PRINTED: 08/18/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  MEDFORD CARE CENTER  MEDFORD, N 98055  MEDFORD, N 9805	STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT PLE CONSTRUCTION AND PLAN OF CORRECTION IDENT FICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
MEDFORD CARE CENTER    SINUARY STATEMENT OF DEFIC ENGLES   185 TUCKERTON RADO			315176	B. WING		
MEDFORD, NJ 08055    MEDFORD, NJ 08055   SUMMARY STATEMENT OF DEFICENCIES   EACH DEFICENCY MUST BE PRECISED BY FULL   RECOULATIONY OR LSC (DENT FY NO INFORMATION)   PREFIX   TAG   CROMPRECITIVE ACTION SHOULD BE CROMPRITED TO THE APPROPRIATE	NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0770372020
SUMMARY STATEMENT OF DEFICE NOISE   PROVIDERS PLAN OF CORRECTION   PREFIX   REGULATORY OR LISCIDENT FY NG INFORMATION   PREFIX   PREFX   PREFIX   PREFX   PRE	MEDFORE	CARE CENTER			185 TUCKERTON ROAD	
FREETIX TAG  REGULATORY OR LSC IDENT FY NO INFORMATION)  FOOD  INITIAL COMMENTS  COMPLAINT # NJ 137523  CENSUS: 102  SAMPLE SIZE: 3  Based on observations, interviews, review of the Medical Records (MR), and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility paintment, who was at risk for elopement, and had a known history of wandering and exit seeking behavior, was appropriately monitored and supervised to prevent elopement or exiting the building. The facility also failed to follow their "Elopement Policy" and their "Incident and Accident Policy." The facility also failed to secure the front door for safety to prevent elopement, for 1 of 3 residents (Resident #2) sampled for elopement. On all \$4.945 p.m., Resident #2 was able to exit the facility when the Supervisor reentered the facility, when failed to reactivate the alarm and lock the door, or have a staff member monitor the exit while the alarm was shut off. On at 94.5 mp., Resident #2 was able to exit the building by the unsecured front door without the knowledge of the staff and was able to exit the building by the unsecured front door without the knowledge of the staff and was able to exit the building by the unsecured front door without the knowledge of the staff and was able to exit the building by the unsecured front door without the knowledge of the staff and was able to mander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the cognitively	IIILDI OILL	OAKE SERVER			MEDFORD, NJ 08055	
COMPLAINT # NJ 137523  CENSUS: 102  SAMPLE SIZE: 3  Based on observations, interviews, review of the Medical Records (MR), and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility failed to ensure a resident with severe cognitive impairment, who was at risk for elopement, and had a known history of wandering and exit seeking behavior, was appropriately monitored and supervised to prevent elopement or exiting the building. The facility also failed to follow their "Elopement Policy" and their "incident and Accident Policy." The facility also failed to secure the front door for safety to prevent elopement, for 1 of 3 residents (Resident #2) sampled for elopement. On a 19 45 p.m., Resident #2 was able to exit the facility unattended when the Nursing Supervisor deactivated the front door alarm, unlocked the front door and Resident #2 then exited the building. When the Supervisor reentered the facility, she failed to reactivate the alarm and lock the door, or have a staff member monitor the exit while the alarm was shut off. On a 19 45 p.m., Resident #2 was able to exit the building by the unsecured front door without the knowledge of the staff and was able to wander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the cognitively	PREFIX	(EACH DEFIC ENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
Based on observations, interviews, review of the Medical Records (MR), and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility falied to ensure a resident with severe cognitive impairment, who was at risk for elopement, and had a known history of wandering and exit seeking behavior, was appropriately monitored and supervised to prevent elopement or exiting the building. The facility also failed to follow their "Elopement Policy" and their "Incident and Accident Policy." The facility also failed to secure the front door for safety to prevent elopement, for 1 of 3 residents (Resident #2) sampled for elopement. On at 9.45 p.m., Resident #2 was able to exit the facility unattended when the Nursing Supervisor deactivated the Front door and Resident #2 then exited the building. When the Supervisor reentered the facility, she failed to reactivate the alarm and lock the door, or have a staff member monitor the exit while the alarm was shut off. On at 9.45 p.m., Resident #2 was able to exit the building by the unsecured front door without the knowledge of the staff and was able to wander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the cognitively	F 000	INITIAL COMMENTS		F 00	00	
Based on observations, interviews, review of the Medical Records (MR), and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility failed to ensure a resident with severe cognitive impairment, who was at risk for elopement, and had a known history of wandering and exit seeking behavior, was appropriately monitored and supervised to prevent elopement or exiting the building. The facility also failed to follow their "Elopement Policy" and their "Incident and Accident Policy."  The facility also failed to secure the front door for safety to prevent elopement, for 1 of 3 residents (Resident #2) sampled for elopement. On at 9.45 p.m., Resident #2 was able to exit the facility unattended when the Nursing Supervisor deactivated the front door and Resident #2 then exited the building. When the Supervisor reentered the facility, she failed to reactivate the alarm and lock the door, or have a staff member monitor the exit while the alarm was shut off. On at 9.45 p.m., Resident #2 was able to exit the building by the unsecured front door without the knowledge of the staff and was able to exit the building by the unsecured front door without the knowledge of the staff and was able to wander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the cognitively		COMPLAINT # NJ 13	37523			
Based on observations, interviews, review of the Medical Records (MR), and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility failed to ensure a resident with severe cognitive impairment, who was at risk for elopement, and had a known history of wandering and exit seeking behavior, was appropriately monitored and supervised to prevent elopement or exiting the building. The facility also failed to follow their "Elopement Policy" and their "Incident and Accident Policy."  The facility also failed to secure the front door for safety to prevent elopement, for 1 of 3 residents (Resident #2) sampled for elopement. On at 9.45 p.m., Resident #2 was able to exit the facility unattended when the Nursing Supervisor deactivated the front door alarm, unlocked the front door and Resident #2 then exited the building. When the Supervisor reentered the facility, she failed to reactivate the alarm and lock the door, or have a staff member monitor the exit while the alarm was shut off. On at 9.45 p.m., Resident #2 was able to exit the building by the unsecured front door without the knowledge of the staff and was able to wander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the cognitively		CENSUS: 102				
Medical Records (MR), and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility failed to ensure a resident with severe cognitive impairment, who was at risk for elopement, and had a known history of wandering and exit seeking behavior, was appropriately monitored and supervised to prevent elopement or exiting the building. The facility also failed to follow their "Elopement Policy" and their "Incident and Accident Policy."  The facility also failed to secure the front door for safety to prevent elopement, for 1 of 3 residents (Resident #2) sampled for elopement. On at 9.45 p.m., Resident #2 was able to exit the facility unattended when the Nursing Supervisor deactivated the front door alarm, unlocked the front door and Resident #2 then exited the building. When the Supervisor reentered the facility, she failed to reactivate the alarm and lock the door, or have a staff member monitor the exit while the alarm was shut off. On at 9.45 p.m., Resident #2 was able to exit the building by the unsecured front door without the knowledge of the staff and was able to exit the building by the unsecured front door without the knowledge of the staff and was able to wander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the cognitively		SAMPLE SIZE: 3				
ARADATADY DIPATADE ARIBIDITED PEDDESENTATIVE'S SIGNATITE TITLE (VENDATE		Medical Records (MR pertinent facility documents as determined that the resident with severe of was at risk for elopernhistory of wandering a was appropriately more prevent elopement or facility also failed to for Policy" and their "Incited The facility also failed to facility also failed safety to prevent elope (Resident #2) sample at 9:45 p.m. exit the facility unatter Supervisor deactivate unlocked the front documents at 9:45 p.m. exited the building. We reentered the facility, alarm and lock the domonitor the exit while at 9:45 p.m. exit the building by the without the knowledge to wander down the dother than the down the	and review of other mentation on 7/9/2020, it the facility failed to ensure a cognitive impairment, who ment, and had a known and exit seeking behavior, nitored and supervised to exiting the building. The collow their "Elopement dent and Accident Policy." It to secure the front door for mement, for 1 of 3 residents d for elopement. On a Resident #2 was able to make the front door alarm, for and Resident #2 then the Supervisor she failed to reactivate the for, or have a staff member the alarm was shut off. On a Resident #2 was able to the unsecured front door the e unsecured front door to the staff and was able the front od with a speed limit thour). The police were			
	ADODATORY	DECTOR'S OR BROW BERK	CLIDDI IED DEDDECENTATIVE CICALATURE	:	TITLE	(YE) DATE

07/28/2020 **Electronically Signed** 

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 DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315176	B. WING		C 07/09/2020
	ROVIDER OR SUPPLIER  D CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 185 TUCKERTON ROAD MEDFORD, NJ 08055	1 0770072020
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	O BE COMPLETION
F 609 SS=E	resident was transpo (ER) via ambulance a injuries. This deficient #2 and all other reside who were history of wandering Immediate Jeopardy identified on 7/9/2020 Facility's Administrate of Nursing (DON) we provided the IJ templ 7/1/2020 through 7/9 lifted when the facility Removal Plan. Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In responneglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, neglimistreatment, including source and misapproare reported immedia hours after the allega that cause the allega serious bodily injury, the events that cause the administrator of the officials (including to adult protective services for jurisdiction in longestices.)	s outside of the building. The rted to the Emergency Room and evaluated for possible t practice placed Resident ents with at a trisk or who had a known and/or elopement in an (IJ) situation. The IJ was at 5:01 p.m., when the present of the IJ and were attentiated of the IJ and were attentiated of the IJ and were attentiated an acceptable. Violations  (4)  See to allegations of abuse, or mistreatment, the facility at that all alleged violations	F 609		7/15/20

PRINTED: 08/18/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		IDENT EICATION NUMBER:		(2) MULT PLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		315176	B. WING			C 07/09/2020	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>  U//</u>	09/2020
				18	85 TUCKERTON ROAD		
MEDFORE	CARE CENTER			М	IEDFORD, NJ 08055		
(X4) ID PREFIX	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENT BY NO INFORMATION	D PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
TAG	REGULATORT OR I	LSC IDENT FY NG INFORMATION)	TAG		DEFICIENCY)	VI E	
F 609	Continued From page	e 2	F	609			
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by:  COMPLAINT # NJ 13  Based on interviews, Records (MR), and of documentation on 7/9 that the facility staff fato the New Jersey De (NJDOH) for 1 of 3 rereviewed for elopemental evacuation of facility also failed to fee	administrator or his or her rative and to other officials in e law, including to the State in 5 working days of the leged violation is verified e action must be taken.  To is not met as evidenced  37523  The review of the Medical ther pertinent facility (2/2020), it was determined ailed to report an elopement epartment of Health esidents (Resident #2) ent risk. The facility also leged fire which required if the residents off a unit. The collow the facility policies occident and the "Reportable efficient practice was			"Preparation and/or execution of this p of correction does not constitute admission or agreement by the provide the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely becaut it is required by provisions of federal anstate law.  1.) The facility is unable to retroactively address the concerns related to the late reporting regarding resident #2. Reside #2 was assessed medically and had not injuries. Resident #2's we checked for placement and function and	er of of se od ee eent ovas	
	·	ace Sheet (FS) Resident #2 Facility on accompany, and , with diagnoses which			all exit doors were checked with no concern. Elopement risk assessment a care plan updated for resident #2. Resident #2 was placed on every 15 minute visual checks. The facility is unable to retroactively address concern	and	
	assessment tool date had a Brief Interview score of	Im Data Set (MDS), an ed Resident #2 for Mental Status (BIMS)  The MDS also indicated uired extensive assistance			related to reporting regarding the temporary internal relocation of residen during a minor smoke event. Event reports were submitted for both of these occurrences on July 15, 2020.  2.) The facility recognizes that certain		

Facility ID: NJ60313

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		1 ` '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		315176	B. WING			C 07/09/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		01,00,2020
MEDEODD	CARE CENTER			185 TUCKERTON ROAD		
WILDI OKL	OAKL CLITTER			MEDFORD, NJ 08055		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	TATEMENT OF DEFIC ENCIES BY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	Continued From page	e 3	F 60	9		
	with Activities of Daily			types of occurrences are requi	ired to be	
		,g ().		reported to the Department of		
	Review of the Care F	Plan (CP) dated 4/9/2020 and		CMS/Federal and State regula	-	
		/2/2020, revealed Resident		including notification to the Om		
	#2 had			The facility further recognizes		
				to report required occurrences		
		ventions on the CP included		company policy may affect all i	residents.	
	but were not limited t					
	-	, the residents picture		3.) The LNHA, Department He		
	-	station and the front		Nursing Administration and Lic		
		safety. Goals included: The		Nurses were re-educated on J	•	
	safe in their environn	the building and will remain		by the Vice President of Opera regarding types of occurrences		
	sale ili tileli elivilolili	nent.		be reported, timeliness of repo		
	Review of the Facility	/'s Flonement Risk		Reportable Events form and fa		
	-	lated 4/5/2020, revealed		Accident/Incident and Elopeme		
		isk for elopement, which		The Shift Supervisor Report ha		
		t limited to: A past history of		amended to include a section t		
	wandering or exiting	the home or facility without		documenting significant occurr	rences and	
	the needed supervisi	on, verbalizing the desire to		includes prompts related to LN	IHA/Nursing	
	leave,	, problems with		Administration notification to fa		
	•	responsible party voicing		reporting/timeliness of reportin	-	
		indicate that the resident		required. Education regarding		
	may try to leave or w			amendment of the Shift Supervision of the Shif		
	included: Identification			was initiated by the ADON to the	ne Sniπ	
		on elopement list, music,		Supervisors on July 9, 2020.		
		ation of room with familiar and diversion activities.		4.) LNHA will audit 5 Shift Sup	orvicor	
	objects and priotos, a	and diversion activities.		Reports weekly for 12 weeks to		
	Review of the Incide	nt/Accident Report dated		significant occurrences are bei		
		ne following documentation		documented and reported time		
	· ·	nt #2 eloped and had a fall		of concern will be addressed.	•	
	•	5 p.m., found in "front drive at		these audits will be reviewed a	at the	
		resident absconded from a		monthly QAPI meeting for the	next 3	
	facility door other tha	n on Wing."		months with follow up provided		
		nt by resident "I want to go		needed.		
		buting factor <u>s" the foll</u> owing				
	areas were marked b	by the nurse:				

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		(X2) MULT PLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315176	B. WING _			C 7/ <b>09/2020</b>	
NAME OF PROVIDER OR SUPPLIER  MEDFORD CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  185 TUCKERTON ROAD  MEDFORD, NJ 08055		07/03/2020	
(X4) ID PREFIX TAG	(EACH DEFIC EN	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	documented, "Reside out one of the doors  Further review of the dated 7/1/2020, reve documented by the 10:00 p.m., the nurs #2 was not in approximately 15 mi immediately initiated. Supervisor was informed supervisor was informed by the police. To injuries and vital sign of apparent injuries stable. The resident hospital for an evaluation facility on apparent injuries stable. The resident hospital for an evaluation of the back-entrance discourse, during which to the front of the but the facility had a residents were evacured.	leses of incident:" the nurse lent wandered off of unit and ."  Le Incident/Accident Report lealed the following statement Admin: At approximately lese on the unit noted Resident lom. The resident was seen nutes prior. A search was at on the unit. The Nursing leader of the unit of	F 6	09			

STATEMENT OF DEFIC ENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	` ′	(X2) MULT PLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315176	B. WING _			C <b>07/09</b> /	2020	
	ROVIDER OR SUPPLIER  D CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP O 185 TUCKERTON ROAD MEDFORD, NJ 08055	CODE	01100		
(X4) ID PREFIX TAG	(EACH DEFIC EN	STATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL R LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIAT		(X5) OMPLETION DATE	
F 609	Administrator (Adminot have a Policy or the "Reportable Ever to them by the State elopement was not a was "found pretty qu"had a lot going on." 7/7/2020, was not rewere not evacuated only moved to a difficult because "there was whole thing was overfurther stated Police responded to the factor of the Police 9:55 p.m., indicated the Facility to conduperson observed set the location. Upon of the person, the officult person had eloped fofficer contacted the confirmed that the pfacility and the facility and the facility resident was not on also indicated that the identify how long the the facility or when he by the staff.  According to the "Rependence of the person by the Administry of the person by the person b	on 7/9/2020 at 4:50 p.m., the n) reported the facility does a Reportable Events, they use ents" form that was provided at the reported because the resident whickly" and the facility staff and the fire on exported because the residents from the building, they were erent area in the building no fire only smoke" and "the er in less than one hour." She and the Fire Company	Fé	609				

STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		' '	PLE CONSTRUCTION  NG	(X3)	X3) DATE SURVEY COMPLETED	
		315176	B. WING _			C 07/09/2020
	ROVIDER OR SUPPLIER  D CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 185 TUCKERTON ROAD MEDFORD, NJ 08055	)DE	01103/2020
(X4) ID PREFIX TAG	(EACH DEFIC EN	TATEMENT OF DEFIC ENCIES BY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 609	outside of the buildin events in the nature operational interrupti limited to the followir disasters, or acciden death of a patient, re evacuation of patient of the facility.  According to the Fac and Accident Policy" last reviewed 01/202 under "Policy:" Accident facility or on facil reported. An incident consistent with the nor any happening invunder "Procedure" s	a resident's whereabouts g. Examples of reportable of physical plant and ons include, but are not ag: Section #3: Fires, ts that result in injury or sidents or employees, or in is or residents from all or part cility's Policy titled "Incident implemented on 9/1999, and 0, indicated the following lents or incidents occurring in ity property are to be is any occurrence not ormal care of the residents volving visitors or employees. ection 10. Notification of the ned: a) Ombudsman b)	F	609		
F 656 SS=D	S483.21(b) Compreh §483.21(b)(1) The faimplement a comprecare plan for each reresident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identical.	nensive Care Plans cility must develop and hensive person-centered sident, consistent with the rth at §483.10(c)(2) and	F	656		7/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		(X2) MULT A. BUILDII	PLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		315176	B. WING _			C 07/09/2020
	NAME OF PROVIDER OR SUPPLIER  MEDFORD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COL 185 TUCKERTON ROAD MEDFORD, NJ 08055	DE	01700/2020
(X4) ID PREFIX TAG	(EACH DEFIC EN	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL R LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	or maintain the resic physical, mental, an required under §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclutreatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation were sident's represented (A) The resident's good desired outcomes. (B) The resident's purpose of the passion of the pass	are to be furnished to attain lent's highest practicable d psychosocial well-being as 3.24, §483.25 or §483.40; and 3.25 or §483.40 but are not resident's exercise of rights ading the right to refuse 3.10(c)(6).  Services or specialized es the nursing facility will of PASARR f a facility disagrees with the NRR, it must indicate its lent's medical record. With the resident and the active(s)-boals for admission and reference and potential for cilities must document the sesed and any referrals to less and/or other appropriate loose.  In the comprehensive care, in accordance with the thin paragraph (c) of this  T is not met as evidenced	F	1.) The care plan for residen updated to reflect safety inter currently in place. Resident # assessed medically and had	ventions 2 was no injuries.	
	Records (MR), and	, review of the Medical other pertinent facility 020, it was determined that		Resident #2's for placement and function and doors were checked with no		

PRINTED: 08/18/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:  (X2) MULT PLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		315176	B. WING		C 07/09/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0770372020
				185 TUCKERTON ROAD	
MEDFORE	CARE CENTER			MEDFORD, NJ 08055	
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 656	Continued From page	÷8	F 65	56	
	Plan (CP) to include i monitoring of the residence from the facility on (Resident #2) sample also failed to follow the	I to update a residents Care interventions for safety and dent after an elopement , for 1 of 3 residents d for elopement. The facility leir policy titled "Care Plan practice was evidenced by		Elopement risk assessment and for Resident#2 was updated. Re number #2 was placed on every minute visual checks.  2.) Care plans for residents deem at risk for wandering behaviors we reviewed by the interdisciplinary.	ned to be vere
	was admitted to the F readmitted on included but were not Review of the Minimu assessment tool date	, with diagnoses which limited to:		(IDT)on July 10, 2020 to verify ap safety interventions are in place. concern were addressed. All reson were reevaluate function and placement. All exit checked for proper closure and functioning, no issues noted. Pric receptionist leaving on a daily ba front lobby door is alarmed. If at the front door alarms need to be one staff member must remain pricate.	Areas of sident's led for doors led for to sis, the any time, shut off,
	score of also indicated under s	The MDS dated section E 900 Behavior, that havior of wandering which		the doors until the door alarm is reactivated.  3.) Licensed nurses were educat facility care plan policy including of care plans and care plan interv	ed on the updating ventions
	(POF) dated July 202 every shift, diagnosis	2's "Physician Order Form" 0, showed the following: - check placement : safety, dated 12/29/2018 check function every hift diagnosis: safety, dated		as needed with new, increased or changed wandering behaviors. Et was initiated by the ADON on Jul 2020. IDT will review care plans residents assessed to be at risk for wandering every 3 months and a any new, increased or changed was helpoviore or assurrances to verify	Education y 9, of for lso with vandering
	revealed Resident #2 , verbalized had a history of pacin	wanting to go home, and		behaviors or occurrences to verif appropriate safety interventions a place and/or have been initiated.  4.) Social Service Director will au plans of 2 residents assessed to for wandering weekly for 12 week	dit care be at risk

Facility ID: NJ60313

STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		\ ' '	PLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		315176	B. WING _	B. WING		C <b>07/09/2020</b>	
NAME OF PE	ROVIDER OR SUPPLIER	0.0170	1	STREET ADDRESS, CITY, STATE, ZIP	CODE	07/09/2020	
TO THE OT THE	TO VIDERY OIL OCIT EIER			185 TUCKERTON ROAD	0002		
MEDFORE	CARE CENTER			MEDFORD, NJ 08055			
	OUR MAR EN CE	ATEMENT OF RESIDENCIES		<u> </u>	- 000000000000000000000000000000000000		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN C ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From page	9	F6	556			
F 030	the , having at the nursing station desk for safety. Goals not exit the building a environment.  Review of the Facility Assessment (ERA) da Resident #2 was at rist the following: A past if exiting the home or fa supervision, verbalized cognitive impairment, making, and responsithat would indicate the leave or wander. Internot limited to: Identific of a larm bracel music, exercise, persfamiliar objects and pactivities.  Review of the Incident 7/1/2020, revealed the bythe nurse: Resider on 7/1/2020, at 10:15 parking lot entrance, facility door other than Description of incident home." Under "contributareas were marked be Under "Possible cause"	the residents picture posted and the front receptionist included: The resident will and will remain safe in their.  Is Elopement Risk ated 4/5/2020, revealed sk for elopement related to nistory of wandering or acility without the needed at the desire to leave, problems with decision ble party voicing concerns at the resident may try to reventions included but were eation bracelet in place, use et, photo on elopement list, onalization of room with hotos, and diversion  It/Accident Report dated e following documentation at #2 eloped and had a fall p.m., found in "front drive at resident absconded from a mon Wing."  It by resident "I want to go outing factors" the following y the nurse:		will also audit care plans new or changed wanderin occurrences weekly for 1: of concern will be address these audits will be review monthly QAPI meeting for months with follow up proneeded.	ng behaviors or 2 weeks. Areas sed. Results of wed at the r the next 3		
	out one of the doors.  During an interview o	nt wandered off of unit and n 7/9/2020 at 1:50 p.m., the DON) was asked what safety					

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		I DENT EICATION NUMBER		PLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315176	B. WING _			C 07/09/2020	
	ROVIDER OR SUPPLIER  D CARE CENTER	1		STREET ADDRESS, CITY, STATE, ZIP ( 185 TUCKERTON ROAD MEDFORD, NJ 08055	CODE	0170072020	
(X4) ID PREFIX TAG	(EACH DEFIC EI	STATEMENT OF DEFIC ENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	eloped from the Fa stated she spoke to see if a was check the function that, I believe the case." and mainten the building alarms know if the CP was CP," or whether Re observation when hon 7/2/2020. "I was were no documentaresident MR to indiwith the above interviewed Care Pl documented "contin wandering and rediunit."  Review of the facility Policy" with a revise reviewed date of 1/2 under Policy: It is the ensure that all resist care plans develop team to ensure quaresident's plan of casection 6. Care plan updated as needed.	put in place after Resident #2 cility on 7/1/2020. The DON of 3 nurses regarding the em, she checked the resident in place, however, she did not of the the the nurses did y gave and a new alarm just in ance checked the function of y she also stated, she did not updated, "I did not update the esident #2 was placed on 1:1 he/she returned to the facility on't here I don't know." There ation or evidence found in the cate that the CP was revised rectate that the cate that the rectate that the resident for rectate that the rectate that the rectate that the resident for rectate that the re	F	556			

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		1 ' '	(X2) MULT PLE CONSTRUCTION A. BUILDING			
		315176	B. WING		07/09/2020	
	ROVIDER OR SUPPLIER  D CARE CENTER	1	-	STREET ADDRESS, CITY, STATE, ZIP CODE 185 TUCKERTON ROAD MEDFORD, NJ 08055	07/05/2020	
(X4) ID PREFIX TAG	(EACH DEFIC EN	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 689 SS=J	CFR(s): 483.25(d)(1  §483.25(d) Accident The facility must ens §483.25(d)(1) The re as free of accident h  §483.25(d)(2)Each r supervision and assi accidents. This REQUIREMEN by: COMPLAINT # NJ  Based on observation Medical Records (M pertinent facility doc was determined that resident with was at risk for elope history of wandering was appropriately m prevent elopement of facility also failed to Policy" and their "Ind The facility also faile safety to prevent elo (Resident #2) sampl 7/1/2020 at 9:45 p.m exit the facility unatte Supervisor deactivat unlocked the front de exited the building. V reentered the facility alarm and lock the d monitor the exit while 7/1/2020 at 9:45 p.m	s. sure that - esident environment remains azards as is possible; and esident receives adequate istance devices to prevent  T is not met as evidenced	F 689	1.) Resident #2 was assessed medicand had no injuries. Upon return from hospital, resident's was checked for placement and function all exit doors checked with no concerned updated. All residents on were re-evaluated for function and placement. All exit doors checked for proper closure and functioning. No is noted. Staff education initiated with supervisor and other staff including importance of door being locked and monitored at all times, not leaving docunlocked and unattended at any time ensuring that if doors are unlocked that they the alarm is activated immediate and review of wanderguard and door alarm policies and protocols. Prior to receptionist leaving on a daily basis, the front lobby door is alarmed by the supervisor and the outside entrance of is locked. If at any time the front door alarms need to be shut off, one staff member must remain present at the cuntil the door alarms are reactivated. Resident #2 will remain on 15 minute	n the and ans. plan plan sues	

		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315176	B. WING _				C / <b>09/2020</b>
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 01.	700/2020
MEDEOD	OADE CENTED			185	TUCKERTON ROAD		
MEDFORL	CARE CENTER			ME	DFORD, NJ 08055		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	TATEMENT OF DEFIC ENCIES BY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From pag without the knowledge to wander down the company of the compan	F 6		visual checks.  2.) All residents may be effected by the concerns identified. An audit of current residents assessed to be at risk for wandering/elopement behaviors was completed on July 9, 2020 by the ADO to verify appropriate safety intervention were in place. Areas of concern were addressed. Residents currently utilizing devices were checked to verify placement and proper functioning.	N ns		
	history of wandering and/or elopement in an Immediate Jeopardy (IJ) situation. The IJ was identified on 7/9/2020 at 5:01 p.m., when the Facility's Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ and were provided the IJ template. The IJ ran from 7/1/2020 through 7/9/2020 at 6:09 p.m., and was lifted when the facility provided an acceptable Removal Plan. This deficient practice was further evidenced by the following:  1. According to the Face Sheet (FS), Resident #2 was admitted to the Facility on and readmitted on with with the facility on the following was admitted to the facility on the face of the fa				verify placement and proper functioning the	nt nts nd N	
					terminated from facility employment on July 14, 2020. Nursing Supervisor #2 an RN who is being trained to be a Supervisor. The date of the occurrence was her first day of supervisor training thus she was not yet aware of supervisor training thus she was not yet aware of supervisor training thus she was not yet aware of supervisor training thus she was not yet aware of supervisor training thus she was not yet aware of supervisors responsibility of facility security procedures. On July 10, 2020, the Administrator completed education to a Supervisors regarding verifying the exideors alarms are on and functioning are at any time the front door alarm needs be shut off, a staff member must remain at the door until the door alarm is	e and sory all t nd if to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	` ′	PLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		315176	B. WING		C		
NAME OF D	ROVIDER OR SUPPLIER	310170	1	STREET ADDRESS, CITY, STATE, ZIP COD	07/09/2020	$\dashv$	
NAME OF P	ROVIDER OR SUPPLIER				=		
MEDFORE	CARE CENTER			185 TUCKERTON ROAD			
				MEDFORD, NJ 08055			
(X4) ID PREFIX TAG	(EACH DEFIC I	/ STATEMENT OF DEFIC ENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	ON	
E 690	0	40					
F 689	Continued From p	age 13	F 6	689			
				reactivated.			
		e Plan (CP) dated 4/9/2020,					
	revealed Resident						
		zes wanting to go home, and		3.) Nursing staff, administration			
		acing on and off the unit.		Department Heads, and recep			
		ne CP included but were not alarm bracelet in		were re-educated by the ADO			
	limited to: a place to the			facility elopement policy and value an elopement occurs. This re			
		nursing station and the front		was completed on July 10, 20			
		or safety. Goals included: The		staff were re-educated regard			
		kit the building and will remain		Accident/Incident and Elopem			
	safe in their enviro	S .		and prompt interventions for r			
				with new, increased or change			
	Review of Resider	nt #2's "Physician Order Form"		wandering behaviors. Topics			
		2020, showed the following:		include importance of visual o			
		- check placement		providing safe and secure env	/ironment		
	every shift, diagno	sis: safety, dated 12/29/2018.		and verifying safety intervention	ons are in		
		- check function every		place, initiated and maintained	9		
		. shift, diagnosis: safety, dated		Supervisors were re-educated			
	12/29/2018.			securing of the facility exits to			
				elopements. This education w			
		ility's Elopement Risk		completed by the ADON on Ju	-		
		) dated 4/5/2020, revealed		Shift supervisor report has be			
	Resident #2 was a	at		to include security check docu			
				with education regarding this overall security check s comp	9		
				ADON on July 10, 2020. In-se			
				provided to shift supervisors,			
				and front line staff regarding t	•		
				lobby door being locked when			
	. Interventi	ons included but were not		present to visually monitor do			
	limited to:			ADON on July 10, 2020.	,,		
	music evercise n	, a photo on the elopement list, ersonalization of room with		4.)ADON will audit 2 elopeme	int		
		d photos, and diversion					
	activities.	a photos, and divorsion		assessments monthly for 3 months for residents assessed to be at risk for			
	GOUVINGS.			wandering behaviors and with			
	Review of the	Consultation for		increased or changed wander			
	Resident #2 dated			behaviors to verify that approp			

		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315176	B. WING _			C 07/09/2020		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C 185 TUCKERTON ROAD MEDFORD, NJ 08055	CODE	31733/2323		
(X4) ID PREFIX TAG	(EACH DEFIC EN	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE		
F 689	"Chief Complaint/Interequested a follow-user recommendations in residents of the medication and segments of the medication of the description of incide home." Under "contrareas were marked lead out one of the description of the descriptio	nted the following: Under erval History," Facility p on resident due to  The cluded; decreasing the for 3 days then discontinuing a day.  Int/Accident Report dated the following documentation ent #2 eloped and had a fall 5 p.m., found in "front drive at resident absconded from a fan on Wing."  Int by resident: "I want to go ibuting factors," the following by the nurse:  Ses of incident:" the nurse ent wandered off of the unit	F6	interventions have been im are in place and are reflect resident's care plan. ADON audit 2 residents utilizing devices weekly for 12 weed device placement and function checked and documented. audit 3 shift supervisor rep 12 weeks to verify security being completed/document concern will be addressed. These audits will be reviewed monthly QAPI meeting for months and follow up as not seen and the seen audits will be reviewed the seen audits will be reviewed monthly QAPI meeting for months and follow up as not seen audits.	ks to verify stion are being ADON will orts weekly for checks are ted. Areas of Results of ed at the the next 3			

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		(X2) MULT PLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315176	B. WING			C 07/09/2020	
	ROVIDER OR SUPPLIER	I		18	TREET ADDRESS, CITY, STATE, ZIP CODE B5 TUCKERTON ROAD IEDFORD, NJ 08055	1 011	03/2020
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 689	no apparent injuries a stable. The resident whospital for an evaluate facility on a found. Upon return to checked the alar be operational. Upon Admin, Nursing Superunal armed and unlook the back-entrance do secure, during which to the front of the build to the front of the build door while it was not Resident's alarm to not Resident's sock at the alarm to not Review of the Facility Resident #2 dated 1:59 a.m., Nursing Streeeived a call from a p.m., reporting the popasserby who observed and alarm to not ground." Vital signs who mormal limits. The resident's received who reported the resident who apparent facility. "No apparent	s were checked, there were and the vital signs were was transported to the ation and returned by the arriver #1 stated, that she ked the front door to check or to ensure they were time the resident wandered ding and exited the doors.  If the following on the cort: The resident wandered ding and exited the front alarmed and unlocked.  In the following on the cort: The resident wandered ding and exited the front alarmed and unlocked.  It is Progress note for a "s Progress" note for a "s P	F	689			

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		IDENT FICATION NUMBER:		X2) MULT PLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315176	B. WING _				09/ <b>2020</b>	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  185 TUCKERTON ROAD			<u> </u>	00,2020	
				MEDFORD, NJ 08055				
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 689	Continued From page	e 16	F 6	889				
	the Admin reported R Facility on staff were notified by was outside. "Between p.m., someone called the resident sitting in further reported that r locked at 6:30 p.m. by when the receptionist around 10:0 #1 unlocked and dearfront door then went to back door had been beack door she would building. "The resident front door after the St Supervisor #1 then cat the alarm not realizing. The resident was wean the supervisor #1 then cat the alarm from trigger on the supervisor when he/she did not sound. The Adpants and socks on we the alarm from trigger opened the door.  During an interview of Certified Nursing Ass Resident #2 was on hand she provided ever between 9:10 and 9:3 him/her to bed. She salarm bracelet was on placement and function the nurse. The CNA had a history wander	through the front door. The through the front door. The the police that the resident an 10:00 p.m. and 10:15. If the police when they saw the driveway." The Admin routinely the front door is by the nursing supervisor cleaves for the night. On 10 p.m., Nursing Supervisor ctivated the alarm to the putside to check that the cocked. If she went out the have been locked out of the nurst have exited out the have been locked out the nurst have exited have exited, however, the alarm dring when the resident had which could have prevented ring when the resident had not have the resident of the nurst have exited the resident had not have the resident had not had not have the resident had not have the resident had not have						
	the nurse. The CNA had a history wander admitted and that is v	reported that Resident #2 ing since the resident was						

STATEMENT OF DEFIC ENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315176	B. WING			C 07/09/2020		
	ROVIDER OR SUPPLIER  CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE  185 TUCKERTON ROAD  MEDFORD, NJ 08055			7770072020		
(X4) ID PREFIX TAG	(EACH DEFIC EN	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 689	spouse and reported verbalized leaving the resident had a histor door causing the ala happened on several stated that on from the facility she sound.  During an interview of DON reported, that the Assessments (ERA) done if the resident's The staff looks at the saying they want to ghistory the family given reported, the nursing checking the last placement every shinnear the front door the separate alarms. The when someone atterdopen the front door.  During an interview of Nursing Supervisor is to lock the front door is to lock the front door.	In #2 was asking for his/her I missing them, but never the facility, however, the y of pushing on the back exit rm to sound, and this I occasions. The CNA further when Resident #2 eloped never heard any alarm  on 7/9/2020 at 11:37 a.m., the he Elopement Risk for are at risk for elopement. Fire behaviors, like wandering, go home or leave, and the es us. The DON also a staff is responsible for arm bracelets for function and ft so that if the resident gets	F 68	39				
	leaves, I lock both do Supervisor #1 then r around 9:30 or 10:00 door with Nursing Su employee entrance of side of the building. job to check the doo	or 7:00 p.m. "When she cors with a key." Nursing eported that on 7/1/2020 p.m. she went out the front upervisor #2 to show her the door, which is located on the It is the nursing supervisors r is locked or secured.						

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		(X2) MULT A. BUILDII	PLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		315176	B. WING _			C 07/09/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 185 TUCKERTON ROAD MEDFORD, NJ 08055	•	01703/2020	
(X4) ID PREFIX TAG	(EACH DEFIC EN	STATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL R LSC IDENT FY NG INFORMATION)	D PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page		F 6	689			
	walked around the bill Supervisor #2. Nurhad the keys with mill when that door is loom the employee door p.m. until 5:30 or 6:00 employee's from cook to come in the front Covid and temperate their shifts.  In addition, the Nurse that they did not conthrough the front do the employee entral back to lock the front from a nurse who reoutside with a reside stated "a passerby resident was in the he/she followed me exit the building In door unlocked. I dea thought the second The doors don't lock Nursing Supervisor time she knew the rewhen the Police we seconds. He/she mill exited the building rewithin seconds the Industry and interview the Maintenance Dinnever called in to chall alarm resident on	tivated the door alarm, then building with Nursing sing Supervisor#1 stated "I e so people could get out cked but no one could get in." is locked, from 6:30 or 7:00 00 a.m., this prevents ming in that door, they need door to get screened for ures taken before starting sing Supervisor #1 reported me back in the building or, but entered the building by note and as they were heading at door she received a call exported the Police were ent. Nursing Supervisor #1 called the Police to say a driveway outside. I guess outside. I never saw him/her at was my mistake that I left the activated the alarm I door would alarm but it didn't. It is just an alarm goes off." #1 further stated, the first esident was missing was be outside. "It was within that have followed us and tight after us because it was police were here."  on 7/9/2020 at 12:34 p.m., rector (MD) reported, he was neek the door alarm or after the elopement of the however, he routinely each morning. He also					

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		' '	(X2) MULT PLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	315176	B. WING			C 07/09/2020		
			185 TUCKERTON	ROAD	1 017	03/2020	
(EACH DEFIC ENC	CY MUST BE PRECEDED BY FULL	D PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
reported, that the alarm are 2 different sound when the residence the alarm. The front of someone opens the building. The outer denter the building, he deactivated residents without the alarm sounds, a key of t	alarm and the front door alarms. The alarm will dent gets within a few feet of door alarm will sound when inside door to exit the oor is locked so no one can owever, if the door alarm is so or staff can exit the building unding. Once the front door is needed to reset the alarm. alarm sounds a code is alarm.  Observation on 7/9/2020 at activated the front door alarm the MD attempted to exit the alarm sounded. The MD anould be heard throughout  O p.m., Resident #2's bracelet was tested with the ent. The resident was alarm bracelet to the later was done 2 times. When end to exit the inner front sounded both times.  p.m., the Security Video was reviewed with the the following timeline:  onist exits the building and the locked the outer door then res.  upervisor #1 unlocked the	F	589				
locked the doors and	alarmed the front doors.						
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFIC ENC REGULATORY OR  Continued From pag reported, that the alarm are 2 different sound when the resid the alarm. The front of someone opens the building. The outer denter the building, ho deactivated residents without the alarm sounds, a key of the alarm sounds alarm sound	CORRECTION    Summary Statement of Defic Encies (Each Defic Ency Must be Preceded by Full Regulatory or LSC IDENT FY NG INFORMATION)    Continued From page 19   reported, that the   alarm and the front door alarm are 2 different alarms. The   alarm will sound when the resident gets within a few feet of the alarm. The front door alarm will sound when someone opens the inside door to exit the building. The outer door is locked so no one can enter the building, however, if the door alarm is deactivated residents or staff can exit the building without the alarm sounding. Once the front door alarm sounds, a key is needed to reset the alarm. If the   alarm sounds a code is needed to reset the alarm.    During an alarm test observation on 7/9/2020 at 12:50 p.m., the MD activated the front door alarm using the key. When the MD attempted to exit the inner front door the alarm sounded. The MD reported the alarm should be heard throughout the facility.    On 7/9/2020 at 12:59 p.m., Resident #2's   alarm bracelet was tested with the Admin and MD present. The resident was observed with a   alarm bracelet to the   alarm sounded to the limit of the check was done 2 times. When the resident attempted to exit the inner front doors the   alarm sounded both times.  On 7/9/2020 at 2:50 p.m., the Security Video	A BUILDING  ROVIDER OR SUPPLIER  CARE CENTER  SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)  Continued From page 19 reported, that the alarm and the front door alarm are 2 different alarms. The alarm will sound when the resident gets within a few feet of the alarm. The front door alarm will sound when someone opens the inside door to exit the building. The outer door is locked so no one can enter the building, however, if the door alarm is deactivated residents or staff can exit the building without the alarm sounding. Once the front door alarm sounds, a key is needed to reset the alarm.  If the alarm sounds a code is needed to reset the alarm.  During an alarm test observation on 7/9/2020 at 12:50 p.m., the MD activated the front door alarm using the key. When the MD attempted to exit the inner front door the alarm sounded. The MD reported the alarm should be heard throughout the facility.  On 7/9/2020 at 12:59 p.m., Resident #2's alarm bracelet was tested with the Admin and MD present. The resident was observed with a alarm bracelet to the alarm sounded both times.  On 7/9/2020 at 2:50 p.m., the Security Video footage for alarm sounded both times.  On 7/9/2020 at 2:50 p.m., the Security Video footage for alarm sounded the following timeline:  6:49 p.m. the receptionist exits the building and Nursing Supervisor #1 locked the outer door then alarms the inner doors.  6:53 p.m. Nursing Supervisor #1 unlocked the door to let a resident back in the building then locked the doors and alarmed the front doors.	TO CARE CENTER    STREET ADDRESS. 185 TUCKERTON MEDFORD, NJ (1)	A BUILDING  315176  3151776  3151776  3151776  3151776  3151776  31517776  3151776  3151776  3151776  3151776  3151776  3151776  31517776  31517776  31517776  31517776  31517776  31517776  31517776  315177776  31517777777777777777777777777777777777	A BUILDING  315176  3151776  31517776  31517776  31517776  31517776  31517776  315177776  315177776  31517777777777777777777777777777777777	

STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		(X2) MULT PLE CONSTRUCTION  A. BUILDING			COMPLETED		
		315176	B. WING _			C 07/09/2020	
	ROVIDER OR SUPPLIER  CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  185 TUCKERTON ROAD  MEDFORD, NJ 08055	I	07/09/2020	
(X4) ID PREFIX TAG	(EACH DEFIC EN	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFI) TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE AP  DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	doors and alarmed to 7:26 p.m. Nursing Sonear the front door. 7:30 p.m. to 8:30 p.m. entrance. 8:47 p.m. Nursing Sobserved at the front Supervisor #1 reachthen the inner left domoved the chairs, a 8:58 p.m., The two Sofront lobby through the entrance. They are addoors either relocking 9:44 p.m. Resident alone, then exits the front door, then out 10:02 p.m. Strobe ligon scene) 10:07 p.m. A CNA atthrough the front door reset any alarms. 10:11 p.m. RN #1 rewith a wheelchair. 10:13 p.m. Supervisibuilding through from During an interview #1 reported; that the resident had eloped called Nursing Super Supervisor the policistated he observed curb in the driveway for injuries, no appa	be mes back in and locked the he front door.  upervisor #1 puts 2 chairs  m. No activity at the front  upervisor #1 and #2 are t entrance. Nursing es up to the inner right door for, deactivated the alarms, and then they go outside. Supervisors returned to the he Service Corridor/employee not observed near the front ag or reactivating the alarms.  #2 enters the front lobby bugh the left side of the inner the outer door.  ghts observed outside. (Police and another staff member exit for.  IN #1) observed exiting or without stopping to shut off enters the building then exits  or #1 and Supervisor #2 exit	F	589			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	` ′	(X2) MULT PLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315176	B. WING				C	
	20,4252.02.0422452	313170	B. W			07/	09/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
MEDFOR	CARE CENTER			185 TUCKERTON ROAD				
				MEDFORD, NJ 08055				
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRECTIVE ACTIO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
				DEFICIENCY)	)			
F 689	Cantinual Francisco	. 04	F.0					
F 009	Continued From page		F 6	089				
		the Emergency Medical						
		rrived, they assessed the						
		the vital signs. Nursing						
		ırsing Supervisor #2 then						
		#1 reported he went back to						
		he did not reset any alarms						
	-	ding to assess Resident #2						
	because they were no	ot sounding.						
	D	Days and data d						
	Review of the Police	•						
		ne Police were dispatched to						
	· •	t a well-being check on a						
	1 -	ted on the curb in front of						
		serving an ankle monitor on						
	-	was led to believe the						
		om the nursing facility. The						
		nursing supervisor who						
		rson was a resident of the						
		was unaware that he/she						
		he officer reported that the confused" and unable to						
	, ,	here he/she was or how they						
		•						
		were requested to the sident's mental status, a						
		, and an alleged fall,						
	however the officer re	eported no visible injuries						
		eaking to the facility staff,						
		at an employee stated that						
		ked out of a normal exit						
		e area because the alarms						
		inaudible beyond the front						
	of the building. The st	-						
		us was normal for his/her						
		hat the resident was known						
		the unit. The staff was						
	l	long the resident was						
		ity or when he/she was last						
	accounted for by the	-						
		ed by the EMTs and asked to						

STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		(X2) MULT PLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315176	B. WING _			C	
	ROVIDER OR SUPPLIER	010110		STREET ADDRESS, CITY, STATE, ZIP CODE  185 TUCKERTON ROAD  MEDFORD, NJ 08055	l	07/09/2020	
(X4) ID PREFIX TAG	(EACH DEFIC EN	STATEMENT OF DEFIC ENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	that the resident like hospitalized and atte to the facility and the that she would sign (RMA) on the reside indicated that the reside to the POA could was transported to the The Police report furth was able to reach a was listed as an emmember reported the occasion in which the from the facility with and was known to walso stated that they was placed appropring the facility given the repeatedly failed to monitor the whereal from eloping from the Review of the facility Policy," with a revise reviewed date of 1/2 under "Purpose:" To well-being of all resident, the facility the resident got out case), and to develo future safety and see In-service must take regarding facility po and what to do in caresident. These in-service resident.	lowever, the staff indicated ely did not need to be empted to return the resident e nursing supervisor stated a Refusal of Medical Attention ent's behalf, however, the staff sident's spouse was the POA. In the nospital.  In the indicated that the officer nother family member who ergency contact. The family at this was not the first elyshe had successfully eloped out the knowledge of the staff wander. The family member of did not believe that he/she intelly within a secured unit in prior history and that the staff ensure the safety by failing to bouts and protect him/her	F	589			

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315176	B. WING _				09/ <b>2020</b>
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  185 TUCKERTON ROAD  MEDFORD, NJ 08055				<u> </u>
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
F 689	and Accident Policy" last reviewed 01/2020 under "Policy:" Accident facility or on facility reported. An incident consistent with the not or any happening invunder "Procedure" set following as determind Department of Health Resident #2 was able unsecured front door the staff and was able driveway and was obmain road with a spechour). The police wer facility that the outside of the building transported to the Enambulance and evaluating the driveway and was obmain road with a spechour). The police wer facility that the outside of the building transported to the Enambulance and evaluating the driveway and was obmain road with a spechour). The police wer facility that the outside of the building transported to the Enambulance and evaluating the facility is deficient practice other residents with the wandering and/or elogopardy (IJ) situation. The IJ was identified when the Facility's Accident provided the from 7/1/2020 throug was lifted when the facility is Accident from 7/1/2020 throug was lifted when the facility is Accident from 7/1/2020 throug was lifted when the facility is Accident from 7/1/2020 throug was lifted when the facility is Accident from 7/1/2020 throug was lifted when the facility is Accident from 7/1/2020 throug was lifted when the facility is Accident from 7/1/2020 throug was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from 7/1/2020 through was lifted when the facility is Accident from	lity's Policy titled "Incident implemented on 9/1999, and 0, indicated the following ents or incidents occurring in ty property are to be is any occurrence not ormal care of the residents olving visitors or employees. ection 10. Notification of the ed: a) Ombudsman b)  It to exit the building by the without the knowledge of e to wander down the served by a motorist near a ed limit of 45 mph (miles per e alerted and notified the resident was g. The resident was ergency Room (ER) via lated for possible injuries. Explaced Resident #2 and all ognitive impairment who end a known history of pement in an Immediate in.  In 7/9/2020 at 5:01 p.m., diministrator (Admin) and the DON) were notified of the IJ et IJ template. The IJ ran in 7/9/2020 at 6:09 p.m., and acility provided an Plan.	F	589			
	A revisit to verify the	Removal Plan occurred on					

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315176	B. WING		C 07/09/2020	
NAME OF PROVIDER OR SUPPLIER  MEDFORD CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  185 TUCKERTON ROAD  MEDFORD, NJ 08055	1 07/03/2020	
(X4) ID PREFIX TAG	( (EACH DEFIC ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION		
F 689	Continued From page 7/16/2020.	e 24	F 689	9		
F 835 SS=E	S483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, well-being of each retries REQUIREMENT by:  COMPLAINT # NJ 1  Based on interviews, review, and review of documentation on 7/S that the facility's admenated for 2 incomplemented for 2 incomplement, and facevacuation of resider practice was evidence.	on.  Ininistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  In is not met as evidenced  37523  Medical Record (MR)  Other pertinent facility  Othe	F 83	1.) The facility is unable to retroactive address the concerns related to the lareporting regarding resident #2. Resi #2 was assessed medically and had rinjuries. Resident #2's checked for placement and function a all exit doors were checked with no concern. Elopement risk assessment care plan updated for resident #2. Resident #2 was placed on every 15 minute visual checks. The facility is unable to retroactively address concerelated to reporting regarding the temporary internal relocation of resided during a minor smoke event. Event	ate dent no was and and rns	
	readmitted on included but were not read to the Minimulassessment tool date	ım Data Set (MDS), an		reports were submitted for both of the occurrences on July 15, 2020.  2.) The facility recognizes that certain of occurrences are required to be reported.	type	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	I ` '	(X2) MULT PLE CONSTRUCTION A. BUILDING		
		315176	B. WING			C <b>07/09/2020</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	0110012020
				185 TUCKERTON ROAD		
MEDFORE	CARE CENTER			MEDFORD, NJ 08055		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 835	Continued From page		F 83			
	also indicated under a Resident #2 had a be occurred daily.	This MDS dated , , section E900 Behavior, that shavior of wandering which		to the Department of Health per CMS/Federal and State regulatio including notification to the Ombu as required. The facility further recognizes that the not reporting required occurrences and not foll facility policy may affect all reside	udsman timely o lowing	of
	revealed Resident #2 verbalizes and had a history of p	that wanting to go home, pacing on and off the unit		3.) Facility administration was re- by the Vice President of Operation July 9, 2020 regarding types of occurrences that must be reported	ons on ed,	
	the Facility to conduct person observed seat the location. Upon obthe person the officer person had eloped fro officer contacted the confirmed that the person facility and the facility resident was not on the	he Officer was dispatched to t a well-being check on a ted on the curb in front of serving an ankle monitor on was led to believe the om the nursing facility. The nursing supervisor who rson was a resident of the was unaware that the ne unit.		timeliness of reporting, Reportable form and facility policies related the Accidents/Incidents and Elopeme Vice President of Operations will notified regarding occurrences the required to be reported to the Deformation of Health and Ombudsman. Shiff Supervisor Reports have also be amended to include security check documentation with education regarding the completed by the ADON on July	o ent. The be at are partmer t en ck garding checks	e nt
	that the facility had a residents were evacuated different part of the fain the building.  During an interview of Administrator (Administrator (Administrato	#1 reported to the surveyor		4.) The Vice President of Operatic audit 3 Shift Supervisor Reports of 12 weeks to verify documental regarding potential reportable evoccurred and the required events reported to the Department of He to the Ombudsman as required til Areas of concern will be address results of these audits will be revithe monthly QAPI meeting for the months will follow up as needed.	weekly ation ents has are ealth and mely. ed. The iewed a	s d e t

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315176	B. WING _			C <b>7/09/2020</b>	
NAME OF PROVIDER OR SUPPLIER  MEDFORD CARE CENTER			STREET ADDRESS, CITY, STATE, ZI 185 TUCKERTON ROAD MEDFORD, NJ 08055				
(X4) ID PREFIX TAG	(EACH DEFIC EN	TATEMENT OF DEFIC ENCIES CY MUST BE PRECEDED BY FULL R LSC IDENT FY NG INFORMATION)	D PREFII TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 835	were not evacuated only moved to a diffe "there was no fire or thing was over in less According to the "Re December 2019, fro Department of Healt provided to the surve specifies the followin continue to require for purposes of reportangement of the facility resident's whereabout Examples of reportangement of the facility resident's whereabout Examples of reportangement of the facility resident's whereabout Examples of reportangement of the facility resident from all or section #3: Fires, directly with a revise residents from all or Review of the facility Policy" with a revise reviewed date of 1/2 under "Purpose" To well-being of all resident got out of the facility will attem resident got out of the facility and security of the safety and s	ported because the residents from the building they were erent area in the building ally smoke" and "the whole as than one hour."  exportable Events" form dated in the New Jersey the (NJDOH) which was every by the Admin, the form and: The Department will accilities to report elopements. Forting, and elopement is a staff is not aware of a cuts outside of the building. The ble events in the nature of perational interruptions limited to the following: sasters, or accidents that att of a patient, residents or accuation of patients or	F	335			

		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		315176	B. WING			C <b>07/09/2020</b>	
NAME OF PROVIDER OR SUPPLIER  MEDFORD CARE CENTER				STREET ADDRESS, CITY, STATE, ZI  185 TUCKERTON ROAD  MEDFORD, NJ 08055	P CODE	01103/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)		D PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	ILD BE COMPLETION	
F 835	According to the Far and Accident" impler reviewed 01/2020, ir "Policy:" Accidents of facility or on facility p An incident is any of the normal care of the involving visitors or es "Procedure" section	cility's Policy titled "Incident mented on 9/1999, and last adicated the following under or incidents occurring in the property are to be reported. Ecurrence not consistent with the residents or any happening employees. Under 10. Notification of the ned: a) Ombudsman b) h	F	835			