STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING _____ B. WING _____	C 12/07/2024

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 #: 181482 Survey Date: 12/7/2024 Census: 82 Sample: 2 + 1 closed record A Complaint and Monitoring Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		1/31/25

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

Electronically Signed | 12/30/2024

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

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and relevant facility record review, the facility failed to ensure that a resident (Resident #1) was assisted out of bed timely to participate in morning activities. This deficient practice was evidenced for one of two residents sampled for self-determination. On 12/7/24 at 8:30 AM, the surveyor interviewed the US FOIA (b)(6) who stated that there were eight staff call-outs because they were not paid. The surveyor reviewed the staffing assignment sheet for the 7 AM - 3 PM shift. The facility census was 82 with three nurses and four Certified Nursing Assistants (CNAs). At 11 AM, Resident #1 requested to speak to the surveyor. Resident #1 stated that NJ Exe wanted to get out of bed, but staff told NJ Exec NJ Exe would have to wait because the facility is short staffed. Resident #1 stated NJ Exe was a NJ Exec Order 26.4b1 required NJ Exec Order 26.4b1 to operate. Resident #1 stated that NJ Exe missed morning activities and coffee today. The surveyor observed the unit nurse was passing out medications and the CNA could not be found for interview. The surveyor reviewed the Staffing Assignment	F 561	1. The facility cannot retroactively address the concern identified. Resident #1 was advised to request to speak with the unit manager/nursing supervisor should NJ Exe feel that staff are not addressing NJ Exe concerns timely. 2. Current residents have the potential to be effected by the concern identified. 3. The Acting Director of Nursing will review staffing policy and procedures with the Staffing Coordinator and Unit Managers/Nursing Supervisors. Daily staffing will be reviewed by the Acting Director of Nursing with the Staffing Coordinator to verify sufficient staff is scheduled and adjusted as needed to meet needs/requirements. Should call-offs occur, Nursing Administration will make every effort to replace the open positions, which may include offering incentives and bonuses to fill needed shifts. 4. Facility staffing will be reviewed and confirmed with the Acting Director of Nursing/Designee on a daily basis. Outcomes of staffing management will be reported at the QAPI committee meeting monthly for the next 3 months by the	

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F 561	Continued From page 2 Sheet and Resident #1's unit census was 28, with one assigned nurse and one assigned CNA for the 7 AM - 3 PM shift. At 2:17 PM, the surveyor observed the resident in a motorized wheelchair in the hallway. Resident #1 stated [NJ Exec] just left the afternoon activity in the Dining Room. Resident #1 stated staff got [NJ Exec] out of bed at 2 PM. Resident #1 stated [NJ Exec Order 26.4b] [redacted] that staff did not get [NJ Exec] out of bed this morning and [NJ Exec] missed morning activities and coffee. The surveyor observed the unit nurse was passing out medications and the CNA could not be found for interview. NJAC 8:39-4.1(a)(24)	F 561	Acting Director of Nursing with follow up provided as needed.	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		1/31/25

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F 725	Continued From page 3 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Refer to F561 Based on observation, interview and facility assignment sheet review, the facility failed to ensure sufficient number of staff were available to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. This deficient practice had the potential to affect all 82 residents and was evidenced by the following: On 12/7/24 at 8:30 AM, the surveyor interviewed the US FOIA (b)(6) who stated there were eight staff call-outs because staff were not paid. The surveyor reviewed the staffing assignment sheet for the 7 AM - 3 PM shift. The facility census was 82 with three nurses and four Certified Nursing Assistants (CNAs). The US FOIA (b)(6) stated she called the US FOIA (b)(6)) regarding the call-outs but was told the US FOIA (b) resigned last night. The surveyor asked what the plan was regarding staffing and the US FOIA (b)(6) stated they have been calling staff asking if they could come in today but so far no one has accepted. Last night's US FOIA (b) stated she left messages with the	F 725	1. The facility cannot retroactively address the concern identified. 2, Current residents have the potential to be effected by the concern identified. 3. The Acting Director of Nursing will review staffing policy and procedures with the Staffing Coordinator and Unit Managers/Nursing Supervisors. Daily staffing will be reviewed by the Acting Director of Nursing with the Staffing Coordinator to verify sufficient staff is scheduled and adjusted as needed to met needs/requirements. Should call-offs occur, Nursing Administration will make every effort to replace the open positions, which may include offering incentives and bonuses to fill needed shifts. Replacement paychecks were issued with funds made immediately available to those employees whose payroll check did not clear. Future payrolls have been secured through owner initiated financing with the next payroll of 12/19/2024 being met without incident.	

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F 725	Continued From page 4 facility's US FOIA (b)(6) early this morning but had not received a response. The US FOIA (b)(6) stated the US FOIA (b)(6)) was on her way to take over the manager duties so that she could act as a unit nurse. The surveyor met the identified US FOIA (b)(6) at 9:59 AM. When the surveyor asked if she was the US FOIA (b)(6) the nurse stated "no; I never officially took the title." The nurse continued that she had worked for the facility for NJ Exec Order 26.4b and came in today to act as the US FOIA (b)(6) due to the short staffing. At 11 AM, Resident #1 requested to speak to the surveyor. Resident #1 stated that NJ Exec wanted to get out of bed, but staff told NJ Exec NJ Exec would have to wait because the facility is short staffed. Resident #1 stated NJ Exec was a NJ Exec Order 26.4b1 that required NJ Exec people to operate. Resident #1 stated that NJ Exec missed morning activities and coffee today. At 12:45 PM, the surveyor interviewed the acting US FOIA (b)(6) for an update regarding staffing. The acting US FOIA (b)(6) stated that department heads were coming in to help with non-nursing activities such as answering call bells and passing out meal trays. The acting US FOIA (b)(6) stated she would continue to call staff to come in but no one had accepted. At 2:42 PM, the surveyor interviewed Resident #2 in NJ Exec room. Resident #2 stated staff NJ Exec Order 26.4b1 The surveyor asked if anything was different with NJ Exec care today. Resident #2 stated the call bell response was slower than usual as it normally would be answered within 5	F 725	The Business Office Manager will monitor facility cashflow and payroll account to verify payroll will be met timely. The Business Office Manager will provided updates to the LNHA weekly to allow for corrective action to be taken if needed prior to the next payroll date. 4. Facility staffing will be reviewed and confirmed with the Acting Director of Nursing/Designee on a daily basis. Outcomes of staffing management will be reported at the QAPI committee meeting monthly for the next 3 months by the Acting Director of Nursing with follow up provided as needed. The LNHA will report payroll status to the QAPI Committee monthly for the next 3 months with follow up provided as needed.	

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F 725	Continued From page 5 minutes, but today it took about 30 minutes. At 3 PM, a consultant to the facility arrived and stated that he brought in food for the staff and was offering bonus' and gift cards for anyone who would pick up an extra shift. The surveyor, facility consultant and the 3 PM - 11 PM [US FOIA (b)] reviewed the 3 PM - 11 PM staffing assignment sheet. According to the assignment sheet, 2 nurses and 4 CNAs called out.	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, [US FOIA (b)(6)] CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Complaint # 181482 Based on observation and interview, the facility failed to designate a [US FOIA (b)(6)]) on a full time basis due to the [US FOIA (b)] resigning on [NJ Exec Order 26.4]. This deficient practice affected all 82 residents	F 727	1. The facility cannot retroactively address the concern identified. The Director of Nursing resigned without notice on Friday, [NJ Ex Order 26.4b1] after normal business hours at approximately 6:40pm. She did not inform her staff. An Acting Director of Nursing was appointed and approved on 12/10/2024.	1/31/25

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F 727	Continued From page 6 and was evidenced as follows: The facility's [US FOIA (b)] called the Department of Health Complaints' Hotline on 12/6/24 at 6:43 PM informing the Department that she resigned effective immediately. The surveyor entered the facility on 12/7/24 at 8:15 AM via a side entrance as the front door was locked and a handwritten sign was taped to the door instructing people to use the back entrance. At 8:50 AM, the surveyor spoke to the 7 AM - 3 PM shift [US FOIA (b)(6)] The [US FOIA (b)(6)] that the facility had eight employees call out due to not being paid. The surveyor asked if the [US FOIA (b)(6)] or [US FOIA (b)] had been called. The [US FOIA (b)(6)] stated she called the [US FOIA (b)(6)] but the [US FOIA (b)] told her that she resigned last night. The surveyor asked if the facility had an [US FOIA (b)(6)]. The [US FOIA (b)(6)] stated yes, and that the nurse was on her way. The surveyor met the identified [US FOIA (b)(6)] at 9:59 AM. When the surveyor asked if she was the [US FOIA (b)(6)] the nurse stated "no; I never officially took the title." The nurse continued that she had worked for the facility for [NJ Exec Order 26.4b] and came in today to help due to the short staffing. NJAC 8:39-25.1(a) NJAC 8:39-25.1(b)	F 727	2, Current residents have the potential to be effected by the concern identified. 3, An Acting Director of Nursing was appointed and approved on 12/10/2024. A Consultant Director of Nursing was engaged and approved on 12/12/2024 to assist the Acting Director of Nursing. The Executive Director has retained the services of 3 professional recruitment companies to conduct searches and vet a potential full time Director of Nursing candidates. 4. The Executive Director will continue to work with professional recruitment companies to secure a Director of Nursing and report progress to the QAPI Committee at their next monthly meeting. Follow up will be provided as needed.	
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical,	F 908		1/31/25

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F 908	Continued From page 7 and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the boiler to provide consistent hot water temperatures within 95 to 120 degrees Fahrenheit. This deficient practice had the potential to affect all 82 residents and was evidenced by the following: On 12/7/24 at 8:30 AM, the surveyor calibrated a thermometer and obtained the following hot water temperatures for the Dogwood Unit: Pantry: 122. At 9:35 AM it was rechecked and the hot water temperature was 101. Shower: 122. At 9:40 AM it was rechecked and the hot water temperature was 101. Room 66: 123. At 9:33 AM it was rechecked and the hot water temperature was 86. Room 81: 116. At 9:36 AM it was rechecked and the hot water temperature was 86. Room 62: 97. At 9:38 AM it was rechecked and the hot water temperature was 101. At 8:53 AM, hot water temperatures for the Birch Unit were obtained and were as followed: Room 9: 62. At 9:45 AM it was rechecked and the hot water temperature was 60. Bath 2: 90. Room 5: 88. At 9:15 AM, hot water temperatures for the Cedar Unit were obtained and were found to be within 95 to 120 degrees Fahrenheit. At 10:50 AM, the surveyor interviewed the	F 908	1. The facility cannot retroactively address the issue identified. 2. The Facility recognizes that current residents have the potential to be affected by the issue identified. Residents will be offered a hot bath or shower with comfortable water temperatures at least 2-3 times per week. This will be monitored by the Nursing Department and the Acting Director of Nursing. 3. To verify water temps are within acceptable range (95-119F) 24/7 and that residents receive showers/bed baths as required, the facility will do the following: - Water temps will be taken by Maintenance and/or a nurse twice on the day and evening shifts, and once on the night shift. - If water temps are found not to be within the required range, the following will occur: The LNHA will be notified and will notify the Acting Director of Nursing. The Acting Director of Nursing will notify her team that water temps are out of range. If a resident requests/requires a shower or bed bath during that time, disposable, rinse free body wipes will be used. The LHNA will address water temperatures reported that are not within the required range and facilitate any	

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F 908	Continued From page 8 maintenance staff (MS #1). MS #1 stated water temperatures were not consistent due to a small boiler that could not keep up with the demand. The surveyor visualized the boiler and holding tank and noted that both were used units. MS #1 also stated that the kitchen dish machine and laundry both pull off the same boiler as domestic. At 12 noon, the surveyor and MS #1 obtained hot water temperatures on all three units after calibrating their thermometers. The hot water temperature ranges were as followed: Dogwood Unit: 108-111. Birch Unit: 99-112 except for Room 9 which remained at 60. Cedar Unit: 107-110. At 2:15 PM, the surveyor obtained hot water temperatures. The Dogwood and Cedar Units' hot water temperatures were within 95 to 120 degrees Fahrenheit. The Birch Unit hot water temperatures ranged from 80-110. Rooms 10 and 11 were 80 and the shower room was 90. NJAC 8:39-31.2(e)	F 908	repairs and/or adjustments needed to meet and sustain the required temperatures. Care staff was educated on the above by the RN Supervisors/RN Nurse Educator on 12/3/24 (on all three shifts). This education will be ongoing until the education of care staff has been completed. 4.Facility Maintenance Department will continue to check water temperatures daily on resident units, dietary and laundry daily to verify temperatures are within required range and take corrective action as needed. (This will be reflected on a daily log/audit sheet) If a water temperature appears to be not within acceptable range for facility and/or resident use, the LNHA will be notified to address the issue. The Maintenance Director will review the water temperature log sheets at the monthly QAPI meeting for the next 3 months to verify water temperatures are within the required range and what measures were taken to resolve any issues if the water temperatures were not within the required range. Follow up will be provided as needed.	

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	060313	A. BUILDING: _____ B. WING _____	C 12/07/2024

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S 000	Initial Comments Complaint #: 181482 Survey Date: 12/7/2024 Census: 82 Sample: 2 + 1 closed record 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 490	8:39-4.1(a)(24) Mandatory Resident Rights (a) Each resident shall be entitled to the following rights: 24. To take part in nursing home activities, and to meet with and participate in the activities of any social, religious, and community groups, as long as these activities do not disrupt the lives of other residents; This REQUIREMENT is not met as evidenced by: Based on observation, interview and relevant facility record review, the facility failed to ensure that a resident (Resident #1) was assisted out of	S 490	1. The facility cannot retroactively address the concern identified. Resident #1 was advised to request to speak with	1/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/30/24

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S 490	Continued From page 1 bed timely to participate in morning activities. This deficient practice was evidenced for one of two residents sampled for self-determination. On 12/7/24 at 8:30 AM, the surveyor interviewed the Manager on Duty/Infection Preventionist who stated that there were eight staff call-outs because they were not paid. The surveyor reviewed the staffing assignment sheet for the 7 AM - 3 PM shift. The facility census was 82 with three nurses and four Certified Nursing Assistants (CNAs). At 11 AM, Resident #1 requested to speak to the surveyor. Resident #1 stated that [redacted] wanted to get out of bed, but staff told [redacted] would have to wait because the facility is short staffed. Resident #1 stated [redacted] was a NJ Exec Order 26.4b1 [redacted] that required NJ Exec Order 26.4b1. Resident #1 stated that [redacted] missed morning activities and coffee today. The surveyor observed the unit nurse was passing out medications and the CNA could not be found for interview. The surveyor reviewed the Staffing Assignment Sheet and Resident #1's unit census was 28, with one assigned nurse and one assigned CNA for the 7 AM - 3 PM shift. At 2:17 PM, the surveyor observed the resident in a motorized wheelchair in the hallway. Resident #1 stated [redacted] just left the afternoon activity in the Dining Room. Resident #1 stated staff got [redacted] out of bed at 2 PM. Resident #1 stated [redacted] that staff did not get [redacted] out of bed this morning and [redacted] missed morning activities and coffee.	S 490	the unit manager/nursing supervisor should [redacted] feel that staff are not addressing [redacted] concerns timely. 2. Current residents have the potential to be effected by the concern identified. 3. The Acting Director of Nursing will review staffing policy and procedures with the Staffing Coordinator and Unit Managers/Nursing Supervisors. Daily staffing will be reviewed by the Acting Director of Nursing with the Staffing Coordinator to verify sufficient staff is scheduled and adjusted as needed to meet needs/requirements. Should call-offs occur, Nursing Administration will make every effort to replace the open positions, which may include offering incentives and bonuses to fill needed shifts. 4. Facility staffing will be reviewed and confirmed with the Acting Director of Nursing/Designee on a daily basis. Outcomes of staffing management will be reported at the QAPI committee meeting monthly for the next 3 months by the Acting Director of Nursing with follow up provided as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060313	A. BUILDING: _____ B. WING _____	C 12/07/2024

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 490	Continued From page 2 The surveyor observed the unit nurse was passing out medications and the CNA could not be found for interview.	S 490		
S1669	8:39-25.1(a) Mandatory Nurse Staffing There shall be a full-time director of nursing or nursing administrator who is a registered professional nurse licensed in the State of New Jersey, who has at least two years of supervisory experience in providing care to long-term care residents, and who supervises all nursing personnel. This REQUIREMENT is not met as evidenced by: Complaint # 181482 Based on observation and interview, the facility failed to designate a Registered Nurse (RN) to serve as the Director of Nursing (DON) on a full time basis due to the DON resigning on [NJ Exec Order 26.4b] This deficient practice affected all 82 residents and was evidenced as follows: The facility's DON called the Department of Health Complaints' Hotline on [NJ Ex Order 26.4b] at 6:43 PM informing the Department that she resigned effective immediately. The surveyor entered the facility on 12/7/24 at 8:15 AM via a side entrance as the front door was locked and a handwritten sign was taped to the door instructing people to use the back entrance. At 8:50 AM, the surveyor spoke to the 7 AM - 3	S1669	1. The facility cannot retroactively address the concern identified. The Director of Nursing resigned without notice on Friday, [NJ Ex Order 26.4b1] after normal business hours at approximately 6:40pm. She did not inform her staff. An Acting Director of Nursing was appointed and approved on 12/10/2024. 2, Current residents have the potential to be effected by the concern identified. 3, An Acting Director of Nursing was appointed and approved on 12/10/2024. A Consultant Director of Nursing was engaged and approved on 12/12/2024 to assist the Acting Director of Nursing. The Executive Director has retained the services of 3 professional recruitment companies to conduct searches and vet potential a full time Director of Nursing.	1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1669	Continued From page 3 PM shift Manager on Duty/Infection Preventionist (MOD/IP). The MOD/IP stated that the facility had eight employees call out due to not being paid. The surveyor asked if the Administrator or DON had been called. The MOD/IP stated she called the DON, but the DON told her that she resigned last night. The surveyor asked if the facility had an Assistant Director of Nursing (ADON). The MOD/IP stated yes, and that the nurse was on her way. The surveyor met the identified ADON at 9:59 AM. When the surveyor asked if she was the ADON, the nurse stated "no; I never officially took the title." The nurse continued that she had worked for the facility for [NJ Exec Order 26.40] and came in today to help due to the short staffing.	S1669	4. The Executive Director will continue to work with professional recruitment companies to secure a Director of Nursing and report progress to the QAPI Committee at their next monthly meeting. Follow up will be provided as needed.	
S2120	8:39-31.1(c) Mandatory Physical Environment Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, PO Box 809, Trenton, New Jersey 08625-0809.	S2120		1/31/25

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S2120	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 12/07/24 in the presence of the facility Maintenance Staff, it was determined that the facility failed to: a) ensure doors in corridors were capable of resisting smoke and/or fire in accordance with NFPA 101:2012 Edition, Section 19.3.6.3.; and b) ensure smoke barrier doors would self-close in accordance with NFPA 101: 2012 Edition Section 19.7.3.8. This deficient practice had the potential to affect 42 residents on the Birch Unit and was evidenced by the following: A) An observation at 9:05 AM on the Birch Unit, revealed that the door to the Clean Linen storage room had no doorknob. There was a hole clear through the door to the exit corridor. In an interview at 11:20 AM, the facility's Maintenance Staff (MS #1) observed the missing doorknob and stated he did not know why it was missing and would have to replace it. B) Observations at 8:57 AM on the Birch Unit revealed the Smoke barrier doors were blocked from closing by a tall clean linen cart and a 2-compartment soiled linen cart. There were no staff available on the unit at the time of observation.	S2120	1. A doorknob was installed on the door to the clean linen room on the birch unit. Clean and soiled linen carts were removed as to allow smoke barrier doors to close as needed. 2. Current residents have the potential to be effected by the concern identified. 3. The Maintenance Director will add inspection of door hardware to the Monthly Preventative Maintenance Schedule to verify doors have doorknobs. Doors without hardware will be fixed when found. Staff will be in serviced by the Educator on not blocking smoke doors from closing by 01/31/2025. The Administrator/designee will add observation of facility doors improperly held open to his daily rounds and provide education to staff when found. Observations and education will be documented. 4. The Maintenance Director will report the results of the inspections of door hardware to the monthly QAPI Committee x3 months with follow up provided as needed. The Administrator/designee will report the results of his rounds to the QAPI Committee monthly x3 months with follow	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2120	Continued From page 5	S2120	up provided as needed.	
S2150	8:39-31.2(e) Mandatory Physical Environment The facility shall be kept in good repair and maintained without harm or jeopardy to residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the boiler to provide consistent water temperatures within 95 - 120 degrees Fahrenheit. This deficient practice had the potential to affect all 82 residents and was evidenced by the following: On 12/7/24 at 8:30 AM, the surveyor calibrated a thermometer and obtained the following water temperatures for the Dogwood Unit: Pantry: 122. At 9:35 AM it was rechecked and the water temperature was 101. Shower: 122. At 9:40 AM it was rechecked and the water temperature was 101. Room 66: 123. At 9:33 AM it was rechecked and the water temperature was 86. Room 81: 116. At 9:36 AM it was rechecked and the water temperature was 86. Room 62: 97. At 9:38 AM it was rechecked and the water temperature was 101. Water temperatures for the Birch Unit were obtained at 8:53 AM and were as followed:	S2150	1. The facility cannot retroactively address the issue identified. 2. The Facility recognizes that current residents have the potential to be affected by the issue identified. Residents will be offered a hot bath or shower with comfortable water temperatures at least 2-3 times per week. This will be monitored by the Nursing Department and the Acting Director of Nursing. 3. To verify water temps are within acceptable range (95-119F) 24/7 and that residents receive showers/bed baths as required, the facility will do the following: - Water temps will be taken by Maintenance and/or a nurse twice on the day and evening shifts, and once on the night shift. - If water temps are found not to be within the required range, the following will occur:	1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060313	A. BUILDING: _____ B. WING _____	C 12/07/2024

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S2150	Continued From page 6 Room 9: 62. At 9:45 AM it was rechecked and the water temperature was 60. Bath 2: 90. Room 5: 88. Water temperatures for the Cedar Unit were obtained at 9:15 AM and were found to be within normal limits. At 10:50 AM, the surveyor interviewed the maintenance staff (MS #1). MS #1 stated water temperatures were not consistent due to a small boiler that could not keep up with the demand. The surveyor visualized the boiler and holding tank and noted that both were used units. MS #1 also stated that the kitchen dish machine and laundry both pull off the same boiler as domestic. The surveyor and MS #1 obtained water temperatures from at 12 noon on all three units after calibrating their thermometers. The water temperature ranges were as followed: Dogwood Unit: 108-111. Birch Unit: 99-112 except for Room 9 which remained at 60. Cedar Unit: 107-110. The surveyor obtained water temperatures at 2:15 PM and the Dogwood and Cedar Units water temperatures were within normal limits. The Birch Unit water temperatures ranged from 80-110. Rooms 10 and 11 were 80 and the shower room was 90.	S2150	The LNHA will be notified and will notify the Acting Director of Nursing. The Acting Director of Nursing will notify her team that water temps are out of range. If a resident requests/requires a shower or bed bath during that time, disposable, rinse free body wipes will be used. The LHNA will address water temperatures reported that are not within the required range and facilitate any repairs and/or adjustments needed to meet and sustain the required temperatures. Care staff was educated on the above by the RN Supervisors/RN Nurse Educator on 12/3/24 (on all three shifts). This education will be ongoing until the education of all care staff has been completed. 4.Facility Maintenance Department will continue to check water temperatures daily on resident units, dietary and laundry daily to verify temperatures are within required range and take corrective action as needed. (This will be reflected on a daily log/audit sheet) If a water temperature appears to be not within acceptable range for facility and/or resident use, the LNHA will be notified to address the issue. The Maintenance Director will review the water temperature log sheets at the monthly QAPI meeting for the next 3 months to verify water temperatures are within the required range and what measures were taken to resolve any	

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S2150	Continued From page 7	S2150	issues if the water temperatures were not within the required range. Follow up will be provided as needed.	

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	315176	A. BUILDING _____ B. WING _____	R-C 02/14/2025

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{F 000}	INITIAL COMMENTS An onsite revisit was conductedon 2/14/2025 to verify the facility's Plan of Correction regarding the 12/7/2024 Complaint and Monitoring visit. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	{F 000}		

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

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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315176 Y1	A. Building B. Wing Y2	2/14/2025 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0561	Correction	ID Prefix F0725	Correction	ID Prefix F0727	Correction
Reg. # 483.10(f)(1)-(3)(8)	Completed	Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.35(b)(1)-(3)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix F0908	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(d)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/31/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/7/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

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

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0490	Correction	ID Prefix S1669	Correction	ID Prefix S2120	Correction
Reg. # 8:39-4.1(a)(24)	Completed	Reg. # 8:39-25.1(a)	Completed	Reg. # 8:39-31.1(c)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	01/31/2025
ID Prefix S2150	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-31.2(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/31/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/7/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING **01** B. WING _____	**12/07/2024**

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

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K 000	INITIAL COMMENTS Survey Date: 12/7/2024 Census: 82 A monitoring survey was conducted on 12/07/2024 at Medford Care Center and the facility was found to be Non-complaint with the Life Safety Code, NFPA 101:2012 Edition.	K 000		
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	K 363		1/31/25

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

Electronically Signed | 12/30/2024

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K 363	Continued From page 1 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 interview on 12/07/24 in the presence of the facility Maintenance Staff, it was determined that the facility failed to ensure doors in corridors were capable of resisting smoke and/or fire in accordance with NFPA 101:2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect 42 residents on the Birch Unit and was evidenced by the following: An observation at 9:05 AM on the Birch Unit, revealed that the door to the Clean Linen storage room had no doorknob. There was a hole clear through the door to the exit corridor. In an interview at 11:20 AM, the facility's Maintenance Staff (MS #1) observed the missing doorknob and stated he did not know why it was missing and would have to replace it. NJAC 8:39-31.1(c), 31.2(e)	K 363	1. A doorknob was installed on the door to the clean linen room on the birch unit. 2. Current residents have the potential to be effected by the concern identified. 3. The Maintenance Director will add inspection of door hardware to the Monthly Preventative Maintenance Schedule to verify doors have doorknobs. Doors without hardware will be fixed when found. 4. The Maintenance Director will report the results of the inspections of door hardware to the monthly QAPI Committee x3 months with follow up provided as needed.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 374		1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 374	Continued From page 2 Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 12/07/24, it was determined that the facility failed to ensure smoke barrier doors would self-close in accordance with NFPA 101: 2012 Edition Section 19.7.3.8. This deficient practice had the potential to affect all 42 residents on the Birch Unit and was evidenced by the following: Observations at 8:57 AM on the Birch Unit revealed the Smoke barrier doors were blocked from closing by a tall clean linen cart and a 2-compartment soiled linen cart. There were no staff available on the unit at the time of observation. NJAC 8:39-31.1(c), 31.2(e)	K 374	1. Clean and soiled linen carts were removed as to allow smoke barrier doors to close as needed. 2. Current residents have the potential to be effected by the concern identified. 3. Staff will be in serviced by the Educator on not blocking smoke doors from closing by 01/31/2025. The Administrator/designee will add observation of facility doors improperly held open to his daily rounds and provide education to staff when found. Observations and education will be documented. 4. The LNHA/designee will round daily to verify no facility doors are improperly held open. Areas of concern will be addressed. The Administrator/designee will report the results of his rounds to the QAPI Committee monthly x3 months with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEDFORD CARE CENTER	**185 TUCKERTON ROAD** **MEDFORD, NJ 08055**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 3	K 374	follow up provided as needed.	

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 _____	R **02/14/2025**

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

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{K 000}	INITIAL COMMENTS An offsite/desk review was conducted on 2/14/2025 to verify the facility's Plan of Correction regarding the 12/7/2024 Monitoring visit. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	{K 000}		

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

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.

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	2/14/2025 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0363	01/31/2025	LSC K0374	01/31/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/7/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO