

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2024
NAME OF PROVIDER OR SUPPLIER Medford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 185 Tuckerton Road Medford, NJ 08055	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>28788</p> <p>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.</p> <p>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).</p> <p>At 11 AM, Resident #1 requested to speak to the surveyor. Resident #1 stated that he wanted to get out of bed, but staff told him he would have to wait because the facility is short staffed. Resident #1 stated he was a hooyer lift (equipment to assist staff with transferring a resident) that required two people to operate. Resident #1 stated that he missed morning activities and coffee today.</p> <p>The surveyor observed the unit nurse was passing out medications and the CNA could not be found for interview.</p> <p>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.</p> <p>At 2:17 PM, the surveyor observed the resident in a motorized wheelchair in the hallway. Resident #1 stated he just left the afternoon activity in the Dining Room. Resident #1 stated staff got him out of bed at 2 PM. Resident #1 stated he feels bad and was mad that staff did not get him out of bed this morning and he missed morning activities and coffee.</p> <p>The surveyor observed the unit nurse was passing out medications and the CNA could not be found for interview.</p> <p>NJAC 8:39-4.1(a)(24)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28788</p> <p>Refer to F561</p> <p>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:</p> <p>On 12/7/24 at 8:30 AM, the surveyor interviewed the Manager on Duty/Infection Preventionist (MOD/IP) 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 MOD/IP stated she called the Director of Nursing (DON) regarding the call-outs but was told the DON resigned last night. The surveyor asked what the plan was regarding staffing and the MOD/IP stated they have been calling staff asking if they could come in today but so far no one has accepted. Last night's MOD stated she left messages with the facility's Consultant Administrator, Administrator and Executive Director early this morning but had not received a response. The MOD/IP stated the Assistant DON (ADON) was on her way to take over the manager duties so that she could act as a unit nurse.</p> <p>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 [AGE] years and came in today to act as the Manager on Duty due to the short staffing.</p> <p>At 11 AM, Resident #1 requested to speak to the surveyor. Resident #1 stated that he wanted to get out of bed, but staff told him he would have to wait because the facility is short staffed. Resident #1 stated he was a hooyer lift (equipment to assist staff with transferring a resident) that required two people to operate. Resident #1 stated that he missed morning activities and coffee today.</p> <p>At 12:45 PM, the surveyor interviewed the acting MOD for an update regarding staffing. The acting MOD 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 MOD stated she would continue to call staff to come in but no one had accepted.</p> <p>At 2:42 PM, the surveyor interviewed Resident #2 in his room. Resident #2 stated staff were great and worked hard. The surveyor asked if anything was different with his care today. Resident #2 stated the call bell response was slower than usual as it normally would be answered within 5 minutes, but today it took about 30 minutes.</p> <p>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.</p> <p>The surveyor, facility consultant and the 3 PM - 11 PM MOD reviewed the 3 PM - 11 PM staffing assignment sheet. According to the assignment sheet, 2 nurses and 4 CNAs called out.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28788</p> <p>Complaint # 181482</p> <p>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 12/6/24. This deficient practice affected all 82 residents and was evidenced as follows:</p> <p>The facility's DON called the Department of Health Complaints' Hotline on 12/6/24 at 6:43 PM informing the Department that she resigned effective immediately.</p> <p>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.</p> <p>At 8:50 AM, the surveyor spoke to the 7 AM - 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.</p> <p>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.</p> <p>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 [AGE] years and came in today to help due to the short staffing.</p> <p>NJAC 8:39-25.1(a)</p> <p>NJAC 8:39-25.1(b)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28788</p> <p>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:</p> <p>On 12/7/24 at 8:30 AM, the surveyor calibrated a thermometer and obtained the following hot water temperatures for the Dogwood Unit:</p> <p>Pantry: 122. At 9:35 AM it was rechecked and the hot water temperature was 101.</p> <p>Shower: 122. At 9:40 AM it was rechecked and the hot water temperature was 101.</p> <p>room [ROOM NUMBER]: 123. At 9:33 AM it was rechecked and the hot water temperature was 86.</p> <p>room [ROOM NUMBER]: 116. At 9:36 AM it was rechecked and the hot water temperature was 86.</p> <p>room [ROOM NUMBER]: 97. At 9:38 AM it was rechecked and the hot water temperature was 101.</p> <p>At 8:53 AM, hot water temperatures for the Birch Unit were obtained and were as followed:</p> <p>room [ROOM NUMBER]: 62. At 9:45 AM it was rechecked and the hot water temperature was 60.</p> <p>Bath 2: 90.</p> <p>room [ROOM NUMBER]: 88.</p> <p>At 9:15 AM, hot water temperatures for the Cedar Unit were obtained and were found to be within 95 to 120 degrees Fahrenheit.</p> <p>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.</p> <p>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:</p> <p>Dogwood Unit: 108-111.</p> <p>Birch Unit: 99-112 except for room [ROOM NUMBER] which remained at 60.</p> <p>Cedar Unit: 107-110.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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 [ROOM NUMBERS] were 80 and the shower room was 90.</p> <p>NJAC 8:39-31.2(e)</p>		