STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING _____ B. WING _____	C 07/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ175898 Survey Dates: 07/30/2024 Census: 92 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Complaint#: NJ175898 Based on observation, interview and review of documentation provided by the facility, it was determined that the facility failed to maintain acceptable standards of essential kitchen equipment in a safe and operable condition. This deficient practice was evidenced by the following: During the interview with the Surveyor on 07/30/2024 at 11:33 A.M., the U.S. FOIA (b) (6) [redacted] stated that the stove in the facility's kitchen was not working. The U.S. FOIA [redacted] further stated "the stove caught on fire in May	F 908	1. The facility cannot retroactively address the concern identified regarding the kitchen stove. There are two other fully functional/operational stoves available in the facility that are being used by the kitchen staff to prepare food/meals. 2. The resident population has the potential to be effected by the concern identified. 3. A replacement stove has been secured for the kitchen. A replacement stove has been delivered and pending wiring by a qualified electrician, the replacement stove will be placed into service. The	10/4/24

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

Electronically Signed | 09/06/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 908	Continued From page 1 2024". The U.S. FOIA stated that the fire department came out to extinguish the fire and deemed the stove was unsafe and needed to be repaired or replaced. The Surveyor toured the facility's kitchen with the U.S. FOIA on 07/30/2024 at 11:50 A.M. and observed the following: The Surveyor observed that the stove was covered with metal sheet pans and the staff was using electric burners to cook the food. During an interview with the Surveyor on 7/30/2024 at 11:50 A.M., the U.S. FOIA confirmed that the stove was not working. The U.S. FOIA stated "not having a stove affects the types of food that the facility would prepare for the residents." The U.S. FOIA stated "certain food items take longer to prepare due to stove not working, but I am still able to make nutritional meals for the residents." The U.S. FOIA further stated that U.S. FOIA (b) (6)) was made aware of the stove not working in the kitchen since May 2024 and was responsible to replace or repair broken equipment in the kitchen. During an interview with the Surveyor on 7/30/2024 at 1:40 P.M., the U.S. FOIA (b) (6) stated that she was aware that the stove in the kitchen needed to be repaired or replaced since May 2024. When asked if there should be a working stove in the kitchen, the U.S. FOIA said "Yes, I would think it would be the main part of the kitchen." The U.S. FOIA said, "my expectation is that if an equipment is broken, it should be replaced timely, the stove should have been replaced." The U.S. FOIA stated that all broken equipment should be reported to the U.S. FOIA (b) who	F 908	replacement stove will be operational on or the completion date of 10/04/2024. The kitchen will continue to utilize the two stoves available in the facility and currently being used by the kitchen staff to prepare food/meals. 4. The dietician will randomly audit two test trays weekly for the next twelve weeks to verify foods are being properly prepared as per the approved menu. Areas of concern will be addressed. Results of the dietician's audits will be reviewed at the Quality Assurance Performance Improvement Committee next quarter with follow up provided as needed.	

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	315176	A. BUILDING _____ B. WING _____	C 07/30/2024

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F 908	Continued From page 2 was responsible for replacing broken kitchen equipment. The [U.S. FOIA] stated that there was no policy that addressed broken kitchen equipment. The Surveyor was unable to reach the [U.S. FOIA (b)] for an interview. NJAC 8:39 31.7(d)	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060313	A. BUILDING: _____ B. WING _____	C 07/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint#: NJ175898 Survey Dates: 07/30/2024 Census: 92 Sample Size: 3 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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: Complaint #: NJ175898 Based on interviews and review of facility documents on 07/30/2024, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents.	S 560	1. The facility cannot retroactively address the concern identified. 2. The Administrator, Executive Director and Director of Nursing have reviewed current hiring initiatives to further incentivize new staff (recruiting) and current staff (retention). Open positions are advertised on multiple job search	10/4/24

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

Electronically Signed | 09/06/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060313	A. BUILDING: _____ B. WING _____	C 07/30/2024

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S 560	Continued From page 1 Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to complaint survey from 07/14/2024 to 07/27/2024 the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: On 07/14/24 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 07/15/24 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 07/16/24 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 07/17/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. On 07/18/24 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs.	S 560	engines. Physical ads have been placed in various locations throughout this and neighboring locations, Recruitment efforts include: sign on bonuses, tuition reimbursement and child care cost sharing programs. Interviews are scheduled at various times to accommodate applicants and on the spot offers are made. Walk in applicants are interviewed directly and offered positions if they qualify for employment. Referral bonuses are available to staff who refer nursing staff. Current staff are offered tuition reimbursement, child care reimbursement and bonuses to work extra shifts in addition to time and one half paid in excess of full time hours. Pay rates for nursing staff have been increased across the board. Nursing and CNA schools have been contacted and visited in an effort to recruit new graduates. Nursing management is utilized for patient care and is "on-call" on a rotating basis to assist with patient needs and staffing to verify that patients receive proper care and treatment. 3. The Director of Nursing will monitor daily staffing and meet with the staffing coordinator to review schedules. The Director of Nursing will be responsible to verify adequate staffing levels to be certain that requirements are being met. Staffing will continue to be reviewed with nursing supervisors daily. 4. The Director of Nursing will review recruitment and retention on an "on-going" basis and report findings to the Quality Assurance Performance Improvement	

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S 560	Continued From page 2 On 07/19/24 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 07/20/24 had 6 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 07/21/24 had 7 CNAs for 94 residents on the day shift, required at least 12 CNAs. On 07/22/24 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. On 07/23/24 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. On 07/24/24 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. On 07/25/24 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. On 07/26/24 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs. On 07/27/24 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.	S 560	Committee on a quarterly basis for the next six months with follow up provided as needed. The Director of Nursing will be responsible to verify that staffing meets the required levels and to take corrective action to address if concerns are identified.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315176		10/4/2024

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 F0908 Reg. # 483.90(d)(2) LSC	Correction Completed 10/04/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
7/30/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060313		10/4/2024

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/04/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
7/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO