STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDFORD CARE CENTER	**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)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 832 Based on interview and record review, it was determined that the facility failed to notify the resident's emergency contact of a facility acquired pressure ulcer for 1 of 6 residents (Resident #6) reviewed. This deficient practice was evidenced by the following: According to the Face Sheet, Resident #6 was readmitted to the facility with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set (MDS), an assessment tool used in the management of care, dated 07/16/2020 reflected that the resident was severely cognitively impaired, incontinent of bowel and bladder, required extensive assist of two persons for bed mobility and had impairment to upper and lower extremities on one side. The MDS further revealed that Resident #6 had been identified as being at risk for developing pressure ulcers and had two facility acquired pressure ulcer at that time. The MDS noted that skin and ulcer treatments were in place and included the use of pressure reducing devices on the wheelchair and the bed, turning/repositioning program, pressure ulcer care, and application of ointment/medications. Review of Resident #6's Weekly Wound Documentation revealed that the resident had a 6 centimeters (cm) x 6.5 cm facility acquired pressure ulcer to the left sacrum (sacral wound) with the onset date of 05/14/2020. Review of the resident's Care Plan (CP), initiated on 05/14/2020, reflected the resident presented with an unstageable sacral wound to the left sacrum. Review of the Nursing Clinical Notes (nursing notes) for the month of May 2020 did not include notification to the emergency contact of Resident #6's left sacral wound. On 08/07/2020 at 1:36 PM, the surveyor conducted an interview with the Registered Nurse (RN) responsible for the care of Resident #6. The RN stated that if a resident presented with a new wound, the nurse was to report the findings to the Director of Nursing (DON), notify the physician and inform the family. The RN further stated she would document family notification in the nursing notes. During an interview with the Administrator on 08/07/2020 at 2:10 PM, the Administrator stated that families were called weekly to provide an update on the residents' COVID status and that clinical change in conditions were not discussed during these COVID status update calls. The Administrator stated it was the responsibility of the nurses and physicians to update the family with any clinical change in status. The Administrator further stated that family notification of change in status should be documented in the resident's medical record. During an interview with the Acting Director of Nursing (DON) on 08/10/2020 at 9:28 AM, the Acting DON stated she expected the nurse to measure the wound, call the physician for any new orders and inform the resident's family. The DON stated that a resident's family should be notified whenever there was a change in the resident's condition. The DON further stated that family notification should be documented in the nursing notes and 24-hour report. During a follow-up interview with the Administrator on 08/10/2020 at 11:20 AM, the Administrator stated the Registered Dietician (RD) placed a call to Resident #6's emergency contact on 05/13/2020 to provide an update on the resident COVID status and wound. During an interview with the RD on 08/10/2020 at 11:29 AM, the RD stated the calls placed to residents' families were to update them on the resident's COVID status and that it was not her responsibility to inform the family of a newly acquired wound. The RD further stated that she did not address wounds during these calls because it was the responsibility of the nurse to inform the family with any change in conditions. During an interview with the Licensed Practical Nurse (LPN) assigned to the COVID unit on 08/10/2020 at 12:51 PM, the LPN stated if a resident presented with a new wound, the nurse should assess the wound, inform the RN and they both would measure the wound, notify the physician, initiate a wound consult, and document findings in the nursing notes and 24-hour report. The LPN further stated she was familiar with the resident and that Resident #6's sacral wound was present when transferred to the COVID unit in May 2020. The LPN stated she specifically spoke to Resident #6's emergency contact to provide an update on the resident's wound. At that time, the surveyor requested documentation that reflected she spoke with Resident #6's emergency contact about the resident's sacral wound. The facility was unable to provide documentation that the LPN informed or discussed Resident #6's sacral wound with the resident's emergency contact. In a follow-up interview with the Administrator on 08/10/2020 at 1:06 PM, the Administrator confirmed that she was unable to find documentation that Resident #6's emergency contact had been notified of the 05/14/2020 sacral wound. Review of the facility's Pressure Ulcer Prevention and Management Policy, with the revision date of 09/2017, revealed the resident, family and/or Power of Attorney (POA)/legal guardian would be informed of newly identified pressure ulcers. Review of the facility's Condition: Significant Change in policy, with the review date of 11/2019, revealed the resident and/or responsible party would be promptly notified by the nurse in the event of a condition change. The policy further revealed the notification including date, time and by whom, should be documented in the clinical record by appropriate personnel and on the 24-hour report. NJAC 8:39-13.1 (c)

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