STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315427	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Pitman	535 N Oak Ave Pitman, NJ 08071

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 - 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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(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 - Actual harm Residents Affected - Few	COMPLAINT#: 404125 Based on interview, medical record review, and review of pertinent facility documentation on 8/13/25, it was determined that the facility failed to ensure a severely cognitively impaired resident's safety when the soup that CNA #1 reheated for Resident #4 and served to the resident without checking the soup temperature, spilled onto the resident's lap. This resulted in a second-degree and third-degree burns to Resident #4's right inner thigh which had an open area that measured 1 centimeter x 1 centimeter (CM), and reddened area that measured 0.5 cm x 11.4 cm from the edges of open area. This deficient practice was identified for 1 of 5 residents (Resident #4) reviewed and was evidenced by the following: A review of the Facility Reportable Event (FRE) sent to the New Jersey Department of Health (NJDOH), indicated that on 5/2/25 at 5:30 P.M., During dinner [Resident #4] sustained a burn injury to [their] right inner thigh when soup spilled on [their] lap. Burn injury noted with open area 1 cm x 1 cm, redness extending 0.5 cm x 11.4 cm beyond edges of open area. The FRE further indicated that staff was to anticipate the resident's needs and that the Resident's care plan includes cognitive impairment and risk for skin injury. The FRE also revealed that, . CNA failed to take temperature of soup prior to serving resident. The surveyor reviewed the Conclusion section of the Addendum to AAS-45: 5/2/25, submitted by the Director of Nursing (DON) which indicated the following:- Resident was seen by wound nurse practitioner and assessed with second degree burn to right inner thigh and third degree burn to right anterior thigh.- [CNA #1] immediately disclosed that he had not used the thermometer to ensure safe temperature of soup prior to resident being served. Resident #4 was no longer at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record revealed that Resident #4 was admitted to the facility with diagnoses that included but were not limited to: dementia, cognitive communication deficit, and peripheral vascular disease (reduced blood circulation in the limbs). Review of Resident #4's comprehensive Assessment Minimum Data Set (MDS), an assessment tool dated 5/20/25, indicated that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 indicating that the resident's cognition was severely impaired. Further review of the MDS revealed that the resident required, Setup or clean-up assistance when eating. A review of Resident #4's care plan (CP) indicated a focus related to the resident having an Assisted Daily Living (ADL) self-care deficit that was initiated on 11/13/24. Interventions for this focus included, Assist me with my meals, initiated on 2/13/25. Further review of the CP revealed a focus related to the resident having the potential for the development of pressure ulcers that was initiated on 12/5/24. Interventions for this focus included that staff were to, Follow facility policies/protocols for the prevention/treatment of skin breakdown, that was initiated on 12/5/24. A review of Resident #4' progress notes (PN) revealed a nursing note dated 5/2/25, at 9:56 P.M., Around [5:20 P.M.]; it was brought to this nurse attention by aide that resident had a acquired a burn noticed after resident was placed in bed. Skin assessed right upper inner thigh to noted to have a 1 cm x 1 cm circular opening, redness area 0.5 cm x 11.4 cm. resident stated [they] pulled the bowl and it spilled. NP called informed of incident and [treatment] ordered. DON and POA notified]. Further review of the resident's PNs revealed a wound care note dated 5/5/25, at 4:48 P.M., that indicated that the purpose of the visit was a subsequent encounter for skin and wound care. The Nurse Practitioner (NP) additionally noted, Staff requested [Resident #4] have a wound/skin consult of patient's right thigh burns, which were caused by hot soup. On evaluation right inner thigh with 70% slough and right anterior thigh with closed blisters. Her assessment further indicated that the resident had a burn of second degree of right thigh and a burn of third degree of right thigh. The NP then proceeded to update the resident's course of treatment. A review of Resident #4's Order Summary Report for May 2025, indicated an active order that was initiated on 5/2/25 for a Silvadene cream to be applied topically, to right upper inner thigh topically two times a day for wound treatment . A review of the resident's Medication Administration Record for May 2025 revealed a corresponding medication to reflect the order. Further review revealed that the resident's Treatment Administration Record was updated to reflect the NP's recommended course of treatment. The surveyor attempted to contact Certified Nurse Assistant (CNA) #1 for an interview without success. A review of his personnel file revealed a facility Performance Enhancement Form dated 5/5/25, which indicated that CNA #1 was suspended 3 days for did not temp food before giving to a resident. the resident was injured as a result. Further review of the personnel file revealed that CNA #1's most recent training on Microwave Use for Heating and Reheating, prior to the incident, occurred on 5/25/23. During an interview with CNA #2 on 8/13/25, at 11:18 A.M., she stated that she had been in-serviced on re-heating