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 _____	12/11/2024

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: 12/11/2024 Census: 82 A 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 639 SS=F	Maintain 15 Months Resident Assessments CFR(s): 483.20(d) §483.20(d) Use A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain 15 months of required medical information in an active resident medical record. This deficient practice affected all 82 residents and was evidenced as follows: On 12/11/24 at 10:23 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1). LPN #1 stated that the Electronic Medical Record (EMR) system had not been operational for some time, and they are unable to access historical information. The surveyor asked how they can get access to the Minimum Data Set (MDS) records, and LPN #1 explained that they have no access to the EMR. She further stated that the resident charts currently contain only face sheets, advanced directives, and some	F 639	1. The facility cannot retroactively address the concern identified. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. EMR was fully restored on 12/13/2024. The Business Office Manager will report payments due to the LHNA monthly to verify payment is remitted timely to avoid interruption of service. 4. The LHNA will update the QAPI Committee on the EMR status monthly for the next 3 months with follow up provided as needed.	12/31/24

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 639	Continued From page 1 documentation from records prior to the implementation of the EMR. The facility has been documenting all medical information on pen and paper due to the lack of access to the EMR. On 12/11/24 at 10:39 AM, the surveyor interviewed Licensed Practical Nurse #2 (LPN #2). LPN #2 explained that the Electronic Medical Record (EMR) system had been non-operational since Thanksgiving and believes the issue is related to the facility's failure to pay the service fee. LPN #2 further stated that, as a result, they have no access to any prior medical records, including care plans, MDS, or progress notes. LPN #2 also mentioned that when attempting to access the EMR, an error message appeared, instructing them to contact the administrator. On 12/11/24 at 12:02 PM, the surveyor conducted an interview with the US FOIA (b)(6) [redacted] who was accompanied by the consulting US FOIA (b)(6) The US FOIA (b)(6) explained that the facility had been unable to access the Electronic Medical Record (EMR) system since Thanksgiving due to outstanding payments. As a result, they have no access to old records at this time, including MDS, care plans, and progress notes, and they are relying on pen and paper for documentation. The US FOIA (b)(6) stated that the facility cannot access historical records until payment is made and that efforts are underway to restore access to the system either today or by the following day at the latest.	F 639		
F 842 SS=F	8:39-35.2 (d)(5) Resident Records - Identifiable Information	F 842		12/31/24

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F 842	Continued From page 2 CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 3 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to maintain and ensure that resident medical records were readily accessible. This deficient practice affected all 82 residents and was evidenced as follows: On 12/11/24 at 10:23 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1). LPN #1 stated that the Electronic Medical Record system had not been operational for	F 842	1. The facility cannot retroactively address the concern identified. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. EMR was fully restored on 12/13/2024. The Business Office Manager will report payments due to the LHNA monthly to	

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F 842	Continued From page 4 some time, and they are unable to access historical information. She further explained that all documentation had reverted to pen and paper, and the only available access to patient information was limited to blood work results, which can be accessed online through a specific platform. On 12/11/24 at 10:39 AM, the surveyor interviewed Licensed Practical Nurse #2 (LPN #2). LPN #2 stated that the Electronic Medical Record (EMR) system had not been working since Thanksgiving, and she believed the issue was due to the facility not paying the service fee. She further explained that, as of that day, all charting has been done on pen and paper. LPN #2 stated that they have no access to any previous medical records, such as care plans, MDS, or progress notes. On 12/11/24 at 12:02 PM, the surveyor interviewed th US FOIA (b)(6) in the presence of the consulting US FOIA (b)(6) The US FOIA (b)(6) stated that the facility has not had access to the Electronic Medical Record (EMR) system since Thanksgiving due to nonpayment. Furthermore, the US FOIA (b)(6) explained that the facility cannot access historical records until payment is made and that they are currently using pen and paper for documentation. The US FOIA (b)(6) also stated that the facility is working to get the system operational either today or, at the latest, the following day. The US FOIA (b)(6) further indicated that the facility owed approximately $100,000, and in order to regain access to the EMR system, a payment of $30,000 in advance was required.	F 842	verify payment is remitted timely to avoid interruption of service. 4. The LHNA will update the QAPI Committee on the EMR status monthly for the next 3 months with follow up provided as needed.	

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F 842	Continued From page 5 8:39-35.2 (d)(6)	F 842		

New Jersey Department of Health

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	060313	A. BUILDING: _____ B. WING _____	12/11/2024

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S 000	Initial Comments Survey Date: 12/11/2024 Census: 82 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		
S2605	8:39-35.2(d)(5) Mandatory Medical Reocrds (d) A medical record shall be initiated for each resident upon admission. The current medical record shall be readily available and shall include at least the following information, when such information becomes available: 5. An assessment and plan of care made by each discipline involved in the resident's care; This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain 15 months of required medical information in an active resident medical record. This deficient practice affected all 82 residents and was evidenced as follows:	S2605	1. The facility cannot retroactively address the concern identified. 2. The facility recognizes that current residents have the potential to be effected by the concern identified.	12/31/24

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

Electronically Signed — 12/30/24

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S2605	Continued From page 1 On 12/11/24 at 10:23 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1). LPN #1 stated that the Electronic Medical Record (EMR) system had not been operational for some time, and they are unable to access historical information. The surveyor asked how they can get access to the Minimum Data Set (MDS) records, and LPN #1 explained that they have no access to the EMR. She further stated that the resident charts currently contain only face sheets, advanced directives, and some documentation from records prior to the implementation of the EMR. The facility has been documenting all medical information on pen and paper due to the lack of access to the EMR. On 12/11/24 at 10:39 AM, the surveyor interviewed Licensed Practical Nurse #2 (LPN #2). LPN #2 explained that the Electronic Medical Record (EMR) system had been non-operational since Thanksgiving and believed the issue was related to the facility's failure to pay the service fee. LPN #2 further stated that, as a result, they have no access to any prior medical records, including care plans, MDS, or progress notes. LPN #2 also mentioned that when attempting to access the EMR, an error message appeared, instructing them to contact the administrator. On 12/11/24 at 12:02 PM, the surveyor conducted an interview with the Licensed Nursing Home Administrator (LNHA), who was accompanied by the consulting LNHA. The LNHA explained that the facility had been unable to access the Electronic Medical Record (EMR) system since Thanksgiving due to outstanding payments. As a result, they have no access to old records at this time, including MDS, care plans, and progress notes, and are relying on pen and paper for documentation. The LNHA stated that the facility	S2605	3. EMR was fully restored on 12/13/2024. The Business Office Manager will report payments due to the LHNA monthly to verify payment is remitted timely to avoid interruption of service. 4. The LHNA will update the QAPI Committee on the EMR status monthly for the next 3 months with follow up provided as needed.	

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S2605	Continued From page 2 cannot access historical records until payment is made and that efforts are underway to restore access to the system either today or by the following day at the latest.	S2605		
S2610	8:39-35.2(d)(6) Mandatory Medical Records (d) A medical record shall be initiated for each resident upon admission. The current medical record shall be readily available and shall include at least the following information, when such information becomes available: 6. Clinical notes for the past three months incorporating written, signed and dated notations by each member of the health care team who provided services to the resident, including a description of signs and symptoms, treatments and/or drugs given, the resident's reaction, and any changes in physical or emotional condition entered into the record when the service was provided; This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to maintain and ensure that resident medical records were readily accessible. This deficient practice affected all 82 residents and was evidenced as follows: On 12/11/24 at 10:23 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1). LPN #1 stated that the Electronic Medical Record system had not been operational for some time, and they are unable to access	S2610	1. The facility cannot retroactively address the concern identified. 2. The facility recognizes that current residents have the potential to be effected by the concern identified. 3. EMR was fully restored on 12/13/2024. The Business Office Manager will report payments due to the LHNA monthly to verify payment is remitted timely to avoid	12/31/24

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S2610	Continued From page 3 historical information. She further explained that all documentation had reverted to pen and paper, and the only available access to patient information is limited to blood work results, which can be accessed online through a specific platform. On 12/11/24 at 10:39 AM, the surveyor interviewed Licensed Practical Nurse #2 (LPN #2). LPN #2 stated that the Electronic Medical Record (EMR) system had not been working since Thanksgiving, and she believed the issue was due to the facility not paying the service fee. She further explained that, as of that day, all charting has been done on pen and paper. LPN #2 stated that they have no access to any previous medical records, such as care plans, MDS, or progress notes. On 12/11/24 at 12:02 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the consulting LNHA. The LNHA stated that the facility had not had access to the Electronic Medical Record (EMR) system since Thanksgiving due to nonpayment. Furthermore, the LNHA explained that the facility cannot access historical records until payment is made and that they are currently using pen and paper for documentation. The LNHA also stated that the facility is working to get the system operational either today, at the latest, the following day. The LNHA further indicated that the facility owes approximately $100,000, and in order to regain access to the EMR system, a payment of $30,000 in advance is required.	S2610	interruption of service. 4. The LHNA will update the QAPI Committee on the EMR status monthly for the next 3 months with follow up provided as needed.	