The MD stated that there were only six certificates because "only six boilers were working." The MD stated that the hot water boiler was recently replaced. Surveyor #5 asked for the annual inspection certificate of the recently replaced hot water boiler and the MD stated that he was not sure if there was one because the boiler was changed prior to MD's date of hire. The MD stated that he believed that the boiler ran well but was "undersized" for the facility and he believed at one point the facility used to have two bigger boilers in use, telling from the empty space next to the smaller boiler. There were also two boiler venting pipes, one of them did not have a boiler hooked up to it, and the other pipe was connected to the current boiler. The other had the venting pipes reduced in size to accommodate the smaller boiler and appeared as though it was retrofitted per the MD, to accommodate a smaller boiler. Surveyor #5 then noticed old inspection stickers on the boiler and asked the MD if the unit was recently replaced, and why did it have an inspection sticker from January of 2016 on it? The MD stated that he was unsure since the boiler was already installed prior to his	S 395		

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S 395	Continued From page 8 employment, and stated that the boiler could have been taken from somewhere else and then was installed at the facility. The MD stated, "This was how it was when I got here, I inherited this". At that time the MD explained the facility boilers to Surveyor #5 which included the following: - (1) boiler that provided hot water for the entire building. Kitchen, laundry, and resident areas. - (12) boilers that were used for heating. Only (6) of those boilers were inspected because only (6) of them were working according to the MD, and the MD stated he got that information from the maintenance staff that worked there prior to his date of hire. On 11/13/24 at 12:31 PM, the survey team interviewed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) regarding the lack of hot water. The DON stated that she had only been at the facility for two months and had been told by the facility that they were "working on it, and some units get it sometimes and some don't." The DON stated she "didn't know what was happening, I do not know of anything" and that the Executive Director (ED) had been aware of the problem. The ADON stated that she had worked at the facility for 16 years and "occasionally the hot water doesn't work, and they "(ED/LNHA) don't share with us." The ADON confirmed that residents and their families have complained about the lack of hot water. On 11/13/24 at 12:37 PM, the survey team interviewed the MD regarding the hot water temperature concerns, who stated he had worked at the building for five months. The MD continued that his staff informed him that there was an issue	S 395		

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with the hot water. The MD stated the boiler was not fit for the property and the use, and was "underrated for the facility size." The MD stated, "the boiler only worked to produce enough hot water when the usage was low." The MD stated that the residents told him about the hot water not working and that not having hot water was "unacceptable." The MD stated hot water should be available 24-7 (24 hours per day and seven days per week), and "occasionally it doesn't work." The MD again confirmed that residents and their families have complained about the lack of hot water, and the ED and LNHA were aware. Surveyor #4 asked the MD if he had ever met the LNHA, and the MD stated, "no, never saw him in the building." The MD stated, "honest truth, I only spoke to him through her [ED]" and stated he "cannot call him." Surveyor #4 then asked about the discussion that occurred through the ED. The MD stated that his staff told him that the facility used to have a bigger system, and the MD stated that the hot water temperature needed to be at least 105 F. The MD stated, "we only talked to him [the LNHA] through [the ED]." The MD stated about four months ago, he was on a conference phone call that the ED set-up between the ED and the LNHA (neither was present at the facility). The MD stated he informed the LNHA that the hot water system needed to be replaced sometime soon. The LNHA had "no response" regarding the MD's concerns, and nothing from the ED either, and he had not heard anything since.

On 11/13/24 at 1:11 PM, Surveyor #4 interviewed the HD and asked if she had ever met the LNHA. She stated she had been there for six months and had never met him. The surveyor asked if the washing machine needed to be at a certain temperature to wash clothing and she stated, "yes", 130 F. The surveyor asked how would you

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S 395	Continued From page 10 know, and she stated, "I don't." The HD confirmed the facility did all linen and laundry in house. On 11/14/24 at 8:44 AM, the MD came to the conference room to show the survey team a cellular phone picture of a thermometer reading of 113 F. The surveyor asked the MD if the hot water was fixed and the water temperature was now consistent, and the MD confirmed that the hot water temperature was not consistent. On 11/14/24 at 10:14 AM, the LNHA met with the survey team to review the concerns with the lack of hot water and the IJ Situation that was presented to the facility on 11/13/24 at 4:19 PM. The LNHA stated that he looked at the IJs "last night, but it was on his phone and he could not read them." The LNHA then stated "I just got the printout this morning", and he now wanted to discuss how the facility was going to respond. The LNHA stated "it [the hot water] was on and off these days", and if they [staff] adhered to the schedule "they would get hot water, and yesterday they did not adhere to the schedule." The LNHA stated he knew there was an issue with the hot water and we implemented a schedule when they should be using the water and "that the [residents] don't remember if they had a shower or not." Surveyor #1: On 11/14/24 at 12:39 PM, Survey #1 interviewed CNA #5, who stated the water was sometimes cold. CNA #5 stated that the resident showers could only be scheduled at 8:00 PM or after because that would be the only way they would have hot water. CNA #5 stated he could not give anyone a shower when they wanted it because of	S 395		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

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the cold water, and the nurses were aware of the hot water concerns. Surveyor #1 asked how CNA #5 knew the nurses were aware of it, and he stated because we reported it.

On 11/14/24 at 12:45 PM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN #1) on the [NJ Exec Orde] unit, who stated that the concern with the hot water had been reported by staff and the staff had reported that during resident care the water being used was cold, and the water for hand hygiene was cold. LPN #1 stated that Management was already aware, and that they entered documentation regarding the water in the maintenance log.

On 11/14/24 at 1:41 PM, Surveyor #1 interviewed a Maintenance Staff employee (MS #1), who stated he was aware of the issue with the hot water and that there was one pipe for the hot water that was smaller.

On 11/14/24 at 2:24 PM, Surveyor #1 interviewed the 3:00-11:00 PM CNA (CNA #6), on the [U.S. FOIA (b)(6] unit, who stated they did not document the resident's refusal of a shower; they informed the nurse.

On 11/15/24 at 10:55 AM, Surveyor #1 interviewed Resident #36 and Resident #8 in their room, and they both stated they had not received [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26.4(b)(1)] because of cold water. They both stated the DON and ADON were aware of the problem. Surveyor #1 asked how not receiving [NJ Ex Order 26.4(b)(1)] made them feel and they both stated, "[NJ Ex Order 26.4(b)(1)]", and they do not know what was going on and they cannot [NJ Ex Order 26.4(] because of cold water.

On 11/14/24 at 2:28 PM, Surveyor #2 interviewed

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Resident #22, who stated that the [NJ Ex Order 26.4(b)] were "terrible." Resident #22 continued that this morning they "got all stripped down" and the staff used a [NJ Exec Order 26.4b1] and went to [NJ Ex Order 26.4(] at 9:30 AM and "the water was so cold I [NJ Ex Order] [redacted]. We came back and I [NJ Ex Order 26.4(b)(1)] with cold water." Resident #22 then stated they "refused [NJ Ex Order 26.4(b)] often because it was [NJ Ex Order 26.4(b)(1)] [redacted] because of the [NJ Exec Order 26.4b1] and the "water was freezing." Resident #22 stated shower days were on Monday and Thursday but unfortunately they had to wait a week, and the "[NJ Ex Order 2] were cold." Resident #22 stated "would like to take a warm shower but [NJ Ex Order 26.4(b)(1)] [redacted]."

On 11/14/24 at 12:45 PM, Surveyor #5 obtained water temperatures from Room #79's (unoccupied resident room) sink which registered a hot water temperature of 98.6 degrees F.

Surveyor #1:

On 11/15/24 at 8:18 AM, Surveyor #1 checked the hot water with MS #1 on the [U.S. FOIA (b)] unit and the hot water temperature in the first shower registered 73.9 degrees F, and the sink registered 73.5 degrees F.

On 11/15/24 at 8:35 AM, Surveyor #1 checked the hot water with the Maintenance Staff (MS #2) in the [NJ Exec Orde] unit second shower which registered 63.3 degrees F.

On 11/15/24 at 8:37 AM, Surveyor #1 interviewed a Hospice Staff employee (HS #1), who revealed that she did not [NJ Ex Order 26.4(b)(1)] because the water was cold, so she was only able to give [NJ Ex Order 26.4(] [redacted]

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S 395	Continued From page 13 On 11/15/24 at 8:39 AM, Surveyor #1 interviewed CNA #4, who stated she did not give [NJ Ex Order 26.4(b)(1)] because the water was cold. On 11/15/24 at 10:47 AM, Surveyor #1 interviewed MS #2, who revealed that residents could not [NJ Ex Order 26.4(b)(1)] because of the cold water, and the ADON and DON had been informed. At that time, the [NJ Ex Order 26.4(b)(1)] log for [NJ Exec Orde] was reviewed and there was no documentation if residents received [NJ Ex Order 26.4(b)(1)] on their scheduled days. Surveyor #3: On 11/15/24 at 8:35 AM, Surveyor #3 observed Resident #46 lying in bed, who stated "I've been [NJ Ex Order 26.4(b)(1)] for about [NJ Ex Order 26.4(b)(1)] because it was cold; it made me feel [NJ Ex Order 26.4(b)(1)]] because there was no substitute for [NJ Ex Order 26.4(b)(1)] anymore." On 11/15/24 at 9:33 AM, Surveyor #3 interviewed CNA #5, who stated I gave Resident #46 a complete bed bath the other day. The CNA continued that the resident had not [NJ Ex Order 26.4(b)(1)] [redacted] for some time because the water was cold. The CNA reported for the past three months, all the units had cold water; that the water was usually hot from 8:30 PM to about 7:00 AM. The CNA stated the water temperature was very inconsistent, and the residents wanted a hot shower. On 11/15/24, Surveyor #5 obtained the following hot water temperatures: At 9:59 AM, Room #5 (unoccupied resident room) - 65.5 degrees F At 10:30 AM, Resident #21 and #47's room - 64 degrees F	S 395		

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S 395	Continued From page 14 At 10:47 AM, Resident #2 and #42's room - 67 degrees F An acceptable Removal Plan (RP) was received on 12/4/24 at 12:24 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; a licensed plumber repaired the hot water system; a hot water management system was put in place to verify hot water was available; residents were offered a hot bath or shower two to three times a week; maintenance and nursing staff checked hot water temperatures twice on the day and evening shifts and once during the night shift to ensure acceptable temperatures; if water temperatures were not acceptable, the LNHA was notified to remedy the issue; and nursing staff utilized rinse free wipes for resident care if water was not within acceptable range and the resident requested care. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24.	S 395		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by:	S 560		1/31/25

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S 560	Continued From page 15 Based on interview and review of pertinent facility documents, it was determined the facility failed to a) maintain the required minimum direct care staff-to-resident ratios for the two weeks from 10/27/2024 to 11/09/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows, and b) ensure two employees received the LGBTQI+ training (which included the 1 staff member representing administration and 1 staff member representing direct care staff), as required by state law.: This deficient practice was evidenced by the following: a) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.	S 560	1. The facility will make every effort to have the required staffing levels. In the event of an emergency or when staffing shortages are anticipated the facility will collaborate with human resources to use contingency capacity strategies to plan and prepare to mitigate the issue. Open positions will be posted for job seekers in traditional sites including educational settings. The Facility will increase recruitment procedures to fill in open positions. Walk-in applicants will be interviewed immediately with "on the spot" offers to qualified candidates. 2. Current residents have the potential to be effected by the concern identified. 3. The Director of Nursing will review staffing policy and procedures with the Staffing Coordinator. Daily staffing will be reviewed by the Director of Nursing with the Staffing Coordinator to verify sufficient staff is scheduled and adjusted as needed for openings. The Director of Nursing/ Staffing Coordinator will monitor staffing via log daily to track progress. The Director of Nursing will work with the Human Resource Manager to fill recruit, hire and orient new hires to fill open positions. The status of the open positions and recruitment status will be reviewed weekly. 4. Facility staffing will be reviewed and confirmed with the Director of Nursing/Designee on a daily basis.	

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S 560	Continued From page 16 For the 2 weeks of staffing prior to survey from 10/27/2024 to 11/09/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -10/27/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -10/28/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -10/29/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -10/31/24 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -11/01/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -11/03/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -11/04/24 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. -11/06/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -11/07/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -11/08/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -11/09/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs On 11/20/24 at 1:04 PM, the surveyor, in the presence of the survey team and the Director of Nursing (DON), interviewed the facility's Staffing Coordinator (SC) who stated she was aware of the staffing regulation requirements and acknowledged that the facility does "not always meet the requirements" and that the facility does not currently use agency staffing to supplement the shortages. A review of the facility policy titled, "Staffing and	S 560	Recruitment activities will be reviewed on a weekly basis. Outcomes of staffing management and Recruitment will be reported at the QAPI committee meeting monthly for the next 3 months with follow up provided as needed.	

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S 560	Continued From page 17 Facility Plan Policy", with a reviewed and approved date of 4/2024 included but was not limited to "The organization will provide qualified and appropriate staffing levels to meet the needs of the resident population. The staffing plan will include all shifts, seven days per week to assure that appropriate staffing levels are scheduled and maintained." The policy further included, "the nurse aide component of the facility's total hourly nurse staffing requirement shall be met by nurse aides who have completed a nurse aide training course approved by the New Jersey State Department of Health and Senior Services." Furthermore "for emergency staffing or when staffing shortages are anticipated, the facility will collaborate with human resources to use contingency capacity strategies to plan and prepare to mitigate the problem. This may include but is not limited to: ...reach out to contracted agencies for supplemental staff ..." b. On 11/13/24 at 10:16 AM, an entrance conference was held with the facility administration and the mandatory LGBTQI+ training was requested for all staff. Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking.	S 560		

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S 560	Continued From page 18 Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this	S 560		

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S 560	Continued From page 19 paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality	S 560		

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S 560	Continued From page 20 The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations	S 560		

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S 560	Continued From page 21 A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ	S 560		

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S 560	Continued From page 22 community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. On 11/13/24 at 10:16 AM, during the entrance conference held with the facility administration, the surveyor requested documentation supporting the : New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." On 11/22/24 at 10:28 AM, the Liscsensed Nursing Home Administrator (LNHA) was unable to provide proof that 2 employees received the LGBTQI+ training (which included the 1 staff member representing administration and 1 staff member representing direct care staff), as required by state law.	S 560		
S2245	8:39-31.6(e) Mandatory Physical Environment Smoking regulations shall be developed, implemented, and enforced in accordance with N.J.S.A. 26:3D-1 et seq. and N.J.S.A. 26:3D-7 et seq.	S2245		1/31/25

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S2245	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to protect the residents by ensuring the facility's NJ Exec Order 26.4b area was maintained to prevent accidental fire. The deficient practice was identified in the NJ Exec Order 26.4b1 and affected 3 of 3 units (Birch, Cedar, and Dogwood). Observations and interview on 11/17/24, with both residents and staff, revealed that the facility did not have a system to ensure that a safe NJ Exec Order 26.4b environment for residents who NJ Exec Order 26.4b was maintained and to ensure there was a process for the safe storage of NJ Exec Order 26.4b1. Observations and interviews also confirmed that the dried leaves that surrounded the courtyard contained NJ Exec Order 26.4b1 and the residents utilized open NJ Exec Order 26.4b1 and dumped their discarded NJ Exec Order 26.4b1 into four plastic lined garbage receptacles that were filled with NJ Ex Order 26.4(b)(1) The residents also held onto their own NJ Exec Order 26.4b1 which included NJ Exec Order 26.4b The facility's failure to ensure that appropriate NJ Exec Order 26.4b1 receptacles were utilized and a process was followed to ensure the safe storage of NJ Exec Order 26 materials posed the likelihood of serious	S2245	1. Leaves around or near the NJ Exec Order 26.4b area were removed. NJ Exec Order 26.4b1 are now retained by the NJ Exec Order 26.4b1 who are responsible to NJ Exec Order 26.4b1 for residents. 2. Current residents have the potential to be effected by the issues identified. There are presently NJ Exec Order 26.4b1 patients who have NJ Exec Order 26.4b privileges. Upon admission, smoking assessments are completed by licensed nurses for residents wishing to smoke. Re-assessments are completed by licensed nurse yearly or when a residents condition indicates a change. Upon assessment, it is determined whether a resident may smoke independently or requires supervision with smoking. Residents deemed capable of smoking independently (by full smoking assessment) will be required to sign a smoking agreement indicating that they are aware of the facility policies as related to smoking. 3. Maintenance Coordinator/Designee will inspect the smoking area minimum of	

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S2245	Continued From page 24 harm, injury, or death due to fire. This resulted in an Immediate Jeopardy situation (IJ). The IJ began on 11/17/24 at 10:52 AM, when the survey team identified NJ Exec Order 26.4b1 in the dried leaves. The facility Administration was notified of the IJ on 11/17/24 at 1:26 PM. The facility submitted and acceptable Removal Plan (RP) on 12/4/24. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. The evidence was as follows: Reference: 11/17/24: The New Jersey Forest Fire Services: Advisory: STAGE 3 FIRE RESTRICTIONS IN EFFECT: In response to prolonged dry conditions and increased wildfire activity until further notice... Current Fire Danger (for facility county) RED: EXTREME. A review of the "Smoking Policy for Residents" dated effective October 2022, included the purpose: to verify that residents that choose to smoke will be properly assessed and be able to smoke outdoors in a "safe environment." Policy: the organization is non-smoking facility and will permit residents to smoke in designated outside areas only. Procedure: 1. Any resident who is a smoker will be informed at the time of admission of the facility smoking policy. Residents admitted will be required to acknowledge the policy and adhere to it...4. Cigarettes may be kept by residents in their locked drawer. 5. Matches and lighters, will be kept in a locked box or in a locked drawer in the medication room/on each unit or in the medication cart. Lighters and/or matches may be taken out to the smoking area by residents but must be turned to staff upon the resident	S2245	twice daily and remove accumulated debris and leaves to mitigate fire hazard. An additional Smoking Post receptacle was purchased and effective November 29, 2024, both doors that are used to access and exit the designated smoking courtyard have a post in place for disposal of cigarette butts. Housekeeping staff will empty ashtrays into the Smoking Posts twice on the day shift and once on the evening shift. In addition, the Smoking Post receptacles will be emptied by housekeeping staff a minimum of once daily. The smoking policy final revision was completed on 12/18/2024. Staff was educated on the revision by Nursing Administration on 12/18/2024 and 12/19/2024. The smoking policy will be reviewed at the next Resident Council Meeting and will be reviewed 2x a year with the Resident Council and if/when changes to the smoking policy occur. The facility smoking policy was revised on 12/18/2024 as follows: a. residents may not possess lighters or matches b. smoking times will be established, smoking monitors will monitor resident smoking including smoking monitors to light cigarettes and verify that cigarette butts are properly extinguished in designated receptacles. This policy revision was individually communicated to residents who smoke on 12/19/24 by the Consultant Administrator and the conversation was documented in the individual resident's medical record.	

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S2245	Continued From page 25 re-entering the facility. 6. Residents "are strictly prohibited from having matches/lighters in their possession inside of the facility." Smoking is strictly prohibited inside the facility. 7. Cigarettes must be extinguished in the ashtrays provided in the smoking area. "Butts" cannot be retained by any resident and taken inside the facility... On 11/17/24 at 10:52 AM, Surveyor #2 and #4 entered the designated NJ Exec Order 26.4b1 and immediately upon entrance observed approximately one foot from the automatic door opener to the courtyard, multiple areas of ash and black marks directly on the red brick wall; spread on four bricks. There were multiple NJ Exec Order 26.4b1 on the ground located in the rocks and mixed in the leaves in the same area of the black and ash marks. There were no observed covered ashtray receptacles located in that area. The landscaping beds were observed throughout the entire courtyard to be covered with dried leaves, pine needles, and other debris. At the time of the observation, Resident #71 greeted the surveyors and confirmed that they smoked and held onto their NJ Exec Order 26.4b materials and NJ Exec Order and brought them into the facility. The surveyor asked about the condition of the courtyard including the debris and leaves, and Resident #71 stated that the landscapers had not been at the facility for months, that "he [Licensed Nursing Home Administrator (LNHA)] isn't paying the bill." When asked how Resident #71 knew that the LNHA did not pay the bills, the resident stated, "we know." On 11/17/24 at 10:55 AM, Surveyor #2 and #4 then observed Resident #34, #85, and #66 at a table outside with two black plastic-like open	S2245	Residents who smoke were and will continue to be required to acknowledge the policy with acknowledgement documented in the resident medical records. The facility staff were educated on the smoking policy changes by administration on 12/19/24. Designated smoking times were established and put into effect following staff and resident education on 12/19/24. 4.The facility smoking policies will be reviewed at resident council twice per year of if a change in the policy occurs. Residents who smoke will be required to sign a new smoking agreement with each review. The policy was reviewed at the next Resident Council Meeting. The Smoking Agreements and the list of residents who smoke shall be reviewed by the QAPI committee on a quarterly basis. Areas of concern will be addressed with follow up as needed. The LNHA/designee will randomly observe three smoking times per week of the next twelve weeks to verify staff and residents are adhering to the revised policy. Areas of concern will be addressed.	

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S2245	Continued From page 26 NJ Exec Order 26.4b in front of Resident #66 and Resident #34 while they were NJ Exec Order 26.4b1 At that time, the surveyors observed no staff were present in the courtyard. The surveyor asked Resident #34 what was done with the NJ Exec Order 26.4b1 when they were finished NJ Exec Order 26.4b? Resident #34 stated that they had to "NJ Exec Order 26.4b1." When asked if anyone ever helped them, all four residents stated there was "never" anyone out there to help them. On 11/17/24 at 10:59 AM, Resident #190 joined the other residents and stated that the facility never kept their [redacted] and did not provide a locked box. The resident continued that they stored their NJ Exec Order 26.4b1 in their jacket pocket which the resident left on their wheelchair. On 11/17/24 11:00 AM, Resident #66 pulled a NJ Exec Order[2] out of their pocket and NJ Exec Order 26.4b1 in front of the surveyors and stated, "I don't have a locked box." The resident continued that staff were aware since they knew that the resident stored their NJ Exec Order 26.4b1 in a bag on the back of their wheelchair. When asked if it was accessible to other residents, Resident #66 stated "anyone can take it (NJ Exec Order 26.4b1 [redacted]." On 11/17/24 at 11:01 AM, Resident #67 stated their NJ Exec Order[2] was kept in an unlocked drawer in their room. On 11/17/24 at 11:06 AM, Resident #79 confirmed there was no locked box in their room. On 11/17/24 at 11:16 AM, Surveyor #5 and Surveyor #6 joined the observation. The surveyors observed that there were NJ Exec Order 26.4b1	S2245		

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S2245	Continued From page 27	S2245		

NJ Exec Or in the NJ Exec Order 26.4b1 in front of Resident #34. The surveyor asked Resident #34 where they discarded their used NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1, Resident #34 stated, "we dump them in the trash." At that time, all four surveyors observed four trash cans in the courtyard and lifted the lids which revealed plastic lined cans filled with debris including; NJ Exec Order 26.4b packs, multiple NJ Exec Order 26.4b1 paper, a cardboard pizza box, and other combustible debris inside the plastic liners. There was one fire extinguisher in the opposite corner of the courtyard with a sticker attached that it was last inspected in June 2024. Two additional black plastic-like NJ Exec Order 26.4b1 were observed on two other tables located in the NJ Exec Order 26.4b1.

On 11/17/24 at 2:00 PM, the Maintenance Director (MD) informed the survey team that he tried to contact the LNHA regarding the IJ, and the phone went to voicemail. The MD stated that he checked all four garbage cans in the NJ Exec Order 26.4b1 courtyard, and confirmed that he observed the NJ Exec Order 26.4b1, papers, and NJ Exec Order 2 inside. The MD acknowledged he understood the concerns shared by the survey team and he discarded all the garbage in all four receptacles located in the courtyard.

An acceptable removal plan was received on 12/4/24 at 12:24 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including leaves around or near resident NJ Exec Order 26.4b1 were removed; NJ Exec Order 26.4b1 were now held by the nursing staff; residents assessed as NJ Exec Order 26.4b1 were given their NJ Exec Order 26.4b1 prior to NJ Exec Order 26.4b and were educated to return upon entrance into

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S2245	Continued From page 28 the building; maintenance inspected the [NJ Exec Order 26.4b] a minimum of twice a day to remove any debris; housekeeping staff [NJ Exec Order 26.4b1] twice on the day shift and once on the evening shift; additional[NJ Exec Order 26.4b1] were purchased; and the [NJ Exec Order 26.4b] policy was reviewed with residents. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24.	S2245		
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents. This REQUIREMENT is not met as evidenced	S2315		1/31/25

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S2315	Continued From page 29 by: Based on interview and documentation review on 11/15/24, in the presence of the Maintenance Director (MD), it was determined that the facility failed to meet with county and municipal emergency management coordinators at least once a year to review and update the written comprehensive evacuation plan, or if county or municipal officials were unavailable for this purpose the facility failed notify the State Office of Emergency Management. This deficient practice had the potential to affect all residents and was evidenced by the following: On 11/15/24, a documentation review of the facility's Emergency Preparedness (EP) plan revealed there was no county, municipal or state emergency management coordinators represented on the annual EP review signature sheet. There was no other documents indicating that the county, municipal or state emergency management officials participated in reviewing and updating the facilities EP plan during the last annual review. In an interview conducted at that time, the MD stated he was not aware of this requirement and confirmed the above findings. No further documentation was provided.	S2315	1. The Administrator with the Director of Maintenance will review the Emergency Preparedness Program dated 11/10/23 and update, as necessary. The facility Emergency Plan will be reviewed and updated by 01/31/2025. The LNHA has coordinated Transfer Agreements with two Long Term Care facilities who have agreed to receive relocated residents in the event of an emergency. 2. Current residents have the potential to be effected by the concern identified. 3. The Emergency Preparedness Program will be reviewed by the appropriate parties and signed legibly to indicate review of the document and acceptance. Staff will be re-in-serviced on the Emergency Preparedness Program by the Educator or designee. In-servicing will be completed by 1/31/25. Information about the Facility Emergency Preparedness Program will be included in new staff orientation. The Consultant Administrator will collaborate with the Administrator to verify review of the Program and sign off when completed with progress reported weekly to the DOH. 4. The Educator will verify review of the Emergency Preparedness Program in new staff orientation and present results of new staff orientation to the QAPI Committee monthly x3 months with follow up provided	

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S2315	Continued From page 30	S2315	as needed. The Administrator will present the Emergency Preparedness Program to the QAPI Committee. Follow up will be provided as needed.	
S2340	8:39-31.6(n) Mandatory Physical Environment The facility shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and pertinent facility documents it was determined that the facility failed to maintain the designated emergency supply of water needed for residents in the event of a loss of normal water supply. This deficient practice was evidenced by the following: A review of the facility's "Emergency Water Management and Supply" policy dated last reviewed 10/2023, included: in order to maintain daily operations and resident care services, the facility has implemented an emergency water supply plan to prepare for, respond to, and recover from a total or partial interruption of the facility's normal water supply...The organization will be prepared with emergency water... one gallon per day for the total licensed beds in the facility for a total of three days... A review of the facility's "Emergency Water" policy	S2340	1. The facility has 540 gallons of water to be dedicated and stored for the mandatory three day Emergency water supply. Inventory shall be taken by the Food Service Director/designee and documented weekly for 4 weeks, every other week for 4 weeks and monthly thereafter. Replenishment will be made as needed. 2. Current residents have the potential to be effected by the concern identified. 3. The LNHA will review the emergency water policy and procedure with the Food Service Director. A letter of commitment from a water supply source such as the contracted food vendor will be secured to verify a provision for emergency water.	1/31/25

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S2340	Continued From page 31 dated last reviewed 10/2023, included: for drinking water, the [Food Service Director] will contact [name redacted] for emergency delivery of bottled water (see attached letter)... The facility was unable to supply the attached letter to verify this statement and process. On 11/13/24 at 10:32 AM, Surveyor #4 conducted an entrance conference with the Director of Nursing (DON). She stated that the facility was licensed for 180 beds (resident capacity) and the current facility census was 93 residents. On 11/15/24 at 11:00 AM, the surveyor observed the emergency food storage closet with the Food Service Director (FSD), and the "3 Day Menu" was posted on the wall. The FSD stated she did not have enough emergency water; it had not been replenished. On 11/16/24 at 1:53 PM, Surveyor #2 entered the kitchen. The Assistant FSD was present and stated the facility received 100 gallons of emergency water and 100 gallons was observed. She could not speak to that amount of emergency water the facility needed to have on hand. On 11/18/24 at 9:56 AM, Surveyor #2 entered the kitchen. The FSD was present and reviewed the emergency water on hand. The FSD and Surveyor #2 counted and observed 100 gallons of water on hand. The FSD stated that 100 gallons was not enough emergency water. On 11/21/24 at 9:57 AM, Surveyor #7 and #10 observed and counted the facility's emergency water with the FSD, which was in two locations. There were 340 gallons of water on hand. The	S2340	The letter will be placed in the Survey and Emergency Plan binders. 4. The Food Service Director will provide a documented log of water inventory and report on the quantity of reserved water in the facility at the QAPI committee meeting monthly x 3 with follow up provided as needed.	

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S2340	Continued From page 32 FSD stated that one gallon of water was needed per resident for three days which would have been 540 gallons. On 11/21/24 at 11:08 AM, Surveyor #10 interviewed the FSD. She stated the purpose of emergency water was to ensure residents could be hydrated. She again acknowledged that 540 gallons of water were required. The FSD also stated that the 540 gallons of water was also enough to rehydrate powdered dry milk which was on the three-day emergency menu. To rehydrate powdered dry milk to eight-ounce portions for each resident per day would have required an additional 68 gallons of water. On 11/21/24 at 12:58 PM, Surveyor #7 reviewed the above concern with the Licensed Nursing Home Administrator (LNHA) and the consultant LNHA in the presence of the survey team. They could not speak to why the facility still did not have an adequate amount of emergency water on hand. On 11/18/24, there were 100 gallons of water on hand (enough for a census of 33.3 residents for three days). On 11/21/24, there were 340 gallons of water on hand (enough for a census of 113.3 residents for three days). A review of the facility's "Emergency Food and Nutrition" menu, with a revised date of 10/27/20, included "Emergency Supply Water = 1 gallon per day, per resident at full census and full staffing." A review of the facility's job description for the FSD with a revised date of 5/2022, included the following: the FSD was responsible to ensure proper and efficient service of food and drink in accordance with administrative policies...	S2340		

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S2410	Continued From page 33	S2410		
S2410	8:39-31.7(h) Mandatory Physical Environment Hot (95 to 110 degrees Fahrenheit) and cold running water shall be provided. Hot water in resident areas shall not exceed 110 degrees Fahrenheit. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to maintain hot water temperatures at a safe level to protect residents from third degree burns and serious injury on NJ Exec O [redacted]). Hot water temperatures obtained on 11/16/24, in both residents' rooms on all three nursing units and in resident shower rooms on the NJ Exec Order 26.4b1 [redacted] registered between 117 degrees Fahrenheit (F) and 131.5 degrees F. Interviews with the Maintenance Director (MD) revealed that the facility's boiler system was "undersized" for the facility size; provided inconsistent hot water temperatures; and the residents' water used should be between 95 degrees F through 115 degrees F. The facility's failure to ensure the residents were protected from excessive hot water temperatures posed the likelihood of serious harm and injury	S2410	1. The facility cannot retroactively address the issue identified. The facility has put in place a hot water management procedure to verify hot water will be available for residents needs. The LNHA initially contacted a licensed plumbing contractor on November 14, 2024 to come to the facility to assess the system and advise on/complete needed repairs. They were in contact several times, and the plumber was at the facility several times to work on the hot water system. Repairs were completed on 12/2/24. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. Residents will be offered a hot bath or shower with comfortable water temperatures at least 2-3 times per week. This will be	1/31/25

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S2410	Continued From page 34 from third degree burns. This resulted in an Immediate Jeopardy situation (IJ). The IJ began on 11/16/24 at 1:25 PM, when the survey team identified water temperatures on the resident units in excess of 120 degrees F. The facility Administration was notified of the IJ on 11/16/24 at 5:38 PM. The facility submitted and acceptable Removal Plan (RP) on 12/4/24. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24. The evidence was as follows: Reference: State Operation Manual; Guidance to Surveyors for Long Term Care Facilities; 483.25 (d)(1); Water Temperature - Water may reach hazardous temperatures in hand sinks, showers, tubs, and any other source or location where hot water is accessible to a resident. Burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. Time and Temperature Relationship to Serious Burns Water Temperature and Time Required for Third degree Burn (Penetrate the entire thickness of the skin and permanently destroy tissue). Water temperature and time required for a third degree burn to occur:	S2410	monitored by the Nursing Department and the Director of Nursing. 3. The facility engaged a licensed plumbing contractor to repair the hot water system. Repairs were made on 11/27 and 12/2 as of 12/2/24 the system is fully repaired and functional as evidenced by the water temp logs. To verify water temps are within acceptable range 24/7 and that residents receive showers/bed baths as required, the facility will do the following: - Water temps will be taken by Maintenance and/or a nurse twice on the day and evening shifts, and once on the night shift. - If water temps are found not to be within the required range, the following will occur: The LNHA will be notified and will notify the Director of Nursing. The Director of Nursing will notify her team that water temps are out of range. If a resident requests/requires a shower or bed bath during that time, disposable, rinse free body wipes will be used. Care staff was educated on the above by the RN Supervisors/RN Nurse Educator on 12/3/24 (on all three shifts). This education will be ongoing until the education of care staff has been completed. 4. Facility Maintenance Department will continue to check water temperatures	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060313	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD 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) COMPLETE DATE
S2410	Continued From page 35 148 F - 2 Seconds 140 F - 5 Seconds 133 F - 15 Seconds 127 F - 1 Minutes 124 F - 3 Minutes 120 F - 5 Minutes On 11/13/24 at 11:25 AM, Surveyor #5 interviewed the MD, who stated that the facility's boiler was "undersized" for the facility. The MD continued that the facility had one boiler that provided hot water for the entire building with six working boilers used for heating. On 11/14/24 at 8:44 AM, the MD came to the conference room to show the survey team a cellular phone picture of a thermometer reading of 113 degrees F. The surveyor asked the MD if the hot water was consistent, and the MD confirmed that the hot water temperature was not consistent. On 11/16/24 at 10:42 AM, Surveyor #6 interviewed the MD, who stated that the hot water temperatures were higher in the afternoon when laundry and the kitchen were not utilizing hot water. The MD continued that the boiler ran continuously so the water when not in use, was held in a holding tank where it increased in temperature until use. The MD stated the water the residents used should be within 95 degrees F to 115 degrees F for safety. On 11/16/24 at 12:02 PM, Surveyor #5 and Surveyor #6 interviewed the MD about the hot water readings. The MD stated that "currently the hot water boiler could not be controlled and when no hot water was being utilized throughout the facility, it produced these hot temperatures." The	S2410	daily on resident units, dietary and laundry daily to verify temperatures are within required range and take corrective action as needed. (This will be reflected on a daily log/audit sheet). Water temperature checks will continue and be a routine daily job task performed by the maintenance department. If a water temperature appears to be not within acceptable range for facility and/or resident use, the LNHA will be notified to address the issue. Water temperature checks will continue daily with results being reviewed with the QAPI team by the Maintenance Director monthly for the next three months. Follow up will be provided as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060313	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD 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) COMPLETE DATE
S2410	Continued From page 36 MD continued and stated he had "no control of the boiler and he did not know enough about the system to adjust it." On 11/16/24 beginning at 1:25 PM, the survey team in the presence of the MD obtained the following water temperatures on all three nursing units that registered over 120 degrees F: NJ Exec Order 26.4b1 Unit: Unoccupied Resident Room #70 - 127.9 degrees F Unoccupied Resident Room #72 - 128.8 degrees F Unoccupied Resident Room #79 - 121.5 degrees F Unoccupied Resident Room #80 - 129.7 degrees F Resident #239's Room - 131.5 degrees F Shower Room #2 - 127 degrees F Pantry - 128.6 degrees F Bathroom by NJ Exec Order 26.4b1 Nurses' Station - 127 degrees F NJ Exec Order 2 Unit: Unoccupied Resident Room #34 - 124.1 degrees F Unoccupied Resident Room #38 - 123.3 degrees F Resident #29's Room - 120.6 degrees F Resident #80's Room - 121.9 degrees F Shower room #1 - 122.7 degrees F Pantry - 121.3 degrees F Resident #24 and #35's Room - 121.2 degrees F Resident #79 and #84's Room - 120.2 degrees F [redacted] Unit:	S2410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060313	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S2410	Continued From page 37 Unoccupied Resident Room #5 - 120.2 degrees F Unoccupied Resident Room #27 - 120.2 degrees F A review of the facility's "Weekly Water [Temperature] Reading 2024" log provided by the MD, revealed that the last weekly temperature obtained was on 11/11/24. The log reflected that the water temperatures were within normal range, but the log did not include at what time the temperatures were obtained. An acceptable removal plan was received on 12/4/24, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; a plumber repaired the hot water system; the Licensed Nursing Home Administrator (LNHA) and maintenance department were educated on acceptable water temperatures, obtaining water temperatures several times a day, and notification to the LNHA of water temperatures outside parameters; maintenance and nursing staff monitored water temperatures daily; and if water temperature was not in acceptable range, nursing staff utilized rinse free body wipes for resident care. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/5/24.	S2410		

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
315176 Y1	A. Building B. Wing Y2	2/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD 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 F0550	Correction	ID Prefix F0558	Correction	ID Prefix F0569	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(f)(10)(iv)(v)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix F0600	Correction	ID Prefix F0607	Correction	ID Prefix F0689	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	02/14/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix F0761	Correction	ID Prefix F0804	Correction	ID Prefix F0812	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix F0814	Correction	ID Prefix F0838	Correction	ID Prefix F0843	Correction
Reg. # 483.60(i)(4)	Completed	Reg. # 483.71(a)(1)(3)(b)(1)(c)(1)-(5)	Completed	Reg. # 483.70(i)(1)(2)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix F0847	Correction	ID Prefix F0865	Correction	ID Prefix F0867	Correction
Reg. # 483.70(m)(1)(2)(i)(ii)(3)-(5)	Completed	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
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025

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
315176 Y1	A. Building B. Wing Y2	2/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880	Correction	ID Prefix F0922	Correction		
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(1)	Completed		
LSC	01/31/2025	LSC	01/31/2025		

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?
12/5/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060313 Y1	A. Building B. Wing Y2	2/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0395	Correction	ID Prefix S2245	Correction	ID Prefix S2315	Correction
Reg. # 8:39-4.1(a)(5)	Completed	Reg. # 8:39-31.6(e)	Completed	Reg. # 8:39-31.6(i)(1-2)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix S2340	Correction	ID Prefix S2410	Correction	ID Prefix	Correction
Reg. # 8:39-31.6(n)	Completed	Reg. # 8:39-31.7(h)	Completed	Reg. #	Completed
LSC	01/31/2025	LSC	01/31/2025	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	
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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/5/2024	☐ 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
315176 Y1	A. Building B. Wing Y2	3/18/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0570	Correction	ID Prefix F0835	Correction	ID Prefix	Correction
Reg. # 483.10(f)(10)(vi)	Completed	Reg. # 483.70	Completed	Reg. #	Completed
LSC	03/04/2025	LSC	03/04/2025	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	
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/5/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060313 Y1	A. Building B. Wing Y2	3/18/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/04/2025	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	
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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/5/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING **01** B. WING _____	**12/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	**185 TUCKERTON ROAD** **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
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 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		1/31/25

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

Electronically Signed | 12/27/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING 01 B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on document review and interview on 11/15/24 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to establish and maintain a comprehensive Emergency Preparedness Program (EPP), that was updated at least annually to include the date of the review and any updates made to the emergency plan based on the review. This deficient practice had the potential to affect all residents and was evidenced by the following: A document review on 11/15/24 revealed that the Medford Care Center EPP manual "forward and signature page" indicated an Administrator sign-off dated: 11/10/23. The signature was from an U.S. FOIA (b) (6) that no longer worked at the facility. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) signature dated: 11/10/23 was a U.S. FOIA (b)(6) that no longer worked at the facility. The U.S. FOIA (b)(6) signature dated: 11/10/23 was not legible.	E 004	1. The Facility cannot retrospectively address this deficiency. 2. Current residents have the potential to be effected by the concern identified. 3. The Administrator with the Director of Maintenance will review the Emergency Preparedness Program and update as necessary. The Emergency Preparedness Program will be reviewed by the appropriate parties and signed legibly to indicate review of the document and acceptance. Staff will be re-in-serviced on the Emergency Preparedness Program by the Educator or designee. Inservicing will be completed by 1/31/25. Information about the Facility□s Emergency Preparedness Program will be included in new staff orientation. The Consultant Administrator will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING 01 B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD 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
E 004	Continued From page 2 There was no documentation within the binder to include the date of the 2024 review or any updates made to the Emergency Preparedness Plan based on the previous review. The finding was verified by the U.S. FOIA (b)(6) at the time of the document review. NJAC 8:39-31.2(e), 31.6(i)1	E 004	collaborate with the Administrator to verify review of the program and sign off when completed with progress reported weekly in the DOH report. 4. The Educator will review of the Emergency Preparedness Plan in new staff orientation and present results of new staff orientation to the QAPI Committee monthly x 3 with follow up provided as needed. The Administrator will present the Emergency Preparedness Program to the QAPI Committee. Follow up will be provided as needed.	
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency	E 007		1/31/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

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E 007	Continued From page 3 Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and a review of the Emergency Preparedness Plan (EPP) policies and procedures in the presence of the U.S. FOIA (b) (6) on 11/15/24, it was determined that the facility failed to include delegations of authority and succession plans in the EPP. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's EPP revealed that there was no plan for delegations of authority and succession plans during an emergency. The page dedicated for these plans was not completed by the facility. In an interview on 11/15/24 at 11:15AM, the facility's U.S. FOIA stated and confirmed that the delegation of authority and succession plans were not completed as he did not get to review the EPP plans for the delegations of authority and succession plans during an emergency.	E 007	1. The Facility cannot retrospectively address this deficiency. 2. Current residents have the potential to be effected by the concern identified. 3. The Administrator with the Director of Maintenance will determine the delegations of authority and succession plans for an emergency by 1/31/25. Staff will be in-serviced on the delegations of authority and succession plans for an emergency by the LHNA/designee by 1/31/25. Information about the Facility Emergency Preparedness Program and delegation of authority and succession plans will be included in new staff orientation. The Consultant Administrator will collaborate with the Administrator to verify the delegations of authority and succession plans for an emergency are completed with progress reported weekly	

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E 007	Continued From page 4 NJAC 8:39-31.2(e)	E 007	to the DOH report. 4. The Educator will verify review of the Emergency Preparedness Program including delegation of authority and succession plans in new staff orientation and present results of new staff orientation to the QAPI Committee monthly x 3 months with follow up provided as needed. The Administrator will present the Emergency Preparedness Program, highlighting the delegations of authority and succession plans, to the QAPI Committee. Follow up will be provided as needed.	
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical	E 015		1/31/25

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E 015	Continued From page 5 supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent documentation, it was determined that the facility failed have all the emergency menu items in stock, in accordance with the facility policy and emergency menu. This deficient	E 015	1. Emergency food PAR levels have been stored to match the emergency menus. Food stores are sufficient for a census of 100. Emergency food items have been	

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E 015	Continued From page 6 practice had the potential to affect all residents and was evidenced by the following: On 11/13/24 at 10:32 AM, Surveyor #4 conducted an entrance conference with the U.S. FOIA (b)(6) [redacted]). The U.S. FOIA (b) stated that the facility was licensed for 180 beds (resident capacity) and the current facility census was 92 residents. On 11/13/2024 at 9:08 AM, Surveyor #4 toured the kitchen with the U.S. FOIA (b)(6) [redacted]). During the tour, Surveyor #4 inquired about food orders. The U.S. FOIA (b) stated there was a food order submitted on 11/5 or 11/6/2024 that was on hold. On 11/15/2024 at 10:10 AM, the U.S. FOIA informed Surveyor #8 that she had to use items from the emergency supply of food about a month ago. A complete inventory was taken of what was in the emergency food storage closet. Surveyor #8 requested the emergency food PAR levels. The FSD stated she would have to get that to the surveyor. On 11/16/24 at 1:53 PM, the Surveyor entered the kitchen. The assistant U.S. FOIA was present and stated that no emergency food had been delivered and was not sure if it had been ordered. She further stated that the facility did not have enough emergency food and that "it should be filled up." The following emergency food items were identified and quantified: 10 - #10 (25 four-ounce (oz) portions per can) cans beef ravioli 3 - #10 cans beef stew 11 - #10 cans chili	E 015	checked to verify proper Use By/expiration dates. Emergency food items have been segregated. 2. Current residents have the potential to be effected by the concern identified. 3. The Dietitian with the Food Service Manager will compare the emergency menus with the emergency food stores weekly and add food items to storage, as necessary. Results of their work will be reported to the Administrator. The Dietitian with the Food Service Manager will check the emergency food stores weekly for Use By/expiration dates with appropriate action taken. Results reported to the Administrator. These audits will continue as part of an ongoing verification of adequate stock. Emergency food levels will be at par for licensed beds by 01/31/2025. Dietary staff will be re-in-serviced on the use of emergency food by the Food Service Manager. Inservicing will be completed by 1/31/25. 4. The Dietitian will present the results of the Dietitian and Food Service Manager□s audits to the QAPI Committee meeting monthly x3 with follow up provided as needed.	

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E 015	Continued From page 7 24 - 48 oz cans chicken broth 12 - 50 oz cans vegetable in beef broth soup 12 - 50 oz cans chicken noodle soup 24 - 50 oz cans tomato soup 6 - 5-pound (lb) containers instant non-fat dried powdered milk 4 - #10 can mashed potatoes 4 - #10 cans sliced peaches 20.5 kg case sliced carrots 8 - #10 cans diced beets 1 - #10 can green peas 6 - #10 case banana pudding 5 - 4 lb can tuna 6 - #10 cans diced pears 30 - 2-liter bottles orange juice 120 - 5 oz cans chicken 6 - #10 cans lemon pudding 240 - 0.5 oz cups peanut butter 6 - 4 lb tubs peanut butter 5 - #10 cans peas and carrots 36 - 1 oz bowls toasty O's cereal 96 - 5/8oz bowls crispy rice cereal 96 - 0.75 oz bowls corn flakes cereal 6 - #10 cans fruit cocktail 6 - #10 cans crushed pineapple On 11/15/24/ at 11:00 AM, the Surveyor #4 observed the emergency food storage closet with the [U.S. FOIA], and the "3 Day Menu" was posted on the wall. The [U.S. FOIA] stated the supply was not full because when the food orders were not able to be ordered, she would take food items from the emergency supply and use them for the regular menu which depleted the emergency supply. On 11/15/2024 at 1:33 PM, a third request was made by the survey team for the emergency food PAR levels. On 11/18/2024 at 9:56 AM, Surveyor #2 entered	E 015		

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E 015	Continued From page 8 the kitchen. The [U.S. FOIA] was present and stated, "we will be shifting food into the emergency closet." On 11/21/2024 at 9:57 AM, Surveyor #7 toured the kitchen with Surveyor #10 and the [U.S. FOIA]. The [U.S. FOIA] stated she was changing the emergency menu and PAR levels based on what was available from vendors. The [U.S. FOIA] could not speak to when that would be completed. The surveyors and the [U.S. FOIA] observed and counted the emergency food supply. The following emergency food items were identified and quantified: 2 cases (cs) 12/48 oz cans boned chicken which had a "Best if Used By" date of 7/30/22. In addition, "EXP 7/30/22" was written in black marker on the side of the case. The [U.S. FOIA] acknowledged this. 2 cs 6/66.5 oz cans tuna 2 cs 96 individual portions of corn flakes 2 cs 96 individual portions of rice crispies 2 cs 96 individual portions of tasty o's cereal 2 cs #10 cans beef ravioli 11 #10 cans chili 1 cs #10 cans beef stew 3 cs 6 / 5 lb powdered dry milk 1 can peas (a #10 can) 2 cs #10 cans peas and carrots 2 cs #10 cans mixed vegetables 2 cs #10 cans carrots plus 3 additional cans 2 cs #10 green beans 10 #10 cans diced beets 1 cs #10 cans 3 bean salad 4 cs 12 cans/ 48 oz soup 5 cs 6 boxes / 32 oz soup	E 015		

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E 015	Continued From page 9 6 cans 6 lb/can dry mashed potato flakes 1 cs 6/4 lb tubs peanut butter 1 cs # 10 cans fruit mix 10 cs 12/5 oz cans chicken 27 cs 6/48 oz juice 5 cs 6/48 oz juice Juice 6/64 oz bottles On 11/21/24 at 11:08 AM, Surveyor #10 interviewed the [redacted] who stated that the purpose of the emergency supply was so the facility could feed residents if they lost power. When asked when the [redacted] was aware of the emergency menu, she stated, "just the other day. I knew there was a menu and I have been gradually restocking the PAR level." The [redacted] stated she had been in that position since August 2024. The [redacted] further stated she was responsible for the emergency food supply and that it should be in a locked closet separate from the in-use food. On 11/21/2024 at 12:58 PM, Surveyor #7 reviewed the concerns with the facility administration that emergency food in stock was not sufficient to meet the needs of the three-day menu and in accordance with facility policy. On 11/21/2024 at 10:23 AM, the survey team met with the facility administration. The facility had no additional information to provide. A review of the "Emergency Food and Nutrition 3 Day Menu," with a revised date of 10/27/20 reflected the facility should have had the following items and amounts in stock to nourish 180 residents in an emergent situation: Required: On 11/15/24 only had: On	E 015		

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E 015	Continued From page 10 11/21/24 only had: Cold cereal - 540 ¾ cup portions 228 ¾ cup portions Peanut butter - 12 - 4 lb tubs 6 - 4 lb tubs and 240 .5 oz portioned cups 6 - 4 oz tubs Juice - 8640 oz 2028 oz Dry powdered milk - 2160 tablespoons 1740 tablespoons Beef ravioli - 5 cs of #10 cans 1 cs and 4 #10 cans 2 cs Chili - 2 cs #10 cans and 3 #10 cans 11 #10 cans 11 #10 cans Tuna - 540 oz 320 oz Peas and Carrots - 1 cs #10 cans and 2 #10 cans 5 #10 cans Three bean salad - 1 cs #10 cans and 2 #10 cans 1 cs #10 cans Vanilla pudding - 1 cs #10 cans and 2 #10 cans No vanilla pudding No vanilla pudding Banana pudding - 1 cs #10 cans and 2 #10 cans 6 #10 cans No banana pudding Chocolate pudding - 1 cs #10 cans and 2 #10 cans No chocolate pudding No chocolate pudding Fruit mix - 1 cs #10 cans and 2 #10 cans 1 cs 1 cs Peaches - 1 cs #10 cans and 2 #10 cans 4 #10 cans No peaches Pineapple - 1 cs #10 cans and 2 #10 cans 1 cs No pineapple	E 015		

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E 015	Continued From page 11 A review of the facility policy "Emergency Disaster and Management," with a last revised date of 10/2023 included the that in the event of an emergency the dietary department would distribute emergency meals. A review of the facility's job description for the U.S. FOIA with a revised date of 5/2022, included the was responsible to ensure proper and efficient service of food and drink in accordance with administrative policies.	E 015		
E 018 SS=F	NJAC 8:39-31.6 (n) Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty	E 018		1/31/25

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E 018	Continued From page 12 staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of	E 018		

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E 018	Continued From page 13 evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation on 11/15/24, it was determined that the facility failed to ensure the Emergency Preparedness Plan (EPP) included a system to track on-duty staff and sheltered patients. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's Emergency Preparedness Plan on 11/15/24 at 11:00 AM, revealed the EPP lacked a system to track the location of on-duty staff and sheltered residents. During an interview at 11:00 AM with the U.S. FOIA (b)(6) he stated that he has not been able to review and update the EPP manual at this time. NJAC 8:39-31.2(e)	E 018	1. The Facility cannot retrospectively address this deficiency. 2. Current residents have the potential to be effected by the concern identified. 3. The Administrator with the Director of Nursing will develop a system to track on duty staff and sheltered residents by 1/31/25. Staff will be re-in-serviced on the staff on duty and sheltered resident tracking system by the Educator or designee. In servicing will be completed by 1/31/25. Information about the Facility Emergency Preparedness Program will be included in new staff orientation. 4. The Educator will verify review of the Emergency Preparedness Program including tracking of on duty staff and sheltered residents in new staff orientation	

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E 018	Continued From page 14	E 018	and present results of new staff orientation to the QAPI Committee monthly x3 months with follow up provided as needed. The Administrator will present the system to track on duty staff and sheltered residents in an emergency to the QAPI Committee for review and recommendations.	
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E 025		1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING **01** B. WING _____	**12/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	**185 TUCKERTON ROAD** **MEDFORD, NJ 08055**

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E 025	Continued From page 15 *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on documentation review on 11/15/24 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) included arrangements, agreements, or memorandums of understanding (MOU) with other facilities for evacuation and relocation. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed the EPP did not contained lists of facilities names, addresses, and phone numbers including arrangements, agreements, or (MOU's) with other facilities and other providers for the intake or discharge of patients in the event of limitation or cessation of operation to maintain the continuity of services to residents. In an interview, the U.S. FOI indicated stated he was	E 025	1. The Facility cannot retrospectively address this deficiency. 2 Current residents have the potential to be effected by the concern identified. 3. Transfer agreements have been procured with 2 long term care facilities. The Administrator with the Director of Nursing will develop a list of facilities names, addresses, and phone numbers including arrangements, agreements or MOUs with other facilities and other providers for the intake of residents, when/if necessary, to be included in the Emergency Preparedness Program by 01/31/2025. Staff will be in-serviced on the emergency facilities list by the Educator or designee. In servicing will be completed by 1/31/25.	

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E 025	Continued From page 16 unaware of this requirement. N.J.A.C 8:39-31.2(e), 31.9(e)	E 025	Information about the Facility Emergency Preparedness Program, including providers for intake of residents in an emergency will be included in new staff orientation. 4. The Educator will verify review of the Emergency Preparedness Program in new staff orientation and present results of new staff orientation to the QAPI Committee monthly x3 months with follow up provided as needed. The Administrator will present the facilities list to the QAPI Committee for review with follow up to include updates provided as needed.	
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC 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 annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID 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. The communication plan must include all of the following:] (8) A method for sharing information from the	E 035		1/31/25

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E 035	Continued From page 17 emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 11/15/24 in the presence of facility U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to include emergency preparedness policies and procedures for sharing emergency preparedness plans with residents and families. This deficient practice had the potential to affect all residents and was evidenced by the following: At 11:00 a.m., the surveyor reviewed the Emergency Preparedness Plan Manual with the facility's U.S. FOIA (b)(6) [redacted]. A review of the manual revealed that there was no policy and procedure for sharing emergency preparedness plans with residents and families. In an interview at the time, the U.S. FOIA (b)(6) [redacted] stated that he did not know about the policy and could not provide any further information prior to the survey team exit. NJAC 8:39-31.2(e)	E 035	1. The Facility cannot retrospectively address this deficiency. 2. Current residents have the potential to be effected by the concern identified. 3. The Administrator/designee will develop a policy and procedure for sharing emergency preparedness plans with residents and families. Staff will be re-in-serviced on the policy for sharing emergency preparedness plans with residents and families by the Educator or designee. In servicing will be completed by 1/31/25. Residents will be educated on emergency preparedness plans in the January 2025 Resident Council Meeting by the LNHA/designee. Information about the Facility□s Emergency Preparedness Program including notification of residents and families will be included in new staff orientation. Information about the Facility□s Emergency Preparedness Program will be included the admission packet for new residents. 4. The LNHA/designee will present the results of any feedback from the resident Council Meeting at the January QAPI Committee Meeting for review and	

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E 035	Continued From page 18	E 035	recommendations. The Educator will verify review of the Emergency Preparedness Program in new staff orientation and present results of new staff orientation to the QAPI Committee monthly x3 months with follow up provided as needed. The Admissions Director will review signed admission packets to verify information about the Facility□s Emergency Preparedness Program is included and present results of audits to the QAPI Committee monthly x3 months with follow up provided as needed.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual	E 039		1/31/25

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E 039	Continued From page 19 natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of	E 039		

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E 039	Continued From page 20 the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 21 (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 22 community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 23 community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 24 (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

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E 039	Continued From page 25 designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039		

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E 039	Continued From page 26 plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD 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
E 039	Continued From page 27 (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 11/15/24 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to participate in the required tabletop and community based emergency drill, and failed to conduct 2 of 2 emergency disaster drills annually in accordance with the Emergency Preparedness guidelines as required by 42 CFR part 483. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's disaster drill documentation for the previous 12 months revealed there was no documented emergency disaster drill. There was also no documentation that the facility attempted to participate in a community based drill, an annual individual facility-based functional exercise, actual natural or man-made emergency, a mock disaster drill or tabletop exercise. In an interview at 10:30 AM, the facility's U.S. FOIA (b)(6) [redacted] confirmed the facility did not participate in or conduct any disaster drills since 6/28/23. NJAC 8:39-31.2(e) Federal (42 CFR 483.73) Emergency Preparedness guidelines	E 039	1. The Facility cannot retrospectively address this deficiency. 2. Current residents have the potential to be affected by the concern identified. 3. The Administrator with the Director of Maintenance will reach out to the local OEM office to discuss scheduling/participating in a community disaster drill. Efforts will be documented. The Administrator with the Director of Maintenance will schedule a tabletop disaster drill exercise. This will be held on January 28, 2025. Please see attached email confirming date and time of the OEM Disaster Drill. After the tabletop drill, from the discussion and feedback, staff will be in-serviced on identified emergency preparedness needs by the Educator or designee. In servicing will be completed by 1/31/25. The Director of Maintenance will develop a calendar for quarterly and annual inspections and document when the next drills are required so that they are scheduled timely. Information about the Facility Emergency Preparedness Program will be included in new staff orientation. 4. The Educator will verify review of the Emergency Preparedness Program in	

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E 039	Continued From page 28	E 039	new staff orientation and present results of new staff orientation to the QAPI Committee monthly x3 months with follow up provided as needed. The Maintenance Director will present the results of the tabletop drill to the February QAPI Committee for review and recommendations and will present the calendar of future inspections and drills. Follow up will provided as needed.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110,	E 041		1/31/25

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E 041	Continued From page 29 when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.	E 041		

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E 041	Continued From page 30 If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that maintenance and testing of generators in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, NFPA 110, NFPA 111 and NFPA 70. This deficient practice had the potential	E 041	1. Annual emergency generator maintenance, including transfer switch maintenance was completed on 09062024. The Director of Maintenance conducted a 4-hour load bank test of the emergency generator with appropriate documentation on 01/16/2025.	

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E 041	Continued From page 31 to affect all residents and was evidenced by the following: A record review on 11/13/2024 revealed quarterly emergency generator maintenance on the emergency generator was conducted on 7/27/23 and again on 2/13/24. In an interview at the time, the U.S. FOIA (b) confirmed that there was no other documentation available regarding the requirement of having the transfer switch on an annual maintenance program consisting of 1 major service and 3 quarterly inspections. A record review revealed a 4-hour load bank test was not conducted. Documentation of the last 4-hour load bank could not be produced. An observation at 11:44 AM revealed the generator contained a lead-acid battery. In an interview at the time, the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid batteries. The U.S. FOIA (b) confirmed that the battery was a lead-acid battery and stated that monthly testing is not conducted. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b) (6) and U.S. FOIA (b) indicated they were unavailable for the conference. N.J.A.C 8:39-31.2(e) NFPA 70, 99, 110, 111	E 041	The Director of Maintenance will test and record electrolyte specific gravity for the emergency generators lead battery by 01/31/2025. 2. Current residents have the potential to be effected by the concern identified. 3. The Director of Maintenance will develop a calendar for quarterly and annual inspections and document when the next quarterly emergency generator service is required so that it is scheduled timely, and the work is completed. This service will include transfer switch maintenance. The Maintenance Director will add testing of lead batteries to the Monthly Preventative Maintenance Schedule. Testing and inspections will be documented. A 4 hour load bank test will be conducted by the Maintenance Director The outside vendor completing the emergency generator service will be in-service the U.S. FOIA (b) (6) and the maintenance staff on the requirements of servicing and testing the emergency generator. 4. The results of the emergency generator service, including the transfer switch and the 4-hour load test, will be reported to the QAPI Committee quarterly x3 by the Maintenance Director. Follow up will provided as needed. The results of the electrolyte specific gravity testing will be presented by the Maintenance Director to the QAPI	

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E 041	Continued From page 32	E 041	Committee monthly x 3 with follow up provided as needed. Maintenance Director will present calendar of future inspections and testing due to the QAPI Committee for review.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by New Jersey Department of Health, Health Facility Survey and Field Operations between 04/13/2024 and 04/15/2024. Medford Care Center was found not to be in compliance with 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 occupancy. Medford Care Center was constructed in 1980. The facility is one story with concrete flooring and concrete steel deck roofing and block bearing walls with metal studs and a concrete and brick exterior. Medford Care Center is therefore a construction Type II (222) facility with a complete sprinkler system and smoke detection in all bedrooms and corridors. The facility has a 45 KW (kilowatt) natural gas stand by generator. The facility is divided into 10 smoke zones.	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.	K 271		1/31/25

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K 271	Continued From page 33 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that discharge from exits was provided with a hard packed all -weather travel surface in accordance with NFPA 101:2012 Edition Section 19.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/14/2024 at 12:43 PM revealed the exit discharge near room 79 was not provided with a hard packed all-weather travel surface. An observation at 12:53 PM revealed the exit in the activities room on D wing did not contain a manual pull station, exited to a gated patio area and the exit discharge was not provided with a hard packed all-weather surface to a public way, as cited on the previous survey dated 04/21/2023. An observation at 1:04 PM revealed the exit discharge near room 57 contained a 10-foot concrete pad that connects with the Physical therapy emergency exit courtyard area that was not provided with a hard packed all-weather surface to a public way, as cited on the previous survey dated 04/21/2023. An observation at 1:15 PM revealed the exit discharge near room 56 was only provided with 1 source light.	K 271	1. The facility is requesting a time limited waiver secondary to winter weather conditions regarding hard pack surfaces. The surfaces identified as not having hard pack surfaces were inspected. Proposals for work will be obtained and reviewed with an estimated completion date of 05/04/2025.Facility Vendors will be contacted to secure the next available dates for required manual pull station and additional lighting requirements as outlined in the concern identified. Facility Maintenance Department will inspect fencing/gating in smoking courtyard and will obtain materials needed for repairs. 2. The facility requires additional time to obtain proposals for work to be completed . Pending winter weather relief, hard pack all weather travel surfaces will be installed as required. The required manual pull station and additional lighting requirement will be completed at the vendor's next available dates. Facility Maintenance Department will obtain materials needed to repair fencing/gating in smoking courtyard. 3. Facility will prioritize installation of the required manual pull station and additional lighting requirements as well as obtained installation date for surfaces requiring hard pack all weather surfaces. Facility Maintenance Department will repair fencing/gating in smoking courtyard.	

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K 271	Continued From page 34 An observation at 1:31 PM revealed exit discharge near room 51 contained a 2-inch raised section of asphalt that would cause a tripping hazard. An observation at 1:46 PM revealed the [NJ Exec Order 26.4b] [redacted] exit discharge was not provided with a hard packed all-weather surface to a public way, as cited on the previous survey dated 04/21/2023. Additionally, the exit gate doors were being held closed with a bungee cord and a section of the gate was broken and chained to the exit gate post to keep it from falling over. In interviews at the time, the [U.S. FOIA (b)] confirmed the observations. These deficient practices have been cited on previous surveys conducted on 04/21/23, 10/26/18 and 08/29/17. All surveys indicated these exit discharges did not have a hard packed all-weather surface. Plans of Correction that were submitted stated that they would be repaired but repairs were not made. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's [U.S. FOIA (b)(6)] and [U.S. FOIA (b)] indicated they were unavailable for the conference.	K 271	4. Facility Maintenance Director will audit exit areas monthly for the next 3 months to identify need for remedy related to changes to exit surfaces and to verify manual pull stations as required as well as need for additional lighting as required. Facility Maintenance Director will inspect fencing/gating in smoking courtyard monthly for the next 3 months to verify fencing/gating remains in good repair. Areas of concern will be addressed. Audit results will be presented at the QAPI Committee meeting for the next 3 months with follow up provided as needed.	
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		1/31/25

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K 291	Continued From page 35 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that a battery-operated emergency backup light was provided at the emergency generator transfer switch in accordance with NFPA 99:2012 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/13/2024 at 11:44 AM revealed the emergency back up generator was not provided with a battery-operated emergency backup light. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) and U.S. FOIA (b) indicated they were unavailable for the conference. N.J.A.C 8:39-31.2(e) NFPA 99	K 291	1. A battery-operated emergency backup light was installed by the emergency generator transfer switch on 01/03/2025. 2. Current residents have the potential to be effected by the concern identified. 3. The Maintenance Director will add inspection of the battery-operated emergency backup light to the Monthly Preventative Maintenance Schedule to verify it is operational. Maintenance staff were in-serviced on the lighting requirements for the emergency generator by the LHNA/designee. Re-education completed 01/31/2025. Maintenance staff completing the inspections will document their findings and report to the Maintenance Director if the backup light is not operational for expedited repair. 4, Results of the inspections of backup lighting for the emergency generator will be reported by the Maintenance Director to the monthly QAPI Committee x 3 with follow up provided as needed.	
K 321 SS=F	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.	K 321		1/31/25

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K 321	Continued From page 36 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 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7, 8.4 and NFPA 13. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/14/2024 at 1:41 PM revealed the door to the soiled utility room on C wing near room 37 did not positive latch when	K 321	1. The soiled utility room on C wing near room 37 and the laundry room door were adjusted so that they latch into the frames. The housekeeping storage room was equipped with a self- closing device. The switch will no longer be used to store combustible supplies. 2, Current residents have the potential to be effected by the concern identified. 3, The Maintenance Director will add	

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K 321	Continued From page 37 tested by the [redacted] In an interview at the time, the [redacted] confirmed the observation. An observation on 11/15/2024 at 11:39 AM revealed the laundry room door did not positive latch when tested by the [redacted]. An observation at 11:43 AM revealed the housekeeping storage room containing approximately 8 cases of toilet paper, 8 cases of paper towels and other combustible items, was over 50 square feet and was not provided with a door that was self-closing or automatic closing. An observation at 11:56 AM revealed the switch room was filled with boxes of personal protective equipment and other combustible items. The storage room was over 50 square feet and was not provided with a door that was self-closing or automatic closing. In interviews at the time, the [redacted] confirmed the observations. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's [redacted] and [redacted] indicated they were unavailable for the conference. N.J.A.C 8:39-31.2(e)	K 321	inspection of room doors to the Monthly Preventative Maintenance Schedule to verify they are latching into the frames. Doors not latching properly will be adjusted at the time of inspection. The Maintenance Director will add inspection of rooms over 50 square feet to the Monthly Preventative Maintenance Schedule to verify they are not being used as a storage room unless they have a self-closing device. Pertinent staff, including Maintenance, Housekeeping and Nursing, will be in-serviced on reporting improperly latching doors, and placing a in work order by the Maintenance Director by 01/31/2025. Staff will be in-serviced on storage room requirements by the Maintenance Director by 01/31/2025.. Maintenance staff completing the monthly inspections will document their findings and adjust any door found not latching into the frame. Maintenance staff completing the monthly inspections will document their findings and report to the Maintenance Director any rooms being utilized for storage without a self-closing device. 4, The Maintenance Director will report the results of the inspections of doors not latching onto frames to the monthly QAPI Committee x3 months with follow up provided as needed, The Maintenance Director will report the results of the inspections of rooms being used for storage without a self-closing device and actions taken to the monthly	

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(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 321	Continued From page 38	K 321	QAPI Committee x3 months with follow up provided as needed.	
K 324 SS=F	Cooking Facilities 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 record review, observations, and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that cooking equipment was maintained in	K 324	1. The Director of Maintenance scheduled the semiannual inspection of the kitchen suppression system with an outside vendor on 01/30/2025. Documentation of the inspection will be	3/19/25

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	315176	A. BUILDING 01 B. WING _____	12/05/2024

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K 324	Continued From page 39 accordance with NFPA 101:2012 Edition, Sections 9.2.3 and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 11/14/2024 revealed the last semiannual inspection of the kitchen suppression system was conducted on 10/10/23, over a year ago. In an interview at the time, the [U.S. FOIA (b)] stated that they would get in contact with the fire sprinkler company to see if they could send over the missing documentation. A record review on 11/15/2024 revealed a service ticket was provided by the [U.S. FOIA (b)] from the sprinkler company for an inspection that was conducted on 9/17/2024, more than 5 months after it was due for inspection. The report which would have identified any findings or concerns was not provided. An observation on 11/15/2024 at 12:03 PM revealed the kitchen range-hood fire suppression system monthly inspection tag was not signed. In an interview at the time, the [U.S. FOIA (b)] confirmed that the tag was unsigned and stated that they were unaware of the requirement to inspect the kitchen range-hood fire suppression system and sign the tag monthly, but would make sure to take care of it going forward. An observation at 12:03 PM revealed the kitchen hood was last cleaned in January of 2024. In an interview at the time, the [U.S. FOIA (b)(6)] confirmed	K 324	provided to the facility when the work is completed. Work was completed on 01/30/2025 The Director of Maintenance scheduled the kitchen hood cleaning with the outside vendor for the next available date. Work was completed on 02/14/2025. 2. Current residents have the potential to be effected by the concern identified. 3. The Director of Maintenance will develop a calendar for quarterly and annual inspections and document when the next semi-annual inspection of the kitchen range hood fire suppression system is required so that it is scheduled timely, and the work is completed. The Director of Maintenance will develop a calendar for quarterly and annual inspections and document when the next semi-annual kitchen hood cleaning is required so that it is scheduled timely, and the work is completed. The Maintenance Director will add inspection of the kitchen range hood fire suppression system to the Monthly Preventative Maintenance Schedule. The inspection will be documented by signing the hood tag. The Administrator/designee will add review of the kitchen range hood fire inspection system hood to his monthly rounds to audit that the tag is signed indicating the Maintenance department inspection was completed. 4. The Maintenance Director will report the results of the Kitchen range hood fire	

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K 324	Continued From page 40 the observation and stated that the company that cleans the kitchen hood and exhaust was backed up with services and they have been unable to make it out to the facility for the scheduled cleanings that were due over 5 months ago. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) and U.S. FOIA (b) indicated they were unavailable for the conference. N.J.A.C 8:39-31.2(e) NFPA 96	K 324	suppression system inspection by the outside vendor, to the QAPI Committee when complete. The results of the Kitchen range hood fire suppression system monthly inspection audit will be reported by the LHNA/designee to the QAPI Committee monthly x3 months with follow up as needed. The results of the kitchen hood cleaning will be reported to the QAPI Committee when completed by the Maintenance Director. The Maintenance Director will review the calendar and future inspections to be completed with the QAPI Committee on a quarterly basis.	
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 record review, observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6), it was determined that the facility failed to ensure that deficiencies, damaged parts, or impairments found while performing the inspection, testing and maintenance of the fire	K 345	1. The Director of Maintenance scheduled the replacement of the heat detectors identified in the last service report by the outside vendor. The Director of Maintenance scheduled the replacement of the Dialer battery identified in the last service report by the	3/19/25

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K 345	Continued From page 41 alarm system were promptly corrected in accordance with NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed fire alarm semi-annual inspections were conducted on 12/22/2023 and 05/03/2024. A "Service Ticket" was provided for a semi-annual fire alarm inspection that was conducted on 10/23/2024, but the report which would indicate deficiencies or impairments was not provided. A fire alarm report dated 12/22/2023 indicated that (7) heat detectors failed and needed to be replaced. These devices were located at the Service Hallway overtop of the vending machine, the Laundry at the Dryers, inside the boiler room x 2, in the kitchen overtop preparation table, the Kitchen near dining room exit, and the first kitchen open storage by sinks. The following semi-annual fire alarm inspection, dated 05/03/2024, indicated that none of the heat detectors that failed the previous inspection were changed. Additionally, 5 more heat detectors failed the current inspection. A notation was left in the service report that stated "All of the heat detectors in the building are expired. They will need to be replaced." "Dialer Battery is Dead. Must be replaced." In an interview at the time, the [redacted] confirmed that the documentation stated that the facility needed to replace all the heat detectors and the [redacted] stated that this was all before he started working there. The surveyor asked the [redacted] if these deficiencies were ever corrected. The [redacted] stated, "I don't think they have been".	K 345	outside vendor. Keystone was onsite 01/30/2025 to begin work. Estimated date of completion 03/10/2025. 2. Current residents have the potential to be effected by the concern identified. 3. The Director of Maintenance will add inspection of the facility heat detectors to the monthly preventative maintenance calendar. Documentation will be made of these inspections. The Director of Maintenance will add inspection of the dialer battery to the monthly preventative maintenance calendar. Documentation will be made of these inspections. The Administrator/designee will verify a report is provided for any fire alarm testing and maintenance work by an outside vendor scheduled by the Maintenance Director. 4. The Director of Maintenance will report the results of the heat detector replacement by the outside vendor to the QAPI Committee when complete. The Maintenance Director will report the results of the heat detectors monthly inspections to the QAPI Committee monthly x3 with follow up provided as needed. The Maintenance Director will report the results of the dialer battery replacement by the outside vendor to the QAPI Committee when complete. The Maintenance Director will report the results of the dialer battery inspections monthly inspections to the QAPI	

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K 345	Continued From page 42 An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) and U.S. FOIA (b) indicated they were unavailable for the conference. N.J.A.C 8:39-31.2(e) NFPA 72	K 345	Committee monthly x3 with follow up provided as needed. The Administrator/designee will report the results of fire alarm testing and maintenance work as specified in the outside vendors report and facility actions taken to the QAPI Committee monthly x3 with follow up provided as needed.	
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 record review, observations, and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6), it was determined that the facility failed to ensure that automatic sprinkler systems were	K 353	1. The Facility cannot retrospectively address this sprinkler deficiency; however, the blue tape was removed from the sprinkler identified in the washing machine area.	1/31/25

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K 353	Continued From page 43 inspected, tested, and maintained in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 11/14/2024 revealed quarterly fire sprinkler inspections were only conducted on 03/08/2024 (Q1) and 09/19/2024 (Q3). In an interview at the time, the [redacted] confirmed that there was no documentation for quarter 2 inspections and stated that they would get in contact with the fire sprinkler company to see if they could send over the missing documentation. No additional documentation was supplied concerning the quarterly fire sprinkler inspections. A record review revealed a 5-year internal inspections of the sprinkler system was last conducted on 6/19/2019, over 5 years ago. An observation on 11/15/2024 at 11:28 revealed the washing machine area contained 4 sprinklers. Three of the 4 sprinklers were green with oxidation. One of the 4 sprinklers was completely wrapped in blue painter's tape. An observation on at 11:31 AM revealed the 5-year inspection tag on the sprinkler riser was dated 06/19/19. An observation at 11:32 AM revealed the gauge on sprinkler riser 1 in the laundry room was from 2017. Sprinkler Gauges shall be changed every 5 years. An observation at 11:37 AM revealed 4 of 5	K 353	2. Current residents have the potential to be effected by the concern identified. 3. The Director of Maintenance will schedule the third quarter fire sprinkler system, with an outside vendor, for the next available date with sprinkles replaced as indicated. Particular attention will be made to the washing machine and dryer area. Fire sprinkler system inspection was completed on 12/19/2024. Additional work was completed on 02/21/2025. The Director of Maintenance will schedule the 5-year internal inspection of the sprinkler system for the next available date with work completed as necessary with particular attention to the sprinkler risers and gauges in the laundry room and sprinkler riser 2 in the therapy room. The five year internal inspection was completed on 02/21/2025. The Director of Maintenance will add inspection of the facility sprinklers to the Monthly Preventative Maintenance Schedule. Documentation will be made of these inspections. Vendor will be on-site 01/30/2025 to begin work. The Director of Maintenance will develop a calendar for quarterly and annual inspections and cleanings and document when the next quarterly sprinkler system inspections is required so that it is scheduled timely, and the work is completed. The Director of Maintenance will develop a calendar for quarterly and annual inspections and cleanings and note when the next 5-year sprinkler inspection is	

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K 353	Continued From page 44 sprinkler heads had heavy lint buildup and 1 of 4 sprinkler escutcheons was too small. An observation at 12:08 PM revealed the 5-year inspection tag on sprinkler riser 2 was dated 06/19/19 and was 4 months overdue for reinspection. An observation at 12:09 PM revealed the gauge on sprinkler riser 2 in the therapy room was from 2017. Sprinkler Gauges shall be changed every 5 years. In an interview at the time, the [redacted] confirmed the observations. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's [redacted] and [redacted] indicated they were unavailable for the conference. N.J.A.C 8:39-31.2 (e) NFPA 25	K 353	required so that it is scheduled timely, and the work is completed. 4. The results of the third quarter fire sprinkler system by the outside vendor will be reported to the QAPI Committee by the Maintenance Director when complete. The results of the 5-year internal inspection of the sprinkler system will be reported to the QAPI Committee by the Maintenance Director when complete. The results of the sprinkler system monthly inspections will be reported to the QAPI Committee monthly by the Maintenance Director with follow up provided as needed. The Maintenance Director will present calendar of future inspections to the QAPI Committee quarterly.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the [redacted]), it was	K 355	1. The Facility cannot retrospectively address the deficiency on the fire extinguisher in the smoking area;	1/31/25

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K 355	Continued From page 45 determined that the facility failed to ensure that portable fire extinguishers were provided, maintained, and installed in accordance with NFPA 101:2012 Edition, Sections 19.3.5.12, 9.7.4.1 and NFPA 10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/14/2024 at 11:46 AM revealed the inspection tag on the fire extinguisher in the smoking area was last signed on 06/05/24, over 4 months ago. An observation on 11/15/2024 at 11:36 AM revealed the portable fire extinguisher was not mounted at least 4 inches above the floor in the laundry room. An observation at 11:59 AM revealed the fire extinguisher near the vending machine was not of a 2-A:10-B:C minimum size. In interviews at the time, the U.S. FOIA (b) confirmed the observations. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) and U.S. FOIA (b) indicated they were unavailable for the conference. N.J.A.C 8:39-31.2 (e) NFPA 10	K 355	however, the fire extinguisher in the smoking area was inspected on 12/03/2024. The portable fire extinguisher in the laundry room was relocated at least 4 inches above the floor. The fire extinguisher near the vending machine was changed to the appropriate size. 2. Current residents have the potential to be effected by the concern identified. 3. The Director of Maintenance will add inspection of the facility fire extinguishers to the Monthly Preventative Maintenance Schedule. Documentation will be made of these inspections, and the extinguisher tag will be dated. The Director of Maintenance will inspect fire extinguishers throughout the facility to verify they are properly mounted at least 4 inches above the floor. The Director of Maintenance will inspect fire extinguishers throughout the facility to verify they are proper size. The Administrator/designee will add review of the fire extinguishers to his rounds to audit that the tag is signed monthly indicating the Maintenance department inspection was completed. 4. The results of the monthly fire extinguisher inspections will be reported to the QAPI Committee monthly x3 by the Maintenance Director with follow up provided as needed. The results of the inspection and actions taken to verify fire extinguishers are	

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K 355	Continued From page 46	K 355	mounted at least 4 inches above the floor will be reported to the QAPI Committee by the Maintenance Director when complete. The results of the inspection and actions taken to verify fire extinguishers are the proper size will be reported to the QAPI Committee by the Maintenance Director when complete. The results of the audits completed by the Administrator/designee will be reported to the QAPI Committee monthly x3 by the Administrator/designee with follow up provided as needed.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		1/31/25

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K 363	Continued From page 47 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b) (6) it was determined that the facility failed to ensure that doors in the corridor could resist the passage of smoke, had positive latching hardware and were not held open by devices other than those that release when the door is pushed or pulled in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3 and 19.3.6.3.10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/13/2024 revealed the door to resident room 5 did not positive latch when tested by the U.S. FOIA (b). An observation on 11/14/2024 revealed the pantry door on C wing was being held open by a trash can and did not close into its frame when tested by the U.S. FOIA (b). The door was not set properly and was hitting the frame.	K 363	1. The door to Resident room 5 was adjusted so that it latched into the frame. The trash can holding the pantry door on C wing was removed. The pantry door on C wing was reset so that it would properly latch into the frame. The door behind the nurse□s station on C wing was reset so that it would properly latch into the frame. Positive latching hardware was installed on the clean linen room door on the birch unit. A doorknob was installed on the door to the clean linen room on the birch unit. 2. Current residents have the potential to be effected by the concern identified. 3. The Maintenance Director will add inspection of room doors to the Monthly Preventative Maintenance Schedule to verify they are latching into the frames.	

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K 363	Continued From page 48 An observation at 1:25 PM revealed the door behind the nurse's station on C wing was being held open by rubbing and sticking to the floor. An observation on 11/15/2024 at 11:11 AM revealed the clean linen room door on the birch unit was not provided with positive latching hardware. The doorknob was removed and you could see into the room from the corridor. In interviews at the time, the [redacted] confirmed the observations. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's [redacted] and [redacted] indicated they were unavailable for the conference. N.J.A.C 8:39-31.2 (e)	K 363	Doors not latching properly will be adjusted at the time of inspection. The Maintenance Director will add inspection of door hardware to the Monthly Preventative Maintenance Schedule to verify doors have doorknobs. Doors without hardware will be fixed when found. Pertinent staff, including Maintenance, Housekeeping and Nursing, will be in-serviced on reporting improperly latching doors, and placing a work order by the Maintenance Director by 01/31/2025. Staff will be in serviced by the Educator on why doors with self-closures cannot be held open by 01/31/2025. The Administrator/designee will add observation of facility doors improperly held open to his rounds and provide education to staff when found. Observations and education will be documented. 4. The Maintenance Director will report the results of the inspections of doors not latching onto frames to the monthly QAPI Committee x3 months with follow up provided as needed. The Maintenance Director will report the results of the inspections of door hardware to the monthly QAPI Committee x3 months with follow up provided as needed. The Administrator/designee will report the results of his rounds to the QAPI Committee x3 months with follow up provided as needed.	

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MEDFORD CARE CENTER	185 TUCKERTON ROAD 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 374	Continued From page 49	K 374		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that smoke barrier doors closed into their frames and were kept clear of anything that could interfere with the free operation of the door in accordance with NFPA 101:2012 Edition, Sections 19.3.7.6, 19.3.7.8, 19.3.7.9, NFPA 105 sections 5.2.2.1 and 5.2.2.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/14/2024 at 1:28 PM revealed the smoke barrier doors near room 46 did not close into its frame when tested by the U.S. FOIA (b). A wreath hook was placed over the door which prevented the door from closing.	K 374	1. The wreath hook placed over the door preventing it from closing was removed. 2. Current residents have the potential to be effected by the concern identified. 3. The Maintenance Director will add inspection of smoke barrier doors to the Monthly Preventative Maintenance Schedule to verify they are latching into the frames. Doors not latching properly will be adjusted at the time of inspection. These audits will be ongoing to verify doors throughout the facility properly latch as required. Staff will be in serviced on why doors must latch properly and to report improperly latching doors by placing a work order with Maintenance by the	1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 374	Continued From page 50 In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation and removed the wreath hook. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) indicated they were unavailable for the conference. N.J.A.C 8:39-31.2 (e) NFPA 105	K 374	Maintenance Director. Education will be completed by 01/31/2025. The Administrator/designee will add observation of smoke barrier doors to his rounds to verify they are closing into the frame. Observations will be documented. 4. The Maintenance Director will report the results of the inspections of smoke barrier doors not latching onto frames to the monthly QAPI Committee x3 months with follow up provided as needed. The Administrator/designee will report the results of his rounds to the QAPI Committee x3 months with follow up provided as needed.	
K 500 SS=F	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview on 11/15/24 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that 1 of 1 hot water boilers were provided with certificates of inspection. This deficient practice had the	K 500	1. The Facility cannot retrospectively address this deficiency. 2. Current residents have the potential to be effected by the concern identified.	1/31/25

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K 500	Continued From page 51 potential to affect all residents was evidenced by the following: At 10:30 AM, the U.S. FOIA (b)(6) was interviewed and asked to provide all boiler documentation. The U.S. FOIA stated that the hot water boiler was installed a while back and could not provide the date of installation as he was working at the facility for only 3-months. Observations revealed the hot water boiler had a signed sticker dated 01/16, from the State of New Jersey Bureau of Boiler and Pressure Vessel Compliance. In an interview, the U.S. FOIA indicated he was not sure if the hot water boiler was installed new or used or if the signed sticker was from another facility's inspection. The U.S. FOIA indicated he was not sure how to go about getting the boiler inspected and could not provide any further documentation. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) and U.S. FOIA (b) indicated they were unavailable for the conference. NJAC 8:39-31.2(e) N.J.S.A 34:7-19 N.J.S.A 12:90-5.14	K 500	3. The Director of Maintenance will contact the State of New Jersey Bureau of Boiler and Pressure Vessel Compliance for education on how to get the boilers inspected and any inspection requirements. The Director of Maintenance will follow the directions provided by the State of New Jersey Bureau of Boiler and Pressure Vessel Compliance and schedule a boiler inspection. Inspection was completed 12/12/2024. The Director of Maintenance will develop a calendar for quarterly and annual inspections and cleanings and if directed by the State of New Jersey Bureau of Boiler and Pressure Vessel Compliance, add the inspection so that it is scheduled timely, and the work is completed. 4. The results of the boiler inspection will be reported to the QAPI Committee when complete.	
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	K 521		1/31/25

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K 521	Continued From page 52 specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that ventilation and air conditioning were in compliance with NFPA 101:2012 Edition, Sections 19.5.2.1 and 9.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/15/2024 at 9:59 AM revealed the bathroom ventilation in resident room 5 was not functioning when tested by the U.S. FOIA (b). An observation at 10:30 AM revealed the Packaged Thermal Air Conditioner (PTAC) unit filters in resident room 26 had heavy dust accumulation. An observation at 10:47 AM revealed the PTAC unit filters in resident room 18 had heavy dust accumulation. In interviews at the time, the U.S. FOIA (b) confirmed the observations. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) and U.S. FOIA (b) indicated they were unavailable for the	K 521	1. The bathroom ventilation in room 5 was repaired. The PTAC unit filters in resident rooms 26 and 18 were cleaned. 2. Current residents have the potential to be effected by the concern identified. 3. The Maintenance Director inspected bathrooms to verify they were in compliance with ventilation requirements. The Maintenance Director inspected PTAC Units in resident rooms to verify they were dust free. The Maintenance Director will add inspection of bathroom ventilation to the Monthly Preventative Maintenance Schedule to verify they are in compliance with ventilation requirements. Necessary repairs will be made at the time of inspection. The Maintenance Director will add filter cleaning of PTAC Units in resident rooms to the Monthly Preventative Maintenance Schedule. 4. The Maintenance Director will report the results of the inspections of bathroom ventilation inspections to the monthly QAPI Committee x3 months with follow up provided as needed.	

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K 521	Continued From page 53 conference. N.J.A.C 8:39-31.2 (e)	K 521	The Maintenance Director will report the results of the PTAC filter cleaning to the monthly QAPI Committee x3 months with follow up provided as needed.	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the	K 741	1. Leaves around or near the smoking area were removed.	1/31/25

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K 741	Continued From page 54 U.S. FOIA (b)(6) it was determined that the facility failed to ensure that U.S. FOIA (b)(6) of noncombustible materials and safe design, and metal containers with self-closing cover devices were readily available to all areas where NJ Exec Order 26.4b is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/14/2024 at 1:46 PM revealed the resident U.S. FOIA (b)(6) area contained 2 outdoor NJ Exec Order 26.4b1 constructed of combustible plastic material. A metal container with a self-closing cover device into which NJ Exec Order 26.4b1 could be emptied was not provided or readily available to the area. In an interview at the time, the U.S. FOIA (b) confirmed the observation. An observation on 11/15/2024 revealed the staff NJ Exec Order 26.4b area contained 1 outdoor NJ Exec Order 26.4b ashtray constructed of combustible plastic material. A metal container with a self-closing cover device into which ashtrays can be emptied was not provided or readily available to the area. In an interview at the time, the U.S. FOIA (b) confirmed the observation. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) and U.S. FOIA (b) indicated they were unavailable for the conference.	K 741	NJ Exec Order 26.4b1 are now retained by the NJ Exec Order 26.4b1 who are responsible to NJ Exec Order 26.4b1 for residents. 2. Current residents have the potential to be effected by the issues identified. There are presently fifteen (15) patients who have smoking privileges. Upon admission, smoking assessments are completed by licensed nurses for residents wishing to smoke. Re-assessments are completed by licensed nurse yearly or when a residents condition indicates a change. Upon assessment, it is determined whether a resident may smoke independently or requires supervision with smoking. Residents deemed capable of smoking independently (by full smoking assessment) will be required to sign a smoking agreement indicating that they are aware of the facility policies as related to smoking. 3. Maintenance Coordinator/Designee will inspect the smoking area minimum of twice daily and remove accumulated debris and leaves to mitigate fire hazard. An additional Smoking Post receptacle was purchased and effective November 29, 2024, both doors that are used to access and exit the designated smoking courtyard have a post in place for disposal of cigarette butts. Housekeeping staff will empty ashtrays into the Smoking Posts twice on the day	

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K 741	Continued From page 55 N.J.A.C 8:39-31.2(e)	K 741	shift and once on the evening shift. In addition, the Smoking Post receptacles will be emptied by housekeeping staff a minimum of once daily. The smoking policy final revision was completed on 12/18/2024. Staff was educated on the revision by Nursing Administration on 12/18/2024 and 12/19/2024. The smoking policy will be reviewed at the next Resident Council Meeting and will be reviewed 2x a year with the Resident Council and if/when changes to the smoking policy occur. The facility smoking policy was revised on 12/18/2024 as follows: a. residents may not possess lighters or matches b. smoking times will be established, smoking monitors will monitor resident smoking including smoking monitors to light cigarettes and verify that cigarette butts are properly extinguished in designated receptacles. This policy revision was individually communicated to residents who smoke on 12/19/24 by the Consultant Administrator and the conversation was documented in the individual resident's medical record. Residents who smoke were and will continue to be required to acknowledge the policy with acknowledgement documented in the resident medical records. The facility staff were educated on the smoking policy changes by administration on 12/19/24.	

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K 741	Continued From page 56	K 741	4. The facility smoking policies will be reviewed at resident council twice per year of if a change in the policy occurs. Residents who smoke will be required to sign a new smoking agreement with each review. The policy will be reviewed at the next Resident Council Meeting. The Smoking Agreements and the list of residents who smoke shall be reviewed by the QAPI committee on a quarterly basis. Areas of concern will be addressed with follow up as needed. The LNHA/designee will randomly observe three smoking times per week of the next twelve weeks to verify staff and residents are adhering to the revised policy. Areas of concern will be addressed.	
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	K 918		3/20/25

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K 918	Continued From page 57 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that maintenance and testing of generators was in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, NFPA 110, NFPA 111 and NFPA 70. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 11/13/2024 revealed, quarterly emergency generator maintenance was conducted on 7/27/23 and again on 2/13/24. In an interview at the time, the U.S. FOIA (b) confirmed that there was no other documentation available regarding the requirement of having the transfer switch on an annual maintenance program consisting of 1 major service and 3 quarterly	K 918	1. The annual emergency generator maintenance was performed on 09/06/2024. Service included transfer switch maintenance. The Director of Maintenance conducted a 4-hour load bank test of the emergency generator with appropriate documentation on 01/16/2025. The Director of Maintenance will test and record electrolyte specific gravity for the emergency generator□s lead battery by 01/31/2025. 2. Current residents have the potential to be effected by the concern identified. 3. The Director of Maintenance will develop a calendar for monthly, quarterly and annual inspections and document when the next quarterly emergency	

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K 918	Continued From page 58 inspections. A record review revealed a 4-hour load bank test was not conducted. Documentation of the last 4-hour load bank could not be produced. An observation at 11:44 AM revealed the generator contained a lead-acid battery. In an interview at the time the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid batteries. The [redacted] confirmed that the battery was a lead-acid battery and stated that monthly testing is not conducted. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) [redacted] indicated they were unavailable for the conference. N.J.A.C 8:39-31.2(e) NFPA 70, 99, 110, 111	K 918	generator service is required so that it is scheduled timely, and the work is completed. This service will include transfer switch maintenance. The Maintenance Director will add testing of the lead batteries to the Monthly Preventative Maintenance Schedule. Testing and inspections will be documented. The outside vendor completing the emergency generator service will in-service the Administrator and the maintenance staff on the requirements of servicing and testing the emergency generator. 4, The results of the emergency generator service, including the transfer switch and the 4-hour load test, will be reported to the QAPI Committee quarterly x3 by the Maintenance Director with follow up provided as needed. The results of the electrolyte specific gravity testing will be presented to the QAPI Committee monthly x3 months by the Maintenance Director with follow up provided as needed..	
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	K 921		1/31/25

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K 921	Continued From page 59 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 observations and interviews between 11/13/2024 and 11/15/2024 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that inspection, testing, and maintenance (ITM) of patient-care-related electrical equipment (PCREE) was conducted in accordance with NFPA 99. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 11/15/2024 at 9:59 AM revealed resident room 5 contained 2 electric hospital beds. The beds did not have any current inspection stickers.	K 921	1. The Facility cannot retrospectively address this deficiency. 2. Current residents have the potential to be effected by the concern identified. 3. The Director of Maintenance will conduct an inspection of electric beds in the facility, including the bed in resident room 5, and label with a dated inspection sticker showing compliance. Resident room 5 has 2 electric beds which were inspected with stickers placed on 01/08/2025 (pictures attached). The Director of Maintenance will develop	

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K 921	Continued From page 60 In an interview at the time, the surveyor asked for ITM of the beds. The [redacted] confirmed that the beds have not been inspected and he was unaware of the requirement, but they would make sure it was done going forward. An observation at 10:24 AM revealed the electric patient bed contained an inspection sticker dated 10/2014, over 10 years ago. In an interview at the time, the [redacted] confirmed that the inspection sticker was dated 10/2014. An attempt was made to conduct a Life Safety Code exit conference at 2:30 PM on 11/15/2024. However, both the facility's U.S. FOIA (b)(6) and [redacted] indicated they were unavailable for the conference. N.J.A.C 8:39-31.2(e) NFPA 99	K 921	a calendar for quarterly and annual inspections and cleanings and add electric beds to the calendar so that they are scheduled timely, and the inspection is completed. The Consultant Administrator will educate the U.S. FOIA (b) (6) on the above listed items. Education to be completed by 01/31/2025. 4. The results of the bed inspections will be reported to the QAPI Committee when completed.	

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
315176 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	03/19/2025	LSC K0345	03/19/2025	LSC K0355	01/31/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	01/31/2025	LSC K0374	01/31/2025	LSC K0500	01/31/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	01/31/2025	LSC K0918	03/20/2025	LSC K0921	01/31/2025
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	

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	
12/5/2024	☐ 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
315176 Y1	A. Building B. Wing Y2	3/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0004	Correction	ID Prefix E0007	Correction	ID Prefix E0015	Correction
Reg. # 483.73(a)	Completed	Reg. # 483.73(a)(3)	Completed	Reg. # 483.73(b)(1)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix E0018	Correction	ID Prefix E0025	Correction	ID Prefix E0035	Correction
Reg. # 483.73(b)(2)	Completed	Reg. # 483.73(b)(7)	Completed	Reg. # 483.73(c)(8)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix E0039	Correction	ID Prefix E0041	Correction	ID Prefix	Correction
Reg. # 483.73(d)(2)	Completed	Reg. # 483.73(e)	Completed	Reg. #	Completed
LSC	01/31/2025	LSC	01/31/2025	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/5/2024	☐ 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
315176 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD 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 K0271	04/08/2025	LSC K0291	04/08/2025	LSC K0321	04/08/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0353	04/08/2025	LSC K0741	04/08/2025	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	
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/5/2024	☐ YES ☐ NO