

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2025
NAME OF PROVIDER OR SUPPLIER Dwellside Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 Chapel Avenue West Cherry Hill, NJ 08002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>COMPLAINT #: 2599447Based on observation, interviews, review of medical records, and review of other pertinent facility documents on 9/10/2025, 9/11/2025, 9/18/2025, and 9/23/2025, it was determined that the facility failed to provide adequate supervision of a severely cognitively impaired resident (Resident #2) with a known history of exit seeking behaviors and documented history of previous attempts to elope from their unit; who eloped from the facility on 8/23/2025. The deficient practice was identified for 1 of 3 residents reviewed (Resident #2).A review of facility record revealed that on 8/23/2025 at approximately 8:15 AM, Resident #2 eloped from the facility while wearing a Wander Guard (WG; alarmed security bracelet) through an alarmed second floor elevator, down to the first floor, and exited the building through the employee entrance door on the first floor. A review of facility document revealed that the Certified Nursing Aide (CNA #3) observed the resident as they exited the building through an employee entrance door as CNA #3 was entering the facility through the same employee door. CNA #3 confirmed during interview on 9/11/2025, that he observed the resident exit the building, but he did not stop the resident because he thought the resident was a visitor because they were well dressed and the exit alarm which was supposed to sound to alert staff that a resident with a WG exited the building, did not sound when Resident #2 exited the building. CNA #3 further stated that he did not recognize Resident #2 because the resident resided on the second floor and I work on B-wing on the first floor. Resident #2 was located in the community five hours later on 8/23/2025 at 1:46 PM, by the local police department and transferred the resident to the hospital for evaluation. The facility's failure to provide adequate supervision to a severely cognitively impaired resident who was at risk for elopement and eloped, posed a likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 8/23/2025 at 8:15 AM, after Resident #2 eloped from the facility. The facility Administration was notified of the IJ on 9/11/2025 at 6:00 PM. The facility submitted an acceptable Removal Plan (RP) on 9/19/2025 at 10:46 AM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 9/23/2025. The evidence was as follows: A review of the facility provided Elopements and Wandering Residents policy dated July 2024, included the facility ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents.Policy Explanation and Compliance Guidelines 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk.4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering.d. Adequate supervision will be provided to prevent accidents or elopements.A review of the Facility Reportable Event (FRE) dated 8/22/2025, that the facility submitted to the New Jersey Department of Health (NJDOH), revealed that on 8/23/2025, at around 9:34 AM, the Nursing Supervisor, a License Practical Nurse (LPN #3), called the Director of Nursing (DON) and informed him that she could not find Resident #2 in the facility. The DON then called the local police and reported the resident missing, and that the police went to the facility and initiated a search for the resident. The police later found Resident #2 in the community and transferred them to the hospital for evaluation.According to the police report dated 8/25/2025, facility staff notified the police of the missing resident on 8/23/2025, at approximately 9:49 AM. The report included that the police arrived at facility and conducted interviews with facility staff, and the staff informed the police that Resident #2 was a known wander and that Resident #2 wore ankle monitors which were supposed to disable the use of elevators and sound alarms to detect if a resident left the building. The report further indicated that their review of the facility's camera footage showed Resident #2 leaving the building at 8:15 AM, heading westbound on [name of street]. The report indicated that police then searched the building several times with negative results. The family member responded back to the facility about the elopement of Resident #2 and mentioned that the resident may return to old addresses. The family member provided the police with two addresses and emphasized that the police check one of the addresses because Resident #2 had previously repeatedly mentioned that address. The police report included that at approximately 1:46 PM, the family member informed the police that Resident #2 showed up to the house (old address). The resident was then taken to the hospital for an evaluation.According to an undated Investigation Summary document provided by the facility, Resident #2 returned back to the facility from the hospital at approximately 6:30 PM on 8/23/25, and that the facility assessed the resident for pain and injury, and none</p>		