STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15c001	A. BUILDING: _____ B. WING _____	C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT COLLI	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Complaint Complaint#: NJ00187437 Census: 104 Sample Size: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;	A 401		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/12/25

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A 401	Continued From page 1	A 401		

This REQUIREMENT is not met as evidenced by:
Complaint#: NJ00187437

Based on interview, and record review, it was determined that the facility failed to provide a safe environment for a resident that was at [redacted] on admission and NJ Ex Order 26. 4B1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 6/16/2025, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of NJ Exec Order 26.4b1 and a "time of event" of 1:43 a.m.., Resident #2 [redacted] at 1:43 a.m. and [redacted] to the [redacted] and was NJ Ex Order 26. 4B1 [redacted] The resident stated he/she was [redacted] to his/her [redacted] The resident was not previously at NJ Ex Order 26, 4B1, and this was an isolated incident. Resident#2 did not sign out at the front desk and security did not require him/her to do so.

On 7/2/2025 at 8:55 a.m., on entrance, the surveyor asked about the incident, the Executive Director (ED) stated that it was an isolated incident for Resident #2. She continued to say that Resident #2 was not an NJ Ex Order 26, 4B1 so there was no photo at the front desk for him/her, the [security] guard at the desk thought the resident was NJ Exec Order 26.4b1 and someone [redacted] Resident #2 NJ Ex Order 26, 4B1, called the [redacted] and the NJ Ex Order 26, 4B1 [redacted] to the

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A 401	Continued From page 2 facility. At 9:55 a.m., the surveyor interviewed Resident #2 about the incident, he/she stated that it was NJ Exec NJ Ex Order 26, 4B1 he/she was going to see his/her NJ Ex Order 26, 4B1, NJ Exec Order 26.4b1 and the NJ Ex Order 26, 4B1 to the facility. At 1:55 p.m., the surveyor reviewed the Medical Record (MR) that revealed Resident #2 had a NJ Ex Order 26, 4B1 . The surveyor review of 'NJ Ex Order 26. 4B1 Scale (ERS)" dated NJ Exec Order 26.4b1 revealed that Resident #2 was an NJ Ex Order 26, 4B1 with a total score of " meaning 'NJ Ex Order 26, 4B1." During surveyor review of the MR revealed an "Incident Note (IN)" dated NJ Exec Order 26.4b1 at 5:03 a.m. written by the Licensed Practice Nurse (LPN) indicated that she was NJ Exec Order 26.4b1 at 2:55 a.m. that Resident #2 was NJ Exec Order 26.4b1 the NJ Ex Order 26 and resident NJ Exec Order 26.4b1 . Resident said he/she NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 his/her NJ Ex Order 26, 4B1 . The resident first attempted to call NJ Ex Order 26, 4B1, but got no answer, he/she became NJ Ex Ord and a Samaritan (a helpful person) called NJ Ex Or and the NJ Ex Order 26, 4B1 to the facility with NJ Exec Order 26.4b1. All parties notified. Review of a 2nd IN written at 11:43 a.m. by the Nurse Mentor/Registered Nurse (NM/RN) documented that the resident was NJ Ex Order 26, 4B1 stated, " ... NJ Ex Order 26, 4B1 .." Review of an additional IN written at 11:45 a.m. by the NM/RN documented that the NJ Ex Order 26, 4B1	A 401		

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A 401	Continued From page 3	A 401		

informed the RN and ED that the resident's NJ Ex Order 26, 4B1 over the NJ Exec Order 26.4b1

The surveyor review of "NJ Ex Order 26. 4B1 Scale (ERS)" dated NJ Exec Order 26.4b1 written by the Registered Nurse (RN) revealed that Resident #2 was an NJ Ex Order 26, 4B1 with a total score of "[redacted]" meaning "NJ Ex Order 26, 4B1." Further review of the ESR revealed that under section "[redacted] Interventions: 1. Interventions Needed for At NJ Ex Order 26. 4B1:" There were no interventions listed.

Review of a 2nd ERS dated NJ Exec Order 26.4 written by the LPN after the resident NJ Ex Order 26, revealed the same total score of "[redacted]". Further review of the ERS revealed that under section NJ Exec Order 26.4b1 " revealed that Resident #2 has no NJ Ex Order 26, 4B1.

Review of a facility "Resident Handbook (RH)" section titled, "Leave of Absence" revealed that residents could leave the premises at any time but due to safety concerns, residents were to sign in and out using the NJ Exec Order 26.4b1 station at the reception desk and the receptionist could help residents if unsure.

At 11:18 a.m., during a phone interview with the Certified Nursing Assistant (CNA) assigned to Resident #2 that night, she stated that NJ Exec Order 26.4 was at the NJ Exec O and the resident was NJ Exec Order 26.4b1 and she was there with the nurse. She continued to say that the resident was NJ Ex Order 26, 4B1, he/she stated he/she was NJ Exec Order 26.4b1 to his/her NJ Ex Order 26, 4B1, and NJ Exec Order 26.4b1 of the day.

At 11:49 a.m., during an interview, the Nurse Mentor/Registered Nurse (NM/RN) stated that Resident #2 was not an NJ Ex Order 26, 4B1, he/she

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A 401	Continued From page 4 was NJ Ex Order 26, 4B1 and NJ Exec Order 26.4b1 . She continued to say that Resident #2 had no NJ Ex Order 26, 4B1, so it was unusual for him/her to NJ Ex Order 2. At 12:34 p.m., during a phone interview with the Security Guard (SG), when the surveyor asked him what happened when Resident #2 NJ Ex Order 26, 4, he stated that he had just NJ Exec Order 26.4b1 at the front desk, a man/woman walked by, NJ Exec Order 26.4b1 , so he thought [the person] was a NJ Exec Order 2 he didn't think twice. He continued to say then about an hour later, the NJ Ex Order 26 brought the resident NJ Ex Order 26, 4B1 facility then he notified his supervisor, the Director of Maintenance (Building Services) and the nurse. In the same interview, when the surveyor asked the SG if he received training on the front desk procedure to sign in and out, the SG stated that prior to the position, he was told of the NJ Exec Order 26 signing in and out, but no formal education. He continued to say that he was not aware of the signing in and out procedure for residents and visitors. At 1:02 p.m., the surveyor interviewed the Director of Building Services (DBS), the SG's supervisor, he stated that the SG was trained on the front desk procedures of signing in and out, prior to the incident. At 1:30 p.m., during a telephone interview with the Licensed Practice Nurse (LPN) who worked that night, she stated that she was not aware that Resident #2 NJ Ex Order 26, 4B1 until the Security guard called her and when she arrived to his/her apartment, the resident NJ Exec Order 26.4b1 and the resident continued to say that	A 401		

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A 401	Continued From page 5	A 401		

he/she called the NJ Ex Order 26, 4B1 on the phone but got no answer so he/she went to see NJ Ex O because NJ Ex Order 26, 4B1. The LPN continued to say that the resident said that NJ Exec Order 26.4b1 , he/she got NJ Ex Order 26, 4B1 and a lady driving by saw him/her, asked if NJ Ex Or and NJ Ex Or called the NJ Ex Order 26, and the NJ Ex Order 26, 4B1 to the facility.

At 3:29 p.m., when the surveyor asked the ED if there was a policy for residents to know to sign in and out of the facility, she stated that each resident received a Resident Handbook (RH) and an Assisted Living (AL) resident could leave the facility at any time which was noted in the RH.

At 4:11 p.m., when the surveyor asked about the meaning of Resident #2's NJ Ex Order 26, 4B1 , the Corporate Director of Clinical Service (CDCS) stated that this meant that the resident NJ Exec Order 2 NJ Ex Order 26, 4B1 everything, he/she was NJ Ex Order 26, 4B1

In the same interview when the surveyor asked how the ESRs dated NJ Exec Order 26.4b1 could be scored the same as "NJ" meaning "NJ E ", if Resident #2 NJ Ex Order 26, , the CDCS stated that since an NJ Ex Order 26, 4B1 occurred, the resident should be a "NJ Ex Order 26, 4B1" and changed to a NJ Ex Order 26, 4B1.

On 7/17/2025, the surveyor reviewed the the NJ Ex Order 26. 4B1 with a report date/time of NJ Exec Order 26.4b1 at 2:25 a.m. which revealed Resident #2 was NJ Ex Or and NJ Exec Order 26.4b1 for his/her NJ Ex Order 26, 4B1, the resident told the NJ Ex Order 26 where he/she resided and the NJ Ex Order 26, 4B1 the resident NJ Ex Order to the facility. The NJ Ex Order 26 followed up with the Nurse Mentor on the phone and the case was closed.

The facility failed to ensure that Resident #2, an

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A 401	Continued From page 6 NJ Ex Order 26, 4B1, was safe in the community by failing to monitor the resident's whereabouts until the resident re-entered the facility an NJ Ex Order 26, 4B1 [redacted] Surveyor review of 3/26/2024 facility policy titled, "Resident Rights (RS-68)" revealed "Policy [-] [The facility] will honor the rights of the residents in the communities...."	A 401		
A 735	8:36-7.2(e)(1-5) Health Care Assmnt. and Health Service Plan (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment.	A 735		

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A 735	Continued From page 7 This REQUIREMENT is not met as evidenced by: Complaint#: NJ00187437 Based on interview, and record review, it was determined that the facility failed to develop and implement a written health service plan (HSP) for a resident that was at NJ Ex Order 26, 4B1 on admission for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 6/16/2025, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of NJ Exec Order 26.4b1 and a "time of event" of 1:43 a.m.., Resident #2 NJ Exec at NJ Ex Order 26, 4B1. and NJ Exec Order 26.4b1 was NJ Ex Order 26. 4B1 The resident stated he/she was NJ Exec Order 26. to his/her NJ Ex Order 26, 4B1. The resident was not previously at NJ Ex Order 26, 4B1, and this was an isolated incident. Resident #2 did not sign out at the front desk and security did not require him/her to do so. On 7/2/2025 at 8:55 a.m., on entrance, the surveyor asked about the incident, the Executive Director (ED) stated that it was an isolated incident for Resident #2. She continued to say that Resident #2 was not an NJ Ex Order 26, 4B1 so there was no photo at the front desk for him/her, the [security] guard at the desk, thought the resident NJ Exec Order 26.4b1 and someone saw Resident #2 NJ Ex Order 26, 4B1, called the NJ Ex Order 26 and the NJ Ex Order 26, 4B1 to the facility.	A 735		

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A 735	Continued From page 8 At 9:55 a.m., the surveyor interviewed Resident #2 about the incident, it was late 9:00 p.m., he/she stated that he/she was going to his/her [redacted], NJ Exec Order 26.4b1 and the NJ Ex Order 26, 4B1 to the facility. At 11:49 a.m., during an interview, the Nurse Mentor/Registered Nurse (NM/RN) stated that rounds were only done for residents who were an NJ Ex Order 26, 4B1, Resident #2 was not, he/she was NJ Ex Order 26, 4B1 and NJ Exec Order 26.4b1. She continued to say that Resident #2 had no [redacted], so it was unusual for him/her to [redacted]. In the same interview, the NM/RN stated that if a resident [redacted], the NJ Ex Order 26, 4B1 was on the HSP. At 1:55 p.m., the surveyor reviewed the Medical Record (MR) that revealed Resident #2 had a NJ Ex Order 26, 4B1 [redacted]. The surveyor review of "NJ Ex Order 26. 4B1 Scale (ERS)" dated NJ Exec Order 26.4b1 revealed that Resident #2 was an NJ Ex Order 26, 4B1 with a total score of [redacted] meaning "NJ Ex Order 26, 4B1". Further review of the ESR revealed that under section "[redacted] Interventions: 1. Interventions Needed for At NJ Ex Order 26. 4B1:" there were no interventions listed. At 4:11 p.m., when asked if a HSP should be developed for a resident at NJ Ex Order 26, 4B1, the Corporate Director of Clinical Service (CDCS) stated that she agreed there should have been a HSP done with interventions in place, like a "picture at the desk" since Resident #2 was at NJ Ex Order 26, 4B1. Surveyor review of a revised 6/19/2025 facility policy titled, "Elopement and Wandering (RS-4)"	A 735		

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A 735	Continued From page 9	A 735		

revealed "Policy [:] All teammates shall follow the prescribed process in order to prevent elopement and minimize harm if a resident does elope...Procedure [:] ...4. A service/care plan must be implemented immediately, reviewed with teammates if the resident is determined to be at risk...Resident Level of Risk [:] If it is determined that the resident is at risk for wandering potentially leading to elopement, an individualized service plan or care plan will be implemented immediately; reviewed with teammates to ensure resident safety is addressed and the following measures should be initiated: Interventions to minimize the potential for resident elopement. Communicate to nursing teammates on all shifts during shift report that the resident is at risk and note on resident profile/CNA (Certified Nursing Assistant) card, A current photo will be taken and located at the front reception desk (or other indicated area)..."

Surveyor review of a 9/2012 facilty policy titled, "Evaluation and Assessment of Resident Needs" revealed "Policy: It is the policy of [the facility] that each resident in Assisted Living will have a Service Evaluation and Nursing Assessment completed prior to or on admission by a registered nurse. If the nursing assessment indicates a need for a health care services, then a Health Service Care Plan will be developed in accordance with state regulations. Purpose: To ensure appropriate services provided to each resident. Procedure: ...3. a Health Care Plan shall be initiated by a Registered Nurse for conditions that are not expected to be resovled with-in 14 days. This plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical, medical or cognitive status...The Health

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A 735	Continued From page 10 Service Plan shall include, but not be limited to orders for treatment or services,...the specific goals of treamtne tor services, if appropriate, the time intervals at which the resident's response to treatment will be reviewed, an the measurers [measures] to be used to assess the effectis to treatment..."	A 735		
A1051	8:36-15.2 Record Availability The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department. This REQUIREMENT is not met as evidenced by: Complaint# : NJ00187437 Based on interview, and record review it was determined that the facility failed to ensure requested full access to the Electronic Medical Records (EMRs) were available for review upon entrance to the surveyor for 3 of 3 residents reviewed, Resident #'s 1, 2, & 3. This deficient practice was evidenced by the following: On 7/2/2025 at 8:55 a.m., during the entrance conference, the surveyor requested full access to the facility's electronic medical record (EMR). At that time the facility's Administrator (Adm) stated that she would be able to provide the surveyor with full access to the EMR. At 10:43 a.m., the surveyor recieved the computer login.	A1051		

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A1051	Continued From page 11 At 10:56 a.m., the surveyor tried the computer login and had to change the password, login unsuccessful. At 11:00 a.m., the surveyor tried the computer login a second time and the login was unsuccesful. At 11:10 a.m., the surveyor called the Executive Director (ED) on her cell phone to inform her that the computer access said "unauthorized" when the password was changed. At 11:22 a.m, the Facility Computer Staff (FCS) arrived to address the login issue, he looked at the login and stated that he will be back, he called the Corporate computer staff (CCS). At 11:31 a.m., the FCS returned, he sat with the surveyor and said to try the login again, screen still said "unauthorized". At 11:40 a.m., the FCS gave the surveyor a new login username, but the login still did not work. At 12:11 p.m., the surveyor informed the ED that there was still no computer access and the ED was informed this may be a deficient practice. She understood. At 12:14 p.m., the surveyor tried the new login username and password with the FCS, the login circled and returned back to the same login screen. At 12:23 p.m., the FCS returned with the ED, the Infection Prevention Registered Nurse present and the CCS on the phone and asked the surveyor to check the internal wifi [wireless	A1051		

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A1051	Continued From page 12 network technology] connection and it was properly connected. At 12:24 p.m., the login still circled on the screen and returned to the same login screen, the [website] browser used was NJ Exec Order 26.4b1. At 12:26 p.m., the FCS stated to try a different browser, NJ Exec Order 26.4b1. At 12:27 p.m., the surveyor tried NJ Exec Order 26.4b1 and there was still a login error. At 12:30 p.m., the surveyor was unable to access the computer system, the login never worked, so the surveyor requested the sample paperwork At 12:30 p.m., the surveyor still had not received full access to the EMRs. At 1:52 p.m., the ED informed the surveyor that in June, the computer system was upgraded which the ED stated, may have been the cause of the problem At the time of the survey, the surveyor was not granted full access to the EMRs, the facility provided paper copies of the requested documents. The surveyor was unable to access the EMRs of residents for review which impeded the investigation and survey process of the Department.	A1051		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15c001	A. BUILDING: _____ B. WING _____	C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT COLLI	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

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A1073	Continued From page 13 health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00187437 Based on interview and record review, it was determined that the facility failed to ensure that residents' Treatment Administration Records (TARs) were accurately documented in the residents' medical record for 2 of 3 residents, Resident #2 and Resident #3, reviewed for *NJ Ex Order 26, 4B1* [redacted] function and placement. This deficient practice was evidenced by the following. On 6/16/2025, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of NJ Exec Order 26.4b1 and a "time of event" of 1:43 a.m.., Resident #2 [redacted] at 1:43 a.m. and NJ Exec Order 26.4b1 and was *NJ Ex Order 26, 4B1* [redacted]. The resident stated he/she was [redacted] to his/her *NJ Ex Order 26, 4B1*. The resident was not previously at *NJ Ex Order 26, 4B1*, and this was an	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1073	Continued From page 14 isolated incident. Resident #2 did not sign out at the front desk and security did not require him/her to do so. 1.At 1:55 p.m., the surveyor reviewed the Medical Record (MR) that revealed Resident #2 had a *NJ Ex Order 26, 4B1* [redacted]. Surveyor review of the MR revealed after Resident#2's *NJ Ex Order 26, 4B1* on NJ Exec Order 26.4b1, review of a "Order Summary Report (OSR)" revealed a Physician's Order (PO) for a *NJ Ex Order 26, 4B1* to check the function and placement every shift dated NJ Exec Order 26.4b1 Further review of Resident #2's TAR dated NJ Exec Order 26.4b1, revealed that there was no documentation that the *NJ Ex Order 26, 4B1* function and NJ Exec Order 26.4b1 were done, per prescriber's orders on the following date: NJ Exec Order 26.4b1 on the Nigh (night) shift. 2. At 2:30 p.m., the surveyor reviewed the MR that revealed Resident #3 had a *NJ Ex Order 26, 4B1* [redacted]. Further review of Resident #3's TAR, dated NJ Exec Order 26.4b1 revealed there was no documentation that the *NJ Ex Order 26, 4B1* placement checks were done, per prescriber's orders on the following dates: NJ Exec Order 26.4b1 [redacted] on the night shift, and on 6/20/2025 for the Eve (evening) shift. At 5:00 p.m., when the surveyor asked about the blank spaces on the TARs, the Corporate Director of Clinical Service (CDCS) stated that a blank space meant the nurse forgot to sign out, "an omission." In the same interview, when the surveyor asked, did omission mean that not documented was not done, the CDCS did not reply.	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15c001	A. BUILDING: _____ B. WING _____	C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT COLLI	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

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A1073	Continued From page 15 Surveyor review of a revised 6/19/2025 facility policy titled, "Elopement and Wandering (RS-4)" revealed "Policy [:] All teammates shall follow the prescribed process in order to prevent elopement and minimize harm if a resident does elope...Procedure [:] ...Resident Level of Risk [:] ...Upon implementation of the use of an electronic safety device, the nursing staff will be responsible for checking the electronic safety device on each shift for proper functioning and will document completed checks on the ... treatment record ...."	A1073		

POC #3
Acceptable
9/26/25

United Methodist Communities
Abundant Life for Seniors

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Collingswood, NJ 08108

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856-854-0879 f
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POC for United Methodist Communities at Collingswood

460 Haddon Avenue

Date of Survey 7-2-2025

Date of Receipt of 2567 8-5-2025

A 401

1. Resident #2 remains in the community in a safe environment. The resident was reevaluated for [redacted] identified as being at [redacted] and appropriate interventions have been implemented. A health service plan has also been implemented.
2. All residents identified as being at risk of elopement have the potential to be affected by this cited practice. Elopement risk scores were reviewed for all residents, and any issues identified were corrected to ensure appropriate interventions are in place.
3. All licensed nurses received in-service education from the Community Staff Educator beginning on July 16, 2025, on the proper completion of the Elopement Risk Evaluation Form. This training ensures that appropriate interventions are implemented when a resident is identified as being at risk or at high risk for elopement. Ongoing education will be done by the Staff Educator and also be provided during the onboarding process for all newly hired licensed nurses by the Staff Educator. This training will be conducted by the Resident Services Staff Educator to promote consistent understanding and compliance with elopement risk assessment procedures. In addition, formal training on the community's elopement procedures educated beginning on July 16, 2025 provided to security guards and receptionist staff by the Director of Building Services. To maintain compliance, ongoing training will be included in the onboarding process for all new security and receptionist personnel. As a visual reminder, a sign was placed on July 16, 2025 at the receptionist desk instructing residents to sign out prior to leaving the community. Receptionists and security staff will also be reminded to verify that residents have signed out and to check the elopement binder before allowing residents to exit the premises.
4. The Director of Resident Living (RN) began conducting weekly audits on July 3rd, 2025 of all completed elopement risk evaluations for four weeks, followed by monthly audits thereafter. These ongoing monthly reviews will ensure continued compliance. In parallel, the Director of Building Services will review the resident sign-out log weekly for four weeks, followed by monthly reviews for three months. These audits will confirm that residents identified as being at risk of elopement have not exited the building unattended and that both security and receptionist staff are following established elopement procedures, including checking the elopement binder. Audit findings from both departments will be shared with the Executive Director and discussed during the quarterly Quality Assurance and Performance Improvement (QAPI) meetings. Corrective actions will be implemented as warranted based on the findings.
5. **Completion Date:** 8.26.2025

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460 Haddon Ave.
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856-854-4331 p
856-854-0879 f
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A 735

1. Resident #2 remains in the community. A health service plan was implemented on [redacted] for NJ Ex Order 26, 4B1
2. All residents may be affected by the cited practice.
3. The Director of Resident Living (RN) and the RN Nurse Mentor will have received education on the proper review of elopement evaluations completed by the Corporate Director of Clinical Services on July 3rd, 2025. They will also be trained to ensure timely implementation of health service plans when risk is identified. Evaluations for newly admitted residents will be reviewed during morning stand-up meetings to confirm that appropriate health service plans are implemented within 14 days of move-in and in a change in condition. A comprehensive audit was conducted beginning July 3, 2025, to verify the accuracy of elopement risk evaluations and to confirm that a health service plan was implemented when indicated. Any discrepancies identified during the audit have been corrected to ensure full compliance.
4. The Corporate Clinical Nurse Manager RN began auditing on July 3rd, 2025 newly completed elopement risk evaluations weekly for four weeks, followed by monthly audits for five months. The purpose is to ensure that residents identified as at risk or high risk have an appropriate health service plan implemented. The audit findings will be shared with the Executive Director and discussed during quarterly Quality Assurance and Improvement (QAPI) meetings. Immediate corrective actions will be taken as needed, and the audit frequency will be adjusted based on outcomes.
5. **Completion date: 8.26.2025**

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856-854-0879 f
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A1051

1. Residents #1, #2, and #3 remain in the community. The community is unable to retroactively address concerns regarding access to electronic medical records. At the time the concern was raised, the IT technician attempted to resolve the issue but was unable to identify the source of the problem. Since then, the issue has been monitored, and a root cause analysis completed on July 28, 2025 by IT to ensure no further disruptions occur.
2. All those attempting to have external access to residents' medical records have the potential to be affected by this cited practice.
3. The Executive Director provided the IT Technician with education on state and federal regulations regarding the requirement for immediate access to medical records during surveys, began on July 2, 2025. In the event that direct access to the community's EMR system is unavailable, the community will maintain four functioning computers configured for surveyor access only. These will remain available until full EMR access is restored, ensuring compliance with regulatory expectations.
4. Direct access to medical records will be monitored during each survey visit to ensure timely availability. The IT Technician will track successful access based on the time required and the ease of entry into the system. Findings will be reported to the Executive Director and reviewed during the quarterly QAPI meeting. Immediate corrective actions will be taken as needed to ensure prompt resolution and continued access to medical records.

Completion Date: 8.26,2025

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A1073

1. Residents #2 and #3 remain in the community and were not negatively impacted by the cited practice. The licensed nurse responsible for omitting documentation in the Treatment Administration Record (TAR) was identified and has received corrective action and targeted education to address the issue on July 2, 2025.
2. All residents with orders for wander guards have potential to be affected by this cited practice.
3. All currently licensed staff began receiving education on July 2, 2025, from the community's Resident Staff Educator. This training will focus on maintaining accurate medical records, with particular emphasis on the nurse's responsibility to timely sign off on the Treatment Administration Record (TAR) for completed items and review the Med Pass Completion Audit Tool on the clinical dashboard before the end of their shift beginning on July 3, 2025, to identify and complete any missed documentation. Failure to complete documentation as required will result in corrective disciplinary action, as warranted.
4. A Treatment Audit Tool has been implemented and completed by the Director of Resident Living RN began on July 08, 2025, daily for four weeks, followed by weekly audits for three months. This process is designed to ensure compliance with documentation requirements on residents' treatment records. All audit findings will be reviewed with the Executive Director and presented during the quarterly Quality Assurance and Performance Improvement (QAPI) meeting. If patterns of non-compliance are identified, immediate corrective disciplinary action will be taken by the Director of Nursing. Additionally, the frequency of audits will be adjusted based on outcomes until the issue is resolved.

Completion Date: 8.26,2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15c001 Y1	A. Building B. Wing Y2	9/26/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT COLLINGSWOOD	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0401	Correction	ID Prefix A0735	Correction	ID Prefix A1051	Correction
Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. # 8:36-15.2	Completed
LSC	08/26/2025	LSC	08/26/2025	LSC	08/26/2025
ID Prefix A1073	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/26/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/2/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO