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 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: 168582 Census: 101 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		

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

Electronically Signed | | 11/07/2023

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

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 ______	C **10/26/2023**

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

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S 000	Initial Comments 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 deficieny 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 870	8:39-9.4(e)(1) Mandatory Administration (e) The facility shall notify the Department immediately by telephone (609-633-8981, or 1-800-792-9770 after office hours), followed within 72 hours by written confirmation, of any of the following: 1. Interruption for three or more hours of physical plant services and/or other services essential to the health and safety of residents; This REQUIREMENT is not met as evidenced by: C#NJ168582 Based on interview and review of other facility documentation on 10/26/23, it was determined that the facility failed to notify the New Jersey Department of Health (NJDOH) immediately and in writing within 72-hours upon a disruption of gas service to the facility for more than 3-hours as	S 870	1. The utility company was immediately contacted and the issue was addressed. The outage has been reported to DOH. Moving forward immediately report all interruptions in service to the NJ DOH. 2. All residents had a potential to be affected. All residents were monitored with	11/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/07/23

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 ____	C 10/26/2023

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

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S 870	Continued From page 1 evidence by the following: During an interview with the surveyor on 10/26/23 at 11:25 AM, the Payroll/Accounts Payable (PAP) person stated that the gas service to the facility had been shut off from approximately 9:00 AM to 4:00 PM. The PAP further stated that the gas service was shut off due to nonpayment and that the checks from the corporate office were delayed. During an interview with the surveyor on 10/26/23 at 1:41 PM, the Licensed Nursing Home Administrator (LNHA) stated she was informed by the Food Service Director (FSD) that there was an issue with one of the stoves in the kitchen and the gas would not come on. The LNHA could not recall the exact date it happened and stated that an electric skillet was available to prepare the residents' food. The LNHA added that the kitchen was the only department affected by the gas service being shut off and that the residents were not affected. The LNHA stated she also had the Business Office Manager (BOM) reach out to the corporate office to find out what was happening. The LNHA added she did not notify the NJDOH of the gas service being turned off because there was no interruption of resident services at the facility. The surveyor requested to speak with the BOM, but the BOM was not available for interview. During an interview with the surveyor on 10/26/23 at 2:08 PM, the FSD stated that on 10/3/23 at approximately 9:40 AM, the stove had stopped working. The stove wouldn't turn on and there was no heat coming from the gas oven. He informed the Maintenance Coordinator (MC), who stated, "We have no gas" and he did not know	S 870	no adverse affects during the outage. The utility issue was addressed and resolved shortly after being identified. 3. The Administrator and DON were educated on the policy and regulation for potential reportable events. Moving forward all outages will be reported to the Department of Health following facility policy and regulations. 4. The Administrator or designee will monitor all potential reportable events and report results at monthly Quality Assurance Performance Improvement (QAPI) meetings for 3 months.	

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 ____	C 10/26/2023

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S 870	Continued From page 2 why." The FSD stated he notified the LNHA about the gas being turned off and the LNHA responded with an "Okay." The surveyor requested to speak with the MC who was on duty on 10/3/23, but he was not available for an interview. Review of the "Reportable Events Policy," last reviewed and approved on 10/2023, reflected under the "Policy" section that "the organization complies with all regulatory and accrediting agencies regarding reportable events." Under the "Procedure" section reflected "1) The following are defined as reportable events based on the Department of Health of New Jersey: ... h) Temporary loss of a major system." The policy revealed that "2) Once a reportable event is identified the Administrator or designee shall call the NJ Department of Health and Senior Services hotline immediately and initiate an internal investigation if warranted. Immediately is defined as telephonic notification followed by written notification within 72 hours. 3) The organization will complete online reportable events form to the NJ Department of Health and Senior Services or fax the information to the hotline."	S 870		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060313		12/18/2023

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 S0870 Reg. # 8:39-9.4(e)(1) LSC	Correction Completed 11/07/2023	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
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
10/26/2023

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