STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315404	A. BUILDING _____ B. WING _____	C 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT COLLINGSWOOD	460 HADDON AVE 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) 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		
F 000	INITIAL COMMENTS Complaint #: NJ173160 Survey Date: 08/13/24 - 08/19/24 Census: 51 Sample: 13 + 1 closed record 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		9/18/24

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

Electronically Signed | 09/05/2024

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F 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to develop a comprehensive person-centered care plan for 1 of 2 residents (Resident #36) reviewed for [redacted] This deficient practice was evidenced by the following:	F 656	F656 1. Resident #36 is [redacted] the community. Upon surveyors notification, immediate review was completed of resident #36 care plan and the care plan was updated appropriately. 2. All residents having oxygen orders have the potential to be affected by this	

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F 656	Continued From page 2 On 8/13/24 at 10:11 AM, the surveyor observed Resident #36 in bed NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) . A review of the Admission Record (an admission summary) revealed Resident #36 had diagnoses which included, but were not limited to, NJ Ex Order 26.4(b) , 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) A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the managment of care, dated NJ Ex Order 26.4(b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 'NJ Ex Or which indicated the resident's cognition was NJ Ex Order 2 Further review of the MDS revealed in Section O: Special Treatments, Procedures and Programs that the resident was NJ Ex Order 26.4(b)(1) on admission and while a resident at the facility. A review of the Order Summary Report, as of NJ Ex Order 26.4(b , included the following active physician's order: NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1)) via NJ Ex Order 26.4(b)(1) every shift, with a start date of NJ Ex Order 26.4(b) . A review of the individualized comprehensive care plan, initiated NJ Ex Order 26.4(b , did not include the resident's use of NJ Ex Order 26.4(b)(1) . On 08/14/24 at 2:02 PM, during an interview with the surveyor, Registered Nurse (RN) #1 stated	F 656	cited deficient practice. An Audit was completed on all residents with oxygen orders and no other residents were identified as being negatively impacted. 3. The U.S. FOIA (b) (6) was provided in-service training by Corporate Manager of Reimbursement and Medical Records on 8/19/24 that focus on the requirements of F656 and the importance of not only following a resident's plan of care but also identifying resident's current plan of care. The Director of Nursing will utilize the clinical dashboard and implement a review of all new oxygen orders in the daily stand-up Monday to Friday to ensure timely communication to the MDS (Minimum Data Set) coordinator of a resident□s new care need(s) and that the resident□s care plan is updated timely. 4. An audit tool was implemented, it includes checking the resident's care plan, Kardex to validate they match each other and contain all pertinent information needed to provide and meet a resident's care needs. The Director of Nursing (DON) will conduct an audit of all(100% of the total census population) residents with new orders for oxygen daily for 4 weeks, then weekly for 1 month and then bi-weekly for 2 months. All findings of concern will be immediately addressed as warranted and reported to the Nursing Home Administrator and to the quarterly quality assurance performance improvement (QAPI) committee. The frequency of the audits will be adjusted according to the outcomes.	

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F 656	Continued From page 3	F 656		

care plans are initiated upon admission and updated as needed if the resident's condition changes. She continued by stating that if a resident was prescribed [NJ Ex Order 26.4] it should be included on the care plan so that everyone knows the resident's needs. She also stated that it was important that [NJ Ex Order 26.] was on the care plan in the event that the resident needs to leave the unit for an appointment, so he/she doesn't leave the unit without it. She also added that if there was an agency nurse, he/she needs to know the resident's needs.

During that interview, RN #1 reviewed Resident #36's care plan and confirmed that [NJ Ex Order 26.4(b)(1)] was not included. The RN stated, "No, I don't see it."

On 08/15/24 at 9:35 AM, during an interview with the surveyor, the [U.S. FOIA (b) (6)] stated that upon admission, the care plan is initiated and that [NJ Ex Order 26.] should have been included on Resident #36's care plan.

On 08/16/24 at 09:00 AM, during an interview with the surveyor, the [U.S. FOIA (b) (6)] stated [NJ Ex Order 26.] should have been included in Resident #36's care plan and that it was normally included as per the facility's policy and procedure.

A review of the facility policy titled, Care Plans, dated 11/9/23, revealed, "POLICY The Interdisciplinary Team shall develop a comprehensive, individualized plan of care for each resident that integrate all elements of needed medical, clinical, and community living supports....PROCEDURE 1. Development of the Care Plan begins at admission, utilizing information gathered from the resident, family,

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F 656	Continued From page 4 admission assessments completed by each discipline, and records from the transferring facility or referral source. ...19. The Care Plan is to be reviewed and updated by all staff providing care or services for the resident. The Care Plan includes a statement of the problem; reasonable, measurable, and time-limited goals; and specific interventions, along with the discipline responsible." NJAC 8:39-11.2(3)h	F 656		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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(i) Medical records. §483.70(i)(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(i)(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-	F 842		9/18/24

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F 842	Continued From page 5	F 842		

(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, 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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(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(i)(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

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F 842	Continued From page 6 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to maintain medical records that were complete by not documenting the completion of treatments for 1 of 1 resident (Resident # 42) reviewed for accidents. This deficient practice was evidenced by the following: On 08/13/24 at 10:56 AM, the surveyor observed Resident #42 sitting outside his/her room in a wheelchair. The resident had a NJ Ex Order 26.4(b)(1) on his/her NJ Ex Order 26.4(b) According to the Admission Record, Resident #42 had diagnoses which included, but were not limited to, NJ Ex Order 26.4(b)(1) and NJ Ex Order . Review of the annual 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 score of NJ Ex which indicated the resident's cognition was NJ Ex Order 26.4(b)(1). Review of the NJ Ex Order 26.4(b)(1) Risk Scale assessment, dated NJ Ex Order 26.4(b), included the resident could NJ Ex Order while in a wheelchair and had a history of NJ Ex Order 26.4(b)(1) Further review of the assessment revealed the resident was a "High Risk NJ Ex Order 26.4(b)(1)." Review of the Care Plan, initiated NJ Ex Order 26.4(b),	F 842	F842 1. Resident #42 was NJ Ex Order 26.4(b)(1) by this cited practice and remains in the community. Upon surveyor notification, in-servicing of license nurses working was immediately implemented on documentation of the medical record. 2. All residents with wander guards have the potential to be affected by this practice. 3. All current license staff will be provided inservice education by the community's Resident Staff Educator regarding maintaining an accurate medical record, with emphasis on the responsibility as a nurse to timely sign off the Treatment Administration Record for items that were completed and to check the med pass completion audit tool on the clinical dashboard for their assignment before the end of their shift for missed documentation on the treatment record and complete. Immediate review of the medication treatment record was implemented and is reviewed by the Nurse Mentor in daily stand up utilizing the clinical dashboard to ensure timely documentation of treatments and to check for missed documentation. Missed documentation will result in corrective disciplinary action as warranted. Initial in-service education to ensure compliance will be completed on all license staff by 9/12/2024. Ongoing education and the medication administration competency will be	

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F 842	Continued From page 7 included the resident was at risk for NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) and a history of NJ Ex Order 26.4(b)(1) with an intervention to "ensure that the NJ Ex Order 26.4(b)(1) is on the NJ Ex Order 26.4(b)." Review of the Order Summary Report, as of NJ Ex Order 26.4(b), included physician's orders for "NJ Ex Order 26.4 function check every shift," and "NJ Ex Order 26.4 check NJ Ex Order 26.4(every shift for NJ Ex Order 26.4(b)(1) precaution." Review of the NJ Ex Order 26.4(b)(1 Treatment Administration Record (TAR) revealed the two NJ Ex Order 26.4(b)(1) treatment orders were not signed out, and left blank, on the following dates: NJ Ex Order 26.4(b)(Evening Shift NJ Ex Order 26.4(b)(Evening Shift NJ Ex Order 26.4(b)(Evening Shift Review of the NJ Ex Order 26.4(b)(1) TAR revealed the two NJ Ex Order 26.4(b)(1) treatment orders were not signed out, and left blank, on the following dates: NJ Ex Order 26.4(b)(Evening Shift Review of the NJ Ex Order 26.4(b)(1) TAR, revealed the two wander guard treatment orders were not signed out, and left blank on the following dates: NJ Ex Order 26.4(b)(Evening Shift NJ Ex Order 26.4(b)(Evening Shift NJ Ex Order 26.4(b)(Evening Shift During an interview with the surveyor on 08/15/24 at 10:53 AM, the U.S. FOIA (b) (6) stated that the facility used NJ Ex Order 26.4(b)(1) devices and that everyone was responsible for checking to ensure they were in place. The U.S. FOIA further stated that it was important to check the NJ Ex Order 26.4(b)(1) to prevent NJ Ex Order 26.4(b) residents from NJ Ex Order 26. the facility.	F 842	provided during on-boarding of new license nurses by the resident service staff educator to ensure compliance with maintaining completed treatment records. 4. A treatment audit tool has been implemented and will be completed by the Director of Nursing daily for 4 weeks then weekly for 3 months to ensure compliance with completed documentation on the residents' treatment record. All findings will be reviewed with the nursing home administrator and in the quarterly quality assurance performance improvement (QAPI) meeting. Any patterns identified, will result in the implementation of an immediate corrective disciplinary action by the director of nursing and the frequency of the audits will be adjusted according to the outcomes until resolution.	

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F 842	Continued From page 8 During an interview with the surveyor on 08/15/24 at 10:55 AM, the U.S. FOIA (b) (6)) stated Resident #42 had a NJ Ex Order 26.4(b)(1). The U.S. FOIA further stated that the nurses check the NJ Ex Order 26.4(b)(1) and function of the NJ Ex Order 26.4(b)(1) every shift and document completion of the treatment on the TAR. The U.S. FOIA added that if there is a blank on the TAR it meant the treatment was not completed, and that it was important to ensure the TAR was signed "so everyone knows the treatment was completed." The U.S. FOIA also stated the importance of checking the NJ Ex Order 26.4(for NJ Ex Order 26.4(b)(1) and function was to prevent residents from NJ Ex Order 26.4(During an interview with the surveyor on 08/15/24 at 11:01 AM, Registered Nurse (RN) #1 stated the nurses were responsible for checking the NJ Ex Order 26.4(b)(1) and function of NJ Ex Order 26.4(b)(1) every shift and documenting the treatment in the TAR. The RN further stated that it was important to document the NJ Ex Order 26.4(b)(1) checks "so everyone knows the NJ Ex Order 26.4(b)(1) is on and functioning." The RN further stated that a blank on the TAR meant the nurse did not document the completion of the treatment. During an interview with the surveyor on 08/15/24 at 11:13 AM, the U.S. FOIA (b) (6)) stated the nurses were responsible for checking the placement and function of the NJ Ex Order 26.4(b)(1) every shift and documenting the completion of the treatment in the TAR. The U.S. FOIA further stated that a blank on the TAR meant the nurse did not sign the treatment as completed. When notified of the blanks in Resident #42's TAR, the U.S. FOIA stated the nurses should have signed the TAR and not left it blank.	F 842		

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F 842	Continued From page 9 The facility was unable to provide a policy related to medical documentation or documenting in the TAR. Review of the RN Job Description, modified 03/29/22, included, "Administers and documents administration of medications, enteral nutrition, and treatments per the physician's order and accurately records all care provided in the EHR [electronic health record]." NJAC 8:39-35.2 (d)	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/18/24

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F 880	Continued From page 10 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 11 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide a safe and sanitary environment to prevent the potential spread of infection and cross-contamination to both residents and staff by failing to: adhere to proper handwashing techniques, clean and sanitize medical equipment in accordance with the facility policy and manufacturer's recommendation and maintain appropriate infection control practices during the medication administration observation for 1 of 2 nurses observed on 1 of 3 nursing units (Franklin Unit). This deficient practice was evidenced by the following: On 08/14/24 at 8:20 AM, the surveyor met with Registered Nurse (RN) #2 at the medication cart. RN #2 wore gloves as she swept debris from the top of the medication cart with her gloved hands. RN #2 then doffed (removed) her gloves and failed to perform hand hygiene before she reached into her pocket and obtained the keys to the medication cart, unlocked the cart, and then returned an unsampled resident's eye drops into the medication cart. RN #2 then proceeded to access the computer that was mounted on top of the medication cart and after medication review, she stated that she needed to obtain vital signs (blood pressure, heart rate and pulse oximetry reading (the amount of oxygen circulating in the blood determined by placing a pulse oximeter	F 880	F880 1. RN#1 is NJ Ex Order 26.4(b)(1) with community but was immediately removed from administering medication upon the surveyor notifying the director of nursing of their observations. Resident #23 and Resident #111 have both been discharged from the community with NJ Ex Order 26.4b1 [redacted] from the cited practice. 2. All residents with physician orders for blood glucose finger sticks, nebulizer treatments, metered dose inhalers, and oxygen orders have the potential to be affected. All other residents have the potential to affected by this cited practice. 3. Immediate in-service training on infection control practices during medication administration was provided to all nurses on the incoming shifts on 8/14/2024. All other current license staff will be provided in-service education on infection control practices during medication administration and competency on the glucometer use by the resident staff educator with emphasis placed on hand hygiene, don/doffing gloves, proper disinfecting of equipment and work field, and use of a barrier when setting supplies down in a resident's room. In-service education will be completed by 9/12/2024, and will remain ongoing for new hires and those returning to work from leave.	

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F 880	Continued From page 12 probe on a finger) from Resident #23. At 8:22 AM, RN #2 wheeled the blood pressure machine into Resident #23's room. RN #2 greeted the resident and the resident NJ Ex Order 26.4(b)(1) of an NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(1) . RN #2 placed a blood pressure cuff on the resident's left upper arm, and placed a pulse oximeter probe on the resident's left index finger. RN #2 wore a surgical mask and pulled the mask out and away from her face when she spoke with the resident. RN #2 then proceeded to remove the blood pressure cuff and pulse oximeter probe from the resident, and then NJ Ex Order 26 the resident's NJ Ex Order 26.4(b)(1) in an effort to NJ Ex Order 26.4 the resident. RN #2 then obtained the blood pressure machine and left the resident's room without first performing hand hygiene. At 8:29 AM, RN #2 failed to clean the blood pressure machine and pulse oximeter after use and placed it in the hallway. RN #2 then returned to the medication cart, accessed the computer, reached into her pocket and obtained the keys to the medication cart and opened it. RN #2 then performed hand hygiene using alcohol based hand rub (ABHR) before she prepared medications for Resident #23. At 8:39 AM, after RN #2 administered medications to Resident #23 with a spoon, she proceeded to wash her hands under the stream of running water for 22 seconds. At 8:43 AM, RN #2 obtained the blood pressure machine and proceeded into Resident #111's room. At that time, RN #2 adjusted the resident's NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) to ensure that the	F 880	4. An infection control observation audit tool has been implemented and the infection prevention will conduct weekly audits on each household(there are 3 units total with a license nurse on each for day or evening shifts) from each unit. Three nurses weekly will be audited) during medication administration for 4 weeks then monthly for 3 months and then the audits will continue ongoing monthly. Any discrepancies or concerns identified during the audits, the infection preventionist will provide immediate Just in Time education and make a referral to the staff educator for remedial competency training. All findings will be reviewed with the nursing home administrator (NHA) and in the quarterly quality assurance performance improvement (QAPI) meeting. Any patterns identified, will result in the implementation of an immediate corrective disciplinary action by the director of nursing and the frequency of the audits will be adjusted according to the outcomes until resolution.	

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F 880	Continued From page 13 NJ Ex Order 2 made contact with NJ Ex Or of the resident's NJ Ex Order 26.4 RN #2 then placed the blood pressure cuff on the resident's left upper arm and placed the pulse oximeter probe on the resident's right middle finger. RN #2 then removed the blood pressure cuff and pulse oximeter from the resident, touched the resident's blankets and NJ Ex Order 2 the resident's NJ Ex Or and exited the resident's room without first performing hand hygiene. At 8:49 AM, RN #2 stated that Resident #111 had a new order to have their NJ Ex Order 26.4(b)(1) and proceeded to remove a NJ Ex Order 26.4(b)(1) from the medication cart. At 8:50 AM, RN #2 donned (put on) gloves before she placed a NJ Ex Order 26.4(b) into the NJ Ex Order 26.4(b)(1) . RN #2 then cleaned Resident #111's right middle finger with an alcohol prep pad, then used a NJ Ex Order 2 to NJ Ex Order 2 the resident's NJ Ex Order and NJ Ex Order 26.4(b)(1) which was placed on the NJ Ex Order 26.4(b) within the NJ Ex Order 26.4(b)(1). RN #2 then placed NJ Ex Order 26.4(b) on the resident's right middle finger to NJ Ex Order 26.4(b)(1) and cleansed the area. At 8:52 AM, RN #2 doffed her gloves and removed the NJ Ex Order 26.4(b)(1) from the NJ Ex Order 26.4(b)(1) with her bare hand. RN #2 then proceeded to dispose of her gloves. At 8:53 AM, RN #2 went into Resident #111's bathroom and laid the NJ Ex Order 2 and NJ Ex Order 26.4(b) on the bathroom counter while she washed her hands under the stream of running water for 20 seconds. RN #2 then returned to the medication cart and disposed of the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b	F 880		

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F 880	Continued From page 14 into the NJ Ex Order 26.4(b)(1) [NJ Ex Order 26.4(b)(1)] on the side of the medication cart. RN #2 failed to clean the blood pressure machine, pulse oximeter, and [NJ Ex Order 26.4(b)(1)] after usage. RN #2 then began to prepare medications for Resident #111 which included but were not limited to: a [NJ Ex Order 26.4(b)(1)] of NJ Ex Order 26.4(b)(1)) per NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) ([NJ Ex Order 26.4(b)(1)]) and NJ Ex Order 26.4(b)(1) ([NJ Ex Order 26.4(b)(1)]). At 9:08 AM, RN #2 returned to Resident #111's room and donned gloves. The resident's breakfast tray was present on the overbed table in front of the resident. RN #2 placed the single dose vial of [NJ Ex Order 26.4(b)(1)] and the NJ Ex Order 26.4(b)(1) ([NJ Ex Order 26.4(b)(1)]) on the resident's overbed table while she administered the [NJ Ex O] medications to the resident. The resident declined to take the [NJ Ex Order 26.4] and requested to take both the NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) after breakfast. At that time, RN #2 proceeded to take Resident #111's NJ Ex Order 26.4(b)(1) treatment and the NJ Ex Order 26.4(b)(1) into the resident's bathroom and placed the medications directly on the resident's bathroom counter that surrounded the sink while she washed her hands under the stream of running water for 21 seconds. At 9:14 AM, RN #2 returned to the medication cart and returned the [NJ Ex Order 26.4b1] to a multi-foil pack container and returned the	F 880		

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NJ Ex Order 26.4(b)(1) into the drawer of the medication cart. RN #2 then proceeded to sign out Resident #111's medications in the computer and then proceeded to review medications for the next resident.

At 10:11 AM, during an interview with the surveyor, RN #2 stated that she had not performed any additional NJ Ex Order 26.4(b)(1) with the NJ Ex Order 26.4 meter after the medication pass observation and had wiped it down with an approved disinfectant wipe. RN #2 then stated that she still had to wipe the NJ Ex Order 26.4(b)(1) down again with a disinfectant wipe since it was placed in the case during the observation prior to being cleaned. RN #2 stated, "I am supposed to wipe it down before I placed it in the case, because the case might get bacteria on it." RN #2 then stated, "I still have to wipe it down and get a new one."

At that time, the surveyor asked RN #2 to describe the process for handwashing. RN #2 stated, "I wash my hands under running water for 15 to 20 seconds." RN #2 stated that if the proper handwashing technique were not followed, it may attract microorganisms and the hands were not cleaned. RN #2 further stated that if the handwashing policy were not followed, it could spread infection and viruses.

At that time, the surveyor asked RN #2 to describe the process for cleaning the blood pressure machine and pulse oximeter. RN #2 stated it was ideal to clean between residents with a disinfectant wipe. RN #2 stated if the blood pressure machine and pulse oximeter were not cleaned between residents, it might transfer microorganisms and can spread bacteria.

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At that time, the surveyor asked RN #2 what could happen if she handled a NJ Ex Order 26.4(b)(1) without gloves and RN #2 stated that the blood or bacteria could get on the skin and be transferred onto her.

At that time, RN #2 stated that she should have cleaned NJ Ex Order 2 of the NJ Ex Order 26.4(b) treatment and NJ Ex Order 26 before she returned it to the multi-use package in the medication cart.

At that time, RN #2 stated that if she touched her mask while speaking with a resident and then touched the resident, medication cart, and computer there could be problems because, "my hands could have been contaminated."

At 10:24 AM, RN #3 approached the surveyor and RN #2 at the medication cart as the surveyor began to interview RN #2 about the proper technique for cleaning both the NJ Ex Order 26.4 meter and the NJ Ex Order 26.4 meter case. RN #3 stated, "we can get a new case or attempt to replace the whole unit."

At 10:29 AM, the surveyor interviewed RN #3 who stated, "we are required to wipe the blood pressure machine down between residents with a disinfectant wipe." RN #3 stated, "we were stricter during COVID, but there is a potential for contamination if it were not cleaned. "

At that time, RN #3 stated that either hand sanitizer or handwashing should have occurred after gloves were doffed. RN #3 stated that there was a risk of spreading anything infectious if hand hygiene was not performed after each resident. RN #3 stated that hands must be washed for 20 to 30 seconds out of the stream of running water.

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F 880	Continued From page 17 At 10:47 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated she recently served in the role of the previous U.S. FOIA (b) (6)) prior to becoming the U.S. FOIA three weeks ago. The U.S. FOIA stated that the current U.S. was not available for interview. The U.S. FOIA stated that once gloves were doffed, staff were supposed to wash their hands, because if it were not done, it was an infection control breach. At that time, the U.S. FOIA stated, "we informed the staff that they were not supposed to touch the outside of their masks because it was not clean." At that time, the U.S. FOIA stated the blood pressure machine and pulse oximeter were supposed to be cleaned between residents with a disinfectant wipe or it was an infection control issue if it were not done. At that time, the U.S. FOIA stated that, "RN #2 shared with us after your observation that she did not clean the NJ Ex Order 26.4(b)(1) after she used it." The U.S. FOIA explained that she asked RN #2 what was observed by the surveyor, and, "she told me that she did not do it." The U.S. FOIA stated, "it was a problem and against our policy." The U.S. FOIA stated that RN #2 should not have handled the NJ Ex Order 26.4(b) and NJ Ex Order 2 without gloves and should not have placed them or the NJ Ex Order 26 and NJ Ex Order 26.4(b) on the bathroom counter. The U.S. FOIA stated that it was an infection control issue if the NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1 and NJ Ex Order 26 were returned to the medication cart without cleaning them first. The U.S. FOIA stated it was her expectation that nursing cleaned the NJ Ex Order 26.4(b)(1) after use and RN #2 did not properly clean the NJ Ex Order 26.4(b)(1) after use as required.	F 880		

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At that time, the [U.S. FOIA redacted] stated that hands were require to be washed outside the stream of water for 30 seconds. The [U.S. FOIA redacted] stated, "If hands were washed under the stream of water, then you are not lathering and ensuring that all surfaces were washed."

At 12:12 PM, the surveyor interviewed the [U.S. FOIA redacted] who stated that hand sanitizer should be used both before and after glove use per facility policy. The [U.S. FOIA redacted] stated that hands were required to be lathered with soap for 20 seconds outside of the stream of running water. The [U.S. FOIA redacted] stated that hands were not effectively washed if they were washed under the stream of water and could infect anyone because that was not effective handwashing. The [U.S. FOIA redacted] stated it was unacceptable to touch the outside of your mask, because the outside was the dirtiest. The [U.S. FOIA redacted] stated staff should wash their hands after they touched equipment. The [U.S. FOIA redacted] stated that there could be contamination if the medication cart was accessed and hand hygiene was not completed prior to use. The [U.S. FOIA redacted] stated that the medication cart and the keys to the cart were the dirtiest part, because everyone touched them.

At that time, the [U.S. FOIA redacted] stated the blood pressure and pulse oximeter should be cleaned before and after use and were considered contaminated if they were not cleaned between residents.

At that time, the [U.S. FOIA redacted] stated RN #2 should have cleaned the [NJ Ex Order 26.4(b)(1) redacted], blood pressure cuff, and pulse oximeter with the approved disinfectant wipes which have a kill time (contact time required to kill germs) of two minutes. The [U.S. FOIA redacted] stated the [NJ Ex Order 26.4(b redacted] for the [NJ Ex Order 26.4(b)(1) redacted] should

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have been placed in a glove when doffed, then discarded in the trash and the [redacted] should have been discarded in the NJ Ex Order 26.4(b)(1). The [redacted] stated gloves should have been donned before the NJ Ex Order 26.4(b)(1) was sanitized with disinfectant wipes. The [redacted] stated, "test strips should never have been handled with bare hands, because you could have blood transmission or an infection waiting to happen." The [redacted] stated when RN #2 placed the NJ Ex Order 26.4(b)(1) back in the case after use, she contaminated the whole case. The [redacted] stated RN #2 should have cleaned the NJ Ex Order 26.4(b)(1) per protocol prior to returning it to the storage case.

At that time, the [redacted] stated when RN #2 placed the [redacted] container and the [redacted] on the sink it would have contaminated them, as well as everything in the cart where the medications were stored. The [redacted] stated RN #2 should have wasted the [redacted] and [redacted] and reordered both of the medications.

The [redacted] provided the surveyor with RN #2's Hand Hygiene Competency dated 01/24/24, Medication Pass Observation Tool dated 01/31/24, and a Glucometer Competency Checklist dated 01/30/24.

On 08/15/24 at 10:15 AM, the [redacted] provided the surveyor with the Manufacturer Technical Brief (Reviewed 10/23) for the glucose meter used by the facility which was reviewed by the surveyor and revealed the following:
To minimize the risk of transmitting bloodborne pathogens, the cleaning and disinfecting procedures should be performed as recommended in the instructions below...The [trademark] glucometer (glucose meter) may only

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be used for testing multiple patients when standard precautions and manufacturer's disinfecting procedures are followed...
-The meter should be cleaned and disinfected after use on each patient.
-The cleaning procedure is needed to clean dirt, blood and other bodily fluids off of the exterior of the meter before performing the disinfecting procedure.
-The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens.
Cleaning and Disinfecting FAQ:
-Why is cleaning and disinfecting of blood glucose monitors a high priority?
Blood glucose meters are at high risk of becoming contaminated with blood borne pathogens such as Hepatitis B Virus (HBV, a serious liver infection), Hepatitis C Virus (HCV, an infection caused by a virus that attacks the liver) and Human Immunodeficiency Virus (HIV, the virus that causes acquired immunodeficiency syndrome (AIDS). Transmission of these viruses from resident to resident has been documented due to contaminated blood glucose devices. According to the Centers for Disease Control and Prevention, cleaning and disinfecting of meters between resident use can prevent the transmission of these viruses through indirect contact.

Review of the facility policy, "Medication Management Program Guidelines (RS-10) (11/6/23) revealed the following:
Cleanse hands using antimicrobial soap and water or community-approved hand sanitizer before beginning a med pass, before handling medication, and before and after contact with resident.
Hand hygiene is performed before putting on

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examination gloves and upon removal for administration of topical, ophthalmic (relating to the eye), injectable, enteral (passing through the intestine either naturally through the mouth or through an artificial opening), rectal and vaginal medications.

Review of the Hand Hygiene (RS-26) Policy (Effective 03/19/18) revealed the following:
Purpose: To prevent the transmission of pathogenic micro-organism from resident to resident and from inanimate surfaces to residents by the hands of all healthcare providers.
Hand hygiene procedure with soap and water:
Turn on water, adjust temperature. Wet hands and wrists with running water before applying soap. Keep hands with fingers downward so water will run into sink and not down arms. Apply soap to hands, use only community approved liquid soap, rub the soap on all surfaces of the hands and wrists using friction, friction can be obtained by rubbing hands rapidly and firmly together, wash all surfaces for at least 20-30 seconds: back of hands palms, wrists, between fingers, including thumbs, under fingernails and around cuticles, rinse hands thoroughly under running water keeping hand downward, avoid touching the sink. Dry hands thoroughly with paper towel(s)...Turn off faucet with a clean paper towel. Discard Paper towel.
Hand hygiene should be done (even when gloves are used):
At the beginning of work.
Before and after contact with each resident.
After contact with blood, bodily fluids, mucous membranes, secretions, excretions...
Before administering medication.
After body fluid exposure.

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F 880	Continued From page 22 Review of the facility policy, "Cleaning & Disinfecting Resident Equipment (RS-29)" (Last approved 03/23/23) revealed the following: Blood Pressure Cuffs/machines...Before use on each resident...with a low level disinfectant. Glucose monitors...Before use on each resident and before going into storage...with a low level disinfectant. NJAC 8:39-19.4 (n)	F 880		

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	030401	A. BUILDING: _____ B. WING _____	C 08/19/2024

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UNITED METHODIST COMMUNITIES AT COLLINGSW(	460 HADDON AVE 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
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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined 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 evidenced by the following: Reference: New Jersey Department of Health (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,	S 560	S560 1. No residents were identified or affected by this cited practice. Efforts to hire community staff will continue until there is adequate staff to serve all residents. Until that time, community will utilize staffing agencies, offer overtime to community staff to fill any open spots in the schedule. 2. All residents have the potential to be affected by this cited practice. 3. Contracts with additional staffing agencies have been secured to supplement community staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience,	9/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030401	A. BUILDING: _____ B. WING _____	C 08/19/2024

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S 560	Continued From page 1 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. For the 2 weeks of staffing prior to survey from 07/28/24 to 08/10/24, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -07/28/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -08/04/24 had 6 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. On 08/16/24 at 09:40 AM, the surveyor interviewed the staffing coordinator who stated that she was aware of the mandated staffing ratios. The staffing coordinator stated that the facility used as needed (PRN) staff as well as agency staff for call outs and staffing needs.	S 560	online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. Weekly recruitment meetings are ongoing with the management team and biweekly with the home office that includes the executive director, nursing home administrator and the associate resource director (Human Resource). Ongoing education will be provided to the staff regarding call offs and how it affects the community, the residents, and their peers by the resident service staff educator and the DON as needed. Managers to provide assist as applicable based on job training and qualifications to support nursing until staffing requirements are met. Staffing patterns will be reviewed in the daily stand up and shift report to ensure staffing patterns are at acceptable level. The administrator will communicate with families monthly to make them aware of staffing patterns and recruitment efforts until staffing stabilizes. License staff and certified nurse aides will be provided inservice education on the importance of communication and notifying the DON (Director of Nursing) or Administrator if they are unable document or to meet the needs of the residents related to staffing. The community census will be adjusted by suspending admissions temporarily to meet staffing requirements as needed. 4. The Administrator and the DON (director of nursing) will review staffing schedules daily as part of the daily standup meeting to ensure adequate staffing for all shifts. The administrator and the Associate Resource Director (HR) will	

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	030401	A. BUILDING: _____ B. WING _____	C 08/19/2024

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S 560	Continued From page 2	S 560	continue to review recruitment and staffing weekly. This will remain an ongoing practice until staffing requirements are maintained. The social worker will conduct a random resident satisfaction survey of care weekly x 1month and then monthly x 3 months and then quarterly as it relates to staffing challenges. Findings of all staffing variances, resident satisfaction, and actions taken will be reviewed in the quarterly quality assurance performance improvement(QAPI)committee meeting through the next 2 quarters of 2024. Based on the outcome of the findings this practice will remain ongoing with review in the quarterly QAPI committee meeting until staffing requirements have been met.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315404	A. Building B. Wing	9/19/2024

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

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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 09/18/2024	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 09/18/2024	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 09/18/2024
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 8/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030401 Y1	A. Building B. Wing Y2	9/19/2024 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/18/2024	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
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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	
8/19/2024	☐ 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
	315404	A. BUILDING **01** B. WING _____	**08/19/2024**

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

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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 08/16/2023 and 08/19/2024, was found to be in noncompliance with the 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. United Methodist Communities at Collingswood is a five-story building without basement, Type I construction, fully sprinklered building. The building was constructed in approximately 1995. The skilled nursing facility is located on the fifth floor of the building. The fifth floor is divided into four smoke compartments.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 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.	K 222		9/18/24

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

Electronically Signed | 09/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315404	A. BUILDING **01** B. WING _____	**08/19/2024**

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

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K 222	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 interview on 08/16/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101:2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:35 AM in the presence of the U.S. FOI[redacted] revealed one set of glass sliding doors located at the front entrance of the facility had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The U.S. FO[redacted] tested the doors by locking and pushed to open, but he could not. In an interview at the time, the U.S. FO[redacted] confirmed the observation. The U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code survey exit conference on 08/19/2024. N.J.A.C. 8:39-31.2(e)	K 222	1. No single resident has been identified to be affected by the deficient practice.8/28/24 Dummy cylinder was furnished on main entrance door with no deadbolt type of locking system. 2. All residents residing in the community have the potential to be affected. 3. The U.S. FOIA (b) (6) was re-educated by the administrator on 9/9/24 on preventive maintenance checks of exterior door and their locking mechanisms ensuring proper documents are secured upon inspections in a timely manner for future inspections. 4. The building service director will conduct an inspection of all exit doors to ensure the means of egress are readily accessible and free of all obstructions or impediments during environmental rounds weekly x 4 then monthly x2. Findings will be reviewed with the administrator and in the quarterly quality assurance performance improvement (QAPI) committee meeting with corrective action as warranted.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		9/18/24

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K 353	Continued From page 3 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/16/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to maintain the automatic fire sprinkler system and ensure the ceiling level was smoke resisting in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8 and NFPA 25: 2011 Edition, Section 5.2.1.1.1(2). This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 08/16/2024 in the presence of DM, revealed the following: 1. At 10:15AM in the resident room #502, the closet sprinkler head had no escutcheon plate. 2. At 11:37 AM in the laundry room, there were 2 openings in the ceiling behind the dryers.	K 353	K353- Sprinkler System- Maintenance and Testing 1. No single resident has been identified to be affected by the deficient practice.8/19/24 Escutcheon was installed in closet.8/20/24 Repairs were made to ceiling tiles as noted in report for food service director□s office as well as the 2 openings in laundry behind the dryers. Fire Barrier Sealant was used in both cases and as noted it was labeled in accordance with E 814 & E84 ASTM. 4-hour control. 2. All residents residing in the community have the potential to be affected. 3. The U.S. FOIA (b) (6) was re-educated by the administrator on 9/9/24 on preventive maintenance checks of penetrations in ceiling tiles as well as	

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K 353	Continued From page 4 3. At 11:45 AM in the food service director office, there were 3 openings in the ceiling. In an interview at the time, the U.S. FO confirmed the observations. The U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code survey exit conference on 08/19/2024. N.J.A.C. 8:39-31.2(e) NFPA 13, 25	K 353	sprinkler escutcheon ensuring that documents are secured upon inspections in a timely manner for future inspections. 4. The building service director will conduct a monthly audit inspection monthly x 3 months then quarterly of all fire sprinklers and ceilings and as well as audit monthly contracted vendor's inspections to ensure compliance. Findings will be reviewed with the administrator and in the quarterly quality assurance performance improvement (QAPI) committee meeting with immediate corrective action as warranted.	
K 364 SS=F	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on	K 364	K364- Corridor Openings	9/18/24

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K 364	Continued From page 5 08/16/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in NFPA 101: 2012 Edition, Section 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations from 9:15 AM to 2:45 PM in the presence of U.S. FOIA [redacted] revealed the following: 1. At 11:05 AM, resident room door #531 had a gap on top when it was tested by U.S. FOIA [redacted] 2. At 11:10 AM, the Whitman Hall set of corridor doors had a gap between them when tested by U.S. FOIA [redacted] In an interview at the time, the U.S. FO [redacted] confirmed the observations. The U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code survey exit conference on 08/19/2024. N.J.A.C. 8:39-31.2(e)	K 364	1. No single resident has been identified to be affected by the deficient practice. 8/20/24 Weather sealant was installed on door trim of 531 sealing the gap as noted the will resist the passage of smoke.8/28/24 Whitman Hall corridor doors a piece of 1 inch by 1/8th inch aluminum cut to fit and installed on 5th floor double hallway door to seal gap and resist the passage of smoke. 2. All residents residing in the community have the potential to be affected. 3. The U.S. FOIA (b) (6) was re-educated on 9/9/24 by the administrator on preventive maintenance checks of fire door along with ensuring that the proper documentation is filled out in a timely manner for future inspections. 4. The building inspector will conduct a audit inspection monthly x 3 months then quarterly of cooridors doors for gaps on each household to ensure compliance. All findings will be reviewed with the administrator and in the quarterly quality assurance performance improvement (QAPI) committee meeting with corrective action as warranted	
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	K 921		9/18/24

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UNITED METHODIST COMMUNITIES AT COLLINGSWOOD	**460 HADDON AVE** **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) COMPLETION DATE
K 921	Continued From page 6 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 observations, documentation review and interview on 8/16/2024 and 8/19/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to provide an electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs 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: Observations from 9:10 AM to 3:30 PM, revealed	K 921	K921- Electrical Equipment 1. No single resident has been identified to be affected by the deficient practice. 8/21/24 Electrical Equipment Inspection was completed on healthcare and all equipment was labeled with electrical safety inspection stickers. 2. All residents residing in the community have the potential to be affected. 3. The U.S. FOIA (b) (6) was re-educated by the administrator on 9/9/24 on electrical testing and maintenance equipment requirements. An electrical internal policy will be written up along with a schedule of inspections for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315404	A. BUILDING **01** B. WING _____	**08/19/2024**

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

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K 921	Continued From page 7 that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers identifying an inspection was performed throughout the facility. In an interview at the time, the [U.S. FO] stated he checked all PCREE equipment but could not provide a policy and procedure for testing of the equipment or evidence of annual testing and maintenance program for PCREE. The [U.S. FOIA (b) (6)] was informed of the deficient practice at the Life Safety Code exit conference on 8/19/2024. NJAC 8:39-31.2(e) NFPA 99	K 921	compliance. 4. The building service director will conduct a audit inspection of all fixed and patient care related equipment monthly x3 month and then quarterly to ensure they have been inspected, tested, and repaired as needed, and a log has been maintained on all equipment showing such. All findings will be reviewed with the administrator and in the quarterly quality assurance performance improvement (QAPI) committee meeting with corrective action as warranted. Audits will be adjusted according to the findings.	

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
315404 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/19/2024 Y3

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

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 K0222	09/18/2024	LSC K0353	09/18/2024	LSC K0364	09/18/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0921	09/18/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO