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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASRR) level one assessment after a resident was newly diagnosed with a mental illness. This deficient practice was identified in 1 of 1 resident reviewed for PASRR (Resident #2) and was evidenced by the following:On 11/20/2025 at 12:10 PM, the surveyor reviewed Resident #2 Electronic Medical Record (EMR) which showed that the resident had a PASRR completed on entry to the facility. Under section one for diagnoses of mental illness it was marked as NO, meaning Resident #2 did not have any mental illness diagnoses when admitted . The PASRR was dated 2/8/2023.A review of the admission Record face sheet (an admission summary) reflected the resident was initially admitted to the facility in February 2023. Medical diagnoses on admission included but were not limited to pain, anxiety, Parkinson's Disease, diabetes, and muscle weakness. A review of the most quarterly Minimum Data Set (MDS), an assessment tool dated 9/4/25 showed that the resident had a Brief Interview of Mental Status (BIMS) of 00 out of 15, meaning the resident had severe cognitive impairment. Review of section I of the MDS titled active diagnoses revealed the resident had a diagnosis of psychotic disorder.A review of Resident #2 quarterly MDS from 12/15/23 under section I for active diagnoses was marked as No for diagnoses of psychotic disorder.A review of the residents most recent psychiatric note dated 10/22/25 under diagnoses and plan it revealed a diagnosis of psychosis.On 11/21/25 at 10:48 AM, the surveyor interviewed the Director of Nursing (DON) regarding Resident #2 PASRR. The DON told the surveyor the Social Worker was responsible for the PASRR but was currently on a leave of absence.On 11/24/25 at 11:00 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding Resident #2 PASRR. The LNHA said the facility did not have a PASRR policy. The surveyor asked the LNHA when a PASRR should be completed and the LNHA responded, on admission or if the resident gets prescribed an antipsychotic or is given a new psychiatric diagnosis.NJAC 27.1 (a)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and review of pertinent facility documents it was determined the facility failed to revise an individual comprehensive care plan for a resident with a repeated fall history. This deficient practice was identified for 1 of 2 residents reviewed for falls (Resident #12) and was evidenced by the following: On 11/19/2025 at 10:24 AM, during the initial tour of the facility the surveyor observed Resident #12 in bed with eyes closed. The resident's bed was in the lowest position and there was a fall mat on the right side of the bed.A review of the admission Record face sheet (an admission summary) reflected Resident #12 was admitted to the facility with diagnoses which included but were not limited to depression, low back pain, anxiety, hypertension, and repeated falls.A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 10/15/25 revealed the resident had a Brief Interview of Mental status score of 4/15, meaning the resident had severe cognitive impairment. Section GG, titled functional status showed the resident required substantial/maximum assistance for sit to stand transfers.A review of incidents, accidents and facility progress notes for Resident #12 revealed the resident had unwitnessed falls on 1/17/25, 2/17/25, and 7/25/25. On 1/17/25, the resident was found on the floor and sustained a small forehead laceration. Neurological assessments were initiated. On 2/17/25 the resident was found on the floor in the bathroom. The resident stated they fell out of bed. The resident complained of knee pain and an Xray was ordered and completed. On 7/25/25, the resident was found laying on the floor next to the bed and sustained a skin tear to the left lower jaw area. The resident was transferred to the hospital for evaluation.A review of Resident #12 Individualized Comprehensive Care Plan (ICCP) included a focus area of fall risk initiated on 10/23/23. The care plan goal was that the resident would be free from falls. The care plan interventions included assess call light ability, do not leave resident alone in the bathroom, educate on calling for assistance, keep items within reach, bedside table within reach, room free of clutter, and ask if the resident needs anything prior to leaving. The care plan did not include new interventions following the 1/17/25, 2/17/25, and the 7/25/25 falls. On 11/24/2025 at 12:17 PM, during an interview with the Director of Nursing (DON), the DON told the surveyor that the facility tries to update the care plans after each fall. The DON acknowledged the care plan was not updated following each of the falls.On 11/25/25 at 9:00 AM, the surveyor reviewed the policy titled Fall Prevention and Management with a revision date of 8/8/25. Under the section post fall management, it included modifying the care plan as indicated.The surveyor reviewed the policy titled Care Plan Policy dated 8/8/25. The policy purpose was to guide the care and treatment provided to each resident. Number 21 of the policy revealed that the care plans would be updated and/or revised for significant changes, change in planned interventions, new diagnoses, medications or abnormal lab work.NJAC 8:30-27.1 (a)

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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. 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)