| 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 03/24/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Pines at Medford | 185 Tuckerton Road<br>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) |
|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT #2718861 Based on interviews and review of pertinent facility documentation on 3/13/26 and 3/24/26, it was determined that the facility failed to provide a timely follow - up management and care of a resident's indwelling catheter to address urologist's recommended procedures. This deficient practice was identified for one of two residents (Resident #2) reviewed for catheter care and was evidenced by the following:A review of the admission Record revealed that Resident #2 was admitted to the facility with diagnoses that included but were not limited to: obstructive and reflux uropathy, congenital malformation of urinary system, and severe intellectual disabilities. Review of Resident #2's quarterly Assessment Minimum Data Set (MDS,) an assessment tool used to facilitate the management of care, dated 2/26/26, indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 99 indicating that the resident was unable to complete the interview. Further review of the MDS revealed that the resident was dependent on staff for toileting. The MDS also indicated that the resident had an indwelling catheter. A review of Resident #2's care plan (CP) indicated that Resident #2 had an indwelling catheter; with intervention to observe and to report changes to the medical doctor. A review of Resident #2's progress notes (PN) revealed a nursing note dated 10/20/25 at 2:44 PM, indicated that the resident went for urology appointment. A nursing note dated 10/20/25 at 4:03 PM, stated that the resident returned from the urology appointment and that the doctor recommended, future [Operating Room] schedule. A review of the Resident #2's electronic medical record (EMR) revealed a visit summary from the urologist appointment dated 10/20/25, which indicated that the resident would be scheduled for the following procedures: cystoscopy, laser lithotripsy of bladder stone, and a Transurethral Resection of the Prostate.There was no documented evidence that the facility followed up with the urologist regarding the aforementioned procedures or that the facility contacted the resident's medical doctor regarding having issues scheduling appointment for the procedures. A Review of the EMR revealed that the resident was admitted to the hospital on [DATE] with an obstructed foley, bilateral hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder), and an acute kidney injury. Further review of the PNs revealed a nursing noted dated 1/11/26 at 5:11 PM that indicated that the resident had cloudy yellow urine, had not been eating, and was lethargic. The note further indicated that an order was obtained to send the resident out for further evaluation. During an interview on 3/13/26 at 4:06 PM, the Infection Preventionist (IP) stated that Resident #2 was last seen by urologist on 10/20/25 and that the urology office was expected to schedule an OR procedure. When asked if the facility had followed-up to contact the office to schedule, he stated that Central supply (CS) staff made attempts to call the urology office and that the office had not provided a date. When asked if the attempts to schedule the resident's appointment was documented; he stated that the Central supply staff did not document in the EMR. During an interview on 3/13/26 at 12:04 PM, Central supply (CS) staff stated that she was responsible for scheduling appointments for residents. During a follow-up interview on 3/13/26 at 4:56 PM, the CS stated that a residents' return from their medical appointments, she scheduled any upcoming appointments and scanned the documents into (continued on next page) |

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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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the computer to be uploaded into the resident's medical record. When asked about the follow-up form from Resident #2's 10/20/25 appointment, she stated that the resident did not have one because there was no follow-up appointment to schedule and that the urology office was to schedule Resident #2 for surgical procedures. The CS staff stated that she called the urology office weekly to set up appointments for all residents. She further stated that she does not have access to the EMR and that she keeps track of her attempts to schedule appointments on paper. When asked to provide the documented attempts for Resident #2, the CS stated stated that she did not save the paperwork. During a joint interview on 3/13/26 at 5:33 PM, with the Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON) both stated that the facility does not have a policy in place related to the scheduling of out-of-facility appointments for residents. The ADON stated that after an appointment, the Consult Sheet was reviewed by nursing and the CS to see when the resident was due for their next appointment. She stated that no form had been completed for Resident #2 because a follow-up appointment was not required, she stated that the urology office was to schedule the resident for surgery. They both stated that they were aware that the CS was calling regularly but that the office had not provided a date. LNHA and DON stated that the CS staff kept track of all of her attempts in her own personal log, and that this was the process that they had in place. When the surveyor informed them that the CS did not have a documented evidence of her attempts to schedule appointments, they provided no other information to the surveyor. The facility did not provide further information regarding action plans for when the CS staff is unable to schedule an appointment and no evidence of attempts to reach the urologist's office. A review of the facility's Charting Documentation policy effective 3/2020, indicated that, The medical record should facilitate communication between the interdisciplinary team . N.J.A.C. 8:39-27.1(a) |