STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315276	A. BUILDING _____ B. WING _____	02/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

(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 000	INITIAL COMMENTS Survey Dates: 02/14/23 - 02/17/23 Survey Census: 109 Sample Size: 28 Supplemental Residents: 0 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		3/31/23

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

Electronically Signed | 03/08/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure the electronic medical record (EMR) reflected the resident's code status and failed to completed a Physician's Orders for Life Sustaining Treatment (POLST) form for one (Resident (R)31) of 28 residents reviewed for code status. Findings include: Review of R303's EMR under the "Clinical" dashboard tab revealed R303 was admitted to the facility on [redacted] R303's [redacted] was not on the dashboard or on the "Face Sheet. Review of R303's "POLST" located in the EMR under the "Misc" tab revealed the "POLST" was not [redacted] Review of R303's "Care Plan" located in the EMR	F 578	1. Immediately upon notification, Director of Social Work addressed and updated Resident #303 [redacted] in the electronic medical record, as well as completed a Physician Order Life Sustaining Treatment (POLST) form for Resident #303. 2. All Residents have the potential to be affected by the alleged deficient practice of not having a code status in their electronic medical record, as well as a completed POLST form. 3. Director of Nursing/Designee conducted a facility-wide Code Status and POLST audit, no other residents were identified with a missing code status and POLST. Director of Nursing /Designee educated Director of Social Work and	

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F 578	Continued From page 2 under the "Care Plan" tab dated [Exec Order 26, 4b1] revealed there was no [Exec Order 26, 4b1 NJAC 8:43E-2.1] or [Exec Order] listed. Interview on 02/15/23 at 11:30 AM with the Director of Nursing (DON) stated that anyone who does not have an advanced directive or [Exec Order] is a FULL CODE. She confirmed R303 did not have [Exec Order 26, 4b1 NJAC] on her "Face Sheet," physician's "Orders" or "Care Plan." . Interview on [Exec Order 26, 4b1 NJAC 8:43E-2.1] R303 stated that she entered into the facility in the evening on [Exec Order 26, 4b1] and no one had discussed [Exec Order 26, 4b1 NJ] or [Exec Order 26, 4b1 NJAC] with her. Interview on 02/15/23 at 12:40 PM with Licensed Practical Nurse (LPN)1 and LPN6 confirmed upon admission they will verify resident's [Exec Order] through hospital records. If a resident did not have [Exec Order 26, 4b1 NJAC], they would contact doctor and family. They would assume the resident was full-code and would enter it into the EMR. Interview on 02/15/23 at 12:52 PM with Social Services Director (SSD) and confirmed she hadn't spoken with the resident about [Exec Order 26, 4b1 NJ] or [Exec Order 26, 4b1 NJAC], yet due to being out last week. She stated when she isn't available the nursing staff or her assistance will assist. Review of the facility's policy titled "Advanced Directives " review dated 12/2022 revealed "1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to	F 578	staff on the importance of obtaining and inputting a code status in the medical record, as well as completing a POLST. 4. Director of Nursing/Designee to conduct an audit weekly x4 weeks, monthly x2 months thereafter, to ensure Code Status and POLST are completed in their entirety. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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F 578	Continued From page 3 implement advance directives and applicable state law. 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative. about the existence of any written advance directives. 7. information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record." NJAC 8:39-4.1(a)2 NJAC 8:39-9.6(e) NJAC 8:39-35.2(d)14	F 578		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		3/31/23

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F 656	Continued From page 4 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop comprehensive plan of care that included a plan of care for [redacted] for one (Resident (R)305) of two residents reveiwed for a plan of care for [redacted] Findings include: Review of R305's "Face Sheet" located in the electronic medical record (EMR) revealed an admission date of [redacted] Review of R305's comprehensive "Care Plan"	F 656	1. Immediately upon notification, Director of Social Work conducted a care plan meeting with Resident #305 to review comprehensive plan of care, including plan of care for [redacted] 2. All Residents have the potential to be affected by the alleged deficient practice of not having a developed comprehensive plan of care, including plan of care for pain.	

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F 656	Continued From page 5 located in the EMR under the "Care Plan" tab dated [redacted] revealed no evidence of a plan of care for [redacted] Review of R305's current physician "Orders" located in the EMR under the "Orders" tab revealed an order for [redacted] at bedtime for [redacted], and an order for [redacted] Interview on [redacted] with R305's representative (RR) revealed [redacted] Interview on [redacted] with the Minimum Data Set Assistant (MDSA) stated the "Care Plans" are completed as a group effort and she is unsure why the resident was not care planned for [redacted]	F 656	3. Director of Nursing /Designee conducted a facility-wide Care Plan audit, no other residents were identified as not having a comprehensive care plan, including pain plan of care. Director of Nursing /Designee educated staff on the developing and conducting comprehensive plans of care, including plan of care for pain. 4. Director of Nursing/Designee to conduct an audit weekly x4 weeks, monthly x2 months thereafter to ensure development and composition of comprehensive care plan, including plan of care for pain. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	
F 660 SS=D	NJAC 8:39-11.2(e)2 NJAC 8:39-27.1(a)(d) Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge	F 660		3/31/23

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F 660	Continued From page 6	F 660		

rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

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F 660	Continued From page 7 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure two of three sampled residents (Resident (R)153 and R305) reviewed for discharge planning had a [redacted] related to discharge to the community. Findings include: 1. Review R153's "Face Sheet" located in the electronic medical record (EMR) revealed an admission date of [redacted]. Review of R153's initial "Care Plan" located in the	F 660	1. Immediately upon notification, Director of Social Work conducted a care plan meeting, including review of discharge planning, for Resident #153 and Resident #305. 2. All Residents have the potential to be affected by the alleged deficient practice of not having a care plan meeting, including review of discharge planning conducted. 3. Director of Nursing /Designee	

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F 660	Continued From page 8 EMR under the "Care Plan" tab revealed no Exec Orde [redacted] related to the resident's discharge to the community. Interview with R153 on 02/14/23 at 11:00 AM revealed she was Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] and had not Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] She further stated on Exec Order 26, 4b1 NJAC 8:43E-2.1 that she was due Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] She revealed she had not Exec Order 26, 4b1 NJAC 8:43E-2 [redacted] Review of the EMR under the "Progress Notes" tab for R153 revealed no note related to discharge until Exec Order 26, 4b1 N [redacted] at which time a discharge meeting was held to address the resident's discharge. Interview with Licensed Practical Nurse (LPN)5 on Exec Order 26, 4b1 NJAC 8:43E-2.1 revealed R153 was a short term stay resident. She revealed R153 had a Exec Order 26, 4b1 NJAC 8 [redacted] that needed to be Exec Order 26, 4b1 NJAC 8:43 [redacted] The appointment for the new Exec Orde [redacted] was canceled by the resident last week due to Exec Order 26, 4b1 N [redacted] and has been rescheduled for 02/28/23. Interview with the Social Services Director (SSD) on Exec Order 26, 4b1 NJAC 8:43E-2.1 confirmed there was not Exec Order 26 [redacted] for discharge for R153 and she would put one together. Interview with the Administrator and Regional Director of Clinical Services (RDCS) on 02/17/23 at 10:15 AM indicated their expectation was that a discharge Exec Order 26, 4b1 NJAC [redacted] be developed in cases of imminent discharge. 2. Review of R305's "Face Sheet" located in the	F 660	conducted a facility-wide Care Plan audit, including review of discharge planning and no other residents were identified as not having a care plan meeting, including discharge planning. Director of Nursing/Designee educated director of Social Work and staff on conducting care plan meetings, including review of discharge planning in accordance with regulation. 4. Director of Nursing/Designee to conduct an audit weekly x4 weeks, monthly x2 months thereafter to ensure care plan meetings, including review of discharge planning is occurring in accordance with regulation. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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F 660	Continued From page 9 EMR revealed an admission date of [redacted] Review of R305's comprehensive "Care Plan" located in the EMR under the "Care Plan" tab dated [redacted] revealed no evidence of a [redacted] Interview on 02/14/23 at 1:07 PM with R305's representative (RR) revealed she would like to receive assistance in getting [redacted] for her [redacted] and have him come home. Interview on 02/17/23 at 12:11 PM with the Minimum Data Set Assistant (MDSA) stated the "Care Plans" are completed as a group effort and she is unsure why R305 was not [redacted] Review of the facility policy titled "Complete Care Management Discharge Policy" dated 09/30/22 did not address a discharge plan of care. NJAC 8:39-35.2(d)16	F 660		
F 689 SS=D	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: Based on record review and interview, the facility	F 689	1. Resident #306 was maintained on one	3/31/23

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F 689	Continued From page 10 failed to ensure one resident (Resident (R)306) of one reviewed for elopement with a history of wandering and risk for elopement was provided supervision and a monitoring system in place to potentially prevent an elopement. Findings include: Review of R306's electronic medical record (EMR) under the "Diagnosis" tab revealed the resident was admitted to the facility on Exec Order 26, 4b1 with diagnoses of Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] Review of R306's "Nursing Comprehensive Assessment" located in the EMR under the "Assessment" tab dated Exec Order 26, 4b1, revealed "Resident made attempts to Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted], resident has conditions which contribute to Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] Review of R306's "Care Plan" located under the "Care Plan" tab in the EMR dated Exec Order 26, 4b1 revealed the resident had decreased safety awareness, and was at risk for Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted], Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]. Placement checked every shift and function checked daily. Review of R306's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of Exec Order 26, 4b1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of Exec Or [redacted] indicating the resident was Exec Order 26, 4b1 [redacted]. The "MDS" indicated R306 was Exec Order 26, 4b1 NJAC 8:43E-2.1	F 689	to one supervision until resident was discharged safely from facility. The fire door was confirmed locked and alarmed per regulation. 2. All Residents have the potential to be affected by the alleged deficient practice of being reviewed for elopement with a history of wandering and risk for elopement and provided supervision and monitoring system in place to potentially prevent elopement. 3. Resident #306 was discharged safely from facility. Director of Nursing/Designee conducted a facility wide audit, including review of those with a history of Exec Order 26, 4b1 NJAC 8:43E-2.1 Two residents were previously identified with Exec Order 26, 4b1 NJAC being followed. Director of Nursing/Designee educated staff on conducting review of Exec Order 26, 4b1 NJAC including those with a history of Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] that they are provided with supervision and Exec Order 26, 4b1 NJAC 8:43E-2.1 in place to prevent Exec Order 26, 4b1 NJAC Maintenance Director/ Designee educated on checking exit doors to ensure Exec Order 26, 4b1 NJAC 8:43E-2.1 fire doors are secured properly. 4. Director of Nursing/Designee to conduct an audit weekly x4 weeks, monthly x2 months thereafter to ensure all residents identified as being high risk to elope are secure and provided with monitoring, as applicable. In addition, Maintenance Director/Designee will audit exit doors to ensure wanderguard monitoring system are functioning	

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F 689	Continued From page 11 setup help. Review of R306's "Nurses Notes" located in the EMR under the "Progress Notes" tab dated [redacted] revealed "R306 with multiple and frequent attempts to [redacted] in place and functioning. Able to redirect. Staff monitoring closely for safety." At [redacted] the note revealed, "R306 [redacted] Nursing was alerted by the sound of the door alarm. Staff immediately responded to the alarm and noted that R306 was not [redacted] where he was seen approx. [approximately] 10 minutes prior. Staff exited the door and saw R306 [redacted] Staff assisted him [redacted] safely without incident. No injuries noted. skin intact. [redacted] intact and functioning on his [redacted] 1:1 [one on one] supervision immediately implemented for safety." Interview on [redacted] with R306's spouse stated she was told by the facility that she and her sons had to find placement for the resident because he cannot stay in the facility after his [redacted] She stated she was told that if she cannot find placement for the resident then she would have to hire someone to come sit with the resident 24/7 or she or her family could do it. Interview on [redacted] and observation with Maintenance Director (MD) confirmed the [redacted] where R306 [redacted] did not have a [redacted] and only the door alarms when it is opened.	F 689	properly. Negative findings to be corrected immediately and reviewed monthy at the Quality Assurance and Performance Improvement meeting.	

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	315276	A. BUILDING _____ B. WING _____	02/18/2023

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COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

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F 689	Continued From page 12 Interview on [redacted] with the Director of Nursing (DON) confirmed R306 had a [redacted] and the [redacted] did not work on all doors. She stated that she assumed the [redacted] was on all doors. She stated when the resident [redacted] they initiated one on one supervision. Interview on [redacted] with the Social Services Director (SSD) confirmed the facility gave a list of facilities to R306's [redacted] to get the resident placement and she is helping the family with finding placement. Interview on [redacted] with the Administrator stated there was a discussion about placing an [redacted] on the door but the decision was not to place it on the door. Interview on [redacted] with Registered Nurse (RN) 1 stated R306 had a [redacted] and the front door alarm alerted them when the [redacted] was near the front door, so they were able to redirect the [redacted] from opening the door and [redacted] She stated the resident [redacted] through the back door and it was not equipped to alert staff when [redacted] was near the door. RN1 further revealed the [redacted] was found on the [redacted] and brought [redacted] with no injuries. NJAC 8:39-27.1(a)	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		3/31/23

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F 697	Continued From page 13 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, and facility policy review, the facility failed to ensure one of 28 sampled residents (Resident (R) 69) reviewed for [redacted] received appropriate [redacted] assessments, [redacted] medication, and [redacted] evaluations. This had the potential for an increase in the resident's risk for [redacted] Findings include: Review of R69's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR), revealed R69 was admitted to the facility on [redacted] R69's diagnoses included [redacted] Review of R69 's "Physician's Orders" under the "Orders" tab located in the EMR dated [redacted] revealed an order for [redacted] Apply to [redacted] in the morning for [redacted] give [redacted] Review of R69's comprehensive "Care Plan" under the "Care Plan" tab dated [redacted] located in the EMR revealed " [redacted] and respond immediately to any complaint of [redacted] ... Complete [redacted] assessment on admission and per facility policy to determine the nature of the discomfort, my desired response and any previously successful strategies used.	F 697	1. Immediately upon notification, Director of Nursing conducted a [redacted] assessment and contacted Doctor and Physiatrist to adjust [redacted] medication for Resident #69. 2. All Residents have the potential to be affected by the alleged deficient practice of not receiving appropriate pain assessments, pain medication and pain evaluations. 3. Director of Nursing /Designee conducted a facility-wide Pain Management audit, no other residents were identified as not receiving appropriate pain medication, assessment, and evaluation. Director of Nursing/Designee educated staff on ensuring residents are receiving appropriate pain medication, assessment, and evaluation. 4. Director of Nursing/Designee to conduct an audit weekly x4 weeks, monthly x2 months thereafter on ensuring residents are receiving appropriate pain medication, assessment, and evaluation. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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F 697	Continued From page 14	F 697		

Evaluate the effectiveness of [redacted] interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results ..."

Review of R69's "Brief Interview for Mental Status (BIMS)" located in the "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the "Assessment" tab of the EMR, revealed R69 scored a [redacted] which indicated R69 was [redacted]

During medication pass observation on [redacted] Licensed Practical Nurse (LPN)2 said th [redacted] was not available and they were waiting for a shipment. LPN did not assess R69 for [redacted] or see if a patch was on the resident.

During an interview using a communication board and observation on [redacted] R69 did not have a [redacted] to [redacted] R69 said [redacted] was not being managed and complained of [redacted]. R69 said the [redacted] can be very bad at times. Using the numeric [redacted] scale from zero to ten [redacted]) R69 said the [redacted] has been an [redacted] at times. R69 said most days she does not get enough [redacted] especially in the morning when it is needed the most.

Review of R69s EMR revealed [redacted] assessments were not completed when R69 had an increase [redacted] or change in condition.

During a concurrent interview using a communication board and observation on [redacted], LPN6 confirmed that R69

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F 697	Continued From page 15 did not a have [redacted] on [redacted] as ordered. R69 told LPN6 that when [redacted] does not get the [redacted], she has [redacted]. LPN6 asked R69 if she was in [redacted] and R69 said [redacted]. R69 complained of [redacted] to the [redacted]. LPN6 looked in both the medication cart and the medication room but did not find R69s [redacted] During an interview on 02/15/23 at 12:30 PM LPN6 said the [redacted] was found and it was put on R69s [redacted] LPN6 also revealed nurses did not perform [redacted] assessments. During an interview on 02/16/23 at 2:01 PM the Minimum Data Set Coordinator (MDSC) said the only time [redacted] assessments are done is during the quarterly assessments. "We are in the process of changing things; the nurses should be doing monthly [redacted] assessments." During an interview on 02/16/23 at 2:17 PM the Director of Nursing (DON) stated, "It's a shame because we have [redacted] in our supply room. She [LPN2] could have put [redacted] [R69] [redacted] on. If somebody is having a change in [redacted] more than mild, we should complete a [redacted] assessment." Review of facility undated policy revealed "The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person centered care plan, and the resident's goals and preferences ... Evaluate the resident for pain upon admission, during periodic scheduled assessments, and with change in condition or ... Evaluate the resident for pain ...during periodic	F 697		

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F 697	Continued From page 16 scheduled assessments, and with change in condition ... Assess patients with pain regularly based on the facility's established intervals. If re-assessment findings indicate pain is not adequately controlled, revise the pain management regimen and plan of care as indicated ..." NJAC 8:39-27.1(a)	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		3/31/23

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F 755	Continued From page 17 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observation, and review of facility policy, the facility failed to ensure medications were available for administering as ordered to meet the needs of one (Resident (R)83) of 11 residents observed during medication pass observation. Findings include: Review of R83's "Physician's Orders" under the "Orders" tab located in the EMR dated [redacted] revealed an order for [redacted] twice a day. During medication pass observation on [redacted] AM LPN5 was unable to fine R83's [redacted] medication. LPN5 said the medication was not available and she would call the pharmacy. LPN5 said the medication was ordered and they did not receive enough medication. LPN5 said, "the medication is important since it is a [redacted]" During an interview on 02/16/23 at 12:03 PM the Director of Nursing (DON) said "We ordered the [redacted] on [redacted] and they only sent 14 and they should have sent 30. The medication was supposed to come in the overnight delivery on [redacted], but it did not." During a phone interview on 02/17/23 at 2:46 PM	F 755	1. Immediately upon notification, Director of Nursing contacted pharmacy to receive medication available as ordered for Resident #83. Once medication was received, resident #83 was administered it as ordered. 2. All Residents have the potential to be affected by the alleged deficient practice of not receiving medication available as ordered. 3. Director of Nursing /Designee conducted a facility-wide Medication availability order audit, no other residents were identified as not receiving medications available as ordered. Director of Nursing/Designee educated staff on ensuring medications are available to be administer as ordered. 4. Director of Nursing/Designee to conduct an audit weekly x4 weeks, monthly x2 months thereafter on ensuring residents medication as ordered. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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F 755	Continued From page 18 the Pharmacist said, " I can't speak to why the medications were not there, but they should be available as ordered." Review of facility's "Administrating Medications" policy dated 02/2023 revealed "Medications shall be administered in a safe and timely manner, and as prescribed ...Medications must be administered in accordance with the orders, including any required time frame ...Medications must be administered within one (l) hour of their prescribed time ...	F 755		
F 759 SS=D	NJAC 8:39-29.6(a) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure the medication error rate was less than 5 percent (%). Observation of medication administration revealed out of 26 opportunities two errors were observed resulting in a medication error rate of 7.69%. Specifically, medications were not available for two residents (Resident (R) 69 and (R) 83) out of 11 residents observed during medication pass. Findings include:	F 759	1. Immediately upon notification, Director of Nursing contacted pharmacy, received, and administered medication as ordered for Resident #83 and Resident #69. 2. All Residents have the potential to be affected by the alleged deficient practice of having a medication error, by not having a medication available. 3. Director of Nursing/Designee conducted a facility-wide Medication	3/31/23

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F 759	Continued From page 19 1. Review of R69's "Physician's Orders" under the "Orders" tab located in the electronic medical record (EMR) dated [redacted] revealed an order for [redacted] During medication pass observation and interview on 02/15/23 at 5:42 AM, Licensed Practical Nurse (LPN)2 said [redacted] was not available and they were waiting for a shipment. 2.Review of [redacted] current "Physician's Orders" under the "Orders" tab located in the EMR revealed an order for [redacted] During medication pass observation on 02/15/23 at 8:30 AM, LPN5 was unable to find [redacted] during medication pass. LPN5 said the medication was not available and she would call the pharmacy. LPN5 said the medication was ordered and they did not receive enough medication. LPN5 said, "the medication is important since it is a [redacted]." During an interview on 02/16/23 at 12:03 PM, the Director of Nursing (DON) said "We ordered the [redacted] on [redacted] and they sent only 14. The medication was supposed to come in the overnight delivery on [redacted], but it did not." During a phone interview on 02/17/23 at 2:46 PM the Pharmacist said, "I can't speak to why the medications were not there but they should be available as ordered."	F 759	availability audit, no other residents were identified as not receiving medications available as ordered. Director of Nursing /Designee educated LPN #2 and LPN #5, as well nursing staff on ensuring medications are available to administer as ordered. 4.Director of Nursing/Designee to conduct an audit weekly x4 weeks, monthly x2 months thereafter on ensuring residents medication as ordered. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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F 759	Continued From page 20 Review of facilities "Administrating Medications" dated 02/2023 revealed "Medications shall be administered in a safe and timely manner, and as prescribed ...Medications must be administered in accordance with the orders, including any required time frame ...Medications must be administered within one (l) hour of their prescribed time ..."	F 759		
F 812 SS=F	NJAC 8:39-29.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Food and Drug Administration website	F 812	1. Immediately upon notification, Food Service Director cleaned thermometer in	3/31/23

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F 812	Continued From page 21 (www.fda.gov) food guide, and facility policy review, the facility failed to ensure proper cleaning of the food thermometer between taking temperatures of different food items. This had the potential to create foodborne illness for 107 of 109 residents who consume food from the kitchen. Findings include: Observation on 02/16/23 at 11:50 AM of Cook (CK) and the Dietary Manager (DM) taking temperatures of food for the lunch meal revealed the CK took the temperature of the salisbury steak and wiped off the thermometer probe with a clean white towel and then took the temperature of the roasted chicken. Interview on 02/16/23 at 11:57 AM, the CK stated he was not educated on the cleaning the thermometer probe after each food item. Interview on 02/16/23 at 12:06 PM, the DM stated he did not educate staff on wiping the probe after taking the temperature of each food item. The DM further revealed the thermometer probe should be cleaned with an alcohol wipe between checking the temperatures of food items. Review of the FDA Food Code found at www.fda.gov revealed, equipment food-contact surfaces and utensils shall be cleaned before using or storing a food temperature measuring device, and at any time during the operation when contamination may have occurred. Review of the facility policy titled "Preventing Foodborne Illness - Food Handling" dated 10/19 revealed I. This facility recognizes that the critical	F 812	an appropriate manner. 2. All Residents have the potential to be affected by the alleged deficient practice of not having proper cleaning of the food thermometer between taking temperatures of different food items. 3. Food Service Director/Designee conducted an audit to ensure all other Kitchen thermometers are being cleaned properly between taking temperatures of different food items. No other thermometers identified as not being cleaned properly between taking temperatures of different food items. Administrator in-serviced Food Service Director and staff on the importance of ensuring proper cleaning proper cleaning of the food thermometer between taking temperatures of different food items. 4. Food Service Director/Designee to conduct an audit weekly x4 weeks, monthly x2 months thereafter to ensure thermometers are being cleaned in an appropriate manner. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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F 812	Continued From page 22 factors implicated in foodborne illness are c. Contaminated equipment. 2. With these factors as the primary focus of preventative measures, this facility strives to minimize the risk of foodborne illness to our residents. 3. All employees who handle, prepare, or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. 9. All food service equipment and utensils will be sanitized according to current guidelines and manufacturers' recommendations." NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812		

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	061612	A. BUILDING: _____ B. WING _____	02/18/2023

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency 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 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	1. No residents were immediately affected by this deficiency. 2. All residents have the potential to be affected by this deficiency. 3. The Director of Nursing/Designee will review the certified nurses aide (C.N.A.) daily staffing sheets on a daily basis for eight weeks to ensure the staffing requirements are met. The facility has advertised open jobs on online recruitment platforms as well as traditional recruitment firms. There are also signed contracts with staffing agencies. 4. The Director of Nursing or designee will	3/31/23

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

Electronically Signed | 03/08/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061612	A. BUILDING: _____ B. WING _____	02/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

(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
S 560	Continued From page 1 requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to	S 560	audit staffing levels three times a week for eight weeks. All findings will be reported and reviewed by the Quality Assurane and Performance Improvement committee monthly.	

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S 560	Continued From page 2 affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 1/29/23 and 2/05/23, revealed the following; The facility was deficient in CNA staffing for residents on 13 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -01/29/23 had 9 CNAs for 109 residents on the day shift, required 14 CNAs. -01/29/23 had 6 total staff for residents on the overnight shift, required 8 total staff. -01/30/23 had 10 CNAs for 107 residents on the day shift, required 13 CNAs. -01/31/23 had 10 CNAs for 106 residents on the day shift, required 13 CNAs. -01/31/23 had 10 total staff for 106 residents on the evening shift, required 11 total staff. -02/01/23 had 11 CNAs for 106 residents on the day shift, required 13 CNAs. -02/03/23 had 10 CNAs for 104 residents on the day shift, required 13 CNAs. -02/03/23 had 10 CNAs for 104 residents on the day shift, required 13 CNAs. -02/05/23 had 8 CNAs for 104 residents on the day shift, required 13 CNAs. -02/06/23 had 9 CNAs for 108 residents on the day shift, required 13 CNAs.	S 560		

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S 560	Continued From page 3 -02/07/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs. -02/08/23 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. -02/09/23 had 11 CNAs for 107 residents on the day shift, required 13 CNAs. -02/10/23 had 7 CNAs for 107 residents on the day shift, required 13 CNAs. -02/11/23 had 8 CNAs for 107 residents on the day shift, required 13 CNAs. -02/11/23 had 5 total staff for 107 residents on the overnight shift, required 8 total staff.	S 560		

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
315276 Y1	A. Building B. Wing Y2	4/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

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 F0578	Correction	ID Prefix F0656	Correction	ID Prefix F0660	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(c)(1)(i)-(ix)	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	03/31/2023
ID Prefix F0689	Correction	ID Prefix F0697	Correction	ID Prefix F0755	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	03/31/2023
ID Prefix F0759	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061612 Y1	A. Building B. Wing Y2	4/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/31/2023	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	
2/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315276	A. BUILDING **01** B. WING _____	**02/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	**69 MAPLE ROAD** **WEST MILFORD, NJ 07480**

(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 . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 02/18/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . BUILDING ONE OF TWO A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/18/23 and 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. Building One of Two for Complete Care at Milford Manor is a one-story building constructed in 1970. The facility has concrete flooring, steel frame roofing and bearing walls and brick exterior. Complete Care at Milford Manor Building One is noted to be a Type II (222) noncombustible construction with complete sprinkler system and complete fire alarm system with smoke detection in all bedrooms and most corridors. The facility has a 100 KW (kilowatt) natural generator that operates at 30% load when tested. The facility has 109 occupied beds. The building has four smoke zones. BUILDING TWO OF TWO A Life Safety Code Survey was conducted by the	K 000		

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Electronically Signed		03/08/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 New Jersey Department of Health, Health Facility Survey and Field Operations on 02/18/23 and 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. Building Two of Two for Complete Care at Milford Manor is also a one-story building completed in 1997. This building has concrete flooring with wood frame roofing and bearing walls and is separated by the fire wall at two locations where the buildings connect or at bedroom 231 and bedroom 123. This building has two smoke zones. .	K 000		
K 291 SS=F	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. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure emergency lighting was provided for the generator transfer switch in accordance with NFPA 101 "Life Safety Code" (2012 edition) 7.9.2.4. and NFPA 110 "Standard for Emergency and Standby Power Systems" (2010 edition) sections 7.3.1 and 7.3.2. This deficient practice had the potential to affect all 109 residents. Findings include:	K 291	1. Upon Notification, Maintenance Director contacted vendor who installed a battery-operated emergency lighting for the transfer switch. 2. All Residents have the potential to be affected by the alleged deficient practice of not having a battery-operated emergency lighting for the transfer switch. 3. Maintenance Director contacted vendor	3/31/23

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K 291	Continued From page 2 An observation on 02/18/23 at 10:40 AM revealed the electrical room, which contained one generator transfer switch, lacked battery operated emergency lighting for the transfer switch. An interview with the Maintenance Director at the time of the observation confirmed the electrical room, which contained the transfer switch, lacked battery powered emergency lighting and stated he was not aware of the requirement. NJAc 8:39-31.2(e) NFPA 99, 110	K 291	who installed a battery-operated emergency lighting for the transfer switch. Administrator in serviced Maintenance Director on the requirement for having a battery-operated emergency lighting for the transfer switch. 4. Maintenance Director/Designee to conduct a monthly audit to ensure the battery-operated emergency lighting for the transfer switch is in good working order. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	
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 observation, record review and interview, the facility failed to complete a smoke detection sensitivity test for all 99 photo electric smoke detectors in the past two years in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2. This deficient practice had the	K 345	1. Upon notification, Maintenance Director contacted alarm company to conduct a full sensitivity test, as well as installed two smoke heads in the corridor for bedrooms 216 and 218. 2. All Residents have the potential to be affected by the alleged deficient practice	3/31/23

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K 345	Continued From page 3 potential to affect all 109 residents. A review of fire safety records from the black binder titled "Contracts/Environmental" at the "fire alarm" tab and provided by the Maintenance Director revealed the most recent fire alarm inspections titled "Record of Inspection and Testing" and "Inspection and Testing" respectively on 12/19/22, 10/25/22, 04/20/22, 10/11/21, 04/06/21 and 10/19/20 did not include a smoke detection sensitivity test. An observation on 02/18/23 from 9:00 AM to 11:40 AM revealed the facility had smoke detection in nearly all corridors and bedrooms. The corridor for bedrooms 216 and 218 extended 50 feet and did not have smoke detection. An interview with the Maintenance Director on 02/18/23 at 3:45 PM, he confirmed he did not have the sensitivity test from the past two years and stated he thought the smoke detectors had been tested for sensitivity. He further stated the facility did not have a self-testing fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	of not having a complete smoke detection sensitivity test for all photo electric smoke detectors, as well smoke detector installed correctly. 3. Alarm Company came to Facility and conducted a full sensitivity test, as well as installed two smoke heads in the corridor for bedrooms 216 and 218. All well and in good working order. Administrator/Designee in-serviced Maintenance Director regarding conducting a full sensitivity test every two years, as well as ensuring smoke detectors are installed correctly. maintenance Director created a calendar to ensure testing is completed as scheduled. 4. Maintenance Director/Designee to ensure a full sensitivity test is conducted every two years, as applicable. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		4/19/23

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K 351	Continued From page 4 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: . Based on observations, record review, and interviews, the facility failed to ensure two Sunrooms were protected with automatic sprinkler systems in accordance with NFPA 13 Standard for Installation of Sprinkler Systems (2010 edition) Section 8.1.1.(1). This deficient practice had the potential to affect 13 residents in one of six smoke zones . Findings include: An observation of the Sunroom, located off of the main dining room, on 02/18/23 at 10:00 AM revealed the room measured approximately 33 feet long by 15 feet wide and did not have fire sprinkler coverage. The room was constructed of partial drywall ceiling with electrical wiring and plexiglass with metal framing. The room contained two upholstered chairs and three upholstered couches, one table with three wooden chairs and one large wooden bookcase and other combustible items.	K 351	1. Upon notification, Maintenance Director contacted vendor to install sprinkler heads in the Sunroom located off main dining room and Sunroom located off the Dayroom on Side 2. Facility filed permits to address the work needed. 2. All Residents have the potential to be affected by the alleged deficient practice of not having sprinkler heads installed in Sunroom located off main dining room and sunroom located off the Dayroom Side 2. 3. Facility filed permits to address the work needed. Vendor to install sprinkler heads in the Sunroom located off main dining room and Sunroom located off of the Dayroom on Side 2. Administrator in-serviced Maintenance Director regarding ensuring sprinkler heads are installed in accordance with regulation. 4. Maintenance Director/Designee to	

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K 351	Continued From page 5 An observation of the Sunroom, located off of the Dayroom near bedroom 215, on 02/18/23 at 10:25 AM revealed the room measured 27 feet long by nine feet wide and did not have fire sprinkler coverage. The room ceiling was constructed of drywall with wiring and plexiglass with metal framing. The room contained wooden chairs and tables and other combustible items. A review of the facility sprinkler records located in a black binder titled Contract/Environmental" and provided by the Maintenance Director revealed under the tab "Sprinklers" a sprinkler report titled "Sprinkler-Annual" dated 09/30/22. Under the second category on page one of the sprinkler report and in a section noted as "to be answered by inspector with the question" "have the sprinkler systems been extended to all areas of the building" with the answer "No". An interview with the Maintenance Director at the time and date of the observations verified the two areas lacked sprinkler coverage. He informed the local fire marshal stated sprinklers were not required in those areas. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 .	K 351	ensure that vendor conducts a full sprinkler inspection bi-annually. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	
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,	K 353		4/19/23

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COMPLETE CARE AT MILFORD MANOR LLC	**69 MAPLE ROAD** **WEST MILFORD, NJ 07480**

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K 353	Continued From page 6 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: . Based on observation, record reviews, and interview, the facility failed to inspect and test the 10,000 gallon exterior sprinkler water tank in accordance with NFPA 25 (2011 edition) Inspection, Testing and Maintenance of Water Based Fire Protection Systems, table 9.1.1.2. and 9.2.1 through 9.2.7. This deficient practice had the potential to affect all 109 residents. Findings include: An observation on 02/18/23 at 10:50 AM revealed the 10,000 gallon exterior water tank used for sprinkler coverage for inside the nursing facility was without a shelter and was covered in a thin layer of insulation to prevent freezing. A review of the specifications/installation information provided by the Maintenance Director revealed the tank was installed on 11/11/94 and constructed of welded steel. It contained an interior of epoxy B in accordance with NFPA 22. An electric heater was factory installed to	K 353	1. Upon notification, Maintenance Director contacted vendor to inspect and test the 10,000-gallon exterior sprinkler water tank. 2. All Residents have the potential to be affected by the alleged deficient practice of not having the 10,000-gallon exterior sprinkler water tank. 3. Facility contacted vendor to conduct: air pressure inspection, heating system inspections, water temperature inspection, exterior inspection, interior inspection, and tests, as well as routine maintenance of the air compressor supplying the tank with air pressure. Administrator in-serviced Maintenance Director regarding ensuring inspection and testing of the 10,000-gallon exterior sprinkler water tank is conducted in accordance with regulation. 4. Maintenance Director/Designee to ensure that vendor conducts an	

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	315276	A. BUILDING **01** B. WING _____	**02/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	**69 MAPLE ROAD** **WEST MILFORD, NJ 07480**

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K 353	Continued From page 7 maintain water temperatures. Interview with the Maintenance Director on 02/18/23 at 2:15 PM revealed he had no records for any service performed on the sprinkler water tank. When asked if he had maintenance records for inspection of the sprinkler water tank such as water level inspections as required in 9.2.1, air pressure inspections as required in 9.2.2, heating system inspections as required in 9.2.3. and water temperature inspections as required in 9.2.4, he stated he did not have records of those inspections. The Maintenance Director also could not provide records of an exterior inspection as required quarterly in 9.2.5.1 and interior inspection every five years as in 9.2.6.1 as well as conduct tests during the interior inspection as required in 9.2.7. He also had no records of routine maintenance of the air compressor supplying the tank with air pressure. A review of a report titled "sprinkler inspection-quarterly dated 12/16/22 from the "Contracts/Environmental" black binder provided by the Maintenance Director revealed under "Other Deficiencies" a statement to "have water level temperature air pressure devices repaired for water tank. Tamper device on control valve needs to be rewired. It reports as a pull station while in the proper position and does not report when closed. Water flow reports as a pull station. Central station did not receive any signals." The reports on such deficiencies date back to 06/29/18. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 .	K 353	inspection and testing of the 10,000 -gallon exterior sprinkler water tank, monthly, with the interior inspection being conducted every five years. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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K 363	Continued From page 8	K 363		
K 363 SS=E	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 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	K 363		3/31/23

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K 363	Continued From page 9 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: . Based on observations and interview, the facility failed to ensure two corridor doors were capable of resisting the passage of smoke in accordance with NFPA 101 "Life Safety Code", (2012 edition) section 19.3.6.3.1. This deficient practice had the potential to affect 11 residents in one of six smoke zones. Findings include: An observation of the corridor door for Room 109 on 02/18/23 at 9:35 AM revealed the door was missing over one foot section of veneer at the bottom corner with large chips and gaps of one and one quarter inch which allowed for smoke to pass through the end of the door. An observation of the staff dining room door, located off of the service corridor near the kitchen, on 02/18/23 at 9:55 AM revealed the door was missing the latching mechanism and was ajar and did not close and latch when the Maintenance Director attempted to close and latch the door. An interview with the Maintenance Director on 02/18/23 at 3:45 PM revealed he had suggested to the administrative staff that many of the corridor doors in the building need to be replaced. NJAC 8:39-31.1(c), 31.2(e)	K 363	1. Upon notification, Maintenance Director repaired the two identified corridor doors needing resistance of the passage of smoke, as well as repair the latching mechanism to staff dining room door located of the kitchen to ensure latching mechanism is functional. 2. All Residents have the potential to be affected by the alleged deficient practice of not having the corridor doors capable of resisting the passage of smoke in accordance with NFPA 101 Life Safety Code, as well as one door not having a functional latching mechanism. 3. Maintenance Director repaired the two identified corridor doors needing resistance of the passage of smoke, as well as repair the latching mechanism to staff dining room door located of the kitchen to ensure latching mechanism is functional. Administrator in-serviced Maintenance Director regarding ensuring corridor doors are capable of resisting the passage of smoke, as well as ensuring latching mechanisms are functional, as applicable. 4. Maintenance Director/Designee to conduct a monthly audit to ensure corridor doors are capable of resisting the passage of smoke, as well as a monthly audit on ensuring latching mechanisms are functional, as applicable. Negative	

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K 363	Continued From page 10	K 363	findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous from the floor to the ceiling in accordance with NFPA 101 Life Safety Code (2012 edition) Section 8.5.2. This deficient practice had the potential to affect all 109 residents. Findings include: An observation of a smoke barrier wall, located at bedroom 211, on 02/18/23 at 11:10 AM revealed	K 372	1. Upon notification, Maintenance Director contacted vendor to ensure restricting the transfer of smoke and smoke barriers were continuous form floor to ceiling. 2. All Residents have the potential to be affected by the alleged deficient practice of not having restricted transfer of smoke and smoke barriers continuous form floor to ceiling. 3. Vendor ensured all identified areas were addressed to ensure smoke barriers were protected by a system or material	3/31/23

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K 372	Continued From page 11 an unsealed opening three inches in diameter measured by the Surveyor and Maintenance Director in the dry wall with red wire running through the opening . An observation of the fire/smoke barrier wall, located at bedroom 231 and above the ceiling tile, on 02/18/23 at 11:20 AM revealed a six inch gap at the top of the concrete wall to the decking/roof above. In addition to the corridor, this gap continued across the concrete wall above the ceiling tile on both sides of the cross corridor doors into adjoining rooms leading to the exterior walls. In the women's locker room, which lead to the exterior wall, an eight inch long by six inches wide unsealed opening was observed in the concrete block wall above the ceiling tile. In the nursing supply room, located on the same wall and above the ceiling tile, there were large gaps two inches in diameter around a sprinkler pipe with large sections of cracked and dislodged sections of concrete block wall. Also, throughout this concrete wall, fire foam was used to fill gaps and holes. The fire foam container was not available for review to determine the fire rating provided by the product. All areas were measured by the Surveyor and Maintenance Director. An observation of the fire/smoke barrier, located at bedroom 125, above the ceiling tile and the cross corridor doors, on 02/18/23 at 11:30 AM revealed a large section of broken, cracked, and missing block wall which measured two feet long by three feet wide below the sprinkler line. The area was partially filled with fire foam. Some sections of the opening were not sealed. An observation of the smoke barrier wall, located	K 372	capable of restricting transfer of smoke barriers continuous from floor to ceiling. Administrator in-serviced Maintenance Director regarding ensuring restricting the transfer of smoke and smoke barriers were continuous form floor to ceiling. 4. Maintenance Director/Designee to conduct a quarterly audit of all smoke barriers to ensure protection by a system of material capable of restricting transfer of smoke and smoke barriers were continues from the floor to ceiling. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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K 372	Continued From page 12 at the conference room above the ceiling tiles and the cross corridor doors, on 02/18/23 at 11:40 AM revealed three unsealed openings in the dry wall which measured two inches in diameter with blue wires, conduit and phone wires penetrating each opening on both sides of the barrier. An interview with the Maintenance Director at the time of each observation of the smoke barrier/fire barrier walls noted above, he stated that in his 10 years at the facility, no one had looked at the fire/smoke barrier walls. He stated many of these issues and unsealed openings were present before he began working at the facility. NJAC 8:39-31.1(c), 31.2(e) .	K 372		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to ensure fire drills included the transmission of the fire alarm signal and	K 712	1. Upon Notification, Maintenance Director contacted vendor to conduct fire drills including transmission to the fire alarm signal an simulation of emergency	3/31/23

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K 712	Continued From page 13 simulation of emergency fire conditions for six of the most recent 12 fire drills in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.1.4. This deficient practice had the potential to affect all 109 residents. Findings include: A review of the fire safety records from a black binder labeled "Contracts/Environmental" provided by the Maintenance Director under the "Fire Drills" tab revealed fire drills were conducted by an outside contractor on 11/08/22 at 6:34 PM verbal only, 10/26/22 at 9:00 AM verbal only, 08/08/22 at 3:36 PM simulated (no alarm test), 05/27/22 at 7:10 PM verbal only-staff in-service, 04/13/22 at 8:55 AM not applicable, and 01/18/23 at 8:30 AM verbal only and lacked a notation for the transmission of the fire alarm signal. The question posed on the form titled "[Vendor Name], Record of Fire Drill" (undated) was "was alarm audible throughout the facility?" The response from the question is noted above after the date and time of the fire drill. An interview with the Maintenance Director on 02/18/23 at 2:15 PM revealed a private company conducted the fire drills. He stated he was not aware of the requirement to test the fire alarm with the fire drill. A review of the facility fire plan as part of the emergency preparedness policy, no title or date of the policy, located in the red binder titled "Emergency Preparedness Policy" provided by the Maintenance Director revealed the plan did not address the need for testing the fire alarm signal or documenting the test.	K 712	fire conditions. 2. All Residents have the potential to be affected by the alleged deficient practice of not having fire drills conducted including transmission to the fire alarm signal an simulation of emergency fire conditions. 3. Vendor conducted fire drills on all three shifts including transmission to the fire alarm signal an simulation of emergency fire conditions. Administrator in-serviced Maintenance Director regarding ensuring fire drills including transmission to the fire alarm signal an simulation of emergency fire conditions are conducted. 4. Maintenance Director/Designee to conduct monthly fire drills including the transmission to the fire alarm signal an simulation of emergency fire conditions. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	

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K 712	Continued From page 14 NJAC 8:39-31.2(e), 31.6(b) .	K 712		
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: . Based on observation, record review and interviews, the facility failed to ensure space heaters used in offices did not exceed temperatures of 212 degrees Fahrenheit in accordance with NFPA 101 Life Safety Code (2012 edition) , section 19.7.8.(2). This deficient practice had the potential to affect 11 residents in one of six smoke zones. Findings include: An observation of the Minimum Data Set (MDS) nurse's office, located near bedroom 220, on 02/18/23 at 9:55 AM revealed a small electric space heater was lying face down on the carpet under a desk. The space heater had a warning label on the top to "keep combustibles three feet from front of heater." The maximum temperature rating was not available. An interview with the Maintenance Director at the time of the observation he stated the staff know not to bring space heaters into the building. He	K 781	1. Upon notification, Maintenance Director immediately removed the space heater. 2. All Residents have the potential to be affected by the alleged deficient practice of facility failure to ensure space heaters used in offices did not exceed temperatures of 212 degrees Fahrenheit. 3. The space heater was removed immediately. Administrator in serviced Director of Maintenance and all staff regarding of ensuring no usage of space heaters in the facility. 4. Maintenance Director/Designee to conduct weekly x4 weeks, monthly thereafter to ensure no space heaters are in use. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance Performance Improvement meeting.	3/31/23

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K 781	Continued From page 15 stated he did not know the heater was there or if the heater reached 212 degrees Fahrenheit or warmer. He also stated the staff are required to allow him to inspect all electrical appliances before being brought into the facility and before using. An interview with the Director of Nursing and Maintenance Director on 02/18/23 at 3:00 PM revealed the facility does not have a policy for use of space heaters, space heater temperature ratings or where the devices can be used. NJAC 8:39-31.2(e), 31.7(f) .	K 781		

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
315276 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

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 K0291	03/31/2023	LSC K0345	03/31/2023	LSC K0351	04/19/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	04/19/2023	LSC K0363	03/31/2023	LSC K0372	03/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0712	03/31/2023	LSC K0781	03/31/2023	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?
2/18/2023	☐ YES ☐ NO