

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315159	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER ELMWOOD HILLS HEALTHCARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 WOODBURY-TURNERSVILLE ROAD , BLACKWOOD, New Jersey, 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
F0000	<p>INITIAL COMMENTS</p> <p>Complaint #: 2629258</p> <p>Census: 289</p> <p>Sample Size: 5</p> <p>A complaint survey was conducted at Elmwood Hills Healthcare Center LLC from 10/9/2025 to 10/10/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.</p> <p>During a survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.25 (d)(2) F 689, when a facility failed to provide adequate [redacted] to protect [redacted] resident (Resident #2) with documented history of [redacted] who [redacted] the facility on [redacted] at 9:45 AM.</p> <p>A review of Facility Reportable Event (FRE) documents revealed that on [redacted], a Licensed Practical Nurse (LPN #1) asked a Certified Nursing Assistant (CNA #1) to use her employee Identification (ID) badge to swipe open the [redacted] on a [redacted] unit door for Resident #2 and CNA #1 did. This allowed Resident #2 to [redacted] because both CNA #1 and LPN #1 thought the resident was [redacted]. The FRE indicated that pictures of residents at risk for [redacted] including Resident #2, were posted on the same entrance door located on the [redacted] unit to help staff identify at-risk residents and [redacted] from [redacted] the unit. LPN #1 and CNA #1 stated they did not check the pictures by the [redacted] and [redacted] Resident #2. The FRE revealed that Resident #2, who was wearing [redacted] on their [redacted] at the time they [redacted] [redacted] the elevator down to the first-floor lobby area and [redacted] through the [redacted] at approximately 9:47 AM. The [redacted] U.S. FOIA (b)(6) was seated at the front desk at the time and observed Resident #2 [redacted]. The [redacted] did not intervene [redacted] Resident #2, as the resident appeared to [redacted] who was entering the facility saw Resident #2 [redacted] and alerted the [redacted] U.S. FOIA</p>	F0000		11/05/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F0000</p>	<p>Continued from page 1 The U.S. F then NJ Ex Order 26.4(b)(1) where Resident #2 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 Resident #2 NJ Ex Order 26.4(b)(1). Nursing staff was immediately notified. The facility administration was provided the IJ template on 10/10/25 at 5:10 PM. An acceptable Removal Plan (RP) was received on 10/15/25 at 2:23 PM, indicating the actions the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include Resident #2 was assessed post incident by U.S. FOIA (b) (6), placed on NJ Ex for safety. A call was placed to the US FOIA (b)(6) by the US FOIA. The US FOIA updated the resident's care plan. As of NJ Ex Order 26.4(b)(1) resident #2 remained in the facility for long term care placement on NJ Ex Order 26.4(b)(1) without any NJ Ex Order 26.4(b)(1) from this incident. On 9/29/2025, the NJ Exec Order 26.4b policy was reviewed and determined no update to the NJ Exec Order 26.4b policy was required at this time. A new system was implemented on 9/29/2025 that all visitors must sign out upon leaving the building. Security staff and receptionist staff were educated on the Elmwood Hills NJ Exec Order 26.4b Policy and the new process for visitors signing out. All Elmwood Hills nursing staff were re-educated 10/10/2025 on identifying elopement behaviors and initiating and completing a new NJ Exec Order 26.4b Assessment, updating the resident's care plan and placing the resident's picture at the entrance of the unit, receptionist desk, and security console. On 9/28/2025, audits were conducted on all residents who are an NJ Exec Order 26.4b risk to ensure they have an appropriate Care Plan, NJ Exec Order 26.4b Assessment and resident picture at receptionist binder and security console. On 10/10/2025 an audit was completed on all new admissions from 9/28/2025 through 10/10/2025 by the U.S. FOIA (b) (6) nurse and U.S. F to assure that residents identified at risk of NJ Exec Order 26.4b had an NJ Exec Order 26.4b care plan in place, ID band and picture on the wall of exit door and front reception desk and security desk. On 10/10/2025 on the 3-11 shift at 6:00 PM an audit was completed by the 3-11 U.S. FOIA (b) (6) on resident ID bands to ensure all residents had an ID band in place and that all resident pictures were present in Point Click Care (PCC), an electronic medical record, as a form of identification. Refusal of pictures and/or ID band were indicated on the resident's care plan. On 10/10/2025 the U.S. FOIA, U.S. FOIA (b) and U.S. F re-reviewed the Elmwood Hills NJ Exec Order 26.4b Policy, and</p>	<p>F0000</p>		

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F0000	Continued from page 2 no changes were indicated. On 10/11/2025 and 10/12/2025 the U.S. FOIA (b) (6) and the ADONs completed the re-education on the NJ Exec Order 26.4b Policy for Elmwood Hills staff. All the Elmwood Hills unit doors continue to remain locked and continue to require a swipe ID card to get off all of the Elmwood Hills Nursing Units, this include NJ Exec Order 26.4b1 . The survey team verified the implementation of the RP on-site during the continuation of the survey and determined that the IJ for F 689 was removed as of 10/16/2025 as of 3:18 PM.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Complaint #: 2629258 Based on interviews, review of medical records, and other pertinent facility documentation on 10/9/2025 and 10/10/25, it was determined that the facility failed to provide adequate NJ Ex Order 26.4(b)(1) for a resident (Resident #2) who was NJ Ex Order 26.4(b)(1) with documented history of NJ Ex Order 26.4(b)(1) and who NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) . The deficient practice was identified for 1 of 3 residents reviewed (Resident #2). A review of Facility Reportable Event (FRE) revealed that on NJ Ex Order 26.4(b)(1) , a Licensed Practical Nurse (LPN #1) asked a Certified Nursing Assistant (CNA #1) to use her employee identification (ID) badge to swipe open the locked door on the NJ Ex Order 26.4(b)(1) unit for Resident #2, which CNA #1 did provide. This allowed Resident #2 to NJ Ex Order 26.4(b)(1) because both CNA #1 and LPN #1 thought the resident NJ Ex Order 26.4(b)(1) . The FRE indicated that pictures of residents at risk for NJ Ex Order 26.4(b)(1) including Resident #2, were located by the	F0689	I. Corrective action(s) accomplished for resident(s) affected: Resident #2 had NJ Ex Order 26.4(b)(1) from this practice. A NJ Ex Order 26.4(b)(1) assessment was completed by the US FOIA (b)(6) without NJ Ex Order 26.4(b)(1) . Resident #2 was placed on NJ Ex Order 26.4(b)(1) for safety and remains in the facility for long-term care placement on NJ Ex Order 26.4(b)(1) . The identified US FOIA (b)(6) received education by the Nursing Supervisor regarding the NJ Exec Order 26.4b Policy. II. Residents identified having the potential to be affected and corrective action taken: All residents who are an elopement risk had the potential to be affected by this practice. An audit of all residents who are an elopement risk was conducted, and no other residents were identified as effected by this practice. III. Measures will be put into place to ensure the deficient practice will not recur: All staff were reeducated by the Assistant Directors of Nursing on the Elopement Policy. The Elopement Policy was reviewed and no updates to the Elopement Policy were required. All Nursing Staff were reeducated by the Assistant Directors of Nursing on identifying elopement behaviors, initiating and completing a new Elopement Assessment, updating the residents care plan and placing the residents' picture at the entrance of the unit, reception desk and security console. A new system was implemented on 9/29/25 that all	11/07/2025

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F0689 SS = SQC-J	<p>Continued from page 3 same entrance door on the second-floor nursing unit to help staff identify at-risk residents and [redacted] from [redacted] the unit. The two staff members on the [redacted] from where the resident [redacted] (LPN # and CNA #1), stated they did not check the pictures by the [redacted] and [redacted] Resident #2. The FRE revealed that Resident #2, who was wearing an ID band on their wrist at the time they [redacted] [redacted], entered the elevator down to the first-floor lobby area and [redacted] through the [redacted] at approximately 9:47 AM. The [redacted] [redacted] was seated at the front desk at the time and observed Resident #2 [redacted]. The [redacted] did not intervene to stop Resident #2, as the resident appeared to [redacted]. A visitor who was entering the facility saw Resident #2 [redacted] and alerted the [redacted] [redacted] then [redacted] where Resident #2 was [redacted] and [redacted] Resident #2 [redacted]. Nursing staff was immediately notified.</p> <p>The facility's Safety Director stated during an interview on 10/10/25 at 9:12 AM, we rely on the unit to not let the residents off the unit. He further indicated that there is a book at the security desk and the reception area with pictures of all residents at risk for [redacted].</p> <p>A review of Progress Note (PN) dated [redacted] at 11:05 PM, revealed that Resident #2 [redacted] to [redacted] and when they [redacted]. Another PN dated [redacted] at 9:37 PM, revealed that Resident #2 asked staff how they [redacted] so that they [redacted]. During interview on 10/10/25 at 8:37 AM with LPN #3, who wrote the [redacted] PN, he confirmed that the resident's [redacted] was documented in the progress note and it was also put on the 24-hour report sheet that was communicated among staff. LPN #3 further stated that he made the certified nursing assistants (CNAs) aware and verbally informed the incoming nurses during the shift report regarding the resident's [redacted].</p> <p>LPN #1 stated during an interview on 10/9/25 at 1:25 PM, Resident #2 did not have [redacted] and Resident #2 stated they were [redacted] and had [redacted]. LPN #1 further stated she genuinely did not know Resident #2, was never given report, and she was not educated that the pictures were residents' [redacted].</p> <p>During [redacted] floor unit tour on 10/9/2025 9:33 AM, the surveyor observed pictures posted on the wall [redacted] which the facility stated was supposed to</p>	F0689	<p>Continued from page 3 visitors must sign out upon leaving the building. Security Staff and Receptionist Staff were educated on Elopement Policy and the new process for visitors to sign out.</p> <p>The Assistant Director of Nursing or designee will complete a weekly audit for 4 weeks and then monthly for 5 months to assure that residents identified at risk of elopement had an elopement care plan in place, ID band and picture on the wall of exit door of their unit, reception desk and security console.</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>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.</p> <p>V. Date of Compliance: 11/7/25</p>	
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F0689 SS = SQC-J	<p>Continued from page 4 help staff to identify residents with [redacted] risks; to intervene if they see such resident [redacted] the unit.</p> <p>The facility's failure to provide adequate [redacted] to ensure the safety of [redacted] resident who was at risk for [redacted] with documented history of [redacted], posed a likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy situation.</p> <p>The IJ began 9/28/2025 at 9:45 AM. The facility was notified 10/10/2025 at 5:10 PM. Facility submitted a Removal Plan on 10/15/2025 at 2:23 PM. The surveyor verified the implementation of the RP on-site visit on 10/16/2025 3:18 PM.</p> <p>The evidence was as follows:</p> <p>A review of the facility's policy titled "Elopement", with an initiated date of November 2013, indicated: "It is the policy of Elmwood Hills Care Center to implement all possible measures to protect our residents, minimize incident of elopement Under Procedures: 2. indicated: "Upon admission and whenever a resident exhibit exit seeking behavior, he/she will be assessed for risk of elopement...4. The nursing department will develop and maintain a list of all residents identified as Elopement/wandering risks (it is identified as a problem on the resident's care plan)..... Photograph will be posted near the main exit door of each floor for easy identification...The photographs will also be posted at the employee entrance security vestibule and in the binder at the front desk."</p> <p>According to the Facility Reportable Event Record (FRE) dated 09/28/2025, that the facility submitted to the New Jersey Department of Health (NJDOH), or [redacted] at approximately 9:45 AM, Resident #2 was observed in the [redacted] by the [redacted] with [redacted]. The [redacted] statement in the FRE reflected that Resident #2 appeared to be [redacted]. Resident #2 asked to [redacted], and [redacted] showed them where the [redacted] was. Security then arrived so that [redacted] could take a break. Resident #2 returned to [redacted] from [redacted] and [redacted]. Security was present and saw Resident #2 [redacted]. As Resident #2 was [redacted] a visitor was entering [redacted] and alerted security that a resident was [redacted].</p>	F0689		

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<p>F0689 SS = SQC-J</p>	<p>Continued from page 5 NJ Ex Order 26.4 Security then NJ Ex Order 26.4(b)(1) where Resident #2 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 Resident #2 NJ Ex Order 26.4(b)(1). Nursing staff was immediately notified. According to the facility provided document "# NJ Exec O NJ Ex Order 26.4(b)(1) Date NJ Ex Order 26.4(b)(1) 10:00", Resident #2 indicated NJ Ex Order 26.4(b)(1) ". Resident #2 was NJ Ex Order 26.4 , was assessed, the facility placed Resident #2 on NJ Ex Order 26.4(b)(1) for safety, and NJ Ex Order 26.4(b)(1) follow up was ordered. A review of LPN #1's statement revealed that she observed Resident #2 coming up the right hallway on the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1). LPN #1 stated that she thought it was one of her residents and when she stopped Resident #2, Resident #2 stated that they were NJ Ex Order 26.4(b)(1) and had NJ Ex Order 26.4(b)(1). LPN #1 stated that she thought Resident #2 was NJ Ex Order 26.4(b)(1) LPN #1 stated that she used an NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to let Resident #2 NJ Ex Order 26.4(b)(1) Resident #2 then NJ Ex Order 26.4(b)(1) A review of the U.S. FOIA (b)(6) U.S. FOIA statement revealed that he was at the front desk when Resident #2 came out of NJ Ex Order 26.4(b)(1) and appeared to NJ Ex Order 26.4(b)(1) He stated that he watched Resident #2 NJ Ex Order 26.4(b)(1) and it was a visitor that came in and alerted him that it was NJ Ex Order 26.4(b)(1)" that NJ Ex Order 26.4(b)(1) The U.S. FOIA stated that he then NJ Ex Order 26.4(b)(1), saw Resident #2 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Resident #2 NJ Ex Order 26.4(b)(1) The surveyor reviewed the medical record for Resident #2. According to the Admission Record (AR) face sheet, Resident #2 was admitted to the facility with 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) According to the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), Resident #2 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15, which indicated the resident's NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1). A review of Resident #2's "Admission Observation V -13" (Admission Assessment) received from the U.S. FOIA (b) (6) NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1), with an effective date of NJ Ex Order 26.4(b)(1) at 6:20 PM, revealed that Resident # 2 needed NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1)</p>	<p>F0689</p>		

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F0689 SS = SQC-J	<p>Continued from page 6 regarding NJ Ex Order 26.4(b)(1) risk, but was not at risk for NJ Ex Order 26.4(b)(1).</p> <p>A review of Resident #2's Care Plan (CP) with an initiated date of NJ Ex Order 26.4(b)(1), and a created-on date of NJ Ex Order 26.4(b)(1), revealed that Resident #2 was NJ Ex Order 26.4(b)(1) related to (r/t) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1).</p> <p>A review of the Progress Note (PN) dated NJ Ex Order 26.4(b)(1) at 11:05 PM, written by LPN #4, revealed that Resident #2 repeatedly kept asking NJ Ex Order 26.4(b)(1) and when they NJ Ex Order 26.4(b)(1).</p> <p>A review of another PN Dated NJ Ex Order 26.4(b)(1) at 9:37 PM, written by LPN #3, revealed that Resident #2 "observed with NJ Ex Order 26.4(b)(1) on unit. resident [SIC] asking staff NJ Ex Order 26.4(b)(1) so [they] NJ Ex Order 26.4(b)(1) pt. (patient) NJ Ex Order 26.4(b)(1) multiple times."</p> <p>A review of PN dated NJ Ex Order 26.4(b)(1) at 1:27 PM, written by RN #1, revealed that at 9:45 AM, Resident #2 was "observed by security NJ Ex Order 26.4(b)(1). Security notified nursing and NJ Ex Order 26.4(b)(1) the resident NJ Ex Order 26.4(b)(1) assessment completed. Family and MD notified. The resident was placed on NJ Ex Order 26.4(b)(1). Consult placed for NJ Ex Order 26.4(b)(1) follow up."</p> <p>A review of the facility's video footage on 10/10/2025 at 12:41 PM in the presence of the U.S. FOIA (b) (6) and U.S. FOIA revealed that when Resident #2 came down the hallway after NJ Exec Order 26.4b1, Resident #2 was wearing an NJ Ex Order 26.4(b)(1).</p> <p>On 10/9/2025 at 12:55 PM, the surveyor conducted a telephone interview with Certified Nursing Assistant (CNA #1) who stated that she was on her way to dispose of trash when LPN #1 asked her to use her badge to allow NJ Ex Order 26.4(b)(1). CNA #1 further stated that she had never seen this resident (Resident #2) before and that she did not NJ Ex Order 26.4(b)(1) to confirm whether they NJ Ex Order 26.4(b)(1).</p> <p>On 10/9/2025 at 1:25 PM, the surveyor conducted a telephone interview with Licensed Practical Nurse (LPN #1), who stated that she saw Resident #2 and told them to stop because she needed to verify them. LPN #1 stated that she initially thought it was one of her residents, but when she got closer, they were not the resident she thought it was. LPN #1 stated she did not see NJ Ex Order 26.4(b)(1), and when she asked Resident #2, they stated that they were NJ Ex Order 26.4(b)(1). LPN #1 stated that she saw a CNA (CNA #1) who was a regular</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 7</p> <p>aide on her unit. She asked CNA #1 if she recognized Resident #2 and the CNA said, no, Resident #2 was not one of their residents. LPN #1 stated that she could not recall who [redacted] Resident #2 [redacted] and that everything was a blur. LPN #1 confirmed that she wrote her statement of the [redacted], approximately 9:35 AM event, on [redacted]. A review of this statement revealed, "I was at my medication cart out front of the main dining room. I observed [Resident #2] coming up the right hallway with [redacted] [Resident #2] as [they were] [redacted] [Resident #2] stated [they were] [redacted] at that point I thought [Resident #2] was [redacted] I used the aide's badge to swipe the door." LPN #1 further stated that she was not familiar with Resident #2's care, that Resident #2 was not on her unit and that she had never seen Resident #2 before. LPN #2 stated she genuinely did not know this Resident #2, was never given report, and it was just an accident. LPN #2 stated that she [redacted] Resident #2 and called a [redacted] U.S. FOIA (b)(6)</p> <p>On 10/9/2025 at 1:54 PM, the surveyor conducted an interview with [redacted] U.S. FOIA (b) (6) who stated that doors are inspected quarterly or as needed. He stated that on [redacted], he walked on the [redacted] and the door was checked, and door was engaged properly along with all the other doors.</p> <p>On 10/9/2025 at 2:00 PM, the surveyor conducted an interview with the Assistant Directors of Nursing (ADON #1 and ADON #2). ADON #1 stated that Resident #2 should not have been [redacted] without an employee, staff, or without [redacted] because Resident #2 was an [redacted] ADON #1 stated that the [redacted] [redacted] has been there for years, and staff are educated upon hire on the purpose of the wall and drills are completed throughout the year.</p> <p>On 10/9/2025 at 3:11 PM, the surveyor conducted an interview with the [redacted] U.S. FOIA (b) (6), who stated that the expectation is for all staff to be aware of all residents at risk for [redacted] based on the pictures on the walls.</p> <p>On 10/9/2025 at 3:38 PM, the surveyor conducted an interview with LPN #2, who was Resident #2's assigned nurse. LPN #2 stated that she [redacted] Resident #2 around 9:35 AM on [redacted]. She stated she gave Resident #2 their medication, checked vitals and asked them to [redacted] LPN #2 stated that when she came in that morning, Resident #2 had their [redacted]</p>	F0689		

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315159</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 10/16/2025</p>	
<p>NAME OF PROVIDER OR SUPPLIER ELMWOOD HILLS HEALTHCARE CENTER LLC</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 425 WOODBURY-TURNERSVILLE ROAD , BLACKWOOD, New Jersey, 08012</p>		
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<p>F0689 SS = SQC-J</p>	<p>Continued from page 8 [redacted] and were [redacted] NJ Ex Order 26.4(b)(1). LPN #2 stated that Resident #2 showed no indication that they [redacted] NJ Ex Order 26.4(b)(1).</p> <p>On 10/10/2025 at 8:32 AM, the surveyor attempted to reach the [redacted] US FOIA (b)(6) who saw Resident #2 in the reception area via telephone and got no response.</p> <p>On 10/10/2025 at 8:37 AM, the surveyor conducted a telephone interview with LPN #3 who wrote the progress note on [redacted] NJ Ex Order 26.4(b) at 9:37 PM. LPN #3 stated that on [redacted] NJ Ex Order 26.4(b) he was passing medications and saw Resident #2 with [redacted] NJ Ex Order 26.4(b)(1). When Resident #2 was asked what they were doing, Resident #2 stated that they [redacted] NJ Ex Order 26.4(b)(1), they wanted to [redacted] NJ Ex Order 26.4(b)(1) and wanted to [redacted] NJ Ex Order 26.4(b)(1). LPN #3 stated that he made the nursing aides on the floor aware, verbally updated the incoming nurse in the shift report, and documented it on the 24-hour report.</p> <p>On 10/10/2025 at 9:12 AM, the surveyor conducted an interview with the [redacted] U.S. FOIA (b) (6) who stated that they relied on the unit to not [redacted] NJ Ex Order 26.4(b)(1) the residents [redacted] NJ Ex Order 26.4(b)(1). He stated that if someone comes to the door to [redacted] NJ Ex Order 26.4(b)(1) they called to verify me if they did not use the employee door and they came in. [redacted] U.S. FOIA further stated that the front doors are open from 8:00 AM to 8:00 PM, and after 8:00 PM all persons must go through the security entrance/exit.</p> <p>On 10/10/2025 at 10:30 AM, the surveyor conducted an interview with the [redacted] US FOIA who stated that on [redacted] NJ Ex Order 26.4(b), he was in the back, in the boiler room, and the [redacted] US FOIA (b)(6) called him and asked him to come to cover for her. He stated he saw someone [Resident #2] going into [redacted] NJ Ex Order 26.4(b)(1). The [redacted] US FOIA stated that when Resident #2 came out of [redacted] NJ Ex Order 26.4(b)(1), they were [redacted] NJ Ex Order 26.4(b)(1), and they [redacted] NJ Ex Order 26.4(b)(1). He stated that as Resident #2 was [redacted] NJ Ex Order 26.4(b)(1), a visitor was coming in, and the visitor came to the counter to sign in and told him that he believed it was a resident that [redacted] NJ Ex Order 26.4(b)(1). The [redacted] US FOIA and Resident #2 was [redacted] NJ Ex Order 26.4(b)(1). He said he [redacted] NJ Ex Order 26.4(b)(1) Resident #2 a couple times and Resident #2 [redacted] NJ Ex Order 26.4(b)(1), so he went behind and finally [redacted] NJ Ex Order 26.4(b)(1) Resident #2. He stated that he asked Resident #2 [redacted] NJ Ex Order 26.4(b)(1). The [redacted] US FOIA said Resident #2 stated that the [redacted] NJ Ex Order 26.4(b)(1), and he asked Resident #2 to [redacted] NJ Ex Order 26.4(b)(1). He stated that Resident #2 agreed and [redacted] NJ Ex Order 26.4(b)(1). The [redacted] US FOIA stated that Resident #2 was [redacted] NJ Ex Order 26.4(b)(1). He stated that he [redacted] NJ Ex Order 26.4(b)(1) Resident #2 to the [redacted] U.S. FOIA (b)(6) office</p>	<p>F0689</p>		

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NAME OF PROVIDER OR SUPPLIER ELMWOOD HILLS HEALTHCARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 WOODBURY-TURNERSVILLE ROAD , BLACKWOOD, New Jersey, 08012	
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F0689 SS = SQC-J	<p>Continued from page 9 on the 1st floor and made them aware that Resident #2 was [redacted] The [redacted] stated that this happened quick and when he got there at the reception area, he did not have time to do anything. He stated that if he was there for a while he would have noticed when they came in. He stated that the [redacted] did not say anything to him and that the [redacted] was still in [redacted] when he [redacted] Resident #2.</p> <p>On 10/10/2025 at 10:55 AM, the surveyor conducted an interview with the [redacted] who stated that the 24-hour shift report is a communication tool between the three shifts, 7-3, 3-11, and 11-7. The [redacted] stated that after Resident #2 exhibited [redacted] Resident #2 should have been reassessed to see if any other interventions could be put in place. The nurse should have done an updated [redacted] assessment. The [redacted] further stated that the expectation was that staff should have been able to identify residents at risk for [redacted] based on [redacted] and [redacted], and that the expectation for the [redacted] and [redacted] was to use the binder.</p> <p>An acceptable Removal plan was received on 10/15/2025 at 2:23 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include:</p> <p>"IJ Removal Plan"</p> <p>Resident #2 was assessed post incident by Nursing Supervisor, placed on [redacted] for safety. A call was placed to the primary physician by the nursing supervisor. The nursing supervisor updated Resident #2's care plan.</p> <p>On [redacted] resident #2 remains in the facility for long term care placement on [redacted] without [redacted] from this incident.</p> <p>On 10/10/2025 all staff were re-educated on the Elopement Policy.</p> <p>On 9/29/2025 the [redacted] Policy was reviewed and determined no updates to the [redacted] Policy was required at this time.</p> <p>A new system was implemented on 9/29/2025 that all visitors must sign out upon leaving the building.</p> <p>Security staff and receptionist staff were educated on the Elmwood Hills [redacted] Policy and the new process for visitors signing out.</p>	F0689		

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<p>NAME OF PROVIDER OR SUPPLIER ELMWOOD HILLS HEALTHCARE CENTER LLC</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 425 WOODBURY-TURNERSVILLE ROAD , BLACKWOOD, New Jersey, 08012</p>		
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<p>F0689 SS = SQC-J</p>	<p>Continued from page 10</p> <p>All Elmwood hills nursing staff were re-educated 10/10/2025 on identifying [redacted] behaviors and initiating and completing a new [redacted] Assessment, updating the resident's care plan and placing the resident picture at the entrance of the unit, receptionist desk, and security console.</p> <p>Elmwood Hills completed an audit on 9/28/2025 on all residents who are an [redacted] risk to ensure they have an appropriate Care Plan, [redacted] Assessment and resident picture at receptionist binder and security console.</p> <p>On 10/10/2025 an audit was completed on all new admissions from 9/28/2025 through 10/10/2025 by the [redacted] U.S. FOIA (b) (6) nurse and [redacted] U.S. FOIA (b) (6) assure that residents identified at risk of elopement had an [redacted] care plan in place, ID band and picture on the wall of exit door and front reception desk and security desk.</p> <p>On 10/10/2025 on the 3-11 shift at 6:00 PM an audit was completed by the 3-11 [redacted] U.S. FOIA (b) (6) on resident ID bands to ensure all residents had an ID band in place and that all resident pictures were present in Point Click Care (PCC) as a form of identification. Refusal of pictures and/or ID band were indicated on the resident's care plan.</p> <p>On 10/10/2025 the [redacted] U.S. FOIA, [redacted] U.S. FOIA (b) (6) and [redacted] U.S. FOI re-reviewed the Elmwood Hills Elopement Policy, and no changes were indicated.</p> <p>On 10/11/2025 and 10/12/2025 the [redacted] U.S. FOIA (b) (6) and the ADONs completed the re-education on the [redacted] NJ Exec Order 26.4b) Policy for Elmwood Hills staff.</p> <p>All the Elmwood Hills unit doors continue to remain locked and continue to require a swipe ID card to get off all the Elmwood Hills Nursing Units, this includes [redacted] NJ Exec Order 26.4b1.</p> <p>The surveyor verified the implementation of the RP on-site during the continuation of the survey and determined that the IJ for F 689 was removed as of 10/16/2025 at 3:18 PM.</p> <p>NJAC 8:39-27.1 (a)</p>	<p>F0689</p>		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER ELMWOOD HILLS HEALTHCARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 WOODBURY-TURNERSVILLE ROAD , BLACKWOOD, New Jersey, 08012	
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S0000	Initial Comments Complaint #: 2629258 Census: 289 Sample Size: 5 The facility was not in compliance with the standards in the New Jersey Administrative code, 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	S0000		11/05/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 2629258 Based on interviews and review of facility documents on 10/9/2025, 10/10/2025, and 10/16/2025, it was determined that the facility failed to ensure staffing ratios were met for 8 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: 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	S0560	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 ADON's and Nursing Supervisor. II. Residents identified having the 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:	11/07/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S0560	<p>Continued from page 1 staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as 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:</p> <p>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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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.</p> <p>For the 2 weeks of staffing prior to complaint survey from 09/21/2025 to 10/04/2025, the facility was deficient in CNA staffing for residents on 8 of 14-day shifts as follows:</p> <p>On 09/21/25 had 27 CNAs for 286 residents on the day shift, required at least 36 CNAs.</p> <p>On 09/22/25 had 33 CNAs for 286 residents on the day shift, required at least 36 CNAs.</p> <p>On 09/23/25 had 34 CNAs for 286 residents on the day shift, required at least 36 CNAs.</p> <p>On 09/28/25 had 29 CNAs for 285 residents on the day shift, required at least 36 CNAs.</p> <p>On 09/29/25 had 34 CNAs for 285 residents on the day shift, required at least 36 CNAs.</p> <p>On 09/30/25 had 34 CNAs for 284 residents on the day shift, required at least 35 CNAs.</p> <p>On 10/02/25 had 34 CNAs for 283 residents on the day shift, required at least 35 CNAs.</p> <p>On 0/04/25 had 30 CNAs for 283 residents on the day shift, required at least 35 CNAs.</p>	S0560	<p>Continued from page 1</p> <p>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 including employee of the month recognition, employee anniversary and recognition 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.</p> <p>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.</p> <p>IV. Corrective Action will be monitored to ensure the deficient practice will not recur:</p> <p>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.</p> <p>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.</p> <p>V. Date of Compliance: 11/7/25</p>	

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F0000	<p>INITIAL COMMENTS</p> <p>An on-site revisit for the facility's Plan of Correction was conducted on 11/25/2025 in relation to the 10/16/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		01/20/2026

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 reverse for further 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.

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S0000	Initial Comments An on-site revisit for the facility's Plan of Correction was conducted on 11/25/2025 in relation to the 10/16/2025 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		01/20/2026

Office of Primary Care and Health Systems Management

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