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 _____	**04/21/2023**

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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 04/14/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/14/23 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. 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 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 does not have load test information available for the natural gas generator. The facility has 114 occupied beds. The facility has 10 smoke zones.	K 000		
K 271 SS=E	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	K 271		5/23/23

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

Electronically Signed | 05/11/2023

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K 271	Continued From page 1 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. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to ensure it provided a hard packed, all-weather transfer in accordance with Survey and Certification letter 05-38 for eight of 16 exit discharges. This deficient practice had the potential to affect 66 of 114 residents. Findings include: An observation of two exit discharges off the Physical Therapy room on 04/14/23 at 9:20 AM revealed the exit discharge led to a concrete landing and surrounding gate. The exit gate did not open, and a small, elevated path was present overgrown completely with grass and very little noticeable gravel. The path was not a hard packed all weather path leading to the public way. The path was so overgrown with grass and weeds that one could not determine where the path led or if it extended to a second grass path 50 yards away. Each exit door had an illuminating sign above it that read "Exit." A review of the floor plan hanging on the wall in the corridor revealed each door was diagramed as a designated exit. An observation of the [redacted] dayroom near bedroom [redacted] on 04/14/23 at 10:00 AM revealed the exit discharge led to a grass surface to another large grass surface 30 yards away. Neither the surface leading from the exit discharge or the secondary surface leading to the larger path were hard packed all weather	K 271	1. The facility is requesting a time-limited waiver. The estimated completion date is 8/31/2023. The surfaces identified as not having a hard packed surface were inspected. Proposals for the work will be obtained and reviewed. The gates that were deemed inoperable were repaired by maintenance on 4/19/23. All other exit surfaces were inspected. Debris was removed. 2. Facility needs additional time to obtain proposals for work to be completed and for the surfaces to be installed. All exit surfaces were checked for hard packed all-weather travel surfaces. 3. The facility will ensure that hard packed surfaces are free of debris. The staff will be in-serviced on utilizing the exits that are readily accessible to the access road. The staff will be in-services by the Maintenance Director during fire drils regarding the presense of upgraded exit surfaces. 4. The maintenance director will randomly audit any changes regarding the change in the exit surfaces monthly for three months and report findings at the monthly QAPI meetings. The completion date for the POC is 5/23/2023.	

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K 271	Continued From page 2 surfaces leading to the public way. No path was visibly present. The path was so overgrown with grass and weeds that one could not determine where the path led or if it extended to a second grass path thirty yards away. The exit door had an illuminating sign above it that read "Exit." The door was diagramed on the floor plan hanging on the wall in the corridor as a designated exit. An observation of the [redacted] exit discharge near the above-mentioned Physical Therapy and bedroom [redacted] on 04/14/23 at 10:10 AM revealed the exit led to a small concrete landing to a surrounding gate. The exit gate did not open, and a small, elevated path was present overgrown completely with grass and very little noticeable gravel. The path was not a hard packed all weather path leading to the public way. The path was so overgrown with grass and weeds that one could not determine where the path led or if it extended to a second grass path 50 yards away. Each exit door had an illuminating sign above it that read "Exit." Each door was diagramed on the floor plan hanging on the wall in the corridor as a designated exit. An observation of the exit discharge on Cedar near bedroom [redacted] on 04/14/23 at 10:35 AM revealed the exit opened to a large concrete courtyard leading to a gate and fence. The gate was inoperable and led to a grass surface that was not a hard packed all weather surface leading to the public way. From the gate to the main surface was completely covered with grass. No path was visibly present. The path was so overgrown with grass and weeds that one could not determine where the path led or if it extended to a second grass path 50 yards away. The exit door had an illuminating sign above it that read	K 271		

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K 271	Continued From page 3 "Exit." The door was diagramed on the floor plan hanging on the wall in the corridor as a designated exit. An observation of the [redacted] dayroom exit discharge near bedroom [redacted] on 04/14/23 at 10:40 AM revealed a small concrete landing leading to a totally enclosed area with a three-foot-high fence without a hard packed all weather surface leading to the public way. The path was so overgrown with grass and weeds that one could not determine where the path led or if it extended to a second grass path 30 yards away. The exit door had an illuminating sign above it that read "Exit." The door was diagramed on the floor plan hanging on the wall in the corridor as a designated exit. An observation of the [redacted] exit discharge near bedroom [redacted] on 04/14/23 at 11:05 AM revealed a large concrete courtyard leading to a gate and fence. The gate was inoperable and led to a grass surface that was not a hard packed all weather surface leading to the public way. From the gate to the main surface was completely covered with grass. No path was visibly present. The path was so overgrown with grass and weeds that one could not determine where the path led or if it extended to a second grass path 50 yards away. The exit door had an illuminating sign above it that read "Exit." The door was diagramed on the floor plan hanging on the wall in the corridor as a designated exit. An observation of the [redacted] dayroom exit discharge near bedroom [redacted] on 04/14/23 at 11:10 AM revealed a large concrete courtyard leading to a gate and fence. The gate was inoperable and led to a grass surface that was not a hard packed	K 271		

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K 271	Continued From page 4 all weather surface leading to the public way. From the gate to the main surface was completely covered with grass. No path was visibly present. The path was so overgrown with grass and weeds that one could not determine where the path led or if it extended to a second grass path 50 yards away. The exit door had an illuminating sign above it that read "Exit." The door was diagramed on the floor plan hanging on the wall in the corridor as a designated exit. In addition, 12 exit discharge areas leading from the sidewalk to the public way path as observed from 9:20 AM to 11:30 AM on 04/14/23 revealed no hard packed surface extending over 200 yards. The paths were full of tree debris, grass, and branches from trees above. This includes exit discharges near bedrooms 57, two exits in Physical Therapy, bedrooms 56, 51, 44, 29, 27, 2, 20, 12 and 71. An interview with the Maintenance Director on 04/14/23 at 3:00 PM indicated the surfaces were present when he started the job three months ago. He stated he knew nothing about the past as to what was done or why. Interview with the Administrator on 04/14/23 at 3:45 PM indicated the surfaces have been this way for years. The Administrator stated, "We were told by New Jersey health department that our current exit discharge surfaces were acceptable as long as an ambulance could access the area and pick up residents in the event of an emergency." NJAC 8:39-31.2(e)	K 271		
K 281 SS=E	Illumination of Means of Egress	K 281		5/23/23

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K 281	Continued From page 5 CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to ensure that illumination of the means of egress including exit discharge was in accordance with NFPA 101 (2012 edition) Life Safety Code, sections 7.8.1.1. and 7.8.1.4. This deficient practice had the potential to affect 49 residents. Findings include: An observation of the exit discharge on [redacted] on 04/14/23 at 10:10 AM near bedroom [redacted] revealed illumination of one emergency light. There was no additional lighting in the area if one light bulb failed. An observation of the exit discharge on [redacted] on 04/14/23 at 10:35 AM near bedroom [redacted] revealed no emergency lighting. There was no additional lighting in the area. An observation of the exit discharge on 04/14/23 at 11:05 AM near bedroom [redacted] on [redacted] revealed no emergency lighting. There was no additional lighting in the area. An observation of the exit discharge on 04/14/23 at 11:10 AM near bedroom [redacted] revealed no	K 281	1. The facility is requesting a time-limited waiver. The estimated date of completion is 6/30/24. The Maintenance Director will assess the lighting on the exterior of the building to ensure adequate lighting is in place and illuminated automatically. Quotes will be obtained for installation of additional lighting fixtures on the exterior of the building. 2. The Facility needs more time to install new emergency lighting which includes obatining proposals, permits and rewiring. All residents may affected by the deficient practice. 3. Staff will be educated on the new emergency lighting at the annual disaster drills. Additional lighting will be supplied to the units including flashlights, lanterns, and head lamps. 4. The Maintenance Director will monitor that all exterior lighting is illuminated at appropratie times one (1) time weekly for three (3) months. Any concerns will be addressed. Results will be reported at the monthly QAPI meetings for three (3)	

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K 281	Continued From page 6 emergency lighting. There was no additional lighting in the area. An observation of the exit discharge on 04/14/23 at 11:30 AM near bedroom [redacted] revealed illumination of one emergency light. There was no additional lighting in the area if one light bulb failed. In addition, [redacted] exit discharge area leading from the sidewalk to the public way path as observed from 9:20 AM to 11:30 AM on 04/14/23 revealed no illumination for the entire path extending over 200 yards. This includes exit discharges near bedrooms [redacted], two exits in Physical Therapy, bedrooms NJ EX Order. 264b1 and [redacted]. An interview with the Maintenance Director at the time of each observation verified the lighting in each area noted. He went on to state the area at the back of the building above had no lighting. An interview with the Administrator on 04/14/23 at 3:45 PM indicated that she was aware of the problem but running electricity to area would be difficult.	K 281	months. The completion date for the POC will be 5/23/2023.	
K 321 SS=E	NJAC 8:39-31.2(e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be	K 321		6/5/23

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K 321	Continued From page 7 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 with facility staff, the facility failed to ensure that two of three hazardous area soiled linen room doors self-closed in accordance with NFPA 101 (2012 edition) Life Safety Code, section 19.3.2.1.3. This deficient practice had the potential to affect 44 of 114 residents. Findings include: An observation of the soiled linen room door on the Dogwood unit near bedroom 64 on 04/14/23 at 9:40 AM revealed when opened three times by facility staff, the soiled linen room door would not self-close. The door became stuck in the frame	K 321	1. The soiled linen room doors were repaired by the maintenance staff to ensure that the automatically closed properly. 2. All resident have the potential to be affected by the deficient practive. 3. The Maintenance Director educated maintenance personnel on the importance of the solied linen doors closing properly. 4. The Maintenance Director will complete rounds one (1) time weekly to ensure that all soiled linen doors	

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K 321	Continued From page 8 and was ajar. The room contained hazardous storage in the form of two 33-gallon soiled linen containers and one 75-gallon soiled linen container. An observation of the soiled linen room door on the Cedar unit near bedroom 37 on 04/14/23 at 10:50 AM revealed when opened three times by facility staff, the soiled linen room door would not self-close. The door became stuck in the frame and was ajar. The room contained hazardous storage, one 75-gallon container of soiled linen and one 33-gallon container of trash storage. An interview with the Maintenance Director at the time of both observations indicated the door frames had too much paint causing the door to stick in the frame and remain ajar. NJAC 8:39-31.2(e)	K 321	authomatically close a required. Audits will be completed for three (3) months. All results will be reviewed at the monthly QAPI meeting for three (3) months.	
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	K 363		6/5/23

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K 363	Continued From page 9 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 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to ensure that corridor bedroom doors were without impediments to closing and resist fire for 20 minutes in accordance with NFPA (2012 edition) Life Safety Code, section 19.3.6.3.1. The deficient practice had the potential to affect 34 of 114 residents. Findings include: An observation on 04/14/23 at 11:15 AM revealed bedroom [redacted] corridor door when closed by facility staff had an impediment to closing and did not resist fire for 20 minutes. When closed by staff, the door became stuck on the floor.	K 363	1. The resident room doors are being inspected and repaired by the maintenance staff to ensure that the close properly. 2. All resident have the potential to be affected by the deficient practive. 3. The Maintenance Director educated maintenance personnel on the importance of the residents doors closing properly. 4. The Maintenance Director will complete rounds one (1) time weekly on 5 resident room to ensure that all resident	

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K 363	Continued From page 10 An observation on 04/14/23 at 11:25 AM revealed bedroom 16 corridor door when closed by staff had an impediment to closing and did not resist fire for 20 minutes. When closed by staff, the door would not latch into the frame. An interview with the Maintenance Director at the time of each observation verified the condition of both doors as not resisting fire for 20 minutes and having impediments to closing. He also indicated he has not checked the doors for impediments or latching recently and has no documentation of any checks. NJAC 8:39-31/1(c), 31.2(e)	K 363	doors close as required. Audits will be completed for three (3) months. All results will be reviewed at the monthly QAPI meeting for three (3) months and as needed.	
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 with staff, the facility failed to ensure that seven of nine smoke barrier walls were continuous from floor to	K 372	1. All smoke barriers with pentration holes will be repaired with Fire Barrier Sealant.	6/5/23

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K 372	Continued From page 11 floor in accordance with NFPA 101 (2012 edition) Life Safety Code section 8.5.2.1. This deficient practice had the potential to affect 64 of 114 residents. Findings include: An observation of a smoke barrier wall near bedroom [redacted] on [redacted] on 04/14/23 at 11:30 AM revealed the decking ridges at the top of the smoke wall at the roof were not sealed for an eight-foot-wide section above the ceiling tile at the cross-corridor doors. An observation of a smoke barrier wall near bedroom [redacted] on [redacted] on 04/14/23 at 11:35 AM revealed the decking ridges at the top of the smoke wall at the roof were not sealed for an eight-foot-wide section above the ceiling tile and cross-corridor doors. An observation of a smoke barrier wall near bedroom [redacted] on [redacted] on 04/14/23 at 11:40 AM revealed the decking ridges at the top of the smoke wall at the roof were not sealed for an eight-foot-wide section above the ceiling tile and cross-corridor doors. An observation of a smoke barrier wall near bedroom [redacted] on [redacted] on 04/14/23 at 12:10 PM revealed the decking ridges at the top of the smoke wall at the roof were not sealed for an eight-foot-wide section above the ceiling tile and cross-corridor doors. In addition, four holes the size of one quarter each with blue wiring passing through were observed not sealed. An observation of a smoke barrier wall near bedroom [redacted] on [redacted] on 04/14/23 at 12:15 PM	K 372	2. All residenmts have the potential to be affected the concern. 3. The Maintenance Director educated the maintenance staff on inspection of fire barriers. 4. The Maintenace Director will inspect all fire barriers monthly for three (3) months. Findings will be reported at the monthly QAPI meeting for 3 months and as needed.	

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	315176	A. BUILDING **01** B. WING _____	**04/21/2023**

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
K 372	Continued From page 12 revealed a gray tube penetrating the wall the size of a softball. The tube had wires passing through and extended through the other side of the wall. The inside of the tube was not sealed. An observation of a smoke barrier wall near bedroom [redacted] on Birch on 04/14/23 at 12:20 PM revealed the decking ridges at the top of the smoke wall at the roof were not sealed for an eight-foot-wide section above the ceiling tile and cross-corridor doors. An observation of a smoke barrier wall near bedroom [redacted] on [redacted] on 04/14/23 at 12:30 PM revealed the decking ridges at the top of the smoke wall at the roof were not sealed for an eight-foot-wide section above the ceiling tile and cross-corridor doors. In addition, a hole the size of a baseball passed through the wall and was not sealed. An interview with the Maintenance Director at the time of each observation verified the conditions noted.	K 372		
K 741 SS=E	NJAC 8:39-31.1(c), 31.2(e) 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	K 741		6/5/23

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	315176	A. BUILDING **01** B. WING _____	**04/21/2023**

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K 741	Continued From page 13 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, interviews, and policy review, the facility failed to ensure safe ash trays and a metal self-closing container were provided in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.4. This deficient practice had the potential to affect all 13 smokers. Findings include: Observation of the smoking area, in the main courtyard, on 04/14/23 at 10:20 AM, revealed two residents in the smoking area, one of which was smoking without a safe ash tray. Resident 99 (R99) was flicking his ashes in the air as he sat in his wheelchair. A plastic planter full of disposed of cigarette butts was within arms reach on the nearby table. No other items resembling an ash tray were available. When asked for the ash tray, R99 motioned to the planter full of disposed	K 741	1. The plastic planter was removed and discarded. Ashtrays were purchased and put in the courtyard for residents' use. 2. All residents have the potential to be affected. 3. The Maintenance Director and Recreation Director educated the residents who smoke on proper disposal of cigarettes in ashtrays. The Recreation Director educated the recreation staff on montoring the smokes when in the smoking area. 4. Maintenance Director will monitor the smoking area one (1) time weekly to ensure residents are utilizing proper smoking disposal recepticles. All concern	

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	315176	A. BUILDING **01** B. WING _____	**04/21/2023**

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K 741	Continued From page 14 cigarette butts and ashes. Further observation of the smoking area on 04/14/23 at 10:20 AM revealed no self-closing metal container available to dump the cigarette butts into from the ash trays after smoking. The Maintenance Director was unable to locate a self-closing metal can. An interview with the Activity Assistant on 04/14/23 at 10:20 AM, revealed he did not know about smoking and was only talking to the residents in the area. He indicated he was not responsible for their supervision. An interview with the Activity Director on 04/14/23 at 10:40 AM in charge of the smoking program indicated she holds cigarettes and lighters for those deemed not safe, but the others are allowed to keep lighters and cigarettes if they are deemed safe. Those not assessed as safe are supervised, those that are safe can smoke at will. An interview with the Administrator on 04/14/23 at 3:45 PM indicated the R99 smokes independently. She also stated all residents are assessed for smoking and using a lighter. R99 is an independent smoker and does not require supervision. She indicated the designated smoking area is the main courtyard. An interview with the Maintenance Director on 04/14/23 at 10:30 AM verified the condition of the area and residents smoking without ash trays and without the use of a self-closing metal can. A review of the facility policy titled "Smoking Policy for Residents" dated revised on 10/22 retrieved off the computer from the Administrator	K 741	will addressed and results will presented at the monthly QAPI meetings for three (3) months.	

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K 741	Continued From page 15 revealed the policy lacked references to safety while smoking such as safe use of ash trays at all times, extinguishing cigarettes in ash trays only, disposing of all ashes and cigarette butts when finished smoking, and how, when, and where to dispose of such cigarette butts. The policy also lacked a reference to final disposal of all cigarette butts at the end of the day or smoking session. The policy also indicated under section of "Policy" "the organization is a non-smoking facility and will permit residents to smoke in designated outside areas only." NJAC 8:39-31.2(e), 31.6(e)	K 741		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, fire safety record review, and interview, the facility failed to ensure that a remote alarm annunciator for the standby generator was in a location readily available to personnel at a regular working station in accordance with NFPA 99 (2012 edition) section 6.4.1.1.16.2 and 6.4.1.1.17. This deficient practice had the potential to affect all 114	K 916	1. After investigation, it was determined that there is an annunciator for the generator located at the nurses desk on the [redacted] Unit. This was installed prior to the employment of the Administrator and Maintneance Director. 2. All residents may be affected by the	6/5/23

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	315176	A. BUILDING **01** B. WING _____	**04/21/2023**

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MEDFORD CARE CENTER	**185 TUCKERTON ROAD** **MEDFORD, NJ 08055**

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K 916	Continued From page 16 residents. Findings include: An observations on the facility tour on 04/14/23 from 9:20 AM to 12:30 PM revealed no evidence of a remote annunciator panel for the emergency electrical generator anywhere in the building. A review of the most recent untitled generator report, dated 01/21/23 located in the untitled binder provided by the Maintenance Director, did not address the remote annunciator panel for the generator. An interview with the Maintenance Director on 04/14/23 at 11:00 AM revealed the facility does not have a remote annunciator for the 45-Kilowatt (KW) natural gas-powered stand by generator. An interview with the Maintenance Man 1 (MM1) on 04/14/23 at 11:00 AM, who is a long-term employee of 17 years, stated there is no remote annunciator panel for the generator. He indicated the generator is the original generator to the building or from 1980. NJAC 8:39-31.2(e)	K 916	remote annunciator in an area observable by staff to alert the emergency generator system. 3. Staff will be re-educated by Maintenance Director on location and operation the remote annunciator in a area observable by staff to alert the emergency generator system. 4. The Director of Maintenance will conduct random audits to monitor the functioning monthly. Any issues will be addressed. Results of the random audits will be reviewed monthly after installation for three months and reviewed at the monthly QAPI meeting for the next three months.	

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	6/9/2023 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	K0271	05/23/2023	LSC	K0281	05/23/2023	LSC	K0321	06/05/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0363	06/05/2023	LSC	K0372	06/05/2023	LSC	K0741	06/05/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0916	06/05/2023	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		

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	
4/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO