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 _____	12/20/2024

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 Survey Date: 12/18/24 through 12/20/24 Census: 79 Sample: 3 A monitoring survey was conducted at Medford Care Center from 12/18/24 through 12/20/24, and the facility was found to be in non-compliance with 43 CFR Part 483 requirements for Long Term Care Facilities. During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR Part 483.25(d)(2) F 689 as the facility failed to implement their Removal Plan (RP) from the Recertification survey dated 12/5/24, by ensuring the facility's [NJ Exec Order 26.4b] area was maintained and monitored to prevent [NJ Exec Order 26.4b1] and resident [NJ Exec Order 2] Observation on 12/18/24, revealed that Resident #1 [NJ 3] another resident's (Resident #2) [NJ Exec Order 26.4b] and stored their own [NJ Exec Order 2] in the facility. Additional observations revealed that Resident #3 [NJ 3] their [NJ Exec Order 26.4b] off of Resident #2's [NJ 3] [NJ Exec Order 26.4b1] There were no observed staff present monitoring the residents [NJ Exec Order 26.] and discarded [NJ Exec Order 26.4b1] were observed throughout the courtyard. Interview with staff on 12/18/24, revealed Resident #1 did not request their [NJ Exec Order 2] to [NJ Exec Order 2] that day and staff were aware [NJ Exec Order 26.4b1] were not discarded appropriately. The facility failed to ensure that appropriate [NJ Exec Order 26.4b] receptacles were utilized, resident [NJ Exec Order 26.4b1] were [NJ 3] safely, and the process was followed to ensure the safe storage of [NJ Exec Order 26]	F 000		

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.

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 _____	12/20/2024

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	Continued From page 1 materials posed the likelihood of serious harm, injury, or death due to [NJ Exec] or accidental resident [NJ Exec Orde] on 12/18/24. The Administration was informed of the concerns for the F 689 and was provided the IJ template on 12/18/24 at 4:07 PM. An acceptable Removal Plan (RP) was received on 12/19/24 at 4:49 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: a [NJ Exec Order 2] was obtained from Resident #1; the facility's [NJ Exec Order 26.4b] policy was updated to include residents cannot possess [NJ Exec Order 26] and/or [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] times established, resident [NJ Exec Order 26.4b] monitors to [NJ Exec O] [NJ Exec Order 26.4b1] and verify [NJ Exec Order 26.4b1] are discarded properly; residents were asked to verify that they did not have [NJ Exec Order 26.4b] or [NJ Exec Order 26.4b] and residents who [NJ Exec Order 26.4b] and staff were educated on the new [NJ Exec Order 26.4b] policy. The survey team verified the RP on-site on 12/19/24, and determined that the IJ for F 689 was removed as of 12/20/24 at 12:52 PM.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING _____ B. WING _____	12/20/2024

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 689	Continued From page 2 This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and document review, it was determined that the facility failed to implement their Removal Plan (RP) from the Recertification survey on 12/05/24, by a) ensuring that [NJ Exec Order 26] were immediately returned by residents upon re-entry into the facility and maintained by the nursing staff to ensure a safe [NJ Exec Order 26.4b] process and b) facility staff ensured the use of appropriate receptacles for disposing [NJ Exec Order 26.4b1] This deficient practice was identified in the [NJ Exec Order 26.4b] courtyard and affected 3 of 3 units ([NJ Exec Order 26.4b1]). Observations on 12/18/24, in the facility's [NJ Exec Order 26.4b] courtyard, identified Resident #1 possessed a [NJ Exec Order] that they used to [NJ Exec O] Resident #2's [NJ Exec Order 26.4b1] Resident #1 was observed upon return into the building, to have kept their [NJ Exec Order 2] Interview with the resident's Licensed Practical Nurse (LPN #1) revealed that Resident #1 had not requested their [NJ Exec Order] from the locked medication cart all day. Additional observations of 12/18/24, revealed Resident #3 [NJ E] their [NJ Exec Order 26.4b] from Resident #2's [NJ Exec Order 26.4b1]. There were no observed staff present at in the courtyard to monitor residents [NJ Exec Order 26.4b1] as well as [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] were observed discarded throughout the courtyard. The facility's failure to ensure that their RP was implemented for safe storage of [NJ Exec Order 26] materials and the use of appropriate [NJ Exec Order 26.4b] receptacles posed the likelihood of serious harm, injury, or death due to [NJ Exec] or accidental resident [NJ Exec Order] This resulted in an Immediate Jeopardy situation	F 689	1 Lighters/matches are now retained by the smoking monitors who are responsible to light cigarettes for residents. Smoking monitors are also responsible to verify that smoking materials are properly extinguished and discarded in the appropriate receptacles. 2. Current residents have the potential to be effected by the issues identified. There are presently fifteen (15) patients who have smoking privileges. 3. The smoking policy final revision was completed on 12/18/2024. Staff was educated on the revision by Nursing Administration on 12/18/2024 and 12/19/2024. The smoking policy will be reviewed at the next Resident Council Meeting and will be reviewed 2x a year with the Resident Council and if/when changes to the smoking policy occur. The facility smoking policy was revised on 12/18/2024 as follows: a. residents may not possess lighters or matches b. smoking times will be established, smoking monitors will monitor resident smoking including smoking monitors to light cigarettes and verify that cigarette butts are properly extinguished in designated receptacles. This policy revision was individually communicated to residents who smoke on 12/19/24 by the Consultant Administrator and the conversation was documented in	

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 _____	12/20/2024

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 689	Continued From page 3 (IJ). The IJ began on 12/18/24 at 8:05 AM, when the two surveyors first identified the facility did not implement their RP to ensure safe [NJ Exec Order 26.4b] The facility Administration was notified of the IJ on 12/18/2024 at 4:07 PM. The facility submitted an acceptable Removal Plan (RP) on 12/19/24. The survey team verified the implementation of the RP during the continuation of the on-site survey on 12/20/24. The evidence was as follows: A review of the facility's RP for the Recertification survey dated 12/05/24, indicated that the facility implemented the following measures to prevent the likelihood of serious harm or injury from occurring or reoccurring by: leaves around or near resident [NJ Exec Order 26.4b] area were removed; [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b] were now held by the nursing staff; residents assessed as independent [NJ Exec Order 26.4b] were given their [NJ Exec Order 26.4b] materials prior to [NJ Exec Order 26.4b] and were educated to return them upon entrance into the building; maintenance inspected the [NJ Exec Order 26.4b] area a minimum of twice a day to remove any debris; housekeeping staff emptied [NJ Exec Order 26.4b] twice on the day shift and once on the evening shift; additional [NJ Exec Order 26.4b] post receptacles were purchased; and the [NJ Exec Order 26.4b] policy was reviewed with residents. A review of the facility's "Smoking Policy for Residents" dated revised and approved 12/2024, included...Purpose: to verify that residents will ...be able to smoke outdoors in a safe environment. Procedure:...5. Matches and lighters will be kept in medication carts. Lighters and/or matches may be taken out to the smoking	F 689	the individual resident's medical record. Residents who smoke were and will continue to be required to acknowledge the policy with acknowledgement documented in the resident medical records. The facility staff were educated on the smoking policy changes by administration on 12/19/24. 4. The facility smoking policies will be reviewed at resident council twice per year of if a change in the policy occurs. Residents who smoke will be required to sign a new smoking agreement with each review. The policy will be reviewed at the next Resident Council Meeting. The Smoking Agreements and the list of residents who smoke shall be reviewed by the QAPI committee on a quarterly basis. Areas of concern will be addressed with follow up as needed. The LNHA/designee will randomly observe three smoking times per week of the next twelve weeks to verify staff and residents are adhering to the revised policy. Areas of concern will be addressed.	

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 _____	12/20/2024

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 689	Continued From page 4	F 689		

area by residents but must be returned to staff upon the resident re-entering the facility. 6. Residents are strictly prohibited from having matches/lighters in their possession inside of the facility...13. The designated smoking area will be maintained by the housekeeping department and the following will occur: a. ashtrays will be empties into smoking post receptacles, twice on the day shift and once on the evening shift, into smoking post receptacles...

On 12/18/24 at 8:05 AM, Surveyor #1 and Surveyor #2 entered the resident NJ Exec Order 26.4b courtyard and observed NJ Exec Order 26.4b1 on the ground in several areas amongst the shrubs, next to the NJ Exec Order 26.4b post, and a NJ Exec Order 2 in an NJ Exec Order 26. on a table. The two surveyors counted NJ Exec Order 26.4b1 in the area.

On 12/18/24 at 9:20 AM, the two surveyors again entered the resident NJ Exec Order 26.4b area. At that time, Resident #1 was observed removing their NJ Exec Order 2 from their pocket and NJ Exec Order 26 Resident #2's NJ Exec Order 26.4b1 The surveyors also observed Resident #3 NJ Exec O their NJ Exec Order 26.4b by placing it against Resident #2's NJ Exec Order 26.4b1. There were no staff observed in the area to supervise the residents.

On 12/18/24 at 9:26 AM, Surveyor #2 observed Resident #1 exiting the NJ Exec Order 26.4b area carrying their NJ Exec Order 2 in their pocket and entered into the facility. Resident #1 then NJ Exec Order 26.4b1 their wheelchair down the hall of the NJ Exec Orde unit, passed the nursing station, and proceeded to their room at the end of another hallway. At 9:34 AM, Resident #1 was still in their room, and they had not returned the NJ Exec Order 2 to the nurse.

On 12/18/24 at 10:30 AM, in the presence of both

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 _____	12/20/2024

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 689	Continued From page 5	F 689		

surveyors, the [US FOIA (b)(6) redacted]) stated that the facility was actively monitoring the [NJ Exec Order 26.4b] area and that housekeeping cleaned the area twice a day. The surveyors informed the [US FOIA (b)(6)] of the observations regarding the [NJ Exec Order 26.4b1] located in several areas on the ground in the [NJ Exec Order 26.4b] courtyard and offered to show her the photographic evidence of the observations. The [US FOIA (b)(6)] declined to see the photographic evidence and did not dispute the surveyors observations.

On 12/18/24 at 2:00 PM, in the presence of both surveyors, the Licensed Practical Nurse (LPN #1) who was responsible for Resident #1, stated that the resident had not requested their [NJ Exec Order] the entire shift, so she had not provided the [NJ Exec Order] or taken a [NJ Exec Order] from Resident #1. At that time, LPN #1 showed the surveyors a [NJ Exec Order 26.4b1] [NJ Exec Order] in a bag in her medication cart that was Resident #1's [NJ Exec Order] The [NJ Exec Order] was not the same one that the surveyors observed Resident #1 had in the courtyard that they brought back to their room.

An acceptable Removal Plan was received on 12/19/24 at 4:49 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including a [NJ Exec Order] was obtained from Resident #1; the facility's [NJ Exec Order 26.4b] policy was updated to include residents cannot possess [NJ Exec Order 26] and/or [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] times established, resident [NJ Exec Order 26.4b] monitors to [NJ Exec O] [NJ Exec Order 26.4b1] and verify [NJ Exec Order 26.4b1] are discarded properly; residents were asked to verify that they did not have [NJ Exec Order 26.4b] or [NJ Exec Order 26.4b] and residents

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 _____	12/20/2024

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 689	Continued From page 6 who [NJ Exec Order 26.4b] and staff were educated on the new [NJ Exec Order 26.4b] policy. NJAC 8:39-31.6(e)	F 689		

New Jersey Department of Health

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 _____	12/20/2024

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 STATE MONITORING REPEAT DEFICENCY The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S 000		
S2245	8:39-31.6(e) Mandatory Physical Environment Smoking regulations shall be developed, implemented, and enforced in accordance with N.J.S.A. 26:3D-1 et seq. and N.J.S.A. 26:3D-7 et seq. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and document review, it was determined that the facility failed to implement their Removal Plan (RP) from the	S2245	1 Lighters/matches are now retained by the smoking monitors who are responsible to light cigarettes for residents. Smoking monitors are also responsible to verify that smoking materials are properly	1/31/25

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

Electronically Signed | 12/30/24

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 _____	12/20/2024

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
S2245	Continued From page 1 Recertification survey on 12/05/24, by a) ensuring that [NJ Exec Order 26.4b] were immediately returned by residents upon re-entry into the facility and maintained by the nursing staff to ensure a safe [NJ Exec Order 26.4b] process and b) facility staff ensured the use of appropriate receptacles for disposing [NJ Exec Order 26.4b1]. This deficient practice was identified in the [NJ Exec Order 26.4b] courtyard and affected 3 of 3 units ([NJ Exec Order 26.4b1] Observations on 12/18/24, in the facility's [NJ Exec Order 26.4b] courtyard, identified Resident #1 possessed a [NJ Exec Order] that they used to [NJ Exec O] Resident #2's [NJ Exec Order 26.4b1] Resident #1 was observed upon return into the building, to have kept their [NJ Exec Order 2] Interview with the resident's Licensed Practical Nurse (LPN #1) revealed that Resident #1 had not requested their [NJ Exec Order] from the locked medication cart all day. Additional observations of 12/18/24, revealed Resident #3 [NJ E] their [NJ Exec Order 26.4b] from Resident #2's [NJ Exec Order 26.4b1]. There were no observed staff present at in the courtyard to monitor residents [NJ Exec Order 26.4b1] as well as [NJ Exec Order 26.4b1] were observed discarded throughout the courtyard. The facility's failure to ensure that their RP was implemented for safe storage of [NJ Exec Order 26] materials and the use of appropriate [NJ Exec Order 26.4b] receptacles posed the likelihood of serious harm, injury, or death due to [NJ Exec] or accidental resident [NJ Exec Order] This resulted in an Immediate Jeopardy situation (IJ). The IJ began on 12/18/24 at 8:05 AM, when the two surveyors first identified the facility did not implement their RP to ensure safe [NJ Exec Order 26.4b1] The facility Administration was notified of the IJ on 12/18/2024 at 4:07 PM. The facility submitted an acceptable Removal Plan (RP) on 12/19/24. The	S2245	extinguished and discarded in the appropriate receptacles. 2. Current residents have the potential to be effected by the issues identified. There are presently fifteen (15) patients who have smoking privileges. 3. The smoking policy final revision was completed on 12/18/2024. Staff was educated on the revision by Nursing Administration on 12/18/2024 and 12/19/2024. The smoking policy will be reviewed at the next Resident Council Meeting and will be reviewed 2x a year with the Resident Council and if/when changes to the smoking policy occur. The facility smoking policy was revised on 12/18/2024 as follows: a. residents may not possess lighters or matches b. smoking times will be established, smoking monitors will monitor resident smoking including smoking monitors to light cigarettes and verify that cigarette butts are properly extinguished in designated receptacles. This policy revision was individually communicated to residents who smoke on 12/19/24 by the Consultant Administrator and the conversation was documented in the individual resident's medical record. Residents who smoke were and will continue to be required to acknowledge the policy with acknowledgement documented in the resident medical records. The facility staff were educated on the smoking policy changes by administration	

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 _____	12/20/2024

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
S2245	Continued From page 2 survey team verified the implementation of the RP during the continuation of the on-site survey on 12/20/24. The evidence was as follows: A review of the facility's RP for the Recertification survey dated 12/05/24, indicated that the facility implemented the following measures to prevent the likelihood of serious harm or injury from occurring or reoccurring by: leaves around or near resident [NJ Exec Order 26.4b] area were removed; [NJ Exec Order 26] and [NJ Exec Order 26.4b] were now held by the nursing staff; residents assessed as [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] were given their [NJ Exec Order 26] materials prior to [NJ Exec Order 26.4b] and were educated to return them upon entrance into the building; maintenance inspected the [NJ Exec Order 26.4b] area a minimum of twice a day to remove any debris; housekeeping staff emptied [NJ Exec Order 26.4b] twice on the day shift and once on the evening shift; additional [NJ Exec Order 26.4b] post receptacles were purchased; and the [NJ Exec Order 26.4b] policy was reviewed with residents. A review of the facility's "Smoking Policy for Residents" dated revised and approved 12/2024, included...Purpose: to verify that residents will ...be able to smoke outdoors in a safe environment. Procedure:...5. Matches and lighters will be kept in medication carts. Lighters and/or matches may be taken out to the smoking area by residents but must be returned to staff upon the resident re-entering the facility. 6. Residents are strictly prohibited from having matches/lighters in their possession inside of the facility...13. The designated smoking area will be maintained by the housekeeping department and the following will occur: a. ashtrays will be empties into smoking post receptacles, twice on the day shift and once on the evening shift, into	S2245	on 12/19/24. 4. The facility smoking policies will be reviewed at resident council twice per year of if a change in the policy occurs. Residents who smoke will be required to sign a new smoking agreement with each review. The policy will be reviewed at the next Resident Council Meeting. The Smoking Agreements and the list of residents who smoke shall be reviewed by the QAPI committee on a quarterly basis. Areas of concern will be addressed with follow up as needed. The LNHA/designee will randomly observe three smoking times per week of the next twelve weeks to verify staff and residents are adhering to the revised policy. Areas of concern will be addressed.	

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 _____	12/20/2024

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
S2245	Continued From page 3 smoking post receptacles... On 12/18/24 at 8:05 AM, Surveyor #1 and Surveyor #2 entered the resident [NJ Exec Order 26.4b] courtyard and observed NJ Exec Order 26.4b1 on the ground in several areas amongst the shrubs, next to the [NJ Exec Order 26.4b] post, and a match in an [NJ Exec Order 26.] on a table. The two surveyors counted NJ Exec Order 26.4b1 in the area. On 12/18/24 at 9:20 AM, the two surveyors again entered the resident [NJ Exec Order 26.4b] area. At that time, Resident #1 was observed removing their [NJ Exec Order 2] from their pocket and [NJ Exec Order 26] Resident #2's [NJ Exec Order 26.4b1] The surveyors also observed Resident #3 [NJ Exec O] their [NJ Exec Order 26.4b] by placing it against Resident #2's [NJ Exec Order 26.4b1]. There were no staff observed in the area to supervise the residents. On 12/18/24 at 9:26 AM, Surveyor #2 observed Resident #1 exiting the [NJ Exec Order 26.4b] area carrying their [NJ Exec Order 2] in their pocket and entered into the facility. Resident #1 then NJ Exec Order 26.4b1 their wheelchair down the hall of the [NJ Exec Ord] unit, passed the nursing station, and proceeded to their room at the end of another hallway. At 9:34 AM, Resident #1 was still in their room, and they had not returned the [NJ Exec Order 2] to the nurse. On 12/18/24 at 10:30 AM, in the presence of both surveyors, the Consultant Licensed Nursing Home Administrator (Consult LNHA) stated that the facility was actively monitoring the [NJ Exec Order 26.4b] area and that housekeeping cleaned the area twice a day. The surveyors informed the Consult LNHA of the observations regarding the [NJ Exec Order 26.4b1] located in several areas on the ground in the [NJ Exec Order 26.4b] courtyard and offered to show her the photographic evidence of the observations. The Consult LNHA declined to see the	S2245		

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 _____	12/20/2024

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
S2245	Continued From page 4 photographic evidence and did not dispute the surveyors observations. On 12/18/24 at 2:00 PM, in the presence of both surveyors, the Licensed Practical Nurse (LPN #1) who was responsible for Resident #1, stated that the resident had not requested their [NJ Exec Order] the entire shift, so she had not provided the [NJ Exec Order] or taken a [NJ Exec Order] from Resident #1. At that time, LPN #1 showed the surveyors a [NJ Exec Order 26.4b1] [NJ Exec Order] in a bag in her medication cart that was Resident #1's [NJ Exec Order] The [NJ Exec Order] was not the same one that the surveyors observed Resident #1 had in the courtyard that they brought back to their room. An acceptable Removal Plan was received on 12/19/24 at 4:49 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including a [NJ Exec Order] was obtained from Resident #1; the facility's [NJ Exec Order 26.4b] policy was updated to include residents cannot possess [NJ Exec Order 26] and/or [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] times established, resident [NJ Exec Order 26.4b] monitors to [NJ Exec O] [NJ Exec Order 26.4b1] and verify [NJ Exec Order 26.4b1] are discarded properly; residents were asked to verify that they did not have [NJ Exec Order 26.4b] or [NJ Exec Order 26.4b] and residents who [NJ Exec Order 26.4b] and staff were educated on the new [NJ Exec Order 26.4b] policy.	S2245		

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 F0689	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(d)(1)(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	
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?
12/20/2024	☐ 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 S2245	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-31.6(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	
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?
12/20/2024	☐ YES ☐ NO