STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15c001	A. BUILDING: _____ B. WING _____	C 08/13/2020

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UNITED METHODIST COMMUNITIES AT COLLINGSW(	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00138400, NJ 00138402, CENSUS: 82 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00138400, NJ 00138402

Based on observation, interview and record review it was determined that the facility failed to enforce and implement its policy and procedures on "Abuse Prevention (AD-7) and Rights of Residents" for 2 of 3 residents reviewed for abuse. This deficient practice was evidenced by the following:

On 8/13/20 at 9:25 a.m., the surveyor informed the Executive Director (ED) about two Reportable Event Reports (RER) dated [redacted] and [redacted] that were reported to the Department of Health (DOH) on [redacted]0. The ED stated that the Director of Residential Living (DRL) did not notify him of the incidents until a few days later.

1. The ED stated that the DRL reported that Resident #1 was afraid of a dark skin girl and explained that the Staff Member (SM) in question was not identified at the time but was later identified as SM #2 after review of the timeline report/video surveillance. He stated that SM #2 was removed from the schedule on [redacted] pending investigation and was terminated from employment on [redacted]. The ED stated that he was made aware of above incident a week later and provided the surveyor with "Alleged of abuse Timeline."

Surveyor review of the "Timeline" report for Resident #1 revealed that on [redacted] at 7:30 a.m., Resident #1 reported to SM #1 about abuse allegation who then reported the abuse to a

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Social Worker (SW) and the SW in turn reported the alleged abuse to the DRL immediately.

Surveyor continued review of the "Timeline" indicated that between [redacted], the DRL reported the abuse allegation to the ED. On 7/29/20, Resident #1 again reported to SM #1 that he/she was afraid of SM #2. SM #1 reported the allegation to the same SW who then reported the incident to the DRL a second time.

According to the "Timeline" documentation, SM #2 was identified and was suspended on [redacted] pending investigation and on [redacted], she was terminated from employment, " ... is terminated from employment after information is uncovered that ... approached ... and ... asking them not to report any issues they may hear about ... but to report to her instead."

At 10 a.m., during tour of the [redacted] unit, the surveyor interviewed Staff Member (SM) #1 regarding abuse and she stated, "Heard it and reported it." SM #1 stated that on [redacted] at approximately 7:30 a.m., she observed that Resident #1 was positioned sideways across his/her bed. She stated that she asked Resident #1 why he/she did not call for help to get back into bed. SM #1 stated that Resident #1 told her that SM #2 stated that he/she [Resident #1] no longer needed assistance and to do things for him/herself.

In addition, SM #1 stated that Resident #1 stated that he/she [Resident #1] was uncomfortable and scared of SM #2 and also that SM #2 was rough while providing care to him/her. SM #1 stated that the resident did not disclose the SM's name at the time but described SM #2 as a tall dark girl. SM #1 stated that she reported the above

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allegation immediately to the DRL on [redacted] and on [redacted] when the resident complained again.

At 10:15 a.m., Resident #1 was observed seated in a wheelchair at a table in his/her room. The surveyor asked the resident about the care he/she received at the facility and in addition, if he/she recalled an incident that occurred with a staff member. The resident stated that the care was good but that there was an aide that was not so nice. Resident #1 stated that SM #2 was "very rough" during care and while assisting him/her into bed. The resident stated that SM #2 was rude and threw him/her across the bed. The resident added that SM #2 provided care to him/her a few times and that her attitude was not good, "She is gone now" and added that he/she felt more comfortable.

At 11:10 a.m., the surveyor reviewed Resident #1's medical record and according to the "Face Sheet" the resident was admitted to the facility in May 2019 with diagnoses which included but were not limited to [redacted]. The "General Service Plan Form" dated [redacted] showed that the resident was alert and oriented to person, place and time and required "Extensive Assistance" with ambulation, bathing, dressing/grooming, and toileting.

At 12 p.m., the surveyor interviewed the DRL regarding the incident that occurred on [redacted] with Resident #1. She stated that on [redacted] or [redacted], SM #1 wrote a note that Resident #1 stated that someone won't assist the resident with his/her care and for the resident to do it by himself/herself. The DRL admitted that she did not speak to the resident or anyone and did not

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A 310	Continued From page 4 investigate the above incident at that time. During continued interview, the DRL stated that SM #1 brought up the same allegation the following week, [week of [redacted]]. She confirmed that it was then that she spoke with Resident #1. The DRL added that based on Resident #1's description of the employee, she was able to identify SM #2 from the assignment sheet. The DRL stated that she reassigned SM #2 to another assignment but on the same unit and reported the incident to the ED who was still on vacation. She stated that the ED returned from vacation on [redacted] and suspended SM #2 on [redacted] pending full investigation and terminated SM #2 from employment on [redacted]. Review of the facility's "Regular Monthly Schedule" provided by the DRL dated July and August 2020, revealed that SM #2 continued work on [redacted]. The facility failed to protect Resident #1 from suspected abuse by employee of the facility who continued to work an additional 6 days after the incident which placed all the residents at risk for further staff to resident abuse. 2. On 8/13/20 at 9:30 a.m., the surveyor interviewed the ED regarding a staff to resident verbal abuse that occurred on [redacted] with Resident #2. The ED stated that on [redacted] SM #3 overheard SM #4 yell at Resident #2. He stated that SM #3 reported the incident the next day [redacted] to the DRL. The ED stated that the DRL investigated the incident but did not report the incident to him and confirmed that SM #4 continued working until [redacted] when she was suspended pending investigation and was terminated on [redacted]	A 310		

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A 310	Continued From page 5 Surveyor review of the "Alleged Abuse Timeline" for Resident #2 provided by the ED revealed that the above incident occurred on [redacted] and was reported to the DRL on [redacted] According to the "Timeline" documentation, between [redacted] SM #3 inquired with a SW about the outcome of the alleged abuse investigation of Resident #2. The SW then reported the alleged abuse to the DRL who stated that she was aware of the allegation and that she had reported the allegation already to the ED. Continued review of the "Timeline" indicated that on [redacted], SM #3 reported alleged abuse to Human Resource Personnel who then reported the alleged abuse to the ED immediately. According to the "Timeline," the ED acknowledged that he was already aware of the allegation and on [redacted], an anonymous report was made to the facility's hotline regarding the alleged abuse. At 9:50 a.m., the surveyor observed Resident #2 in a hallway of the [redacted] unit self-propelling in a wheelchair. The resident agreed to an interview and propelled into his/her room with the surveyor. The surveyor asked the resident about the care he/she received at the facility and the resident stated that it was sometimes alright and went from one topic to another about showers and someone throwing his/her clothes on the floor, "I try to be nice to people." The resident was not able to recall the incident that occurred on [redacted] when SM #3 overheard SM #4 verbally abused the resident. At 12 p.m., the surveyor interviewed the DRL regarding alleged abuse with Resident #2. The DRL stated that SM #3 verbally reported to her the week of [redacted] that she was concerned	A 310		

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because SM #4 verbally abused Resident #2. She stated that SM #4 told Resident #2, "I could take this bag and wrap it around your neck" when the resident asked SM #4 to take his/her laundry down stairs to the lobby for his/her son to pick up. The DRL stated that she spoke with Resident #2 and SM #4 and confirmed that she did not notify the ED until [redacted]

At 12:25 p.m., the surveyor reviewed Resident #2's medical record and according to the resident's "Face Sheet," the resident was admitted to the facility in February 2015 with diagnoses which included but were not limited to [redacted]. The "General Service Plan Form" date[redacted] indicated that the resident was oriented with occasional forgetfulness and required assistance with Activities of Daily Living.

Surveyor review of the Reportable Event Report (RER) dated [redacted] under "Date of Event" [redacted] and under "Narrative" was documented, "Incident was reported by CNA that she overheard another CNA ... being verbally abusive toward resident stating that she heard ... state, "I can take this bag and wrap it around your neck."

At 1:15 p.m., the surveyor interviewed SM #3 who overheard SM #4 regarding the above incident with Resident #2. She stated that on [redacted] at 9 a.m., on the [redacted] day room she overheard SM #4 say to Resident #2, "Get out, get out, get this pissy ass out of here." She continued that the resident then asked SM #4, "who is going to take my laundry downstairs for my [redacted] to pick up and wash?" SM #3 stated that SM #4 replied, "You make me sick; I can't stand your pissy ass, I should take that bag and wrap

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around your damn neck." SM #3 stated that she reported the incident to the DRL the next morning [redacted]. SM #3 stated that she did not report the above incident immediately to avoid confrontation with SM #4 when the surveyor asked why she did not report the incident the same day.

On 8/19/20 at 3:45 p.m., post survey, the surveyor interviewed SM #3. She stated that on [redacted] that Resident #2 reported to her that someone [SM #4] was mean and would not assist to take his/her laundry down and called him/her [Resident #2], a "Pissy ass." SM #3 stated that she reported the incident immediately to Nurse ... who directed her to the DRL and she left a note under the DRL's door.

Review of the facility's "Regular Monthly Schedule" provided by the DRL dated July and August 2020, revealed that SM #4 continued work on [redacted] and [redacted]

The facility failed to protect Resident #2 from suspected abuse by employee of the facility who continued to work an for additional 12 days after the incident which placed all the residents at risk for further staff to resident abuse.

Surveyor review of the facility's policy and procedure titled, "Abuse Prevention (AD-7) last revised 10/10/17 indicated, "The ED assumes overall responsibility for the coordination, and implementation of the Abuse Prevention Program."

"All reports of abuse or suspected abuse are reported to the DON/DOW/Administrator and ED verbally immediately."

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A 310	Continued From page 8 "A timely, thorough and objective investigation is initiated immediately." "If the alleged abuse involves an associate, the suspected or identified associate is removed from resident care, a statement is obtained, and the associate is suspended until the investigation is complete and a determination has been made."	A 310		
A 565	8:36-5.10(a)(3) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 3. All suspected cases of resident abuse, neglect, or misappropriation of resident property, including, but not limited to, those which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly for residents over 60 years of age; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00138400, NJ 00138402 Based on interview and record review it was determined that the facility failed to report two abuse allegations to the Department of Health	A 565		

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(DOH) immediately that occurred on [redacted] and [redacted] and were not reported unti[redacted] for 2 of 3 residents reviewed for abuse, Resident #1 and Resident #2. This deficient practice was evidenced by the following:

On 8/3/20 at 9:25 a.m., the surveyor interviewed the Executive Director (ED) regarding the two Reportable Event Reports (RER) of alleged staff to resident abuse that occurred on [redacted] and [redacted] During interview with the ED, he stated that he would take the blame for not reporting the staff to residents' abuse that occurred on the aforementioned dates in a timely manner to the DOH. The ED explained that he reported the incidents on [redacted] when he returned from vacation.

1. The ED continued that about a week after the 7/23/20 incident with Resident #1, the Director of Residential Living (DRL) reported to him (ED) that Resident #1 was afraid of a dark skin girl. He stated that the Staff Member (SM) in question was not identified at the time but was later identified as SM #2 after review of the timeline report/video surveillance. He stated that SM #2 was removed from the schedule on [redacted] pending investigation and was terminated from employment on [redacted]

At 10:15 a.m., Resident #1 was observed seated in a wheelchair at a table in his/her room. The surveyor asked the resident about the care he/she received at the facility and in addition, if he/she recalled an incident that occurred with a staff member. The resident stated that the care was good but that there was an aide that was not so nice. Resident #1 stated that SM #2 was "very rough" during care and while assisting him/her into bed. The resident stated that SM #2

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A 565	Continued From page 10	A 565		

was rude and threw him/her across the bed. The resident added that SM #2 provided care to him/her a few times and that her attitude was not good, "She is gone now" and added that he/she felt more comfortable.

At 11:10 a.m., the surveyor reviewed Resident #1's medical record and according to the "Face Sheet" the resident was admitted to the facility in [redacted] with diagnoses which included but were not limited to [redacted] The "General Service Plan Form" dated [redacted] showed that the resident was alert and oriented to person, place and time and required "Extensive Assistance" with ambulation, bathing, dressing/grooming, and toileting.

Surveyor review of the Reportable Event Report (RER) dated [redacted] and "Event date" [redacted] revealed, "Incident was reported by CNA that resident stated that he/she is scared of the aide, indicating aide will not assist him/her care, he/she described the aide as a "big, tall, black girl." When asked to give a name, resident would not give a name, when ask if he/she feared anyone, resident responded no."

2. At 9:30 a.m., the surveyor interviewed the ED regarding a staff to resident verbal abuse that occurred on [redacted] with Resident #2. The ED stated that on [redacted], SM #3 overheard SM #4 yell at Resident #2. He stated that SM #3 reported the incident the next day [redacted]] to the DRL. The ED stated that the DRL investigated the incident but did not report the incident to him until [redacted]. He stated that SM #4 was suspended on [redacted] pending investigation and was terminated from employment on [redacted]

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A 565	Continued From page 11 At 9:50 a.m., the surveyor observed Resident #2 in a hallway of the [redacted] unit self-propelling in a wheelchair. The resident agreed to an interview and propelled into his/her room with the surveyor. The surveyor asked the resident about the care he/she received at the facility and the resident stated that it was sometimes alright and went from one topic to another about showers and someone throwing his/her clothes on the floor, "I try to be nice to people." The resident was not able to recall the incident that occurred on [redacted] when SM #3 overheard SM #4 verbally abused the resident. At 12:25 p.m., the surveyor reviewed Resident #2's medical record and according to the resident's "Face Sheet," the resident was admitted to the facility in [redacted] with diagnoses which included but were not limited to [redacted]. The "General Service Plan Form" date [redacted] indicated that the resident was oriented with occasional forgetfulness and required assistance with Activities of Daily Living. Surveyor review of the RER dated [redacted], under "Date of Event" [redacted] indicated, "Incident was reported by CNA that she overheard another CNA ... being verbally abusive toward resident stating that she heard ... state, "I can take this bag and wrap it around your neck." According to surveyor review of the facility policy titled "Abuse Prevention (AD-7)" which was last revised on 10/10/17, revealed under "Reporting-Post Investigation" "The Executive Director or designee will notify the following agencies of any suspected cases of: New Jersey Department of Health and Senior Services must be called immediately at 1-609-633-8991 to	A 565		

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A 565	Continued From page 12 report that the community is investigating an allegation of abuse, neglect, etc. After business hours, call 1-800-792-9770. A written confirmation must follow the call within 72 hours to describe the results of the investigation." Refer to 8:36-3.4(a)(1)	A 565		