

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Aspen Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Pemberton Brown Mills Rd Pemberton, NJ 08068	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Aspen Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Pemberton Brown Mills Rd Pemberton, NJ 08068	
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Complaint #: 2594123 Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy to ensure residents were protected from physical abuse after a cognitively impaired resident (Resident #2) was found with a bruise to their left clavicle (collar bone) of unknown origin on 8/17/25. This deficient practice was identified for 1 of 5 residents reviewed for abuse (Resident #2). On 8/17/25, staff observed a faint discoloration and minor swelling to Resident #2's left clavicle at approximately 12:20 PM. At the time, the Licensed Practical Nurse/Supervisor (LPN/S #1) did not immediately initiate an investigation. On 8/18/25, Resident #2 complained of pain and had limited range of motion to their left arm. Resident #2's physician was made aware, and an X-ray was ordered revealing Resident #2 had a closed, displaced fracture of the resident's left clavicle. An interview with the Assistant Director of Nursing (ADON) on 10/30/25 at 2:15 PM, confirmed that LPN/S #1 did not initiate an investigation on 8/17/25, when the resident's bruised collar bone was first discovered, and staff continued to work until 8/18/25, when an investigation was initiated, and staff were suspended pending the outcome of the investigation. The facility's failure to immediately implement their abuse and neglect policy, and not immediately protect Resident #2 who had an injury of unknown origin placed Resident #2, as well as all residents at risk for abuse. This posed the likelihood of serious physical harm and psychological, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 8/17/25 at 12:20 PM, when a bruise of unknown origin was identified on Resident #2, and the facility did not immediately implement their abuse policy and protect the resident. The facility was notified of the IJ on 10/30/25 at 5:45 PM. The facility submitted an acceptable Removal Plan (RP) on 10/31/25 at 12:12 PM. The surveyors verified the implementation of the RP on-site during the continuation of the survey on 10/31/25 at 1:35 PM. The evidence was as follows: Refer F610A review of the facility's policy titled Resident Abuse/Neglect Policy and Procedure, revised February 17, 2025, included its purpose was to ensure prevention, protection, prompt reporting, and interventions in response to alleged, suspected, or witnessed abuse, neglect, mistreatment, misappropriation of property, or exploitation of any facility resident. All employees are expected to and must immediately report any injury sustained by a resident, whether or not the nature of the injury is known. Protection, Investigation and Reporting: A. Protection: 1. While an alleged abuse/neglect investigation is being conducted, accused individuals not employed by the facility will be denied access to the resident. Employees of the facility who are under investigation will be temporarily suspended until the Administrator has reviewed the results of the investigation. B. Notification: 1. Any staff member witnessing or receiving an allegation of abuse/neglect of any resident shall notify the Nursing Supervisor immediately after witnessing the incident or receiving the allegation of abuse/neglect. 2. The Administrator/GO (Grievance Officer) and the DON (and/or designees) shall then be immediately notified of the incident, and an investigation will be initiated. A review of the Facility Reported Event (FRE) submitted to the New Jersey Department of Health (NJDOH) dated 8/19/25, revealed the following: On Sunday 8/17/25, Resident #2 was noted with discoloration to the clavicle area due to combative and aggressive behavior during care. On Monday 8/18/25, the resident presented with decreased range of motion (ROM) and showed signs and symptoms of pain to the left arm. The physician was notified, and an X-ray was ordered to rule out a left clavicle fracture. The resident was sent to the emergency room for orthopedic evaluation. A review of the facility's Investigation Summary include for the Investigative Findings that Resident #2 was alert and confused with intermittent times of clarity and was interviewed on 8/19/25. When asked what happened, the resident acted out to nursing staff by leaning forward and stretching [their] arms in front of [the resident]. The resident stated that [they] fell but was unable to describe further. When asked how [the resident] got [themselves] up, the resident stated, my knees. The facility concluded that the resident had a history of independent ambulation and a history of falls. Based on staff and resident interviews and skin assessments, there were no significant findings to indicate abuse. On 10/30/25 at 10:25 AM, the Director of Nursing (DON) provided a folder that included an Incident Report dated 8/17/25, and a written statement from LPN/S #1 dated 8/17/25. A review of the Incident Report dated 8/17/2025 at 12:00 PM, completed by LPN/S #1, included type/nature of the incident was other with a location reported as the resident's room. Under nursing description, there was a box to indicate if the incident had been witnessed and LPN/S #1 did not check the box. The description of the findings were, during afternoon rounds, resident is noted with faint red/purple discoloration to left collar bone area with minor swelling that was not present earlier in the shift/during AM</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Aspen Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Pemberton Brown Mills Rd Pemberton, NJ 08068	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Aspen Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Pemberton Brown Mills Rd Pemberton, NJ 08068	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Complaint #: 2594123Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an injury of unknown origin within two hours of initial identification. The injury was discovered on 8/17/25, when Resident #2 was noted to have discoloration and minor swelling to the left clavicle (collarbone). The injury was later diagnosed as a fracture on 8/19/25, and the facility failed to rule out possible abuse as required by policy. This deficient practice was identified for 1 of 5 residents (Resident #2) reviewed for abuse. The evidence was as follows: On 8/17/25, staff at the facility identified an injury of unknown origin for Resident #2 at approximately 12:20 PM. At the time, no immediate investigation was initiated and the NJDOH was not notified. Two days later, the injury was then determined to have resulted in a closed, displaced fracture of the resident's left clavicle. During survey on 10/30/25, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) both stated they had not been informed of the injury when it was first discovered on 8/17/25. They explained that the Licensed Practical Nurse/Supervisor (LPN/S) who identified the injury should have reported it to them immediately so that an investigation could begin, and all notifications completed including to the NJDOH. However, this did not occur. As a result, an investigation was not started until 8/19/25, approximately over 24 hours after the injury had been first noted. A review of the Facility Reported Event (FRE) dated 8/19/25, submitted to the NJDOH revealed the following: On 8/17/25, Resident #2 was observed with discoloration to the clavicle area, noted during care when the resident was combative and aggressive. On 8/18/25, the resident was noted to have decreased range of motion in the left arm and exhibited signs and symptoms of pain. The physician was notified, and an X-ray was ordered. On 8/19/25, X-ray results confirmed a left clavicle fracture. The physician was notified, and the resident was transferred to the emergency department for evaluation. During an interview with the surveyor on 10/30/25 at 2:15 PM, the ADON stated that an investigation should have been initiated immediately regarding Resident #2's left clavicle discoloration, the cause was of unknown origin. She noted that an investigation was eventually started on 08/18/25, after LPN #1, who provided care to the resident on 08/18/25, reported that the resident had decreased range of motion in the left arm. The ADON stated that the staff providing direct care to the resident should have been placed off duty on 08/17/25 pending the investigation. She further stated that, after reviewing the nursing note and considering the resident's inability to describe how the incident occurred, she realized that the facility's policy might not have been followed. The ADON also stated that the NJDOH and the Ombudsman should have been notified on the same day or the following day, but she was unsure of the exact timeframe for reporting, which she believed to be within 72 hours. During an interview with the surveyor on 10/30/25 at 3:55 PM, the DON stated that the incident involving Resident #2's discoloration to the left clavicle occurred when she was not in the building and that it should have been reported to the NJDOH and investigated immediately. On 10/31/25 at 11:03 AM, the surveyor attempted to contact the RN #1 by telephone regarding Resident #2's incident to conduct an interview. According to the ADON, the RN only worked on weekends. The RN did not answer the phone, and a voicemail message was left requesting a return call. On 10/31/25 at 11:31 AM, the surveyor attempted to contact the LPN/S by telephone regarding Resident #2's incident to conduct an interview. According to the ADON, the LPN/S only worked on weekends. The LPN/S did not answer the phone, and a voicemail message was left requesting a return call. A review of a facility policy dated 2/25 titled, Resident Abuse/Neglect Policy and Procedure, revealed that, All employees are expected to and must immediately report any injury sustained by a resident, whether or not the nature of the injury is known. The Department of Health and Senior Services, and the office of the ombudsman if the resident is 60 or over, will be notified immediately (as soon as possible but not to exceed two hours) of the incident, followed by a written report within 5 days of the incident and if the alleged violation is verified, the facility shall take all appropriate corrective action. NJAC 8:39-9.4(f)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Aspen Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Pemberton Brown Mills Rd Pemberton, NJ 08068	

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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Aspen Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Pemberton Brown Mills Rd Pemberton, NJ 08068	
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Complaint #: 2594123 Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to immediately implement its abuse and neglect policy by immediately investigating an injury of unknown origin that was discovered on 8/17/25, to protect the resident to rule out abuse. On 8/17/25, a cognitively impaired resident (Resident #2) was noted to have discoloration and minor swelling to the left clavicle (collar bone), and it was determined to be a clavicle fracture on 8/18/25. This deficient practice was identified for 1 of 5 residents reviewed for abuse (Resident #2). On 8/17/25, staff observed a faint discoloration and minor swelling to Resident #2's left clavicle at approximately 12:20 PM. At the time, the Licensed Practical Nurse/Supervisor (LPN/S #1) did not immediately initiate an investigation. On 8/18/25, Resident #2 complained of pain and had limited range of motion to their left arm. Resident #2's physician was made aware, and an X-ray was ordered revealing Resident #2 had a closed, displaced fracture of the resident's left clavicle. An interview with the Assistant Director of Nursing (ADON) on 10/30/25 at 2:15 PM, confirmed that LPN/S #1 did not initiate an investigation on 8/17/25, when the resident's bruised collar bone was first discovered, and staff continued to work until 8/18/25, when an investigation was initiated, and staff were suspended pending the outcome of the investigation. The facility's failure to immediately implement their abuse and neglect policy by not immediately investigating an injury of unknown origin placed Resident #2, as well as all residents at risk for abuse. This posed the likelihood of serious physical and psychological harm, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 8/17/25 at 12:20 PM, when a bruise of unknown origin was identified on Resident #2, and the facility did not immediately implement their abuse policy to investigate. The facility was notified of the IJ on 10/30/25 at 5:45 PM. The facility submitted an acceptable Removal Plan (RP) on 10/31/25 at 12:12 PM. The surveyors verified the implementation of the RP on-site during the continuation of the survey on 10/31/25 at 1:35 PM. The evidence was as follows: Refer F600A review of the facility's policy titled Resident Abuse/Neglect Policy and Procedure, revised February 17, 2025, included its purpose was to ensure prevention, protection, prompt reporting, and interventions in response to alleged, suspected, or witnessed abuse, neglect, mistreatment, misappropriation of property, or exploitation of any facility resident. All employees are expected to and must immediately report any injury sustained by a resident, whether or not the nature of the injury is known. Employees under investigation would be denied access to the resident and temporarily suspended until the LNHA had reviewed the results of the investigation. Notification: Any staff member witnessing or receiving an allegation of abuse/neglect of any resident shall notify the Nursing Supervisor immediately after witnessing the incident or receiving the allegation of abuse/neglect. The Administrator/[Grievance Officer (GO)] and the [Director of Nursing (DON)] and/or designees shall then be immediately notified of the incident, and an investigation will be initiated. When an allegation of abuse/neglect is made, the Administrator/GO or his/her designee shall lead an investigation that includes the following: 1. If the allegation is physical abuse, a complete physical assessment of the resident must be completed and documented in the medical record. 2. If abuse/neglect is suspected or confirmed, the resident shall be assessed to determine the need for counseling. 3. The Administrator or his/her designee will form an investigatory team that will thoroughly investigate the allegation and document the investigation. An incident report will be completed. Interviews will be conducted and statements obtained from all staff members, residents, family, volunteers, and others that may have witnessed or have knowledge with respect to the alleged incident. All such statements will be in writing and placed in the investigatory file related to the alleged incident. The employee file of any accused staff will be reviewed. Medical records of the resident including but not limited to documentation related to the physical assessment of the resident, as well as any assessment relating to the resident's psychosocial condition, will be reviewed. and findings documented and placed in the investigatory file. A review of the Facility Reported Event (FRE) submitted to the New Jersey Department of Health (NJDOH) dated 8/19/25, revealed the following: On Sunday 8/17/25, Resident #2 was noted with discoloration to the clavicle area due to combative and aggressive behavior during care. On Monday 8/18/25, the resident presented with decreased range of motion (ROM) and showed signs and symptoms of pain to the left arm. The physician was notified, and an X-ray was ordered to rule out a left clavicle fracture. The resident was sent to the emergency room for orthopedic evaluation. A review of the facility's Investigation Summary include for the Investigative Findings that Resident #2 was alert and confused with intermittent times of clarity and was interviewed on 8/19/25. When asked what happened, the</p>		