

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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, NJ 08012	

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>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>Complaint #: 2629258Based 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 supervision for a resident (Resident #2) who was cognitively impaired with documented history of exit seeking behaviors; and who eloped out of the facility building on 9/28/2025. The deficient practice was identified for 1 of 3 residents reviewed (Resident #2). A review of Facility Reportable Event (FRE) revealed that on 9/28/2025, 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 second floor secured unit for Resident #2, which CNA #1 did provide. This allowed Resident #2 to exit the unit because both CNA #1 and LPN #1 thought the resident was a visitor. The FRE indicated that pictures of residents at risk for elopement, including Resident #2, were located by the same entrance door on the second-floor nursing unit to help staff identify at-risk residents and stop them from eloping out of the unit. The two staff members on the second floor from where the resident exited, (LPN # and CNA #1), stated they did not check the pictures by the exit door and did not recognize Resident #2. The FRE revealed that Resident #2, who was wearing an ID band on their wrist at the time they eloped, exited the second-floor unit, entered the elevator down to the first-floor lobby area and exited the building through the front door at approximately 9:47 AM. The security guard (SG) was seated at the front desk at the time and observed Resident #2 exit the building. The SG did not intervene to stop Resident #2, as the resident appeared to be a visitor. A visitor who was entering the facility saw Resident #2 outside on the sidewalk and alerted the SG. The SG then went outside where Resident #2 was in front of the building and escorted Resident #2 back into the building. Nursing staff was immediately notified. 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 elopement. A review of Progress Note (PN) dated 9/24/2025 at 11:05 PM, revealed that Resident #2 repeatedly kept asking to go home and when they were leaving. Another PN dated 9/25/2025 at 9:37 PM, revealed that Resident #2 asked staff how they could get out so that they could go home. During interview on 10/10/25 at 8:37 AM with LPN #3, who wrote the 9/25/2025 PN, he confirmed that the resident's exit seeking behavior 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 repeated verbalizations about going home.LPN #1 stated during an interview on 10/9/25 at 1:25 PM, Resident #2 did not have a bracelet on and Resident #2 stated they were visiting their cousin and had laundry. 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 at risk for elopement. During second floor unit tour on 10/9/2025 9:33 AM, the surveyor observed pictures posted on the wall by the exit door, which the facility stated was supposed to help staff to identify residents with elopement risks; to intervene if they see such resident try to leave the unit. The facility's failure to provide adequate supervision to ensure the safety of a cognitively impaired resident who was at risk for elopement, with documented history of exit seeking behaviors, posed a likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy situation. 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. The evidence was as follows: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. According to the Facility Reportable Event Record (FRE) dated 09/28/2025, that the facility submitted to the New Jersey Department of Health (NJDOH), on 9/28/2025 at approximately 9:45 AM, Resident #2 was observed in the front lobby by the receptionist with two bags full of clothes. The receptionist's statement in the FRE reflected that Resident #2 appeared to be a visitor carrying laundry. Resident #2 asked to use the</p>		