STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Haven Rehab and Nursing Center	350 Oxford Road Oxford, NJ 07863

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint: 2989444 Based on interviews, record review, and review of other pertinent facility documents on 04/24/2026, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) the fall with injury and the elopement of a cognitively impaired resident (Resident #1). This deficient practice was identified for 1 of 4 residents reviewed for accident and incidents and was evidenced by the following:According to the admission Record, Resident #1 was admitted to the facility with diagnoses including but not limited to: follicular lymphoma (slow-growing cancer of lymph nodes, bone marrow and other organs); schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves), auditory hallucinations (hearing sounds, voices, or noises that are not present in reality). Review of the brief interview for mental status (BIMS) assessment dated [DATE] revealed that Resident #1 had severely impaired cognition. Review of the Elopement/Wandering Risk Assessment dated 04/01/2026 revealed that Resident #1 was determined to be an elopement risk. Review of Resident #1's care plan (CP) initiated on 04/01/2026 revealed that the resident wandered and was an elopement risk related to the resident's impaired safety awareness. Interventions included provision of structured activities; walking inside and outside; and use of an elopement alarm. Further review of Resident #1's CP revealed that the resident was at risk for falls related to deconditioning, and gait and balance problems. Interventions included anticipating and meeting the resident's needs; and educating the resident, family, and caregivers about safety and what to do if a fall occurred. A review of a progress note (PN) written by the Director of Nursing (DON) dated 04/01/2026 at 10:28 PM revealed that Resident #1 had a fall and was transferred to the hospital. Review was conducted of a facility Resident Accident/Incident Report (RA/IR) with Resident #1's name; an event date of 04/01/2026; and time of incident of 7:45 PM at the top. Under Description and Facts of Event the document revealed that nursing staff noted that the resident was not in their room or the dayroom. This section of the document further revealed that nursing staff observed the resident's window screen was removed and their window was open. The resident was observed outside laying on the ground. Further review of the RA/IR revealed that the fall was documented as unwitnessed, the extent of the resident's injuries was unknown, and the resident was transferred to the hospital. Review was conducted of an Investigation Report (IR) from [NAME] Township Police Department dated 04/01/2026 at 7:49 PM. The IR revealed that Emergency Medical Services (EMS) suspected internal injuries and requested a helicopter to transport Resident #1 to the hospital due to suspected serious injuries. Further review of the IR revealed that the height from Resident #1's window to the ground outside was between 17 and 18 feet. An interview was conducted with Registered Nurse (RN) #1 on 04/24/2026 at 1:12 PM. RN #1 stated that she was working in the facility when Resident #1 exited through the window. RN #1 stated that on 04/01/2026 at 7:00 PM or 7:15 PM, she was doing rounds with the Assistant Director of Nursing (ADON), when Resident #1 was not seen. RN #1 and the ADON began to check other rooms for the resident and shortly afterward the ADON called out for RN #1 to call 911. RN #1 called 911, then went to Resident #1's room where she saw the window open and Resident #1 outside on the ground. RN #1 further stated that when she (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed Resident #1 on the ground, one of the resident's legs appeared to be shorter than the other. RN #1 stated that this could be a sign that the resident's leg was broken. An interview was conducted with the Licensed Nursing Home Administrator (LNHA) on 04/24/2026 at 4:05 PM. The LNHA stated that falls with major injuries should be reported to NJDOH. The LNHA stated that Resident #1's fall was not reported because the facility was unable to get information from the hospital on the extent of the resident's injuries. During the same interview the LNHA stated that Resident #1's exit through the window was not reported to NJDOH as an elopement because the resident did not leave the facility grounds, so it was not considered an elopement. The facility policy Falls and Fall Risk Managing with an implementation date of May 2025 and a reviewed/revised date of April 2026 was reviewed. The facility policy revealed that a fall is when a resident unintentionally comes to rest on the ground, floor or other lower level. The policy revealed that unless there is evidence suggesting otherwise, when a resident was found on the floor it should be considered a fall. The facility policy Elopement and Wandering Residents with an implementation date of May 2025 and a reviewed/revised date of April 2026 was reviewed. The facility policy revealed that an elopement occurs when a resident leaves the premises or a safe area without authorization and/or the necessary supervision to do so. Under Procedure for Locating Missing Resident the facility policy revealed, g. Appropriate reporting requirements to the State Survey Agency shall be conducted. The facility policy Incidents and Accidents with an implementation date of May 2025 and a reviewed/revised date of April 2026 was reviewed. The facility policy revealed that it was the policy of the facility for staff to report, investigate, and review any accident or incident that involved a resident and occurred on facility property. Under Definitions: revealed, an Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident, and an incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operations of the organization. Under Policy Explanation the facility policy revealed that The purpose of incident reporting can include [.] Meeting regulatory requirements for analysis and reporting of incidents and accidents. Under Compliance Guidelines The facility policy further revealed, 4. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the facility's abuse prevention policy. 5. The following incidents/accidents require an incident/accident report but are not limited to [.] Elopement [.] Falls. The facility policy Compliance with Reporting Allegations of Abuse/Neglect/Exploitation with an implementation date of May 2025 and a reviewed/revised date of April 2026 was reviewed. The facility policy revealed that it was the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment [.] which are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. Under Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: revealed When suspicion of abuse/neglect/exploitation [.] occur, the following procedure will be initiated [.] 2. The Administrator or designee will: a. Notify the appropriate agencies immediately; as soon as possible, but no later than 2 hours after discovery or forming the suspicion. NJAC 8:39 - 9.4(f)