STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315404	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Collingswood	460 Haddon Ave Collingswood, NJ 08108

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who was dependent on staff for transfers was safely and properly transferred with two staff members via mechanical lift. Instead, the resident was transferred using mechanical lift by one staff member from their chair to their bed. This deficient practice was identified for 1 of 2 residents (Resident #29) reviewed for accidents and was evidenced by the following: On 11/20/25 at 10:30 AM, Resident #29 was observed in the bed and had just received care from the Certified Nursing Assistant (CNA). The surveyor observed the resident had soft padding on the right and left upper side rails of the bed. A review of the admission Record (an admission summary) showed Resident #29 was admitted to the facility with medical diagnoses which included but were not limited to dementia, urinary retention, failure to thrive, and vitamin deficiency.A review of the a Significant Change Minimum Data Set (MDS), an assessment tool, dated 10/12/25 revealed under Section GG-functional abilities that the resident was dependent for bed to chair transfer meaning the helper does all the effort, resident does none of the effort to complete activity, or the assistance of two or more helpers is required for the resident to complete the activity. Resident #29 had a Brief Interview of Mental Status of 4/15, meaning the resident was severely cognitively impaired.On 11/20/25 at 12:22 PM, the surveyor reviewed a Facility Reported Event (FRE). The report included that on 9/30/25 the residents spouse approached the Unit Mentor (UM) regarding pain in the resident's right wrist. An assessment was completed by the physician and an Xray was ordered of right wrist, forearm and elbow.It was documented on the FRE that it was unknown if wrist pain was fall related, and it was an unwitnessed injury. Further review showed that no one witnessed the resident fall. Additional review showed that on 9/29/25 the resident was transferred from the wheelchair to the bed but did not fall. The resident's spouse was in the room at the time of transfer, and it was uneventful. A review of the investigation portion of the FRE showed that the resident was out of bed on 9/29/25. Resident #29 was ordered a mechanical lift with a two person assist to get out of the bed. The investigation revealed that although Resident #29 did not fall, the CNA assigned to Resident #29 did not follow the plan of care or physician orders by using the two persons assist with transfer and was suspended from employment. Review of the FRE conclusion was that the resident did not fall and most likely hit their wrist on the side rail of the bed. On 11/20/25 at 1:14 PM, the surveyor reviewed the physician orders which showed an active order dated 9/15/25 for Hoyer (mechanical) lift transfers with two persons assist.A review of the Individualized Comprehensive Care Plan (ICCP) showed a fall focus, initiated 2/24/24. Interventions included but were not limited to transfer with assist of 2 with mechanical lift.On 1/21/2025 at 10:23 AM, during an interview with the Director of Nursing (DON) the surveyor asked about the incident with Resident #29. The DON told the surveyor that after investigating the incident it was determined the resident did not fall and the arm injury occurred when resident punched the bed rail. The DON said, The CNA did not follow the policy, meaning the CNA transferred resident alone, not with two people.On 11/25/25 at 9:40 AM, the surveyor reviewed the policy titled, Safe Handling, dated 8/8/25. Under the mechanical lift usage guidelines it was written that lifts required two persons to use.NJAC 8:39-27.1(a)