STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint NJ #'s: 165862, 166907, 166986, 172048, 172394, 176228, 181161, 182633, 184181, and 185522 Survey Dates: 4/30/25 to 5/9/25 Census: 290 Sample size: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		6/22/25

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

Electronically Signed | 05/30/2025

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 DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 636	Continued From page 1 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 636	Continued From page 2 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to complete a discharge Minimum Data Set (MDS), an assessment tool, as required for 1 of 1 resident (Resident #275) system selected for MDS over 120 days. This deficient practice was evidenced by the following: The MDS is a comprehensive federally mandated process for clinical assessment of all residents that should be completed and submitted to the Quality Measure System. The facility must complete the assessment at discharge and electronically transmit the MDS no later than 14 days after completing the assessment. The surveyor reviewed the electronic medical record (EMR) for Resident #275. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but was not limited to, [redacted] (NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1), and [redacted]. Further review of Resident #275's EMR revealed that the resident was discharged from the facility, but the discharge MDS was not completed. On 5/6/25 at 11:48 AM, the surveyor interviewed the U.S. FOIA (b) (6), who stated that she oversees and completed the MDS assessments. She further stated that assessments should be completed upon admission to the facility,	F 636	I. Corrective action(s) accomplished for resident(s) affected: Resident #275 was discharged from the facility on [redacted]. A discharge assessment was opened and completed for resident #275 and transmitted electronically. The U.S. FOIA (b) (6) [redacted]) was re-educated by the Director of Nursing regarding timely completion of assessments at discharge and electronically transmitting the MDS no later than 14 days after completing the assessment. II. Residents identified having the potential to be affected and corrective action taken: All residents residing in this facility had the potential to be affected by this practice. An audit was completed for any missing MDS assessments. No other residents were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The MDS policy was reviewed by the Administrator, Director of Nursing and Director of MDS. No updates were required to the policy. The U.S. FOIA (b) (6) was re-educated by the Director of Nursing regarding timely completion of assessments at discharge and electronically transmitting the MDS no later than 14 days after completing the assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 636	Continued From page 3 quarterly, annually, with any significant changes, and at discharge. At that time, the U.S. FOIA (b) (6) checked Resident #275's EMR and confirmed that the discharge MDS had not been completed, and she stated that the assessment should have been initiated the day the resident was discharged and submitted within 14 days. The U.S. FOIA (b) (6) then completed Resident #275's discharge assessment after surveyor inquiry. On 5/7/25 at 9:33 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who confirmed that the discharge MDS was not completed and transmitted timely. A review of the facility's "Resident Assessment Instrument (RAI) Process MDS/ Care Area Assessment (CAA)/Plan of Care Guidelines, guide, revised January 2025 included, "Guidelines: The Resident Assessment Instrument (RAI) provides a tool for an interdisciplinary approach to develop a plan of care for the resident. ... Purpose 3. It is the responsibility of the Registered Nurse Assessment Coordinator (RNAC) to coordinate the RAI process. ...Procedure 4. The RNAC is responsible for overseeing an MDS assessment schedule for all residents and for creating and coordinating completion of the assessments in a timely manner." NJAC 8:39-11.1	F 636	A new audit has been implemented to check for any missing assessments that were not transmitted electronically by 14 days after completing the assessment. The Director of MDS will utilize the audit and report any concerns to the Director of Nursing with follow-up actions as necessary. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of MDS will conduct four weekly audits for four weeks then monthly audits for five months on completion of assessments and electronically transmitting the MDS no later than 14 days after completing the assessment. Results of these audits will be reviewed with the Director of Nursing and Administrator for analysis, tracking, and trending. Any corrective actions required as a result of these audits will be addressed by the Administrator and the Director of Nursing. The Director of MDS will report on the results of audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA Committee will determine the need for any additional monitoring of timely completion of assessments after the 2nd quarterly meeting. Date of Compliance: 6/22/25	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 658	Continued From page 4 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #: NJ176228 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) follow a physician's order to apply a NJ Ex Order 26.4(b)(1) [redacted], b.) accurately identify a resident's NJ Ex Order 26.4(b)(1) was applied in the electronic medical record (EMR), c.) properly identify a resident's NJ Ex Order 26.4(b)(1) status in the EMR, and d.) monitor NJ Ex Order 26.4(b)(1) according to the physician's orders in the EMR. This deficient practice was identified for 2 of 2 Residents (Resident #104 and #196) reviewed for NJ Ex Order 26.4(b)(1) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	I. Corrective action(s) accomplished for resident(s) affected: Resident # 196 had NJ Ex Order 26.4(b)(1) from this practice. Resident # 104 had NJ Ex [redacted] from this practice. The Licensed Nurses who were responsible for applying and signing the EMR for NJ Ex Order 26.4(b)(1) [redacted] as ordered by the physician received Inservice by the Assistant Director of Nursing. Resident # 196 had NJ Ex Order 26.4(b)(1) from this practice Residents #104 had NJ Ex Order 26.4(b)(1) from this practice. The Certified Nursing Assistants responsible for completing the Point of Care (POC) received 1:1 in-servicing by the Assistant Director of Nursing on using proper coding to properly identify a resident`s NJ Ex Order 26.4(b)(1) status when completing the POC for residents with the NJ Ex Order 26.4(b)(1) Resident # 196 had NJ Exec Order 26.4b1 from this practice Residents #104 had NJ Ex [redacted] from this practice. The Certified Nursing Assistants responsible for NJ Ex Order 26.4(b)(1) the NJ Ex Order 26.4(b)(1) [redacted] were in -serviced by the Assistant Director of Nursing on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 658	Continued From page 5 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1). On 4/30/25 at 10:24 AM, during the initial tour of the facility, the surveyor observed Resident #104 sleeping in bed with NJ Ex Order 26.4(b)(1) hanging at the bedside by the provided hook and was contained within NJ Ex Order 26.4(b)(1). The surveyor reviewed the medical record for Resident #104. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b) included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated the resident's NJ Exec Order 26.4b(1) was NJ Ex Order 26.4(b)(1). Further review of the MDS identified under Section NJ E indicated that the resident had an	F 658	emptying the NJ Ex Order 26.4(b)(1) by end of their shift and notify the licensed Nurse for their assignment. The Licensed Nurses who were responsible for recording the amount of NJ Ex Order 26.4(b)(1) for residents with a NJ Ex Order 26.4(were in serviced by the Assistant Director of Nursing on documentation of NJ Ex Order 26.4(b)(1) on the ETAR as ordered by the physician. II. Residents identified having the potential to be affected and corrective action taken: Residents who have an indwelling urinary catheter had the potential to be affected by this practice. An audit was conducted for the use of the Indwelling Urinary Catheter Stabilization Device as ordered of all residents with an indwelling catheter. No other residents were identified as affected by this practice. Residents who have an indwelling urinary catheter had the potential to be affected by this practice. An audit was conducted of Point of Care (POC) documentation of all residents with an indwelling catheter. No other residents were identified as affected by this practice. Residents who have an indwelling urinary catheter had the potential to be affected by this practice. An audit was conducted of recording the amount of Urine output for residents with a Urinary Indwelling Catheter and no other residents were identified as affected by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 658	Continued From page 6 NJ Exec Order 26.4b1. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26, that the resident was at risk for a NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b) use. Interventions included: Monitor for signs/symptoms of NJ Ex Or (NJ Ex Order 26.4(b)(1) , notify physician of NJ Ex Order 26.4(b)(1) provide NJ Ex Order 26.4(b) care every shift as ordered and as needed, monitor for NJ Ex Order 26.4(b)(1), and secure NJ Ex Order 26.4(b)(1) to prevent NJ Ex Order 26.4(b A review of the Order Summary Report (OSR), dated as of NJ Ex Order 26.4(b)(1), included the following physician orders (PO): A PO, dated NJ Ex Order 26.4(, to apply NJ Ex Order 26.4(b)(1) , check NJ Ex Order 26.4(b)(1) and placement every shift. A PO, dated NJ Ex Order 26.4(, to monitor and document NJ Ex Order 26.4(b)(1) every shift. If no output in eight hours, notify physician every shift. A review of Resident #104's NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR) revealed that on the following dates and shifts there was no documentation to indicate that the resident had NJ Ex Order 26.4(b)(1): NJ Ex Order 26.4(b) Day Shift NJ Ex Order 26.4(b) Night Shift NJ Ex Order 26.4(b) Day Shift A review of the Certified Nursing Assistant (CNA) Plan of Care (POC) Response History for Resident #104's NJ Ex Order 26.4(b)(1), of the 30 days look back period (through multiple shifts on each day), only 27 responses correctly identified NJ Ex Order 26.4(b)(1) Not Rated due to NJ Ex Order 26.4(b)(1)	F 658	this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Licensed Nursing Staff were educated by the Assistant Director of Nursing regarding ensuring Indwelling Urinary Catheter stabilizing device is in use as ordered by the physician and signed on the ETAR as applied. The Assistant Director of Nursing or designee will review ETAR of residents with the Urinary Indwelling Catheter to ensure Stabilizing device is used as ordered and signed on the ETAR weekly x 4 weeks and then monthly x 5 months to ensure that Indwelling Urinary Catheter stabilizing device is being applied as signed on the ETAR. As ordered by the physician. Identified concern will be addressed immediately. The Certified Nursing Staff were in serviced by the Assistant Director of Nursing regarding using proper coding to properly identify a resident`s incontinence status when completing the POC for residents with the urinary indwelling catheter. The Assistant Director of Nursing or designee will review the POC report of residents with the indwelling urinary catheter for proper coding to properly identify a resident`s incontinence status when completing the POC weekly x 4 weeks and then monthly x 5 months. Identified documentation concerns will be addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 658	Continued From page 7 NJ Ex Order 26.4(b)(1) Other selections that were checked off included: 'NJ Ex Order 26.4(b)(1) and 'NJ Ex Order 26.4(b)(1) Not Rated due to NJ Ex Order 26.4(b)(1)." 2.) On 4/30/25 at 10:16 AM, during the initial tour of the facility, the surveyor observed Resident #196 sleeping in bed with NJ Ex Order 26.4(b)(1) hanging at the bedside by the provided hook and was contained within NJ Ex Order 26.4(b)(1) On 5/2/25 at 11:52 AM, the surveyor interviewed Resident #196 who stated that they did not have NJ Ex Order 26.4(b)(1) device applied to NJ Ex Order 26.4(b)(1) When asked if the facility emptied the NJ Ex Order 26.4(b)(1) every shift Resident #196 responded, "sometimes they do and sometimes they don't". The surveyor reviewed the medical record for Resident #196. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Ex Order 26.4((NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). A review of the resident's most recent Quarterly MDS, dated NJ Ex Order 26.4(b)(included the resident had Brief Interview for Mental Status Score (BIMS) score of NJ Ex out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26 Further review of the MDS identified under Section NJ E that the resident had NJ Ex Order 26.4(b)(1).	F 658	The Certified Nursing Assistants were in-serviced by the Assistant Director of Nursing on emptying the Indwelling Urinary Catheter drainage bag by the end of their shift and notify the licensed Nurse for their assignment. The Licensed Nurses were in serviced by the Assistant Director of Nursing on documentation of urine output on the ETAR as ordered by the physician. The Assistant Director of Nursing or designee will review ETAR of residents with the indwelling catheter weekly x 4 weeks and then monthly x 5 months to assure that Indwelling Urinary Catheter output amount is recorded on the ETAR as ordered by the physician. Identified concern will be addressed immediately. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to ensure compliance. The Director of Nursing or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to ensure compliance The Director of Nursing or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 658	Continued From page 8 A review of the resident's Individual Comprehensive Care Plan (ICCP) included a focus area, dated [NJ Ex Order 26.4(b)(1)], that the resident was at risk for NJ Ex Order 26.4(b)(1). Interventions included: Monitor for signs/symptoms of [NJ Ex Order 26.4(b)(1)], notify physician of abnormalities, provide [NJ Ex Order 26.4(b)(1)] care every shift as ordered and as needed, monitor for NJ Ex Order 26.4(b)(1) and secure [NJ Ex Order 26.4(b)(1)] to prevent [NJ Ex Order 26.4(b)(1)]. A review of the OSR, dated as of [NJ Ex Order 26.4(b)(1)], included the following PO: A PO, dated [NJ Ex Order 26.4(b)(1)], to apply [NJ Ex Order 26.4(b)(1)], check [NJ Ex Order 26.4(b)(1)] and placement every shift. A PO, dated [NJ Ex Order 26.4(b)(1)], to monitor and document NJ Ex Order 26.4(b)(1) every shift. If no output in eight hours, notify physician every shift. A review of Resident #196's [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] TAR revealed that on the following dates and times, there was no documentation to indicate that the resident had [NJ Ex Order 26.4(b)(1)]: [NJ Ex Order 26.4(b)(1)] Night Shift [NJ Ex Order 26.4(b)(1)] Day Shift [NJ Ex Order 26.4(b)(1)] Night Shift [NJ Ex Order 26.4(b)(1)] Day Shift [NJ Ex Order 26.4(b)(1)] Night Shift A review of the CNA (Certified Nursing Assistant) POC (Plan of Care) Response History for Resident #196 included: NJ Ex Order 26.4(b)(1), of the 30 days look back period (through multiple shifts on each day), only 10 responses correctly identified "[NJ Ex Order 26.4(b)(1)] Not Rated due to NJ Ex Order 26.4(b)(1)." Other selections that were checked off included: "[NJ Ex Order 26.4(b)(1)] "[NJ Ex Order 26.4(b)(1)]	F 658	V. Date of Compliance: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 658	Continued From page 9 and "NJ Ex Order 26.4(b)(1) Not Rated due to NJ Ex Order 26.4(b)([redacted] On 5/2/25 at 11:22 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]) who stated that the NJ Ex Order [redacted] of residents who had NJ Ex Order 26.4(b)(1) should be monitored, including the resident's NJ Ex Order 26.4 [redacted] When asked what should be monitored, the US F [redacted] indicated that the CNA was to NJ Ex Order 26.4(b)(1) [redacted] and report the amount to the nurse for documentation. The US F [redacted] further confirmed that a resident's Medication Administration Record (MAR) and TAR should not have any blanks because it could allow for the possibility of missing an infection. On 5/5/25 at 10:58 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who acknowledged that resident's NJ Ex Order 26.4(b)(1) should be documented by the nurse to monitor for possible NJ Ex Order 26.4(b)(1) and that there should not be any blanks on the MAR and TAR. When asked about the CNA POC, LPN/UM #1 confirmed that the CNA should not document a NJ Ex Order 26.4(b)(1) resident as NJ Ex Order 26.4(b)(1) The surveyor questioned what precautions were put into place to prevent NJ Ex Order 26.4(b)(1), LPN/UM #1 indicated that a NJ Ex Order 26.4(b)(1) should be applied to resident's NJ Ex O [redacted] as per physician order and facility policy. On 5/5/25 at 11:15 AM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #1 who reported that CNAs were to empty the resident's NJ Ex Order 26.4(b)(1) but the nurses should be documenting the NJ Ex Order 26.4 [redacted] When asked if there should be any blanks in the MAR and TAR, RN/UM #1 stated no because it could mean a possible infection. The surveyor reviewed	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 658	Continued From page 10	F 658		

Resident #104 and #196's CNA POC with RN/UM #1 who confirmed that the CNAs should have identified both residents as '[NJ Ex Order 26.4(b)(1)] Not Rated due to[NJ Ex Order 26.4(b)(1)]." Upon review of Resident #104 and #196's MAR and TAR, RN/UM #1 confirmed that there were blanks in the MAR and TAR for [NJ Ex Order 26.4(b)(1)].

On the same date at 11:27 AM, the surveyor requested RN/UM #1 to accompany the surveyor to Resident #196's room to see if the [NJ Ex Order 26.4(b)(1)] was present on the resident's [NJ Ex Or] With permission from the resident, RN/UM #1 checked and confirmed that the [NJ Ex Order 26.4(b)(1)] was not present.

On the same date at 11:34 AM, the surveyor requested RN/UM #1 to accompany the surveyor to Resident #104's room to see if the [NJ Ex Order 26.4(b)(1)] was present on the resident's [NJ Ex Or] With permission from the resident, RN/UM #1 checked and confirmed that the [NJ Ex Order 26.4(b)(1)] was not present. The surveyor reviewed both Resident #104 and #196's MAR and TAR with RN/UM #1 confirmed that resident's orders were checked off as being applied.

On 5/6/25 at 12:07 PM, the surveyor interviewed the [U.S. FOIA (b) (6)], in the presence of the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)], who acknowledged that residents with [NJ Ex Order 26.4(b)(1)] should be monitored and documented in the MAR and TAR, there should not be any blanks in the MAR and TAR, [NJ Ex Order 26.4(b)(1)] should be applied to prevent [NJ Ex Order 26.4(b)(1)] of the [NJ Ex Order 26.4(b)(1)] and documented accordingly, and CNAs should not have identified residents with [NJ Ex Order 26.4(b)(1)] as '[NJ Ex Order 26.4(b)(1)]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 658	Continued From page 11	F 658		

A review of the facility's "Physician Orders" policy, last updated 8/2024, included the following under Policy: The licensed nurse confirm and carried out all given orders timely. The following was included under Procedure: The licensed nurse will administer medications and treatment and care as ordered by the physician.

A review of the facility's "Urinary Catheters" policy, last revised 1/23/24, included the following under Standards of Care For the Patient With an Indwelling Urinary Catheter: Catheters should be properly secured with the appropriate device after insertion to prevent movement and urethral traction.

A review of the facility's "Integrated Medication Management (IMM) in [name redacted]" policy, last revised January 2025, included the following under Policy: To provide a centralized Electronic Health Record (EHR) and a full medication and treatment administration system that is accurate and dependable. The following was identified under Procedure: [name redacted] is securely accessed over the Internet for real-time accuracy and dependability, and the eMAR (Electronic Medication Administration Record)/eTAR (Electronic Treatment Administration Record) modules provide accurate and complete documentation of the resident and their medication and treatment information.

A review of the facility's "Job Description Certified Nursing Assistant," last revised November 2017, included the following under Responsibilities: Skin Checks Daily. The following was included under Adherence to Facility Procedures: All procedures in performing tasks of the job are performed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 658	Continued From page 12	F 658		

following facility policy. The following was included under Documentation: Intake and output are accurately recorded on the proper form.

A review of the facility's "Job Description Licensed Practical Nurse", last revised November 2017, included the following under Responsibilities: Accurate and Timely Documentation, and Accurate and timely evaluation of residents. The following was identified under Documentation: Intake and output are accurately recorded on the proper form, and MARS/TARS are filled in properly with no GAPS. The following was identified under Adherence to Facility Procedures: All procedures in performing tasks of the job are performed following facility policy. The following were identified under Documentation: Intake and output are accurately recorded on the proper form. The following was identified under Adherence to Facility Procedures: All procedures in performing tasks of the job are performed following facility policy.

A review of the facility's "Job Description Unit Manager", last revised November 2017, included the following under Documentation: Ensures MARS/TARS/ADL sheets and BMS are filled in properly with no GAPS. The following was identified under Adherence to Facility Procedures: All procedures in performing tasks of the job are performed following facility policy. The following were identified under Documentation: Intake and output are accurately recorded on the proper form.

A review of the facility's untitled policy included the following under Purpose: (facility name redacted) provides accurate nursing documentation supportive of the skilled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 658	Continued From page 13 nursing/extended care services received by our residents. The following was identified under Procedure: 1. the compliance in the following guidelines throughout the documentation process includes the following:... Entries are to be factual, complete and accurate, contain clinical observations.	F 658		
F 677 SS=D	NJAC 8:39-27.1(a) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint #: NJ165862, NJ184181 Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that NJ Ex Order 26.4(b)(1) care was provided to a NJ Ex Order 26.4(b)(1) resident in a timely manner. This deficient practice was identified for 1 of 4 residents (Resident #247) reviewed for Activities of Daily Living (ADL) care and was evidenced by the following: On 4/30/25 at 10:16 AM, during the initial tour of the NJ Exec Order 26.4b1, the surveyor observed Resident #247 NJ Exec Order 2 and NJ Exec O lying in bed, the bed sheets were NJ Ex O and there was NJ Ex Order 26.4(b)(1) in the room. At that time, the surveyor requested Licensed Practical Nurse/Unit Manager (LPN/UM	F 677	I. Corrective action(s) accomplished for resident(s) affected: Residents #247 Received NJ Ex Order 26.4(b)(1) care immediately. Complete body assessment was completed and NJ Ex [redacted] noted from this practice. The Certified Nursing Assistant responsible for completing the NJ Ex Order 26.4(b)(1) care received 1:1 in-servicing by the Assistant Director of Nursing on Completing NJ Ex Order 26.4(b)(1) care in a timely manner. II. Residents identified having the potential to be affected and corrective action taken: Residents incontinent of bladder had the	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 677	Continued From page 14 #3) to check the resident for NJ Ex Order 26.4(b)(1) care. The resident stated, NJ Ex Order 26.4(b)(1)." LPN/UM #3 checked the resident's NJ Ex Order 26.4(b)(1) which was NJ Ex Order 26.4(b)(1) and the bed sheet NJ Ex Order 26.4(b)(1). LPN/UM #3 then stated, "I will get the aide," and that the resident should have been changed in the morning during the Certified Nursing Assistant (CNA) morning rounds. On 4/30/25 at 10:28 AM, CNA #1 entered the resident's room and checked the resident's NJ Ex Order 26.4(b)(1). The surveyor observed that the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1) and the resident's NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) were NJ Ex Ord The resident stated, "NJ Ex Order 26.4(b)(1)." CNA #1 then stated "I am just getting to [him/her] now." CNA#1 further stated that the resident was sleeping that morning, and she did not want to bother him/her. On 5/1/25 at 12:54 PM, the surveyor reviewed the medical record for Resident #247. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Ex Order 26.4(, NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26.4(b)(1). Further review of the MDS revealed the resident was dependent for NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1).	F 677	potential to be effected by this practice. The clinical team conducted walking rounds on the identified unit to assess all residents who were in bed and had not received complete care at that time yet. No other residents were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The Certified Nursing Staff were educated by the Assistant Director of Nursing regarding the timely completion of incontinent care. The Director of Nursing or designee will complete rounds on the identified unit daily x 1 week, weekly x 3 weeks and then monthly x 5 months. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to ensure compliance. V. Date of Compliance: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 677	Continued From page 15 A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [NJ Ex Order 26.4(b)], that the resident was at risk for [NJ Ex Order 26.4(b)(1)] related to [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)]. Interventions included: Provide prompt [NJ Ex Order 26.4(b)(1)] care and apply [NJ Ex Order 26.4(b)(1)] as needed. The ICCP also included a focus area, dated [NJ Ex Order 26], the resident required up to [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4(b)(1)] with ADLs. Interventions included: [NJ Ex Order 26.4(b)(] with [NJ Ex Order 26.4(b)(1)]. On 5/1/25 at 12:32 PM, the surveyor interviewed CNA #2 who stated that [NJ Ex Order 26.4(b)(1)] rounds would be completed first thing in the morning, again before lunch, and last rounds would be completed around 2:00 PM. On 5/1/25 at 12:42 PM, the surveyor interviewed CNA #3 who stated that [NJ Ex Order 26.4(b)(1)] rounds would be completed when the CNA first came in the morning, then after lunch around 1:00 PM, then again before end of shift around 2:30-3:00 PM. On 5/1/25 at 12:55 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #3 who stated that [NJ Ex Order 26.4(b)(1)] rounds were completed two times a shift - at the beginning of the shift and any time after lunch. On 05/1/25 at 1:06 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #1 who stated [NJ Ex Order 26.4(b)(1)] rounds should be completed every two hours on every resident. On 05/2/25 at 12:17 PM, the surveyor interviewed the [U.S. FOIA (b) (6)]) who stated that	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 677	Continued From page 16 she would expect the CNAs to complete NJ Ex Order 26.4(b)(1) rounds every two hours. The CNAs would usually start their rounds after they clock in at 7:00 AM and night shift typically completed their last NJ Ex Order 26.4(b)(1) rounds between 5:00 and 5:30 AM. The U.S. FOIA (b) further stated that it was important to complete timely NJ Ex Order 26.4(b)(1) care to prevent any NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b) to the resident. On 5/7/25 at 1:51 PM, in the presence of the survey team, th U.S. FOIA (b) (6) the U.S. FOIA (b) the U.S. FOIA and the U.S. FOIA (b) (6), the surveyor reviewed the concern with NJ Ex Order 26.4(b)(1) care. A review of the facility's "Incontinence Management" policy, updated February 2025, included that all incontinent residents would be checked frequently during the shift to keep them dry and comfortable. NJAC 8:39-27.1(a) NJAC 8:39-27.2(h)	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 688	Continued From page 17 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and pertinent facility documentation, it was determined that the facility failed to ensure that treatment to NJ Ex Order 26.4(or NJ Ex Order 26.4(b)(1) were provided for 1 of 1 resident (Resident #11) reviewed for NJ Ex Order 26.4(b)(1) This deficient practice was evidenced by the following: On 5/6/25 at 10:30 AM, the surveyor observed Resident #11 lying in bed in watching television. The resident's NJ Ex Order 26.4(b)(was resting on the bed without NJ Ex Order 26.4(b)(1) in place (NJ Ex Order 26.4(b)(1)). On 5/7/25 at 11:22 AM, the surveyor observed Resident #11 lying in bed watching television. The resident's NJ Ex Order 26.4(b)(was resting on the bed without NJ Ex Order 26.4(b)(1) in place. The surveyor reviewed the electronic medical record (EMR) for Resident #11. A review of the Admission Record, an admission summary, revealed the resident had diagnoses	F 688	I. Corrective action(s) accomplished for resident(s) affected: Residents #11 refused to NJ Ex Order 26.4(b)(1) . NJ Ex Or was NJ Ex Order 26.4(b)(1) and NJ Ex Order 2 when staff assisted NJ Ex O to use a NJ Ex Order 26.4(b)(1). Hospice Nurse and NP was made aware, and an order was received to discontinue NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) daily on 5/7/25. Resident #11 had NJ Ex Order 26.4(b)(1) from this practice. The Licensed Nurse who was responsible for NJ Ex Order 26.4(b)(1) as signed on the ETAR received 1:1 in-service from the Assistant Director of Nursing on NJ Ex Order 26.4(b)(1) as signed on the ETAR and update the prescriber if resident is refusing to use the NJ Ex Order 26.4(b)(1) II. Residents identified having the potential to be affected and corrective action taken: Residents who have an order for rolled gauze ordered to prevent contractures had the potential to be affected by this practice. An audit of residents with an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 688	Continued From page 18 which included, but were not limited to: NJ Exec Order 26.4b1 A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated the resident's NJ Exec Order 26.4b was NJ Ex Order 26.4(b)(1). Further review of the MDS revealed the resident had NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). A review of the resident's individual comprehensive care plan (ICCP), dated NJ Ex Order 26.4(, included a focus area indicating that the NJ Ex Order of the resident's NJ Ex Order 26.4(b)(were NJ Ex Order 26.4(b)(1) Interventions included: Applying NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(as tolerated, reapplying as needed, and removing for NJ Ex Order 26.4(and NJ Ex Order 26.4(b)(1). A review of the NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR) revealed a physician's order dated NJ Ex Order 26.4(b) for the application o NJ Ex Order 26.4(b)(1) to the resident's NJ Ex Order 26.4(b)(1). The order directed that the NJ Ex Order 26.4(b)(be worn at all times, removed for hygiene, and that the NJ Ex Ord be checked every shift. Further review of the TAR indicated that facility day shift nurses documented the application of the resident's NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 and NJ Ex Order 26. However, the surveyor did not observe Resident #11 wearing the NJ Ex Order 26.4(b)(1) on either date, and there was no documentation in the EMR to show that the resident had refused the NJ Ex Order 26.4	F 688	order for hand roll was conducted, and no other residents were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The licensed staff were reeducated by the Assistant Director of Nursing regarding assurance that residents with an order for rolled hand gauze is being applied as signed on the ETAR. The Assistant Director of Nursing or designee will complete a weekly audit for x 4 weeks and then monthly for 5 months regarding rolled gauze use and observe hand roll being applied as signed on the ETAR. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to ensure compliance. V. Date of Compliance: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 688	Continued From page 19 On 5/7/25 at 1:56 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that nurses should not have documented the application of a resident's NJ Exec Order 26.4b1 if it was not applied. On 5/7/25 at 2:16 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the resident was discharged from NJ Ex Order 26.4(in NJ Ex Order 26 and no staff training had been completed for the resident's NJ Ex Order 26.4(b)(1) because the NJ Ex Order 26.4(b)(was not considered a specialized device. The U.S. FOIA (b) (6) further stated if there was a physician's order and a care plan for the resident's NJ Ex Order 26.4(b)(1) the facility staff were expected to apply the NJ Ex Order 26 as directed. A review of the facility's undated and unnamed policy revealed, under the procedure section, that "the following elements will be in place to achieve maximum potential: range of motion: passive or active to maintain flexibility and useful motion in the joints of the body."	F 688		
F 695 SS=D	NJAC 8:39 - 27.1 (a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 695	Continued From page 20 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that NJ Exec Order 26 was administered in accordance with a physician's order for 1 of 1 resident (Resident #146) reviewed for NJ Exec Order 26.4b1 care. This deficient practice was evidenced by the following: On 4/30/25 at 10:23 AM, the surveyor observed Resident #146 who was seated in a wheelchair at the bedside. The resident was receiving NJ Ex Order 26.4(b)(from an NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)). When interviewed, the resident stated that he/she was ordered NJ Ex Order 26.4(b)(1 but the NJ Ex Order 26.4(b)(1) was NJ Ex Order and they needed to NJ Ex Order 26.4(b)(1) On 5/1/25 at 11:59 AM, the surveyor observed Resident #146 seated on the side of the bed with noted NJ Ex Order 26.4(b)(1). The resident stated that he/she had been NJ Ex Order 26.4(b)(1) and was trying to NJ Ex Order 26.4(b)(1). The resident's NJ Ex Order 26.4(was set at NJ Ex Order 26.4(b)(1) On 5/2/25 at 10:48 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #2 who stated that she thought that Resident #146 was on NJ Ex O , but she would have to look at the physician's order to be certain. LPN #2 accompanied the surveyor into the resident's room and looked at the resident's NJ Ex Order 26.4(	F 695	I. Corrective action(s) accomplished for resident(s) affected: Residents #146 is NJ Ex Order 26.4(b)(1) with the complex medical diagnosis which includes but not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4 The resident was seen and examined by the NP on NJ Ex Order 26.4 and order was changed to NJ Ex Order 26.4(b)(1) by the NJ Ex Order 26 and remained stable with NJ Ex Order 26.4(b since then. The Licensed Nurse who was responsible for applying the NJ Ex Order 26.4(as ordered received 1:1 in-servicing by the Assistant Director of Nursing on applying the NJ Ex Order 26.4(as ordered or updating the provided as warranted II. Residents identified having the potential to be affected and corrective action taken: All residents who have an order for Oxygen use had the potential to be affected by this practice. An audit of residents with a physician order for oxygen were audited. All residents dial of oxygen flow matched as ordered by the physician and signed on the ETAR. No other resident was identified as affected by this practice. III. Measures will be put into place to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 695	Continued From page 21 NJ Ex Order 26.4(b)(1) settings. The LPN then stated that the NJ Ex Order 26.4(was set at NJ Ex Order 26.4(b)(1) . The resident stated that he/she thought that the NJ Ex Order 26.4(b)(1) was acting up and the nurse turned it up because it felt like nothing was coming out through the NJ Ex Order 26.4(b)(1). LPN #2 stated that she was off for the past couple of days and needed to see if the physician's order was changed. On 5/2/25 at 10:56 AM, LPN #2 reported to the nurse's station and asked Licensed Practical Nurse/Unit Manager (LPN/UM) #2 if Resident #146's NJ Ex Order 26.4(order was changed. LPN/UM #2 reviewed the resident's electronic health record (EHR) and stated that the resident was ordered NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(When interviewed, LPN #2 stated that she would have called the doctor to see what the doctor recommended because it was not her place to adjust the NJ Ex Order 26.4(b)(1) setting without a physician's order. At that time, the surveyor interviewed LPN/UM #2 who stated that nursing should have first assessed the resident, checked the NJ Ex Order 26.4([redacted] to make sure that it functioned properly, and then called the doctor for recommendations. LPN/UM #2 further stated that you could not just increase the NJ Ex Order 26.4([redacted] setting without a physician's order. The surveyor reviewed the medical record for Resident #146. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Ex Order 2 [redacted] (NJ Ex Order 26.4(b)(1)	F 695	ensure the deficient practice will not recur: The Licensed Nurses were reeducated by the Assistant Director of Nursing in relation to the importance of administering oxygen as ordered by the physician and signing the ETAR as such. The Assistant Director of Nursing or designee will complete a weekly audit for the next 4 weeks then monthly x 5 months regarding use of Oxygen applied as signed on the ETAR. Any discrepancies will be rectified immediately IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to ensure compliance V. Date of Compliance: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 695	Continued From page 22	F 695		

NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)).

A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26 Further review of the MDS included the resident required NJ Ex Order 26.4(

A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Ex Order 26.4(b)(1), that the resident had a potential for NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1). Interventions included: Provide NJ Ex Order 26.4(as ordered.

A review of the Order Summary Report (OSR) included the following physician's orders (PO): A PO, dated NJ Ex Order 26.4(b), for NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1)) as needed for NJ Ex Order 26.4(b)(1)) every shift.

A review of the NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR) included an order for NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(as needed for NJ Ex Order dated NJ Ex Order 26.4(b)(1 that was signed out as administered on the NJ Ex Order 26.4(day shift.

A review of the NJ Ex Order 26.4(b)(1) TAR included an order for NJ Ex Order 26.4(b via NJ Ex Orde at NJ Ex Order 26. as needed for NJ Ex Order dated NJ Ex Order 26.4(b), that was signed out as administered on NJ Ex Order 26.4 for the day, evening, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 695	Continued From page 23 night shifts. Further review of the TAR revealed that the order was also signed out on [redacted] during the day shift. A review of the Progress Notes (PN) included a PN that was written by the U.S. FOIA (b) (6) [redacted], dated [redacted] at 11:23 AM, and included, NJ Ex Order 26.4(b)(1) [redacted]. Further review of the PN included a PN, dated [redacted] at 12:22 PM, which revealed, the resident was seen today [redacted]) to follow up [redacted] and [redacted]), NJ Ex Order 26.4(b)(1) [redacted]), attempted to NJ Ex Order 26.4(b)(1) on Friday, but was not successful. Resident stated [redacted] was unchanged, [redacted] without [redacted] A [redacted] was ordered which revealed no [redacted]. On 5/2/25 at 12:35 PM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]) who stated that an [redacted] order that was given by the physician should have been followed. The [redacted] stated that the [redacted] order was on the Treatment Administration Record (TAR) and the nurses were required to look at the [redacted] each shift to ensure that the order was followed and document their findings accordingly. The [redacted] stated that it was not appropriate to increase the [redacted] because the nurses wanted to follow the physician's orders. On 5/8/25 at 9:34 AM, in the presence of the survey team and the U.S. FOIA (b) (6) [redacted] the [redacted] stated that the nurses must ensure that the [redacted] was set at the correct setting per the physician's order.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 695	Continued From page 24 A review of the facility's "Oxygen tubing and Respiratory products" policy, revised January 2025, included, "Oxygen will be administered as ordered by the physician... The Licensed nurse must sign the ETAR (electronic treatment administration record) during the shift ensuring the correct amount of Oxygen is administered as ordered."	F 695		
F 757 SS=D	NJAC 8:39-27.1(a) Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 757	Continued From page 25 Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to administer NJ Ex Ord medication according to the physician's order for 1 of 5 residents (Resident #155) reviewed for unnecessary medications. This deficient practice was evidenced by: On 5/7/25 at 9:21 AM, the surveyor observed Resident #155 sitting in their room. When asked about NJ Ex Order the resident stated he/she had NJ Ex Order 26.4(b)(1) in his/her NJ Ex Order 26.4(b)(1). The resident further stated that their NJ Ex Ord was typically a level NJ out of 10, but that they received as needed NJ Ex Ord medication that brought the NJ Ex Ord level down to a leve NJ Ex Order 26.4(b)(1) which was effective for the resident. The surveyor reviewed the medical record for Resident #155. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, date NJ Ex Order 26.4(included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26 Further review of the MDS revealed the resident had NJ Ex Order 26.4(b)(1) that he/she described as NJ Ex Order 26.4(b)(1). A review of the individual comprehensive care	F 757	I. Corrective action(s) accomplished for resident(s) affected: Residents #155 continue to receive NJ Ex Order 26.4(b)(1) 1 tablet by mouth every 4 hours as needed for NJ Ex Order 26.4(b)(1) management. NJ Ex Order 26.4(b)(1) give 2 tablets by mouth every 6 hours as needed for NJ Ex Order 26.4(b)(1) NJ Ex Ord. A consultation was ordered with NJ Ex Ord management specialist. The Identified Licensed Nurses received 1:1 in-service by the Assistant Director of Nursing on administering PRN NJ Ex Ord medication based on the NJ Ex Ord scale. II. Residents identified having the potential to be affected and corrective action taken: Residents who have an order PRN Opioids had the potential to be affected by this practice. An audit of residents with an order for Opioids PRN use was conducted, and no other residents were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: The licensed staff were reeducated by the Assistant Director of Nursing regarding administering PRN Opioids based on the physician`s order and documenting the appropriate pain level on the EMAR. Assistant Director of Nursing or designee will complete a weekly audit for x 4 weeks and then monthly for 5 months regarding administering PRN Opioids based on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 757	Continued From page 26 plan (ICCP) included a focus area, revised [NJ Ex Order 26], that the resident received [NJ Ex Order 26.4(b)(1)]) medication related to [NJ Ex Order 26.4(b)(1)]. Interventions included: Monthly medication regimen review conducted by U.S. FOIA (b) (6) and assess [NJ Ex Ord] using numeric scale if able. A review of the Order Summary Report (OSR), dated as of [NJ Ex Order 26], included the following physician order (PO): A PO, dated [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26.4(b)(1)] give one tablet by mouth every four hours as needed for [NJ Ex Order 26.4(b)(1)] A review of the U.S. FOIA (b) (6) Monthly Report ([NJ Ex Order 26.4(b)(1)] dated [NJ Ex Order 26.4(b)(1)], included the following recommendation: "Medication error(s) noted. Documented [NJ Ex Ord] level of [NJ]'s does not match as needed [NJ Ex Order 26.4(b)(1)] indication of [NJ Ex Order 26.4(b)(1)]. Please review." Further review of the [NJ Ex Order 26] revealed the section "Action Taken," to be filled out by the facility, was blank. A review of the [NJ Ex Order 26.4(b)(1)] Medication Administration Record (MAR) revealed a PO for [NJ Ex Order 26.4(b)(1)] give one tablet by mouth every six hours as needed for [NJ Ex Order 26.4(b)(1)], dated [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26]. The PO was signed out as administered for a documented [NJ Ex Ord] level of "[NJ] (zero) on the following date(s): -[NJ Ex Order 26.4(b)(1)] at 9:36 AM A review of the [NJ Ex Order 26.4(b)(1)] MAR revealed a PO for [NJ Ex Order 26.4(b)(1)] give one tablet by mouth every six hours as needed for [NJ Ex Order 26.4(b)(1)], dated [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4(b)(1)]. The PO was signed out as	F 757	physician`s order and documenting the appropriate pain level on the EMAR. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to ensure compliance. V. Date of Compliance: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 757	Continued From page 27 administered for a documented [redacted] level of '[redacted] on the following date(s): [redacted] at 11:01 AM Further review of the [redacted] MAR revealed a PO for [redacted] give one tablet by mouth every four hours as needed for [redacted] dated [redacted] to [redacted]. The PO was signed out as administered for a documented [redacted] on the following date(s): [redacted] at 12:10 AM [redacted] at 11:00 PM [redacted] at 10:20 AM [redacted] at 12:43 PM A review of the [redacted] MAR revealed a PO for [redacted] give one tablet by mouth every four hours as needed for [redacted], dated [redacted] to [redacted]. The PO was signed out as administered for a documented [redacted] level of '[redacted] on the following date(s): [redacted] at 10:28 AM [redacted] at 10:53 AM [redacted] at 9:08 AM A review of the [redacted] MAR revealed a PO for [redacted] give one tablet by mouth every four hours as needed for [redacted], dated [redacted] - [redacted]. The PO was signed out as administered for a documented [redacted] of '[redacted] on the following date(s): [redacted] at 11:13 AM Further review of the [redacted] MAR revealed a PO for [redacted] give one tablet by mouth every four hours as needed for [redacted] dated [redacted] to [redacted]. The PO was signed out as administered for a documented [redacted] level of '[redacted] on the following date(s):	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 757	Continued From page 28 NJ Ex Order 26.4(b) at 9:45 PM A review of the NJ Ex Order 26.4(b)(1) MAR revealed a PO for NJ Ex Order 26.4(b)(1) give one tablet by mouth every four hours as needed for NJ Ex Order 26.4(b)(1), dated NJ Ex Order 26.4(to NJ Ex Order 26. The PO was signed out as administered for a documented NJ Ex Ord level of 'NJ E on the following date(s): NJ Ex Order 26.4 at 8:29 AM Further review of the NJ Ex Order 26.4(b)(1) MAR revealed a PO for NJ Ex Order 26.4(b)(1) give one tablet by mouth every four hours as needed for NJ Ex Order dated NJ Ex Order 26 to NJ Ex Order 26.4(b). The PO was signed out as administered for a documented NJ Ex Ord level of 'NJ E on the following date(s): NJ Ex Order 26.4 at 4:56 PM and 9:07 PM Further review of the NJ Ex Order 26.4(b)(1) MAR revealed a PO for NJ Ex Order 26.4(b)(1) give one tablet by mouth every four hours as needed for NJ Ex Order 26.4(b)(1) , dated NJ Ex Order 26.4(. The PO was signed out as administered for a documented NJ Ex Ord level of 'NJ E on the following date(s): NJ Ex Order 26.4(b) at 9:06 PM NJ Ex Order 26.4(b) at 5:18 PM A review of the NJ Ex Order 26.4(b)(1) MAR revealed a PO for NJ Ex Order 26.4(b)(1) give one tablet by mouth every four hours as needed for NJ Ex Order 26.4(b)(1) , dated NJ Ex Order 26.4(b)(The PO was signed out as administered for a documented NJ Ex Ord level of 'NJ E on the following date(s): NJ Ex Order 26.4 at 5:13 PM On 5/7/25 at 9:24 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the numerical NJ Ex Ord scale was as follows: NJ Ex Order 26.4(b)(1) The	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 757	Continued From page 29	F 757		

LPN further stated that as needed [NJ Ex Ord] medication should never be administered for a [NJ Ex Ord] level of [NJ Ex Order 26.4(b)] and that it was important to administer [NJ Ex Ord] medication according to the PO in order to keep the resident's [NJ Ex Ord] man [NJ Exec Order 26.4] and prevent [NJ Ex Order 26.4(b)(1)]

On 5/7/25 at 9:28 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the numerical [NJ Ex Ord] scale was as follows: [NJ Ex Order 26.4(b)(1)] . The LPN/UM further stated that as needed [NJ Ex Ord] medication should only be administered for a [NJ Ex Ord] level of [NJ Ex Orde], not for a level of [NJ E] The LPN/UM further stated that when the [U.S. FOIA (b) (6)] made a recommendation, it should be addressed as soon as possible to ensure the accuracy of medications.

On 5/7/25 at 9:40 AM, the surveyor interviewed the [U.S. FOIA (b) (6)]) who stated the nurses should not administer as needed [NJ Ex Order 26.4(b)(1)] for a [NJ Ex Ord] level of [NJ E] The [U.S. FO] further stated the nurses should follow the PO as a part of professional standards.

On 5/7/25 at 9:55 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated the numerical [NJ Ex Ord] scale was as follows: [NJ Ex Order 26.4(b)(1] . The [U.S. FOIA (b] further stated that as needed [NJ Ex Ord] medication should not be administered for a [NJ Ex Ord] level of [NJ] and that the nurse was required to administer as needed [NJ Ex Ord] medication according to the PO. When asked about the [NJ Ex Order 26.4(] the [U.S. FOIA (b] stated recommendations were reviewed with the physician within one week in order to provide comprehensive care of the resident. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 757	Continued From page 30 U.S. FOIA (E further stated that nurses should not have continued to document a NJ Ex Orde level of N for the as needed NJ Ex Order 26.4(b)(1) after the U.S. FO identified the error on the NJ Ex Order 26.4(A review of the facility's "Consultant Recommendations Policy," dated 11/25/24, included, "Consultant recommendations will be reviewed by the licensed nurse. The attending physician will be notified as soon as possible. Nurse will document the date, time, and reason for call in the medical record." A review of the facility's "Pain Assessment/Management and Documentation Policy and Procedure," revised 1/22/25, included, "Pain and pain relief will be documented using the most appropriate pain scale based on the resident's cognition status. An appropriate medication will be administered based on that pain scale and assessment/observation of each resident." A review of the facility's "0-10 Scale of NJ Ex Orde Severity" chart revealed the following: 0 - No NJ Ex Orde 1 - Minimal 2 - Mild 3 - NJ Ex Order 26.4(b)(1) 4 - Moderate 5 - NJ Ex Order 26.4(b)(1) 6 - NJ Ex Order 26.4(b)(1) 7 - Unmanageable 8 - NJ Ex Order 26.4(9 - NJ Ex Order 26.4(10 - NJ Ex Order 26.4(b)(1) NJAC 8:39-27.1(a)	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 757	Continued From page 31	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842	Continued From page 32 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint # NJ00176228 Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to maintain	F 842	I. Corrective action(s) accomplished for resident(s) affected: Residents #82 had NJ Ex Order 26.4(b)(1) from this practice. A complete body	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842	Continued From page 33 complete and accurate medical records in accordance with acceptable standards of practice. The facility failed to ensure a.) weekly NJ Ex Ord assessments were accurately documented in the Treatment Administration Record (TAR) and b.) the physician's orders were followed and accurately documented the medication administration on the Medication Administration Record (MAR). This deficient practice was identified in 1of 2 residents (Resident #82) reviewed for NJ Ex Order 26.4(b)(1) and 1of 1 resident (Resident #60) reviewed for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and was evidenced by the following: 1.) On 4/30/25 at 10:34 AM, the surveyor observed Resident #82 NJ Exec Order 2 and NJ Exec Ord lying in bed with a NJ Ex Order 26.4(b)(1) on the bed. The surveyor reviewed the medical record for Resident #82. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) without NJ Ex Order 26.4(b) . A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b) included that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which	F 842	assessment was completed by the registered Nurse and correct coding was documented on the ETAR. The identified Licensed Nurses received education by the Assistant Director of Nursing regarding following the facility policy and physician orders while completing weekly NJ Ex Ord assessment and documenting the correct code of ongoing NJ Ex Ord integrity concerns on the ETAR. Resident #60 had NJ Ex Order 26.4(b)(1) from this practice. Resident received new NJ Ex Order 26.4(b)(1) on NJ Exec Order 26.4. The identified Licensed nurses received 1:1 education by the Assistant Director of Nursing regarding accurately documentation of placement of Hearing aids on the ETAR II. Residents identified having the potential to be affected and corrective action taken: Residents who have an existing injury /wound have the potential to be affected by this practice. An audit of residents with previously noted injury / wound was conducted, and no other residents were identified as affected by this practice. Residents who have an order for hearing aids have the potential to be affected by this practice. An audit of residents with hearing aids was conducted, and no other residents were identified as affected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842	Continued From page 34 indicated the resident's NJ Exec Order 26.4(b)(1) was NJ Exec Order 26.4(b) Further review of the MDS revealed the resident had a NJ Ex Order 26.4(b)(1), with treatments including NJ Ex Order 26.4(b)(1) care and NJ Ex Order 26.4(b)(1) for bed and chair. A review of the individual comprehensive care plan (ICCP) included a focus area that the resident was at risk for NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) risk for NJ Ex Order 26.4(b)(1) and use of NJ Ex Order 26.4(b)(1). Interventions included: Weekly NJ Ex Ord assessment completed by nurse, provide prompt NJ Ex Order 26.4(b)(1) care, and utilization of NJ Ex Order 26.4(b)(1) to chair and NJ Ex Order 26.4(b)(to bed. A review of the Order Summary Report (OSR), dated as of NJ Exec Order 2, included the following physician orders (PO): A PO, dated NJ Ex Order 26.4(b) for Weekly NJ Ex Ord assessment NJ Ex Order 26.4(b)(1) Every day shift every Tuesday. A PO, dated NJ Ex Order 26.4(, for NJ Ex Order 26.4 care: NJ Ex Order 26.4(b)(1) Apply to NJ Ex Order 26.4(b)(1) every day shift for NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1)), pat dry, apply NJ Ex Order 26.4(b)(1) cover with NJ Ex Order 26.4(b)(1), with a discontinuation date of NJ Ex Order 26.4(b)(1 A PO, dated NJ Ex Order 26.4(b) , for NJ Ex Order 26.4 care: NJ Ex Order 26.4(b)(1) , Apply to NJ Ex Order 26.4(b)(1) every day shift	F 842	The licensed staff were reeducated by the Assistant Director of Nursing regarding following the facility policy and physician orders while completing weekly skin assessment and documenting the correct code of ongoing skin integrity concerns on the ETAR. The Assistant Director of Nursing or designee will complete a weekly audit for 4 weeks and then monthly for 5 months regarding following physician orders while completing weekly skin assessment and documenting the correct code of ongoing skin integrity concerns on the ETAR The licensed staff were reeducated by the Assistant Director of Nursing following the facility policy and physician orders while signing for hearing aids on ETAR. Assistant Director of Nursing or designee will complete a weekly audit for 4 weeks and then monthly for 5 months regarding following physician orders while signing for hearing aids on ETAR. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Director of Nursing or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to assure compliance. V. Date of Compliance: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842		F 842		

Continued From page 35

for NJ Ex Order 26.4(b)(1), with a discontinuation date of NJ Ex Order 26.4(b).

A PO, dated NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) pat dry, NJ Exec Orde NJ Ex Order 26.4(b)(1), cover with NJ Ex Order 26.4(b)(1) every day and evening shift for NJ Ex Order 26.4 care

The surveyor reviewed the Progress Notes (PN) which included the following:

A Nurses Note (NN), dated NJ Ex Order 26.4(b) at 3:46 PM, revealed the nurse observed NJ Ex Order 26.4(b)(1) the resident's NJ Ex Order 26.4(b)

A Physician Progress Note (PPN), dated NJ Ex Order 26.4(b) at 10:30 AM, revealed the resident complained that NJ Ex Order 26.4(b)(1) and that the Certified Nursing Assistant (CNA) reported NJ Ex Order 26.4(b)(1) that morning to the nurse.

A U.S. FOIA (b) (6)) NJ Ex Order 26.4(b)(1) Note, dated NJ Ex Order 26.4(b) at 4:44 PM, included, consulted for NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26.4(b)(1) treatment initiated."

A NP NJ Ex Order 26.4(b) Progress Note, dated NJ Ex Order 26.4(b) at 3:21 PM, included that the NJ Ex Order 26.4(b)(1) was reclassified as an NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) NJ Ex Order 26.4(b)(1) with updates to NJ Ex Order 26.4 care recommendations.

A NP NJ Ex Order 26.4(b) Progress Note, dated NJ Ex Order 26.4(b) at 4:06 PM, included that the NJ Ex Order 26.4(b)(1) was reclassified as NJ Ex Order 26.4(b)(1) NJ Ex Orde) with updates to NJ Ex Order 26.4 care recommendations noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842	Continued From page 36	F 842		

A further review of the weekly NP Progress Notes, dated [redacted], and [redacted], included the [redacted] continued as [redacted] and recommended [redacted] care treatments were ordered by the physician as indicated above.

A review of the [redacted] Treatment Administration Record (TAR), included the [redacted] physician's order for weekly [redacted] assessments were coded as: [redacted]

A review of the [redacted] through [redacted] TAR showed a [redacted] entered for the following dates: [redacted].

On 5/7/25 at 10:51 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #4 who stated that when a new [redacted] was found it would be reported to the nurse.

On 5/7/25 at 10:54 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #6 who stated that weekly [redacted] assessments would be done on the resident's [redacted] day, which included a [redacted] by the nurse, and documented in the TAR using the coding of [redacted] The LPN further stated: a [redacted] should be documented for a [redacted] and [redacted] should be documented for a previously noted [redacted]

On 5/7/25 at 11:01 AM, the surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842	Continued From page 37	F 842		

the LPN/Unit Manager (LPN/UM) #3 who stated that weekly [redacted] assessments would populate in the TAR, the nurse would complete a [redacted] assessment and document in the TAR using the [redacted] coding. When asked what should be documented for a [redacted] that already exists, the LPN replied, a "[redacted]" for a previous [redacted].

On 5/7/25 at 11:10 AM, the surveyor interviewed the [redacted]) who stated that the nurses complete [redacted] weekly and document on the TAR using the code. The [redacted] further stated that a previously noted [redacted] should be coded with a "[redacted]" ([redacted]). When asked about the documentation of "[redacted]"s from [redacted] through [redacted] the [redacted] stated the nurses "inadvertently" put in the wrong number and that it should be "[redacted]" for [redacted]

On 5/7/25 at 1:51 PM, in the presence of the [redacted]), the [redacted] the [redacted], the [redacted], and the survey team, the surveyor reviewed the above concern.

A review of the "Skin Inspection" policy, revised and updated 8/24, included "1. Skin inspections will be conducted on admission, readmission, and weekly thereafter for all residents as scheduled by the licensed nurse. 2. The licensed nurse will observe all body surfaces of the resident and document in ETAR record of PCC (Electronic Medical Record)"

A review of the facility's "Wound" policy, revised January 2025, included "(3) Weekly skin observation/assessment will be conducted by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842	Continued From page 38	F 842		

licensed nurse" and (15) All wounds will be assessed weekly. Documentation will be maintained in the resident's medical record."

2.) On 4/30/25 at 10:46 AM, the surveyor observed Resident #60 seated in their wheelchair in the hallway on the 2-West Unit. At that time, the surveyor observed the resident was not wearing their NJ Ex Order 26.4(b)(1).

On 5/1/25 at 9:06 AM, the surveyor reviewed the electronic medical records (EMR) for Resident #60.

A review of the Admission Record, an admission summary, revealed the resident had diagnoses, which included, NJ Ex Order 26.4(b)(1) [redacted]).

A review of the comprehensive Minimum Data Set (MDS) an assessment tool used to faciltitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] Further review of the MDS revealed the resident had NJ Ex Order 26.4(b)(1).

A review of the Medication Administration Record (MAR) revealed a physician's order (PO) dated [redacted] to check the placement of NJ Ex Order 26.4(b)(1) [redacted] six times daily at 5:00 AM, 8:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, and 8:00 PM while the resident was up. An additional (PO) dated [redacted] instructed nursing staff to apply the [redacted] in the morning and to remove and place them on the charger in the medication room every evening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842	Continued From page 39 A review of the individual comprehensive care plan (ICCP), dated NJ Ex Order 26.4, included a focus area indicating that the resident has NJ Ex Order 26.4(b)(related to NJ Ex Order 26.4(b)(1) and used NJ Ex Order 26.4(b)(1). Interventions included: Nursing will apply and store NJ Ex Order 26.4(b)(1) daily and ensure NJ Ex Order 26.4(b)(1) are place. A review of the MAR indicated that day and evening shift nurses documented the resident's NJ Ex Order 26.4(b)(1) were applied each morning, removed each evening, and placed on the charger in the medication room every day, and that the NJ Ex Order 26.4(b)(1) were checked for placement while the resident was upon the following days: On NJ Ex Order 26.4(b)(at 8:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, and 8:00 PM, On NJ Ex Order 26.4(b)(at 5:00 AM, 8:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, and 8:00 PM. There was no documentation in the EMR indicating that the resident's NJ Ex Order 26.4(b)(1) were missing or that he/she had refused to wear them on either date. On 5/1/25 at 11:14 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #4 who stated that on the morning of NJ Ex Order 26.4(, she noticed the resident's NJ Ex Order 26.4(b)(1) were not on NJ Ex Order 26.4(b)(1) in the medication room. LPN #4 admitted that she did not document that the NJ Ex Order 26.4(b)(1) were missing on that date. On 5/6/25 at 10:22 AM, the surveyor interviewed LPN/Unit Manager (LPN/UM) #5 who stated that she was notified on NJ Ex Order 26.4(during the day that the resident's NJ Ex Order 26.4(b)(1) were missing and initiated an investigation. LPN/UM #5 stated that she spoke with both the evening Certified	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 842	Continued From page 40 Nurse Aide (CNA) and the nurse who had provided care for the resident during the shift prior to the discovery of the NJ Ex Order 26.4(b)(1) and both staff members reported that they did not recall seeing the NJ Ex Order 26.4(b)(1). On 5/7/25 at 1:55 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that the nurses should not have documented that the resident's NJ Ex Order 26.4(b)(1) were being applied and removed if they were not. A review of a facility's "Personal Care" policy, dated February 2025, revealed, "Hearing aides are to be placed in appropriate ear by resident or nursing staff as needed in the a.m. They are to be removed in the p.m. at hour of sleep by resident or staff, as needed, and stored in a labeled container." NJAC 8:39-27.1(a) NJAC 8:39-35.2(d)(g)	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 883	Continued From page 41 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 883	Continued From page 42 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the NJ Ex Order 26.4(b)(1) was administered to a resident upon admission to the facility. This deficient practice was identified for 1 of 5 residents (Resident #72) reviewed for NJ Ex Order 26.4(b)(1) and was evidenced by the following: Reference: Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report Pneumococcal Vaccine for Adults Aged >19 Years: Recommendations of the Advisory Committee on Immunization Practices (ACIP), United States, 2023 Recommendations and Reports / September 8, 2023 / 72(3);1-39 Adults aged >19 years who have received PCV13 only are recommended to receive a single dose of PCV20 at an interval >1 year after receipt of the PCV13 dose or to receive >1 dose of PPSV23 to complete their pneumococcal vaccine series. -When PPSV23 is used instead of PCV20, the minimum recommended interval between PCV13 and PPSV23 administration is >8 weeks for adults with an immunocompromising condition, a CSF leak, or a cochlear implant and >1 year for adults without these conditions. Either PCV20 or a second PPSV23 dose is recommended >5 years after the first PPSV23 dose for adults aged	F 883	I. Corrective action(s) accomplished for resident(s) affected: Residents #72 received NJ Ex Order 26.4(b)(1) [redacted] on NJ Ex Order 26 The U.S. FOIA (b) (6) [redacted] received 1:1 in-service by the Director of Nursing on ensuring NJ Ex Order 26.4(b)(1) is administered as requested by the resident. II. Residents identified having the potential to be affected and corrective action taken: Residents who have consented to receive pneumonia vaccine had the potential to be affected by this practice. An audit of immunization of Pneumonia vaccine for all residents was conducted, and no other residents were identified as affected by this practice. The facility will continue to offer and administered the pneumonia vaccine to all residents as warranted. III. Measures will be put into place to ensure the deficient practice will not recur: The Infection Preventionist Nurse and all licensed staff were reeducated by the Director of Nursing regarding ensuring that a Pneumonia Vaccine is administered as requested by the resident. The Infection Preventionist Nurse or designee will complete a weekly audit for x 4 weeks and then monthly for 5 months regarding immunization of Pneumonia vaccine.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 883	Continued From page 43 19-64 years with specified immunocompromising conditions but not for adults with a CSF leak or a cochlear implant. In addition, those who received both PCV13 (at any age) and PPSV23 (no PCV20) but have not received a dose of PPSV23 at age >65 years are recommended to receive either PCV20 or a single and final dose of PPSV23 at age >65 years and >5 years since the previous PPSV23 dose. On 4/30/25 at 10:57 AM, the surveyor requested Resident #72's signed consent form for receipt of the NJ Ex Order 26.4(b)(1). On 5/1/25 at 9:00 AM, the facility provided Resident #72's NJ Ex Order 26.4(b)(1)/Consent/Declination & Education form, dated [redacted], which revealed the consent was signed by the resident's [redacted] for the resident to receive the NJ Ex Order 26.4(b)(1) [redacted] On 5/1/25 at 9:09 AM, the surveyor reviewed the medical record for Resident #72. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, [redacted] NJ Ex Order 26.4(b)(1) [redacted], and [redacted]. A review of the resident's [redacted] Audit Report, as of [redacted], did not include any documentation related to the NJ Ex Order 26.4(b)(1) [redacted] A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated	F 883	IV. Corrective actions will be monitored to ensure the deficient practice will not recur: The Infection Preventionist Nurse or designee will forward the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to assure compliance. V. Date of Compliance: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 883	Continued From page 44 NJ Ex Order 26.4(b), included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26.4(b)(1). Further review of the MDS included the resident was not offered the NJ Ex Order 26.4(b)(1). A review of the Order Summary Report (OSR), with a date range of NJ Ex Order 26.4(b) to NJ Ex Order 26.4(b), included the following physician order (PO): A PO, dated NJ Ex Order 26.4(b), for NJ Ex Order 26.4(b)(1) [redacted] one time only for NJ Ex Order 26.4(b)(1) [redacted] for 1 (one) day [after surveyor requested consent forms]. A review of the NJ Ex Order 26.4(b)(1) Medication Administration Record (MAR) revealed that the NJ Ex Order 26.4(b)(1) was administered on NJ Ex Order 26 at 12:35 PM. On 5/2/25 at 11:01 AM, in the presence of the survey team, the surveyor interviewed the U.S. FOIA (b) (6) who stated that upon admission, residents were given education and screened for the NJ Ex Order 26.4(b)(1) and then consent was obtained. The U.S. FOIA (b) (6) then administered the NJ Ex Order 26.4(b)(1) and documented the administration of the NJ Ex Order 26.4(b) in the Electronic Medical Record (EMR) under the NJ Ex Order 26.4(b)(1) tab. The U.S. further stated that it was important to administer the NJ Ex Order 26.4(b)(1) [redacted], if indicated, to prevent NJ Ex Order 26.4(b)(1) At that time, the surveyor reviewed Resident #72's signed consent form dated NJ Ex Order 26.4(b) with the U.S. F. The U.S. stated that Resident #72's NJ Ex Order 26.4(b)(1) was missed and should	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
F 883	Continued From page 45	F 883		

have been administered by the admitting nurse when the consent was obtained.

On 5/7/25 at 11:20 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that the resident should have been assessed for the NJ Ex Order 26.4(b)(1) upon admission, and obtained consent from the resident or family if indicated, and the admitting nurse should administer the NJ Ex Order 26.4(b upon admission.

On 5/7/25 at 1:51 PM, in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b) the U.S. FOIA (b) (6) , and the U.S. FOIA (b) (6) , the surveyor reviewed the concern that the NJ Ex Order 26.4(b)(1) was not administered upon admission and was administered on NJ Ex Order 26 after surveyor inquiry.

On 5/7/25 at 2:08 PM, the NJ Ex Order obtained Resident #72's New Jersey NJ Ex Order 26.4(b)(1) Information System form from the resident's family physician, which revealed that Resident#72 had received the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1)

On 5/8/25 at 9:27 AM, the U.S. FOIA (b) in the presence of the U.S. FOIA (b) (6 and the U.S. FOIA (b) (6) , confirmed that the resident had received the NJ Ex Order 26.4(b on NJ Ex Order 26.4(b)(1) and received the NJ Ex Order 26.4(b on NJ Ex Order 26 and she stated that, according to the CDC NJ Ex Order 26.4(b)(1) timing form for adults, the NJ Ex Order 26.4(b)(1) can be administered starting one year after receiving the NJ Ex Order 26.4(b)(1).

A review of the facility's "Pneumococcal vaccine" policy, revised January 2025, included to offer pneumococcal immunizations to all residents (unless contraindicated) as per CDC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
F 883	Continued From page 46 recommendations. Upon admission, review the resident's medical record including hospital records if available be to determine whether any pneumococcal vaccines have been received. The licensed nurse to educate resident/responsible party/legal guardian regarding Pneumonia vaccine and obtain a consent. The licensed nurse will administer Pneumonia vaccine as requested by the resident/responsible party and ordered by the physician/nurse practitioner. NJAC 8:39-19.4 (i)	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ165862, NJ166907, NJ166986, NJ172394, and NJ185522 Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 43 of 49 day shifts reviewed, and for 4 of 49 overnight shifts reviewed and was evidenced by the following: Reference: New Jersey Department of Health	S 560	I. Corrective Action accomplished for Resident(s) affected: Director of Nursing/Designee meets daily and before weekends with a staffing coordinator to review staff sufficiency to ensure minimum staffing hours requirement is met along with extra hours needed to meet special services need of our residents as required at N.J.A.C 8:39-25.1. Staffing coordinators will send daily emails with the staffing number to the Administrator and Director of Nursing and ADONs and Nursing Supervisor. II. Residents identified having the	6/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 01/01/2023 to 01/07/2023, the facility was deficient in CNA staffing for residents as follows: -01/01/23 had 31 CNAs for 274 residents on the day shift, required at least 34 CNAs. -01/02/23 had 26 CNAs for 274 residents on the day shift, required at least 34 CNAs. -01/03/23 had 30 CNAs for 274 residents on the day shift, required at least 34 CNAs. -01/04/23 had 28 CNAs for 274 residents on the day shift, required at least 34 CNAs. -01/05/23 had 23 CNAs for 279 residents on the day shift, required at least 35 CNAs. -01/06/23 had 24 CNAs for 278 residents on the	S 560	Potential to be affected and corrective action taken: All residents residing in the facility had the potential to be affected. A random sample of Twenty alert and oriented residents were interviewed regarding staff response times to requests for assistance with concerns reported to the Director of Nursing for rectification. III. Measures to be put in place to ensure the deficient practice will not recur: The Call Out Policy was reviewed by the facility administration and staff have been reeducated by the Facility Educator on the policy. Referral and Sign-on Bonuses are offered for both Licensed and Certified Nursing Staff. The Retention and Recruitment Coordinator and Nurse Educator meet at area Nursing and CNA Schools and host job fairs. Interviews are done on the spot. Staffing needs for the day are assessed daily and evaluated if the Nursing Management (Unit Managers, ADON, and Facility Educator) needs to assist with resident care. Staff recognition is done monthly, a monthly incentive is offered for staff that do not call out. Elmwood Hills established a recruitment and retention committee. Elmwood Hills hired a recruitment and retention employee. Elmwood Hills does weekly Orientation. Elmwood Hills uses multiple employment search engines and multiple social media platforms. Elmwood Hills does recruitment events at area CNA schools; interviews are done on the spot. Elmwood Hills continues to offer flexible schedules to staff. Alert and Oriented residents will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S 560	Continued From page 2 day shift, required at least 35 CNAs. -01/07/23 had 20 CNAs for 277 residents on the day shift, required at least 35 CNAs. 2. For the 2 weeks of Complaint staffing from 05/21/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -05/21/23 had 24 CNAs for 280 residents on the day shift, required at least 35 CNAs. -05/22/23 had 32 CNAs for 280 residents on the day shift, required at least 35 CNAs. -05/23/23 had 24 CNAs for 280 residents on the day shift, required at least 35 CNAs. -05/25/23 had 29 CNAs for 280 residents on the day shift, required at least 35 CNAs. -05/26/23 had 29 CNAs for 280 residents on the day shift, required at least 35 CNAs. -05/27/23 had 33 CNAs for 288 residents on the day shift, required at least 36 CNAs. -05/28/23 had 25 CNAs for 283 residents on the day shift, required at least 35 CNAs. -05/29/23 had 32 CNAs for 281 residents on the day shift, required at least 35 CNAs. -05/30/23 had 26 CNAs for 280 residents on the day shift, required at least 35 CNAs. -06/02/23 had 34 CNAs for 280 residents on the day shift, required at least 35 CNAs. -06/03/23 had 25 CNAs for 279 residents on the day shift, required at least 35 CNAs. -06/03/23 had 10 total staff for 279 residents on the overnight shift, required at least 20 total staff. 3. For the week of Complaint staffing from 08/20/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:	S 560	interviewed regarding the timeliness of staff response when requesting help as part of their Quarterly care conference meetings. This date will be reported to Social Services quarterly to the QA Committee for the next two meetings, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements. IV. Corrective Action will be monitored to ensure the deficient practice will not recur: The Director of Nursing (DON)/Designee will conduct daily Certified Nursing (CNA) staffing schedule audits for the next six months. The DON/designee will report audit findings to the Administrator for analysis, tracking and trending. The Administrator will report the findings of the Certified Nursing Assistant staffing audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA committee will determine the need for any additional monitoring of Certified Nursing Assistant staffing after the 2nd quarterly meeting. V. Date of Compliance: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S 560	Continued From page 3 -08/20/23 had 28 CNAs for 280 residents on the day shift, required at least 35 CNAs. -08/21/23 had 32 CNAs for 277 residents on the day shift, required at least 35 CNAs. -08/22/23 had 33 CNAs for 274 residents on the day shift, required at least 34 CNAs. -08/25/23 had 27 CNAs for 274 residents on the day shift, required at least 34 CNAs. -08/26/23 had 20 CNAs for 274 residents on the day shift, required at least 34 CNAs. 4. For the week of Complaint staffing from 02/25/24 to 03/03/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -02/25/24 had 27 CNAs for 290 residents on the day shift, required at least 36 CNAs. -02/26/24 had 29 CNAs for 290 residents on the day shift, required at least 36 CNAs. -02/27/24 had 28 CNAs for 290 residents on the day shift, required at least 36 CNAs. -02/28/24 had 30 CNAs for 290 residents on the day shift, required at least 36 CNAs. -03/01/24 had 26 CNAs for 293 residents on the day shift, required at least 37 CNAs. -03/02/24 had 31 CNAs for 293 residents on the day shift, required at least 37 CNAs. -03/03/24 had 27 CNAs for 291 residents on the day shift, required at least 36 CNAs. 5. For the 2 weeks of staffing prior to survey from 04/13/2025 to 04/26/2025, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -04/13/25 had 25 CNAs for 290 residents on the day shift, required at least 36 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S 560	Continued From page 4 -04/14/25 had 23 CNAs for 288 residents on the day shift, required at least 36 CNAs. -04/16/25 had 29 CNAs for 288 residents on the day shift, required at least 36 CNAs. -04/17/25 had 34 CNAs for 288 residents on the day shift, required at least 36 CNAs. -04/17/25 had 20 total staff for 288 residents on the overnight shift, required at least 21 total staff. -04/18/25 had 24 CNAs for 288 residents on the day shift, required at least 36 CNAs. -04/19/25 had 29 CNAs for 288 residents on the day shift, required at least 36 CNAs. -04/20/25 had 27 CNAs for 288 residents on the day shift, required at least 36 CNAs. -04/20/25 had 20 total staff for 288 residents on the overnight shift, required at least 21 total staff. -04/21/25 had 32 CNAs for 286 residents on the day shift, required at least 36 CNAs. -04/22/25 had 33 CNAs for 286 residents on the day shift, required at least 36 CNAs. -04/23/25 had 33 CNAs for 286 residents on the day shift, required at least 36 CNAs. -04/24/25 had 33 CNAs for 286 residents on the day shift, required at least 36 CNAs. -04/25/25 had 33 CNAs for 286 residents on the day shift, required at least 36 CNAs. -04/26/25 had 28 CNAs for 286 residents on the day shift, required at least 36 CNAs. On 5/6/25 at 12:02 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she had worked at the facility since [redacted] When the surveyor asked the SC if she was familiar with the minimum staffing requirements for nursing homes, the SC stated the ratios were: 1:8 on the 7-3 shift, 1:10 on the 3-11 shift, and 1:14 on the 11-7 shift. The SC stated that she felt that the facility met the required staffing needs. The SC further stated that if there was a short fall, then	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S 560	Continued From page 5 the facility utilized the SC, the Unit Clerks, or the Recruiter who were also CNAs to provide resident care. On 5/7/25 at 11:17 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the minimum staffing requirements for nursing homes was 1:8 on the 7-3 shift, 1:10 on the 3-11, and 1:14 on the 11-7 shift. The DON stated the facility did their best every single day to meet the ratios. On 5/7/25 at 11:39 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the minimum staffing requirements for nursing homes was 1:8 on the 7-3 shift, 1:10 on the evening shift, and 1:14 on the 11-7 shift. The LNHA stated the facility met the ratios for the most part, but there were times when they did not. A review of the facility's "Nursing Staffing Policy" revised and updated Jaunaury 2025, included: "committed to adhering to the Nursing Staffing Standards set forth by the New Jersey Administrative Code (N.J.A.C) and relevant state legislation..." and, "Certified Nurse Aide (CNA) Ratios...: Day Shift: One direct care staff per eight residents Evening Shift: One direct care staff member per ten residents Night Shift: One direct care staff member per fourteen residents."	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director	S1680		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S1680	Continued From page 6 of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S1680	Continued From page 7 This REQUIREMENT is not met as evidenced by: Complaint #s: NJ165862, NJ185522 Based on review of the Nursing Staffing Reports for the two weeks prior to survey from 4/13/2025 to 4/26/2025, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 04/13/25 Required Staffing Hours: 768.50 -04/13/25 had 720 actual staffing hours, for a difference of -48.50 hours.	S1680	I. Corrective Action accomplished for Resident(s) affected: Director of Nursing/Designee meets daily and before weekends with a staffing coordinator to review staff sufficiency to ensure the minimum staffing hours requirement is met along with the extra hours needed to meet the special services needs of our residents as required at N.J.A.C 8:39-25.1. Staffing coordinators will send daily emails with the staffing number to the Administrator and Director of Nursing and ADONs and Nursing Supervisor. II. Residents identified having the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S1680	Continued From page 8 For the week of 04/20/25 Required Staffing Hours: 767.75 -04/20/25 had 752 actual staffing hours, for a difference of -15.75 hours. A review of the facility's "Contingency Staffing Plan" dated 8/1/24, included: "To assure that there is sufficient qualified staff available at all times to provide nursing and related services in conjunction with other essential personnel to meet the resident's needs safely in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care; and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment..."	S1680	Potential to be affected and corrective action taken: All residents residing in the facility had the potential to be affected. A random sample of Twenty alert and oriented residents were interviewed regarding staff response times to requests for assistance with concerns reported to the Director of Nursing for rectification. III. Measures to be put in place to ensure the deficient practice will not recur: The Call Out Policy was reviewed by the facility administration and staff have been reeducated by the Facility Educator on the policy. Referral and Sign-on Bonuses are offered for both Licensed and Certified Nursing Staff. The Retention and Recruitment Coordinator and Nurse Educator meet at area Nursing and CNA Schools and host job fairs. Interviews are done on the spot. Staffing needs for the day are assessed daily and evaluated if the Nursing Management (Unit Managers, ADON, and Facility Educator) needs to assist with resident care. Staff recognition is done monthly, a monthly incentive is offered for staff that do not call out. Elmwood Hills established a recruitment and retention committee. Elmwood Hills hired a recruitment and retention employee. Elmwood Hills does weekly Orientation. Elmwood Hills uses multiple employment search engines and multiple social media platforms. Elmwood Hills does recruitment events at area CNA schools; interviews are done on the spot. Elmwood Hills continues to offer flexible schedules to staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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
S1680	Continued From page 9	S1680	Alert and Oriented residents will be interviewed regarding the timeliness of staff response when requesting help as part of their Quarterly care conference meetings. This date will be reported to Social Services quarterly to the QA Committee for the next two meetings, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements. IV. Corrective Action will be monitored to ensure the deficient practice will not recur: The Director of Nursing (DON)/Designee will conduct daily Certified Nursing (CNA) staffing schedule audits for the next six months. The DON/designee will report audit findings to the Administrator for analysis, tracking and trending. The Administrator will report on the findings of the Certified Nursing Assistant staffing audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA committee will determine the need for any additional monitoring of Certified Nursing Assistant staffing after the 2nd quarterly meeting. V. Date of Compliance: 6/22/25	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315159 Y1	A. Building B. Wing Y2	6/26/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0636	Correction	ID Prefix F0658	Correction	ID Prefix F0677	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	06/22/2025	LSC	06/22/2025	LSC	06/22/2025
ID Prefix F0688	Correction	ID Prefix F0695	Correction	ID Prefix F0757	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(d)(1)-(6)	Completed
LSC	06/22/2025	LSC	06/22/2025	LSC	06/22/2025
ID Prefix F0842	Correction	ID Prefix F0883	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. #	Completed
LSC	06/22/2025	LSC	06/22/2025	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/9/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060411	A. Building B. Wing	6/26/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/22/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 06/22/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
5/9/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING **01** B. WING _____	**05/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD** **BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 5/7/25, 5/8/25 and 5/9/25 and the facility was found to be in non-compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING Health Care Occupancies. Elmwood Hills Healthcare Center was constructed in 1996. A support services building separates the Long-Term Care facility from a Joint Commission psychiatric hospital. The support services building was surveyed as it contains a large therapy area used by long-term care residents. The facility is a Type II (111) with concrete flooring, brick/block bearing walls, steel studs and steel supported roof with plywood over steel roof decking. The facility has a complete sprinkler system and smoke detection in all bedrooms and corridors. The facility has a 1500 KW (kilowatt) stand by diesel generator that tests under load at 33%. The facility has 290 occupied beds. The facility has 10 smoke zones.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height	K 161		6/22/25

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

Electronically Signed | 05/30/2025

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 DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING **01** B. WING _____	**05/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
K 161	Continued From page 1 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.	K 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 161	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/7/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) , it was determined that the facility failed to provide acceptable construction standards in accordance with NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6. This deficient practice was observed for 1 of 6 sections and had the potential to affect all residents as evidenced by the following: An observation at 11:37 AM with the U.S. FOI and the U.S. FOIA (b) (6 revealed in Electrical Room L243-A, that the exposed beams supporting the floor were not protected. The construction type of the building Type II (000) is required to be Type II (111). In an interview at the time, the U.S. FOI stated and agreed that exposed beam supporting the floor in the Electrical Room L243-A was not protected. The U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM. NJAC 8:39-31.2(e)	K 161	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: The exposed beams in Electrical Room L243-A were immediately assessed and was encased in fire-resistant materials. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. All similar structural areas in the facility were inspected by the Director of Maintenance and found compliant. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator on construction classification compliance and all fire-rated assemblies will be re-verified quarterly. Monitoring of structural fireproofing was added to the quarterly Preventive maintenance schedule. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director will perform quarterly audits of structural fireproofing for six months and present results to QA x2 Quarters. 5. Compliance Date: 6/22/25	
K 222 SS=F	Egress Doors CFR(s): NFPA 101	K 222		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING **01** B. WING _____	**05/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
K 222	Continued From page 3 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 222	Continued From page 4 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 5/8/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) it was determined that the facility failed to ensure that doors in a required means of egress were not equipped with a latch or lock in accordance with NFPA 101:2012 Edition, Section 19.2.2.2.4 and 7.2.1.6.2. This deficient practice had the potential to affect all residents and was evidenced for 2 of 2 sliding doors by the following: 1). An observation at approximately 11:37 AM revealed the long term care/support services exit/egress door (external set) was provided with thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit.	K 222	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: Signage was posted to instruct visitors and residents what to do in case of an emergency. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All exit doors in the facility were re-inspected by the Maintenance Director and confirmed compliant. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: Monthly door lock inspections will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 222	Continued From page 5 2). An observation at approximately 11:40 AM of the long term care/support services exit/egress door (internal set) revealed a thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. There was no signage indicating the procedure to open the door potentially confusing or prohibiting visitors and residents from using the facility designated exit and could restrict emergency use of the exit. In interviews with the U.S. FOI and the U.S. FOIA (b) (6) at the time, both confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM.	K 222	included in the facilitys monthly life safety rounds. In-service training on exit door locking compliance was conducted by the Administrator with Maintenance Director. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly audits of egress doors will be performed for six months and reviewed in QA Committee x2 Quarters.. 5. Compliance Date: 6/22/25	
K 271 SS=F	N.J.A.C 8:39-31.2 (e) Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/8/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)	K 271	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice:	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 271	Continued From page 6 (U.S. FOIA (b) (6) it was determined the facility failed to maintain a stable, level walking surface at exit discharge for 2 of 8 exterior exits in accordance with NFPA 101: 2012 Edition, Section 7.7, 7.1.6.2, 7.1.10.1 and 19.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following: 1). An observation at 11:22 AM of the exit discharge at stairway #106 revealed that the sidewalk to the access roadway had an approximately 2-inch step in the sidewalk leaving the walking surface not nominally level. In interviews at the times, the U.S. FOI and the U.S. FOIA (b) (6) both confirmed the observations. 2). An observation at 11:52 AM of the laundry and central supply exit door to the loading dock revealed approximately 60-feet of walking surface approximately 4-feet above ground level was observed to not have any guard rail or edge protection. The loading dock did not have a ramp or steps to ground level. In interviews at the times, the U.S. FOI and the U.S. FOIA (b) (6) both confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM.	K 271	The sidewalk will be repaired and a guardrail/edge protection will be installed on the loading dock. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice . All exit pathways were re-evaluated and no additional hazards were found. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator on Discharge from Exit requirements. Exit discharge surfaces will be included in the facilitys monthly life safety rounds. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly audits of egress doors will be performed for six months and reviewed in QA Committee x2 Quarters 5. Compliance Date: 6/22/25	
K 281 SS=F	N.J.A.C. 8:39-31.2 (e) Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit	K 281		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 281	Continued From page 7 discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 5/8/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) , it was determined the facility failed to ensure required illumination was arranged so that the failure of any single lighting unit did not result in an illumination level of less than 0.2 ft-candle in any designated area in accordance with NFPA 101: 2012 Edition, Section 7.8 and 7.8.1.4. The deficient practice was observed for 4 of 6 exterior areas, had the potential to affect all residents and was evidenced by the following: 1). An observation at 10:48 AM outside exit door LT9, revealed that only a single bulb emergency lighting fixture was provided. 2). An observation at 11:04 AM outside exit door LT14, revealed that the exit discharge from the sidewalk to the front car parking lot, approximately 90-feet, did not have any emergency lighting. 3). An observation at 11:24 AM outside exit door 106, revealed that the exit discharge from the sidewalk to the access roadway, approximately 30-feet, did not have any emergency lighting. 4). An observation at 11:41 AM outside the exit door from the LTC facility through the Northbrook Behavioral Healthcare services exit discharge sidewalk to the rear car parking lot, approximately	K 281	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: 1) A second bulb was immediately added outside Exit LT9 2) Lighting was installed outside Exit Door LT14 3) Lighting was installed outside Exit Door 106 4) Lighting was installed outside Exit Door from the LTC facility through Northbrook Behavioral Healthcare 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. All exit areas were audited for proper illumination levels and found to be compliant. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator on Egress Lighting requirements. Emergency lighting will be checked during routine monthly maintenance rounds. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly lighting checks will be performed for six months and reviewed in QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 281	Continued From page 8 200-feet, did not have any emergency lighting. In interviews at the times, the [redacted] and the [redacted] both confirmed the observations. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM.	K 281	Committee x2 Quarters. 5. Compliance Date: 6/22/25	
K 293 SS=F	NJAC 8:39-31.2 (e) Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview 5/8/25 in the presence of the [redacted]) and the [redacted]), it was determined that the facility failed to ensure that exit signs were installed above doors through which the egress path leads and that directional exit signs were provided in accordance with NFPA 101:2012 Edition, Section 7.10.1.2.2 and 7.10.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:57 AM revealed that an illuminated exit sign was not provided above the	K 293	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: A compliant exit sign with adequate lighting was installed. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. All exit signage throughout the facility was verified and found to be in compliance. 3. What measures will be put into place or	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 293	Continued From page 9 exit door of the enclosed courtyard. The exit sign on the interior door to the courtyard was observed to be a paper exit sign with no photoluminescence values. In an interview at the time, the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/2025 at 12:45 PM. N.J.A.C 8:39-31.1(c), 31.2 (e)	K 293	what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator on Exit Signage requirements . Emergency signage will be checked during routine monthly maintenance rounds. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly Signage checks will be performed for six months and reviewed in QA Committee x2 Quarters. 5. Compliance Date: 6/22/25	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 321	Continued From page 10 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/8/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) , it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice had the potential to affect all residents in that identified area for 1 of 4 sets of doors observed and was evidenced by the following: An observation at 10:38 AM revealed that the courtyard glass enclosure approximately 5-feet from the building was storing a three gallon filled gas can and gas fired equipment filled with gas. The structure was not protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors). In an interview at the time, the U.S. FOI and the U.S. FOIA (b) (6 both confirmed the observations. The facility U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM.	K 321	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: Gas can and equipment were immediately removed and relocated to fire-rated storage. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. All hazardous material storage locations were reviewed and were found to be compliant. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: Maintenance staff were in serviced by the Administrator regarding the correct storage of Gas Cans. Proper storage of gas and equipment will be checked during routine monthly maintenance rounds 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly Gas storage checks will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 321	Continued From page 11 NJAC 8:39-31.2 (e)	K 321	performed for six months and reviewed in QA Committee x2 Quarters. 5. Compliance Date: 6/22/25	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/7/25 in the presence of the facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that the fixed interior wall surfaces have a flame spread rating of Class A or B in accordance with NFPA 101:2012, 10.2.3* and 10.2.8.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a tour of the facility from 09:30 AM to 12:55 PM in the exit/egress corridor, revealed carpet on the lower section of the walls by resident room L257. The carpet measured approximately 36-inches up from the floor the flame spread rating could not be determined.	K 331	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: Carpet was sprayed with approved NFPA standard fire retardant. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. All interior wall finishes will be reviewed for compliance and if found deficient will be corrected. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator on flame	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 331	Continued From page 12 The [U.S. FOI] and the [U.S. FOIA (b) (6)] both were asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface. The MD did not produce any documentation on the interior surfaces flame spread rating (class A or B). In an interview with the [U.S. FOI] and the [U.S. FOIA (b) (6)] at the time of the observation, both indicated they could provide a flame spread rating but no further documentation was provided. The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM. N.J.A.C. 8:39-31.2(e)	K 331	spread rating requirements and will be re-verified quarterly. Monitoring of flame spread rating was added to the quarterly Preventive maintenance schedule. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director will perform quarterly audits of interior wall and ceiling finish fire rating for six months and present results to QA x2 Quarters. 5. Compliance Date: 6/22/25	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 5/7/25 and 5/8/25 in the presence of the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)], it was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) of the fire alarm was in accordance with NFPA 101:2012	K 345	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: 1) System was inspected by vendor on May 12 and found to be operating correctly 2) The furniture blocking the pull station at nurse station L174 was	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 345	Continued From page 13 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: 1). An observation on 5/7/25 and 5/8/25 at 9:30 AM, revealed that the fire alarm annunciator panel in the Courtyard Nurses Station indicated: System Trouble with an activated amber light. In an interview during the observations, the U.S. FOI indicated the fire alarm system would randomly go into trouble mode at times and indicated the fire alarm vendor was troubleshooting a grounding issue. The U.S. FOI confirmed that the facility fire alarm vendor stated the system would operate normally in the event of an activation and did not require a fire watch, but did not produce any further documentation indicating so. The fire alarm annunciator panel was in normal mode at the Life Safety Code exit Conference on 5/9/25. A fire alarm policy and procedure was provided, but it did not indicate the procedures during a fire alarm system trouble mode. 2). An observation on 5/8/25 at 11:10 AM revealed at nurse station L174, that the manual pull station was obstructed from an activation by furniture. In an interview the U.S. FOI and the U.S. FOIA (b) (6) both confirmed the finding during the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM. N.J.A.C 8:39-31.2 (e)	K 345	immediately removed 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. All fire alarm stations and annunciators inspected and were found to be in good use and unobstructed. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator on Fire Alarm system testing and maintenance. The U.S. FOIA (b) (6) was also in serviced regarding fire watch procedures. Monthly inspections will be done to ensure pull stations are unobstructed and the system is functioning correctly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly fire alarm checks will be performed for six months and will be reviewed in QA Committee x2 Quarters. 5. Compliance Date: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 345	Continued From page 14 NFPA 70, 72	K 345		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/8/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) it was determined that the facility did not install sprinklers as required by CMS regulation § 483.90(a) physical environment and in accordance with NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and NFPA 13, 2012 Edition, Section 8.5.5.3. The deficient practice had the potential to affect all residents and was evidenced for 6 of 6 stairways and 1 of 2 communication rooms by the following:	K 351	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: 1) 6 of the 6 Sprinkler heads will be installed 2) Sprinkler will be adjusted to provide coverage under ductwork in room S107 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. All areas were	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 351	Continued From page 15 1). Observations at 9:00 AM to 12:45 PM with the U.S. FOI and U.S. FOIA (b) (6) revealed that 6 of 6 accessible landing exit/egress areas were not provided with sprinkler coverage in the area by the door leading to the public way. In an interview, the U.S. FOI and the U.S. FOIA (b) (6) both confirmed the observations. 2). An observation at 10:10 AM revealed in the communications room S107, that no fire sprinkler coverage was provided underneath the approximately 4-foot by 6-foot wide ductwork. In an interview, the U.S. FOI and the U.S. FOIA (b) (6) both confirmed the observations. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 13	K 351	inspected and were found to be compliant. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator on Sprinkler coverage requirements. Sprinkler coverage to be reviewed during biannual fire system maintenance. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Documentation of sprinkler inspections submitted to QA quarterly x4. 5. Compliance Date: 6/22/25	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 363	Continued From page 16 requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 5/8/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 2 of 32 rooms observed, had the potential to affect all residents and was evidenced by the following:	K 363	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: Obstructions were removed from Room #174 and the beauty Salon. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. The Maintenance Director completed an audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 363	Continued From page 17 Observations from 9:15 AM to 12:45 PM in the presence of the U.S. FOI and the U.S. FOIA (b) (6) revealed resident room doors did not operate properly as follows: - Room # 174 - the door would not latch into its frame due to a wreath obstructing the door from closing. - Beauty Salon door was observed to be propped open with a door stop wedge on both 5/7/25 and 5/8/25. In an interview the U.S. FOI and the U.S. FOIA (b) (6) both confirmed the above findings. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	throughout the facility to ensure no other doors were blocked open and that the doors had positively latching hardware. No other areas were noted as deficient in this practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator that doors cannot be propped open. Monitoring of corridor doors has been added to the monthly task list of the Director of Maintenance to maintain compliance with door closing and latching. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly maintenance audits for door latching and closing compliance to be reported to QA x2 Quarters. 5. Compliance Date: 6/22/25	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum	K 374		6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 374	Continued From page 18 clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 5/8/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection in accordance with NFPA 101:2012 Edition. This deficient practice was identified for two (2) of nine (9) smoke barrier door sets observed, had the potential to affect 50 residents in the facility and was evidenced by the following: An observation at 10:28 AM revealed the set of smoke barrier doors at L243A were provided with an electro-magnetic hold-open device. The doors were observed in the closed position and having an approximately 1/2-inch gap between the meeting edges of the set of smoke doors, compromising the integrity of the smoke door requirements to the exit/egress corridor. The U.S. FOI and the U.S. FOIA (b) (6 both confirmed the findings above during the observations. It was noted that the set of doors were identified on the evacuation floor plan as smoke doors and were included in the annual fire door inspection dated: 11/12/24. The plan identified the doors as #102 smoke doors. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM.	K 374	1. What corrective action(s) will be accomplished for those residents affected by the deficient practice: Gaps were sealed and door integrity was restored. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. All smoke barriers were inspected for performance and were deemed to be compliant. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator on the Smoke Barrier Doors compliance including gaps in doors. Monthly fire door testing will verify compliance with smoke resistance requirements. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly maintenance audits for door compliance to be reported to QA x2 Quarters. 5. Compliance Date: 6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING **01** B. WING _____	**05/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
K 374	Continued From page 19 NJAC 8:39-31.1(c), 31.2(e)	K 374		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews on 5/8/25 in the presence of the	K 921	1. What corrective action(s) will be accomplished for those residents affected	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING 01 B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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) COMPLETION DATE
K 921	Continued From page 20 U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that Patient Care Related Electrical Equipment (PCREE) was inspected, tested and maintained (ITM) in accordance with NFPA 99 :2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 5/7/25 revealed that documentation regarding the ITM of PCREE was not included in the materials that were provided for review. Observations from 09:45 AM to 12:45 PM revealed that modified plugs were installed on resident electric beds in the following areas: L-158 yellow modified plug L-228 bed-1 black modified plug. L-228 bed-2 white modified plug with no grounding pin. L-230 bed-1 yellow modified plug. L-237 bed-2 black modified plug. L-264 bed-1 black modified plug. L-264 bed-2 white modified plug with no grounding pin, cord was pinched outer sheathing was slit open. L-285 private room white modified plug with no grounding pin. S-119 yellow modified plug. S-132 yellow modified plug. In an interview at the time, the U.S. FOI confirmed the observations and stated that they annually inspected resident beds but were not checking electric cords and plugs.	K 921	by the deficient practice: All modified cords were replaced and logs for electrical safety testing created. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this practice. Facility-wide audit of PCREE completed and checking of cords and plugs were added to the log. Cords and plugs not in compliance will be repaired. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The U.S. FOIA (b) (6) was re-educated by the Administrator regarding modified cords. Quarterly Cord and Plug testing will verify compliance with Modification requirements. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Monthly maintenance audits for cord and plug integrity to be reported to QA x2 Quarters. 5. Compliance Date:6/22/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING **01** B. WING _____	**05/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD** **BLACKWOOD, NJ 08012**

(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) COMPLETION DATE
K 921	Continued From page 21 No additional documentation for the ITM of PCREE was provided. No policy and inventory was provided. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 5/9/25 at 12:45 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K 921		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315159 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/26/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0161	06/22/2025	LSC K0222	06/22/2025	LSC K0271	06/22/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	06/22/2025	LSC K0293	06/22/2025	LSC K0321	06/22/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0331	06/22/2025	LSC K0345	06/22/2025	LSC K0351	06/22/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	06/22/2025	LSC K0374	06/22/2025	LSC K0921	06/22/2025
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	
5/9/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO