STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	**185 TUCKERTON ROAD MEDFORD, NJ 08055**

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F 000	INITIAL COMMENTS COMPLAINT # NJ 137523 CENSUS: 102 SAMPLE SIZE: 3 Based on observations, interviews, review of the Medical Records (MR), and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility failed to ensure a resident with severe cognitive impairment, who was at risk for elopement, and had a known history of wandering and exit seeking behavior, was appropriately monitored and supervised to prevent elopement or exiting the building. The facility also failed to follow their "Elopement Policy" and their "Incident and Accident Policy." The facility also failed to secure the front door for safety to prevent elopement, for 1 of 3 residents (Resident #2) sampled for elopement. On [redacted] at 9:45 p.m., Resident #2 was able to exit the facility unattended when the Nursing Supervisor deactivated the front door alarm, unlocked the front door and Resident #2 then exited the building. When the Supervisor reentered the facility, she failed to reactivate the alarm and lock the door, or have a staff member monitor the exit while the alarm was shut off. On [redacted] at 9:45 p.m., Resident #2 was able to exit the building by the unsecured front door without the knowledge of the staff and was able to wander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the cognitively	F 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/28/2020

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F 000	Continued From page 1 [redacted] resident was outside of the building. The resident was transported to the Emergency Room (ER) via ambulance and evaluated for possible injuries. This deficient practice placed Resident #2 and all other residents with [redacted] who were at risk or who had a known history of wandering and/or elopement in an Immediate Jeopardy (IJ) situation. The IJ was identified on 7/9/2020 at 5:01 p.m., when the Facility's Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ and were provided the IJ template. The IJ ran from 7/1/2020 through 7/9/2020 at 6:09 p.m., and was lifted when the facility provided an acceptable Removal Plan.	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		7/15/20

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F 609	Continued From page 2 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 137523 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 7/9/2020, it was determined that the facility staff failed to report an elopement to the New Jersey Department of Health (NJDOH) for 1 of 3 residents (Resident #2) reviewed for elopement risk. The facility also failed to report an alleged fire which required internal evacuation of the residents off a unit. The facility also failed to follow the facility policies titled "Incident and Accident" and the "Reportable Events" form. This deficient practice was evidenced by the following: 1. According to the Face Sheet (FS) Resident #2 was admitted to the Facility on [redacted], and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] The MDS also indicated that Resident #2 required extensive assistance	F 609	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1.) The facility is unable to retroactively address the concerns related to the late reporting regarding resident #2. Resident #2 was assessed medically and had no injuries. Resident #2's [redacted] was checked for placement and function and all exit doors were checked with no concern. Elopement risk assessment and care plan updated for resident #2. Resident #2 was placed on every 15 minute visual checks. The facility is unable to retroactively address concerns related to reporting regarding the temporary internal relocation of residents during a minor smoke event. Event reports were submitted for both of these occurrences on July 15, 2020. 2.) The facility recognizes that certain	

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F 609	Continued From page 3 with Activities of Daily Living (ADLs). Review of the Care Plan (CP) dated 4/9/2020 and a reviewed date of 7/2/2020, revealed Resident #2 had [redacted]. Interventions on the CP included but were not limited to: having a [redacted] in place to the [redacted], the residents picture posted at the nursing station and the front receptionist desk for safety. Goals included: The resident will not exit the building and will remain safe in their environment. Review of the Facility's Elopement Risk Assessment (ERA) dated 4/5/2020, revealed Resident #2 was at risk for elopement, which included but were not limited to: A past history of wandering or exiting the home or facility without the needed supervision, verbalizing the desire to leave, [redacted], problems with decision making, and responsible party voicing concerns that would indicate that the resident may try to leave or wander. Interventions included: Identification bracelet, use of a [redacted], photo on elopement list, music, exercise, personalization of room with familiar objects and photos, and diversion activities. Review of the Incident/Accident Report dated 7/1/2020, revealed the following documentation by the nurse: Resident #2 eloped and had a fall on 7/1/2020, at 10:15 p.m., found in "front drive at parking lot entrance, resident absconded from a facility door other than on [redacted] Wing." Description of incident by resident "I want to go home." Under "contributing factors" the following areas were marked by the nurse: [redacted]	F 609	types of occurrences are required to be reported to the Department of Health per CMS/Federal and State regulations, including notification to the Ombudsman. The facility further recognizes that failure to report required occurrences and follow company policy may affect all residents. 3.) The LNHA, Department Heads, Nursing Administration and Licensed Nurses were re-educated on July 9, 2020 by the Vice President of Operations regarding types of occurrences that must be reported, timeliness of reporting, Reportable Events form and facility Accident/Incident and Elopement policies. The Shift Supervisor Report has been amended to include a section for documenting significant occurrences and includes prompts related to LNHA/Nursing Administration notification to facilitate reporting/timeliness of reporting as required. Education regarding this amendment of the Shift Supervisor Report was initiated by the ADON to the Shift Supervisors on July 9, 2020. 4.) LNHA will audit 5 Shift Supervisor Reports weekly for 12 weeks to verify that significant occurrences are being documented and reported timely. Areas of concern will be addressed. Results of these audits will be reviewed at the monthly QAPI meeting for the next 3 months with follow up provided as needed.	

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F 609	Continued From page 4	F 609		

[redacted].
Under "Possible causes of incident:" the nurse documented, "Resident wandered off of unit and out one of the doors."

Further review of the Incident/Accident Report dated 7/1/2020, revealed the following statement documented by the Admin: At approximately 10:00 p.m., the nurse on the unit noted Resident #2 was not in [redacted] room. The resident was seen approximately 15 minutes prior. A search was immediately initiated on the unit. The Nursing Supervisor was informed. During the search Nursing Supervisor #1 received a call from a nurse on another unit reporting that the police were in the driveway. Nursing Supervisor #1 was informed by the police that a passerby saw the resident sitting on the curb in the driveway and notified the police. The resident was assessed for injuries and vital signs were checked, there were no apparent injuries and the vital signs were stable. The resident was transported to the hospital for an evaluation and returned to the facility on [redacted] at 12:45 a.m., no injuries were found. Upon return to the facility the nurse checked the [redacted] alarm bracelet and found it to be operational. Upon further investigation by the Admin, Nursing Supervisor #1 stated, that she unalarmed and unlocked the front door to check the back-entrance door to ensure they were secure, during which time the resident wandered to the front of the building and exited the doors.

During resident interviews on 7/9/2020, unsampled Resident #1 reported to the surveyor that the facility had a fire 2 days prior, the residents were evacuated from their rooms to a different part of the facility, and the Firemen were in the building.

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During an interview on 7/9/2020 at 4:50 p.m., the Administrator (Admin) reported the facility does not have a Policy on Reportable Events, they use the "Reportable Events" form that was provided to them by the State. The Admin stated the elopement was not reported because the resident was "found pretty quickly" and the facility staff "had a lot going on." She also stated the fire on 7/7/2020, was not reported because the residents were not evacuated from the building, they were only moved to a different area in the building because "there was no fire only smoke" and "the whole thing was over in less than one hour." She further stated Police and the Fire Company responded to the facility.

Review of the Police Report dated 7/1/2020 at 9:55 p.m., indicated the Police were dispatched to the Facility to conduct a well-being check on a person observed seated on the curb in front of the location. Upon observing an ankle monitor on the person, the officer was led to believe the person had eloped from the nursing facility. The officer contacted the nursing supervisor who confirmed that the person was a resident of the facility and the facility staff was unaware that the resident was not on the unit. The police report also indicated that the staff were unable to identify how long the resident was missing from the facility or when he/she was last accounted for by the staff.

According to the "Reportable Events" form dated December 2019, from the NJDOH provided to the surveyor by the Admin, the form specifies the following: The Department will continue to require facilities to report elopements. For purposes of reporting, and elopement is whenever the facility

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F 609	Continued From page 6 staff is not aware of a resident's whereabouts outside of the building. Examples of reportable events in the nature of physical plant and operational interruptions include, but are not limited to the following: Section #3: Fires, disasters, or accidents that result in injury or death of a patient, residents or employees, or in evacuation of patients or residents from all or part of the facility. According to the Facility's Policy titled "Incident and Accident Policy" implemented on 9/1999, and last reviewed 01/2020, indicated the following under "Policy:" Accidents or incidents occurring in the facility or on facility property are to be reported. An incident is any occurrence not consistent with the normal care of the residents or any happening involving visitors or employees. Under "Procedure" section 10. Notification of the following as determined: a) Ombudsman b) Department of Health.... N.J.A.C. 8:39-9.4	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		7/10/20

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F 656	Continued From page 7 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 137523 Based on interviews, review of the Medical Records (MR), and other pertinent facility documents on 7/9/2020, it was determined that	F 656	1.) The care plan for resident #2 was updated to reflect safety interventions currently in place. Resident #2 was assessed medically and had no injuries. Resident #2's [redacted] was checked for placement and function and all exit doors were checked with no concerns.	

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F 656	Continued From page 8 the Facility staff failed to update a residents Care Plan (CP) to include interventions for safety and monitoring of the resident after an elopement from the facility on [redacted], for 1 of 3 residents (Resident #2) sampled for elopement. The facility also failed to follow their policy titled "Care Plan Policy." This deficient practice was evidenced by the following: 1. According to the Face Sheet (FS), Resident #2 was admitted to the Facility on [redacted], and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] The MDS dated [redacted] also indicated under section E 900 Behavior, that Resident #2 had a behavior of wandering which occurred daily. Review of Resident #2's "Physician Order Form" (POF) dated July 2020, showed the following: [redacted] - check placement every shift, diagnosis: safety, dated 12/29/2018. [redacted] - check function every day 7 a.m. - 3 p.m., shift diagnosis: safety, dated 12/29/2018. Review of the Care Plan (CP) dated 4/9/2020, revealed Resident #2 had [redacted], verbalized wanting to go home, and had a history of pacing on and off the unit. Interventions on the CP included but were not limited to: having a [redacted] alarm bracelet in place to	F 656	Elopement risk assessment and care plan for Resident#2 was updated. Resident number #2 was placed on every 15 minute visual checks. 2.) Care plans for residents deemed to be at risk for wandering behaviors were reviewed by the interdisciplinary team (IDT)on July 10, 2020 to verify appropriate safety interventions are in place. Areas of concern were addressed. All resident's on [redacted] were reevaluated for function and placement. All exit doors checked for proper closure and functioning, no issues noted. Prior to receptionist leaving on a daily basis, the front lobby door is alarmed. If at any time, the front door alarms need to be shut off, one staff member must remain present at the doors until the door alarm is reactivated. 3.) Licensed nurses were educated on the facility care plan policy including updating of care plans and care plan interventions as needed with new, increased or changed wandering behaviors. Education was initiated by the ADON on July 9, 2020. IDT will review care plans of residents assessed to be at risk for wandering every 3 months and also with any new, increased or changed wandering behaviors or occurrences to verify appropriate safety interventions are in place and/or have been initiated. 4.) Social Service Director will audit care plans of 2 residents assessed to be at risk for wandering weekly for 12 weeks and	

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F 656	Continued From page 9 the [redacted], having the residents picture posted at the nursing station and the front receptionist desk for safety. Goals included: The resident will not exit the building and will remain safe in their environment. Review of the Facility's Elopement Risk Assessment (ERA) dated 4/5/2020, revealed Resident #2 was at risk for elopement related to the following: A past history of wandering or exiting the home or facility without the needed supervision, verbalized the desire to leave, cognitive impairment, problems with decision making, and responsible party voicing concerns that would indicate that the resident may try to leave or wander. Interventions included but were not limited to: Identification bracelet in place, use of a [redacted] alarm bracelet, photo on elopement list, music, exercise, personalization of room with familiar objects and photos, and diversion activities. Review of the Incident/Accident Report dated 7/1/2020, revealed the following documentation by the nurse: Resident #2 eloped and had a fall on 7/1/2020, at 10:15 p.m., found in "front drive at parking lot entrance, resident absconded from a facility door other than on [redacted] Wing." Description of incident by resident "I want to go home." Under "contributing factors" the following areas were marked by the nurse: [redacted]. Under "Possible causes of incident:" the nurse documented, Resident wandered off of unit and out one of the doors. During an interview on 7/9/2020 at 1:50 p.m., the Director of Nursing (DON) was asked what safety	F 656	will also audit care plans of residents with new or changed wandering behaviors or occurrences weekly for 12 weeks. Areas of concern will be addressed. Results of these audits will be reviewed at the monthly QAPI meeting for the next 3 months with follow up provided as needed.	

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interventions were put in place after Resident #2 eloped from the Facility on 7/1/2020. The DON stated she spoke to 3 nurses regarding the [redacted] system, she checked the resident to see if a [redacted] was in place, however, she did not check the function of the [redacted] "the nurses did that,... I believe they gave [redacted] a new alarm just in case." and maintenance checked the function of the building alarms, she also stated, she did not know if the CP was updated, "I did not update the CP," or whether Resident #2 was placed on 1:1 observation when he/she returned to the facility on 7/2/2020. "I wasn't here I don't know." There were no documentation or evidence found in the resident MR to indicate that the CP was revised with the above interventions.

Further review of the CP revealed under Problems, dated 7/2/2020 the nurse documented "Reviewed Care Plan" and under "interventions" documented "continue to monitor resident for wandering and redirect as appropriate back to unit."

Review of the facility policy titled "Care Plan Policy" with a revised date of 11/2016, and a reviewed date of 1/2020, revealed the following under Policy: It is the policy of the facility to ensure that all residents will have appropriate care plans developed by the interdisciplinary team to ensure quality care and promote the resident's plan of care. Under "Procedure" section 6. Care plans will be reviewed and updated as needed by each discipline and new issues will be addressed as appropriate.

N.J.A.C. 8:39-11.2(e)1

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 137523 Based on observations, interviews, review of the Medical Records (MR), and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility failed to ensure a resident with [redacted], who was at risk for elopement, and had a known history of wandering and exit seeking behavior, was appropriately monitored and supervised to prevent elopement or exiting the building. The facility also failed to follow their "Elopement Policy" and their "Incident and Accident Policy." The facility also failed to secure the front door for safety to prevent elopement, for 1 of 3 residents (Resident #2) sampled for elopement. On 7/1/2020 at 9:45 p.m., Resident #2 was able to exit the facility unattended when the Nursing Supervisor deactivated the front door alarm, unlocked the front door and Resident #2 then exited the building. When the Supervisor reentered the facility, she failed to reactivate the alarm and lock the door, or have a staff member monitor the exit while the alarm was shut off. On 7/1/2020 at 9:45 p.m., Resident #2 was able to exit the building by the unsecured front door	F 689	1.) Resident #2 was assessed medically and had no injuries. Upon return from the hospital, resident's [redacted] was checked for placement and function and all exit doors checked with no concerns. Elopement risk assessment and care plan updated. All residents on [redacted] were re-evaluated for function and placement. All exit doors checked for proper closure and functioning. No issues noted. Staff education initiated with supervisor and other staff including importance of door being locked and monitored at all times, not leaving door unlocked and unattended at any time, ensuring that if doors are unlocked that they the alarm is activated immediately and review of wanderguard and door alarm policies and protocols. Prior to receptionist leaving on a daily basis, the front lobby door is alarmed by the supervisor and the outside entrance door is locked. If at any time the front door alarms need to be shut off, one staff member must remain present at the doors until the door alarms are reactivated. Resident #2 will remain on 15 minute	7/10/20

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F 689	Continued From page 12 without the knowledge of the staff and was able to wander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the [redacted] resident was outside of the building. The resident was transported to the Emergency Room (ER) via ambulance and evaluated for possible injuries. This deficient practice placed Resident #2 and all other residents with [redacted] who were at risk or who had a known history of wandering and/or elopement in an Immediate Jeopardy (IJ) situation. The IJ was identified on 7/9/2020 at 5:01 p.m., when the Facility's Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ and were provided the IJ template. The IJ ran from 7/1/2020 through 7/9/2020 at 6:09 p.m., and was lifted when the facility provided an acceptable Removal Plan. This deficient practice was further evidenced by the following: 1. According to the Face Sheet (FS), Resident #2 was admitted to the Facility on [redacted], and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] This MDS also indicated under section E900 Behavior, that Resident #2 had a behavior of wandering which occurred daily.	F 689	visual checks. 2.) All residents may be effected by the concerns identified. An audit of current residents assessed to be at risk for wandering/elopement behaviors was completed on July 9, 2020 by the ADON to verify appropriate safety interventions were in place. Areas of concern were addressed. Residents currently utilizing [redacted] devices were checked to verify placement and proper functioning of the [redacted]. All exit doors were checked for proper closure and functioning. Elopement risk assessment and care plan were updated for residents assessed to be at risk for wandering and elopement behaviors. An audit was completed on July 9, 2020 by the ADON to verify that [redacted] devices are regularly checked for placement and function at specified intervals and documentation of these interval checks is present. Areas of concern were addressed. Nursing Supervisor #1 was terminated from facility employment on July 14, 2020. Nursing Supervisor #2 is an RN who is being trained to be a Supervisor. The date of the occurrence was her first day of supervisor training and thus she was not yet aware of supervisory responsibility of facility security procedures. On July 10, 2020, the Administrator completed education to all Supervisors regarding verifying the exit doors alarms are on and functioning and if at any time the front door alarm needs to be shut off, a staff member must remain at the door until the door alarm is	

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F 689	Continued From page 13 Review of the Care Plan (CP) dated 4/9/2020, revealed Resident #2 had [redacted], verbalizes wanting to go home, and had a history of pacing on and off the unit. Interventions on the CP included but were not limited to: a [redacted] alarm bracelet in place to the [redacted], and the resident's picture was posted at the nursing station and the front receptionist desk for safety. Goals included: The resident will not exit the building and will remain safe in their environment. Review of Resident #2's "Physician Order Form" (POF) dated July 2020, showed the following: [redacted] - check placement every shift, diagnosis: safety, dated 12/29/2018. [redacted] - check function every day 7 a.m. - 3 p.m. shift, diagnosis: safety, dated 12/29/2018. Review of the Facility's Elopement Risk Assessment (ERA) dated 4/5/2020, revealed Resident #2 was at [redacted]. Interventions included but were not limited to: [redacted], a photo on the elopement list, music, exercise, personalization of room with familiar objects and photos, and diversion activities. Review of the [redacted] Consultation for Resident #2 dated [redacted], indicated the Nurse	F 689	reactivated. 3.) Nursing staff, administration, Department Heads, and receptionists were re-educated by the ADON regarding facility elopement policy and what to do if an elopement occurs. This re-education was completed on July 10, 2020. Nursing staff were re-educated regarding facility Accident/Incident and Elopement policies and prompt interventions for residents with new, increased or changed wandering behaviors. Topics discussed include importance of visual observations, providing safe and secure environment and verifying safety interventions are in place, initiated and maintained. Nursing Supervisors were re-educated regarding securing of the facility exits to prevent elopements. This education was completed by the ADON on July 10, 2020. Shift supervisor report has been amended to include security check documentation with education regarding this change and overall security check s completed by the ADON on July 10, 2020. In-services were provided to shift supervisors, receptionists and front line staff regarding the front lobby door being locked when staff not present to visually monitor doors, by the ADON on July 10, 2020. 4.)ADON will audit 2 elopement assessments monthly for 3 months for residents assessed to be at risk for wandering behaviors and with new, increased or changed wandering behaviors to verify that appropriate safety	

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F 689	Continued From page 14 Practitioner documented the following: Under "Chief Complaint/Interval History," Facility requested a follow-up on resident due to [redacted] The recommendations included; decreasing the residents [redacted] for 3 days then discontinuing the medication and starting [redacted] 2 times a day. Review of the Incident/Accident Report dated 7/1/2020, revealed the following documentation by the nurse: Resident #2 eloped and had a fall on 7/1/2020, at 10:15 p.m., found in "front drive at parking lot entrance, resident absconded from a facility door other than on [redacted] Wing." Description of incident by resident: "I want to go home." Under "contributing factors," the following areas were marked by the nurse: [redacted]. Under "Possible causes of incident:" the nurse documented, Resident wandered off of the unit and out one of the doors. Further review of the Incident/Accident Report dated 7/1/2020, revealed the following statement documented by the Admin: At approximately 10:00 p.m., the nurse on the unit noted Resident #2 was not in [redacted] room. The resident was seen approximately 15 minutes prior. A search was immediately initiated on the unit. The Nursing Supervisor was informed. During the search Nursing Supervisor #1 received a call from a nurse on another unit reporting that the police were in the driveway. Nursing Supervisor #1 was informed by the police that a passerby saw the resident sitting on the curb in the driveway and notified the police. The resident was assessed for	F 689	interventions have been implemented and are in place and are reflected on the resident's care plan. ADON will randomly audit 2 residents utilizing [redacted] devices weekly for 12 weeks to verify device placement and function are being checked and documented. ADON will audit 3 shift supervisor reports weekly for 12 weeks to verify security checks are being completed/documented. Areas of concern will be addressed. Results of these audits will be reviewed at the monthly QAPI meeting for the next 3 months and follow up as needed.	

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injuries and vital signs were checked, there were no apparent injuries and the vital signs were stable. The resident was transported to the hospital for an evaluation and returned to the facility on [redacted] at 12:45 a.m., no injuries were found. Upon return to the facility the nurse checked the [redacted] alarm bracelet and found it to be operational. Upon further investigation by the Admin, Nursing Supervisor #1 stated, that she unalarmed and unlocked the front door to check the back-entrance door to ensure they were secure, during which time the resident wandered to the front of the building and exited the doors.

The Admin concluded the following on the Incident/Accident Report: The resident wandered to the front of the building and exited the front door while it was not alarmed and unlocked. Resident's [redacted] alarm bracelet was on and under the resident's sock and clothing, possibly caused the [redacted] alarm to not trigger.

Review of the Facility's Progress note for Resident #2 dated [redacted], with a "Note time" of 1:59 a.m., Nursing Supervisor #1 reported, she received a call from another staff member at 9:45 p.m., reporting the police responded to a passerby who observed a resident sitting on the ground in the driveway of the facility and an ambulance had been called. The resident was "in usual alert and confused state of mind sitting on ground." Vital signs were assessed and within normal limits. The resident was sent to the Emergency Room (ER) for an evaluation. The facility nurse received a call from the ER nurse who reported the resident will be returning to the facility. "No apparent injuries noted."

During an interview on 7/9/2020 at 10:53 a.m.,

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the Admin reported Resident #2 eloped from the Facility on [redacted], through the front door. The staff were notified by the police that the resident was outside. "Between 10:00 p.m. and 10:15 p.m., someone called the police when they saw the resident sitting in the driveway." The Admin further reported that routinely the front door is locked at 6:30 p.m. by the nursing supervisor when the receptionist leaves for the night. On [redacted] around 10:00 p.m., Nursing Supervisor #1 unlocked and deactivated the alarm to the front door then went outside to check that the back door had been locked. If she went out the back door she would have been locked out of the building. "The resident must have exited out the front door after the Supervisor." Nursing Supervisor #1 then came back in and reactivated the alarm not realizing Resident #2 was outside. The resident was wearing a [redacted] alarm bracelet on the [redacted] and the [redacted] alarm sensor is located at the front door, the alarm should have sounded when he/she exited, however, the alarm did not sound. The Admin stated the resident had pants and socks on which could have prevented the alarm from triggering when the resident opened the door.

During an interview on 7/9/2020 at 11:14 a.m., the Certified Nursing Assistant (CNA) reported Resident #2 was on her assignment on [redacted], and she provided evening care to the resident between 9:10 and 9:30 p.m., and then assisted him/her to bed. She stated the residents [redacted] alarm bracelet was on the [redacted] and the placement and function of the [redacted] is checked by the nurse. The CNA reported that Resident #2 had a history wandering since the resident was admitted and that is why he/she had a [redacted] alarm bracelet in place. In addition, the CNA stated that

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on [redacted], Resident #2 was asking for his/her spouse and reported missing them, but never verbalized leaving the facility, however, the resident had a history of pushing on the back exit door causing the alarm to sound, and this happened on several occasions. The CNA further stated that on [redacted], when Resident #2 eloped from the facility she never heard any alarm sound.

During an interview on 7/9/2020 at 11:37 a.m., the DON reported, that the Elopement Risk Assessments (ERA) for [redacted] are only done if the resident's are at risk for elopement. The staff looks at their behaviors, like wandering, saying they want to go home or leave, and the history the family gives us. The DON also reported, the nursing staff is responsible for checking the [redacted] alarm bracelets for function and placement every shift so that if the resident gets near the front door the [redacted] alarm will sound. The [redacted] alarm and the front door alarm are 2 separate alarms. The front door alarm sounds when someone attempts to leave and pushes open the front door.

During an interview on 7/9/2020 at 11:56 a.m., Nursing Supervisor #1 reported, her responsibility is to lock the front door when the front desk receptionist leaves for the evening, which is usually around 6:30 or 7:00 p.m. "When she leaves, I lock both doors with a key." Nursing Supervisor #1 then reported that on 7/1/2020 around 9:30 or 10:00 p.m. she went out the front door with Nursing Supervisor #2 to show her the employee entrance door, which is located on the side of the building. It is the nursing supervisors job to check the door is locked or secured. Nursing Supervisor #1 stated she unlocked the

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front door and deactivated the door alarm, then walked around the building with Nursing Supervisor #2. Nursing Supervisor#1 stated "I had the keys with me so people could get out when that door is locked but no one could get in." The employee door is locked, from 6:30 or 7:00 p.m. until 5:30 or 6:00 a.m., this prevents employee's from coming in that door, they need to come in the front door to get screened for Covid and temperatures taken before starting their shifts.

In addition, the Nursing Supervisor #1 reported that they did not come back in the building through the front door, but entered the building by the employee entrance and as they were heading back to lock the front door she received a call from a nurse who reported the Police were outside with a resident. Nursing Supervisor #1 stated "a passerby called the Police to say a resident was in the driveway outside. I guess he/she followed me outside. I never saw him/her exit the building.... It was my mistake that I left the door unlocked. I deactivated the alarm.... I thought the second door would alarm but it didn't. The doors don't lock just an alarm goes off." Nursing Supervisor #1 further stated, the first time she knew the resident was missing was when the Police were outside. "It was within seconds. He/she must have followed us and exited the building right after us because it was within seconds the Police were here."

During an interview on 7/9/2020 at 12:34 p.m., the Maintenance Director (MD) reported, he was never called in to check the door alarm or [redacted] alarm after the elopement of the resident on [redacted], however, he routinely checks the alarms each morning. He also

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reported, that the [redacted] alarm and the front door alarm are 2 different alarms. The [redacted] alarm will sound when the resident gets within a few feet of the alarm. The front door alarm will sound when someone opens the inside door to exit the building. The outer door is locked so no one can enter the building, however, if the door alarm is deactivated residents or staff can exit the building without the alarm sounding. Once the front door alarm sounds, a key is needed to reset the alarm. If the [redacted] alarm sounds a code is needed to reset the alarm.

During an alarm test observation on 7/9/2020 at 12:50 p.m., the MD activated the front door alarm using the key. When the MD attempted to exit the inner front door the alarm sounded. The MD reported the alarm should be heard throughout the facility.

On 7/9/2020 at 12:59 p.m., Resident #2's [redacted] alarm bracelet was tested with the Admin and MD present. The resident was observed with a [redacted] alarm bracelet to the [redacted]. The [redacted] check was done 2 times. When the resident attempted to exit the inner front doors the [redacted] alarm sounded both times.

On 7/9/2020 at 2:50 p.m., the Security Video footage for [redacted], was reviewed with the Admin and revealed the following timeline:

6:49 p.m. the receptionist exits the building and Nursing Supervisor #1 locked the outer door then alarms the inner doors.
6:53 p.m. Nursing Supervisor #1 unlocked the door to let a resident back in the building then locked the doors and alarmed the front doors.
7:24 p.m. Nursing Supervisor #1 goes outside

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and looks around, comes back in and locked the doors and alarmed the front door.
7:26 p.m. Nursing Supervisor #1 puts 2 chairs near the front door.
7:30 p.m. to 8:30 p.m. No activity at the front entrance.
8:47 p.m. Nursing Supervisor #1 and #2 are observed at the front entrance. Nursing Supervisor #1 reaches up to the inner right door then the inner left door, deactivated the alarms, moved the chairs, and then they go outside.
8:58 p.m., The two Supervisors returned to the front lobby through the Service Corridor/employee entrance. They are not observed near the front doors either relocking or reactivating the alarms.
9:44 p.m. Resident #2 enters the front lobby alone, then exits through the left side of the inner front door, then out the outer door.
10:02 p.m. Strobe lights observed outside. (Police on scene)
10:07 p.m. A CNA and another staff member exit through the front door.
10:10 p.m. Nurse (RN #1) observed exiting through the front door without stopping to shut off or reset any alarms.
10:11 p.m. RN #1 reenters the building then exits with a wheelchair.
10:13 p.m. Supervisor #1 and Supervisor #2 exit building through front doors.

During an interview on 7/9/2020 at 5:07 p.m., RN #1 reported; that the Police called to report a resident had eloped from the facility. RN #1 then called Nursing Supervisor #1 to inform the Supervisor the police were on site. RN #1 further stated he observed Resident #2 sitting on the curb in the driveway. He assessed the resident for injuries, no apparent injuries were noted, then he went inside to get a wheelchair for the

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resident. Shortly after the Emergency Medical Technicians (EMTs) arrived, they assessed the resident and checked the vital signs. Nursing Supervisor #1 and Nursing Supervisor #2 then came outside so RN #1 reported he went back to his unit. RN #1 stated he did not reset any alarms before exiting the building to assess Resident #2 because they were not sounding.

Review of the Police Report dated [redacted] at 9:55 p.m., indicated the Police were dispatched to the Facility to conduct a well-being check on a person observed seated on the curb in front of the location. Upon observing an ankle monitor on the person the officer was led to believe the person had eloped from the nursing facility. The officer contacted the nursing supervisor who confirmed that the person was a resident of the facility and the facility was unaware that he/she was not on the unit. The officer reported that the resident was "highly confused" and unable to specifically identify where he/she was or how they got there. The EMTs were requested to the location due to the resident's mental status, a [redacted], and an alleged fall, however, the officer reported no visible injuries were noted. Upon speaking to the facility staff, the officer reported that an employee stated that the resident likely walked out of a normal exit rather that the service area because the alarms to alert the staff were inaudible beyond the front of the building. The staff also reported the resident's mental status was normal for his/her known baseline and that the resident was known to wander away from the unit. The staff was unable to identify how long the resident was missing from the facility or when he/she was last accounted for by the staff. In addition, the resident was evaluated by the EMTs and asked to

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go to the hospital. However, the staff indicated that the resident likely did not need to be hospitalized and attempted to return the resident to the facility and the nursing supervisor stated that she would sign a Refusal of Medical Attention (RMA) on the resident's behalf, however, the staff indicated that the resident's spouse was the POA. Since the POA could not be reached the resident was transported to the hospital.

The Police report further indicated that the officer was able to reach another family member who was listed as an emergency contact. The family member reported that this was not the first occasion in which he/she had successfully eloped from the facility without the knowledge of the staff and was known to wander. The family member also stated that they did not believe that he/she was placed appropriately within a secured unit in the facility given the prior history and that the staff repeatedly failed to ensure the safety by failing to monitor the whereabouts and protect him/her from eloping from the facility.

Review of the facility policy titled "Elopement Policy," with a revised date of 1/2017, and a reviewed date of 1/2020, revealed the following under "Purpose:" To maintain the safety and well-being of all residents within the facility. Under "Procedure:" section 8. Upon locating the resident, the facility will attempt to determine how the resident got out of the facility (if this is the case), and to develop a plan of care to insure the future safety and security of the resident, such as: In-service must take place for all three shifts regarding facility policies on wandering residents and what to do in case of an elopement of a resident. These in-services must include all Department Heads and facility receptionist.

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	315176	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

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F 689	Continued From page 23	F 689		

According to the Facility's Policy titled "Incident and Accident Policy" implemented on 9/1999, and last reviewed 01/2020, indicated the following under "Policy:" Accidents or incidents occurring in the facility or on facility property are to be reported. An incident is any occurrence not consistent with the normal care of the residents or any happening involving visitors or employees. Under "Procedure" section 10. Notification of the following as determined: a) Ombudsman b) Department of Health....

Resident #2 was able to exit the building by the unsecured front door without the knowledge of the staff and was able to wander down the driveway and was observed by a motorist near a main road with a speed limit of 45 mph (miles per hour). The police were alerted and notified the facility that the [redacted] resident was outside of the building. The resident was transported to the Emergency Room (ER) via ambulance and evaluated for possible injuries. This deficient practice placed Resident #2 and all other residents with cognitive impairment who were at risk or who had a known history of wandering and/or elopement in an Immediate Jeopardy (IJ) situation.

The IJ was identified on 7/9/2020 at 5:01 p.m., when the Facility's Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ and were provided the IJ template. The IJ ran from 7/1/2020 through 7/9/2020 at 6:09 p.m., and was lifted when the facility provided an acceptable Removal Plan.

A revisit to verify the Removal Plan occurred on

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F 689	Continued From page 24 7/16/2020.	F 689		
F 835 SS=E	N.J.A.C. 8:39-4.1(a)11 Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 137523 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 7/9/2020, it was determined that the facility's administration failed to ensure that the facility's policies on reporting events were implemented for 2 incidents, by failing to report an elopement, and failing to report an internal evacuation of residents for a fire. This deficient practice was evidenced by the following: 1. According to the Face Sheet (FS) Resident #2 was admitted to the Facility on [redacted], and readmitted on [redacted] with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2	F 835	1.) The facility is unable to retroactively address the concerns related to the late reporting regarding resident #2. Resident #2 was assessed medically and had no injuries. Resident #2's [redacted] was checked for placement and function and all exit doors were checked with no concern. Elopement risk assessment and care plan updated for resident #2. Resident #2 was placed on every 15 minute visual checks. The facility is unable to retroactively address concerns related to reporting regarding the temporary internal relocation of residents during a minor smoke event. Event reports were submitted for both of these occurrences on July 15, 2020. 2.) The facility recognizes that certain type of occurrences are required to be reported	7/10/20

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F 835	Continued From page 25 had a Brief Interview for Mental Status (BIMS) score of [redacted] This MDS dated [redacted], also indicated under section E900 Behavior, that Resident #2 had a behavior of wandering which occurred daily. Review of the Care Plan (CP) dated 4/9/2020, revealed Resident #2 had [redacted] verbalizes that wanting to go home, and had a history of pacing on and off the unit Review of the Police Report dated [redacted] at 9:55 p.m., indicated the Officer was dispatched to the Facility to conduct a well-being check on a person observed seated on the curb in front of the location. Upon observing an ankle monitor on the person the officer was led to believe the person had eloped from the nursing facility. The officer contacted the nursing supervisor who confirmed that the person was a resident of the facility and the facility was unaware that the resident was not on the unit. During resident interviews on 7/9/2020, unsampled Resident #1 reported to the surveyor that the facility had a fire 2 days prior, the residents were evacuated from their rooms to a different part of the facility, and the Firemen were in the building. During an interview on 7/9/2020 at 4:50 p.m., the Administrator (Admin) reported the facility does not have a Policy on Reportable Events, they use the "Reportable Events" form that was provided to them by the State. The Admin stated the elopement was not reported because the resident was "found pretty quickly" and the facility staff "had a lot going on." She also stated the fire on	F 835	to the Department of Health per CMS/Federal and State regulations, including notification to the Ombudsman as required. The facility further recognizes that the not reporting timely of required occurrences and not following facility policy may affect all residents. 3.) Facility administration was re-educated by the Vice President of Operations on July 9, 2020 regarding types of occurrences that must be reported, timeliness of reporting, Reportable Events form and facility policies related to Accidents/Incidents and Elopement. The Vice President of Operations will be notified regarding occurrences that are required to be reported to the Department of Health and Ombudsman. Shift Supervisor Reports have also been amended to include security check documentation with education regarding this change and overall security checks completed by the ADON on July 9, 2020. 4.) The Vice President of Operations will audit 3 Shift Supervisor Reports weekly for 12 weeks to verify documentation regarding potential reportable events has occurred and the required events are reported to the Department of Health and to the Ombudsman as required timely. Areas of concern will be addressed. The results of these audits will be reviewed at the monthly QAPI meeting for the next 3 months will follow up as needed.	

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F 835	Continued From page 26	F 835		

7/7/2020 was not reported because the residents were not evacuated from the building they were only moved to a different area in the building "there was no fire only smoke" and "the whole thing was over in less than one hour."

According to the "Reportable Events" form dated December 2019, from the New Jersey Department of Health (NJDOH) which was provided to the surveyor by the Admin, the form specifies the following: The Department will continue to require facilities to report elopements. For purposes of reporting, and elopement is whenever the facility staff is not aware of a resident's whereabouts outside of the building. Examples of reportable events in the nature of physical plant and operational interruptions include, but are not limited to the following: Section #3: Fires, disasters, or accidents that result in injury or death of a patient, residents or employees, or in evacuation of patients or residents from all or part of the facility.

Review of the facility policy titled "Elopement Policy" with a revised date of 1/2017, and a reviewed date of 1/2020, revealed the following under "Purpose" To maintain the safety and well-being of all residents within the facility. Under "Procedure" section 8. Upon locating the resident, the facility will attempt to determine how the resident got out of the facility (if this is the case) and to develop a plan of care to insure the future safety and security of the resident, such as: In-service must take place for all three shifts regarding facility policies on wandering residents and what to do in case of an elopement of a resident. These in-services must include all Department Heads and the facility receptionist.

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F 835	Continued From page 27 According to the Facility's Policy titled "Incident and Accident" implemented on 9/1999, and last reviewed 01/2020, indicated the following under "Policy:" Accidents or incidents occurring in the facility or on facility property are to be reported. An incident is any occurrence not consistent with the normal care of the residents or any happening involving visitors or employees. Under "Procedure" section 10. Notification of the following as determined: a) Ombudsman b) Department of Health.... N.J.A.C. 8:39-9.3(a)2	F 835		