TATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION	(X3) DATE COMP		
		60a005	B. WING			C 07/09/2019	
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
PRING H	ILLS AT MORRISTOWN		NG PLACE STOWN, NJ 07960				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
A 000	Initial Comments		A 000				
	Initial Comments: TYPE OF SURVEY:	COMPLAINT					
	COMPLAINT #: NJ0	0122972, NJ00125734					
	CENSUS: 100						
	SAMPLE SIZE: 4						
	all of the standards in Administrative Code Licensure of Assisted Comprehensive Pers Assisted Living Progr submit a plan of corre completion date for e that the plan is implet deficiencies may resu	8:36, Standards for d Living Residences, sonal Care Homes and rams. The facility must ection, including a sach deficiency and ensure mented. Failure to correct ult in enforcement action in <i>v</i> isions of New Jersey Title 8, Chapter 43E,					
A 310	1. Ensuring the c	or designee shall be ot limited to, the following:	A 310				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

New Jers	ey Department of Hea	lth			FOr	RM APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		60a005	B. WING		07	C 7/ <b>09/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SPRING H	ILLS AT MORRISTOWN	17 SPR	ING PLACE			
		MORRIS	STOWN, NJ 07960			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
A 310	Continued From page	e 1	A 310			
	by: Complaint #NJ00122 Based on interview a determined that the fa (ED) failed to develop the safety and securit application, monitorin wanderguards (wand are placed on a resid resident attempts to h area of the facility), fo #1, Resident #2 and h practice was evidence On 7/9/19 at 12:30 p. (DON) provided the s	nd record review it was acility Executive Director o policies and procedures for ty of residents,including the g and removal of erguards are devices that ent to alert staff when a eave a safe or designated or 3 of 4 residents, Resident Resident #4. This deficient ed by the following: m. the Director of Nursing surveyor with a list of				
	After the surveyor rev surveyor conducted r follows:	t high risk for elopement. viewed the document the nedical record reviews as				
	#1's medical record a resident was admitted with a diagnosis of de reviewed a facility do Scale" (WRS) for the 2/22/18, 8/15/18 and documented that Res	d to the facility on 6/26/17 epression. The surveyor cument titled, "Wander Risk following dates 6/26/17, 2/11/19 and observed sident #1 was assessed to				
	that the resident had dementia.	der. The WRS revealed a medical diagnosis of				
	-	/18 revealed that the ger wearing a wanderguard." medical record revealed that				

STATEMENT	sey Department of Hea T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
	CI CONNECTION	DENTRICATION NOMBER.	A. BUILDING:				
		60a005	B. WING		07	C 07/09/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
SPRING H	ILLS AT MORRISTOWN	17 SPRI	NG PLACE				
		MORRIS	TOWN, NJ 07960				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
A 310	Continued From page	e 2	A 310				
	resident had a diagno Additionally, the med	ented evidence that the osis of dementia. ical record did not reveal any ation or removal of the					
	2. On 7/9/19 at 1:15 p.m., the surveyor reviewed Resident #2's medical record and observed that the resident was admitted to the facility on 3/3/17 with a diagnosis of dementia. According to the WRS dated 3/3/17, Resident #2 was assessed to be at high risk to wander. The WRS's dated 9/2/17, 3/1/18, 8/21/18 and 2/20/19 documented that the resident was at risk to wander. There was no documented evidence that a wanderguard was applied or removed from Resident #2.						
	Resident #4's medica the resident was adm 6/30/17 with a diagno According to surveyo 7/14/17 and 7/13/18, diagnosis of dementia wandering. However review of the medical have a diagnosis of d contained within the r resident had a history	psis that included dementia. r review of the WRS dated Resident #4 did not have a a and was not at risk for r, according to surveyor I record, Resident #4 did lementia and documentation record revealed that this					
	Behavioral Health Vis record, Resident #4 e 4/3/19, and had a wa "Progress Notes" (PI that the resident cut o 4/14/19 the PN revea	r review of the "Mental and sit Note" in the medical eloped from the facility on nderguard applied. The N) dated 4/10/19 revealed off the wanderguard. On aled that the resident again guard and on 5/6/19 the PN					

STATEMEN	EXAMPLE A CONTRACT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			PLETED
		60a005	B. WING		C 07/09/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SPRING H	IILLS AT MORRISTOWN	-	NG PLACE STOWN, NJ 07960			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
A 310	revealed that the resi handbag. On 6/8/19 resident was last obs breakfast. Resident # the local police and w The PN also docume facility reapplied the w the resident again rer On 7/9/19 at 3:56 p.m the Executive Directo regarding the facility's the use and monitorin who wore wandergua was not able to provid the use of these devid she uses her nursing	dent placed it in his/her the PN revealed that the erved in the building at #4 was located at 1 p.m. by vas returned to the building. nted that on 6/8/19 the wanderguard and by 5 p.m. moved the wanderguard. n., the surveyor interviewed or (ED) and the DON is policies and procedures for ng of the safety of residents ards. The ED stated that she de a policy or procedure for ces. The DON stated that judgement on when to apply e to explain what the criteria	A 310			
A 357	distribute a statement residents of assisted comprehensive perso assisted living progra to the following rights	ng provider will post and t of resident rights for all living residences, onal care homes, and ms. Each resident is entitled : ceive a level of care and ues the	A 357			
	This REQUIREMENT	is not met as evidenced				

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
	ST CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:			
		60a005	B. WING		07	C / <b>/09/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
SPRING H	ILLS AT MORRISTOWN		NG PLACE STOWN, NJ 07960			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
A 357	Continued From page	9 4	A 357			
	by: Complaint #NJ00122	972, NJ00125734				
	Based on interview a	nd review of records it was				
	determined that the facility failed to consistently					
	supervise and or monitor a resident based upon their assessed needs for 1 of 4 residents					
	reviewed, Resident #4. This deficient practice					
	was evidenced by the	•				
	On 7/9/19 at 11:06 a.	m., the surveyor interviewed				
		enance (DOM) who stated				
		uipped with magnetic locks				
		ears, (hardware that prevents ened usually for 15 seconds				
	÷ .	alarm that the door has				
	•	OOM stated that only 2 doors				
		ne wanderguard receivers.				
		a resident eloped from the				
	a wanderguard receiv	r that was not equipped with /er.				
	On 7/9/19 at 1:30 p.n	n., the surveyor reviewed				
		I record and observed that				
	the resident was adm	itted to the facility on isis of dementia. According				
		ehavioral Health Visit Note,"				
		om the facility on 4/3/19.				
	-	wed the Executive Director				
		opement who stated that the				
		n sounded and that the d to the alarm but did not				
		rking lot. The ED further				
	stated that the reside	•				
	-	as located directly outside				
		ent. According to continued				
		ed that the facility staff did t was missing until the				
	resident did not appe	. พลง การงกาย นกแก่ เกษ				1

STATEMEN	sey Department of Hea FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:		с	
		60a005	B. WING		07	/09/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SPRING H	IILLS AT MORRISTOWN		NG PLACE STOWN, NJ 07960			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
A 357	Continued From page	e 5	A 357			
	at approximately 9:30	) a.m.				
	Resident #4 was four police department at The ED stated that the location after leaving resident's return to the was applied to the re- placed on hourly safe	ed in the medical record that nd by police and was at the 6 p.m. in New York State. he resident took a bus to this the building. Upon the he facility, a wanderguard sident and he/she was ety checks.				
	6/8/19. Continued in that on 6/8/19 the res breakfast and was loo police department ap building. The ED furt	a second elopement on terview with the ED revealed sident was last seen at cated at 1 p.m. by the local proximately 1 mile from the ther stated that on 6/8/19 the ing through the front door I the wanderguard.				
	dated 4/10/19 revealed the wanderguard and building at 6:40 a.m. documented that the wanderguard and up 6/8/19, the wandergu however, by 5 p.m. the the device. The PN a	resident again removed the bon return to the building on uard was reapplied, ne resident again removed also documented that the on 1:1 observation arranged				
	6/12/19 revealed that to wander. The resid assessment revealed elopement risk with ir	cale" (WRS) completed on t the resident was a high risk lent's Service Plan and I that the resident was an hterventions to provide the lerguard and place the ecks.				

STATEMENT	ey Department of Heal OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		60a005	B. WING	B. WING		C 7/ <b>09/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
SPRING H	IILLS AT MORRISTOWN		NG PLACE STOWN, NJ 07960			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
A 357	Continued From page	96	A 357			
	the ED and the DON. family was not able to monitoring for more th the facility provided h resident.					
	assessed to be a high history elopement and wanderguard. There evidence that addition was added after the s	nt #4 as the resident was n elopement risk, had a d a history of cutting off the were no documented nal supervision or monitoring				
A 447	8:36-5.1(a) General F	Requirements	A 447			
	personal care home of shall provide and/or of services to residents, qualified persons, in a Jersey Nurse Practice N.J.A.C. 13:37, this of needs of each residen	g residence, comprehensive or assisted living program coordinate personal care and based on assessment by accordance with the New e Act, N.J.S.A. 45:11-23 and hapter, and the individual ht, in a manner which ages assisted living values.				
	This REQUIREMENT by: Complaint #NJ00122	is not met as evidenced 972, NJ00125734				

STATEMENT	ey Department of Hea	ITN (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		60a005	B. WING		07	C 7/09/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		17 SPRI	NG PLACE			
SPRING F	IILLS AT MORRISTOWN	MORRIS	TOWN, NJ 07960			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
A 447	Continued From page	e 7	A 447			
	Based on observation review it was determi consistently ensure a maintain the security assure resident safet reviewed, Resident # facility on 4/3/19 and practice was evidence On 7/9/19 at 11:00 a. facility, the surveyor of doors in the facility w wanderguard receive located at the front er the other receiver wa fully enclosed secure the 4 doors exited inter parking lot. On 7/9/19 at 11:06 a. the Director of Mainter that all doors were ex- and delayed egress to a door from being oper and once opened an been opened). Only equipped with the was 0n 7/9/19 at 1:30 p.m Resident #4's medicat that the resident was 6/30/17 with a diagno dementia. The surve Notes" (PN) section of	n, interview and record ned that the facility failed to respectively for 1 of 4 residents 4, who eloped from the 6/8/19. This deficient ed by the following: m., during a tour of the observed that 2 of 6 exit ere equipped with rs. One receiver was ntrance to the building and s located at the exit, to a patio area. The balance of o different locations in the m., the surveyor interviewed enance (DOM), who stated quipped with magnetic locks bars, (hardware that prevents ened usually for 15 seconds alarm that the door has 2 doors in the facility were inderguard receivers. n., the surveyor reviewed al record which documented admitted to the facility on basis which included eyor reviewed the "Progress of the medical record and				
	on 4/3/19. The surveyor then int Director (ED) regardin	ent #4 eloped from the facility terviewed the Executive ng the elopement and the resident exited the				

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		60a005	B. WING		07	C 7/09/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
SPRING H	ILLS AT MORRISTOWN		NG PLACE TOWN, NJ 07960			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI
A 447	Continued From page	e 8	A 447			
	building through a do	or that was located directly				
		butside his/her apartment. The ED stated that				
		larm sounded and the facility				
		e alarm, however, the staff				
	did not see anyone ir	the parking lot. The ED				
	also stated that the facility staff did not know that					
		sing until the resident did not				
	· · · ·	nedications at approximately				
	9:30 a.m.					
	The resident was loc	ated by the police				
		in New York State. The ED				
	stated that the reside	nt took a bus to the location				
		after he/she left the building. Upon the resident's				
	-	a wanderguard was applied				
		e resident was placed on				
	hourly safety checks.					
		e General Service Plan				
		dated 4/11/19 revealed that the resident				
	•	ently and was assessed to . A wanderguard was				
	-	nt and the staff were to check				
	· · · · ·	ently. According to a PN				
	dated 4/10/19, Resid	, ,				
		so documented on 4/14/19,				
		/19 5/26/19 that the resident				
	refused to wear the w	vanderguard.				
	On 6/8/19 the PN do	cumented that the resident				
		the building at breakfast and				
		the resident was unable to				
		ocumented that Resident #4				
	was located by the lo					
		from the building. The PN				
		hat on 6/8/19 the facility				
		guard, however, by 5 p.m. oved it. On 6/9/19 and				
		was that the resident				
	refused to wear the w					

STATEMENT	ey Department of Heal OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO				
	ST CONTRECTION	IDENTIFICATION NONDER.	A. BUILDING:				
		60a005	B. WING		07	C 07/09/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
SPRING H	ILLS AT MORRISTOWN		NG PLACE STOWN, NJ 07960				
	SUMMARY ST			PROVIDER'S PLAN O	E CORRECTION	(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE	
A 447	Continued From page	9	A 447				
	dementia environmer	7/4/19 with a plan to tt to a facility with a secure nt.					
	the security of exit do at high risk for elopen	evelop a system to maintain ors for a resident who was nent, had a history of consistently removed the					
A1073	8:36-15.6(b) Residen	t Records	A1073				
	care and service prov according to the stand	ion and/or notes from all ce providers shall be the standards of					
	This REQUIREMENT by: Complaint #NJ00122	is not met as evidenced 972, NJ00125734					
	determined that the fa document in the medi treatment and coordin with the standards of of 4 residents reviewed	nd record review it was acility failed to accurately ical record the condition, nation of care in accordance professional practice for 1 ed, Resident #4. This s evidenced by the following:					
	On 7/9/19 at 1:30 p.m	the surveyor reviewed					

Tool       REGULATORY OR LSC IDENTIFYING INFORMATION)       Tool       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       DATE         A1073       Continued From page 10       A1073       A1073       Essident #4's medical record and observed that the resident was admitted to the facility on 6/30/17 with a diagnosis of dementia. The surveyor then reviewed the facilitys, "Wandering Risk Scale" (WRS) dated 7/14/17 and 7/13/18       A1073         According to surveyor review of the resident did not have a diagnosis of dementia and was not at risk for wandering.       According to surveyor review of the resident's medical record, the surveyor observed hospital discharge note dated 6/9/17 which documented that the resident was brought to the emergency room by the local police department after hes/he, "tried to check in at an assisted living facility without any prior arrangement." The hospital records also revealed that the resident diagnosed the resident to k a bus to Wisconsin to find somewhere to live. The hospital records ruther disclosed that during the course of the hospital stay, the Physician diagnosed the resident the resident lacked "insight into the potential dangers and consequences of leaving the hospital without assistance or support."       Resident #4's medical record also contained a letter dated 8/14/17 from the resident's son which documented that the resident was diagnosed earlier that year with dementia and had a history of "running away" from wherever they get settled. The letter continued that "The the past yearhas left four places where family/friends have attempted to locate" Three was also a note from a Clinical Neuropsychologit dated 3/1/19	STATEMENT	ey Department of Hea OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
E04005         B. WNG				A. BUILDING.			С	
SPRINCH LIS AT MORRISTOW         DEPRINCE PROVIDERS PLAN OF CORRECTION, NU OPERATION, NU OPERATION, NU PREVIDENCE DE PROVIDERS PLAN OF CORRECTION SHOULD BE COURS OF HIS SHOULD TO BE CHARTED SHOULD THE RESIDENT THE SHOULD S			60a005	B. WING		07		
BARING HILLS AT MORRISTOWN         MORRISTOWN, NJ 07960           (P4) ID PRETX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCED BY FULL (EACH DEFICIENCY MUST BE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BE (EACH DEFICIENCY MUST BE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         000 (EACH DEFICIENCY)           A1073         Continued From page 10         A1073           Resident #4's medical record and observed that the resident was admitted to the facility on 6/30/17 with a diagnosis of dementia. The surveyor then reviewed the facility on 6/30/17 with a diagnosis of dementia. The surveyor observed hospital which documented that the resident did not have a diagnosis of dementia and was not at risk for wandering.         A1073           According to surveyor review of the resident's medical record, the surveyor observed hospital discharge note dated 6/9/17 which documented that the resident was brought to the emergency room by the local police department after he/site, "tited to check in at an assisted living facility without any prior arrangement." The hospital records also revealed that the resident took a bus to Wisconsin to find somewhere to live. The hospital records further disclosed that during the course of the hospital stay, the Physician diagnosed the resident with a severe cognitive impairment and documented that the resident lacked "insight into the potential dangers and consequences of leaving the hospital without assistance or support."         Resident #4's medical record also contained a letter dated 8/14/17 from the resident's son which documented that the resident was alongosed earlier that year with dementia and had a history of "running away" from wherever they get settled. The letter continued that "the heasy tearhas left four pla	NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
MAID PREFX TAC         SUMMARY STREMARY OF DEPICIENCIES EXPLOSEDENCE WIST BE REFACTEDED BY TALL DEPICIPATION SHOULD BE REGULATORY OR LSC DENTIFYING INFORMATION)         D PREFX TAC         PROVIDENT CONSECTIVE CATORS SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Open CROSS-REFERENCED TO THE APPROPRIATE DATE	SPRING H	ILLS AT MORRISTOWN						
Resident #4's medical record and observed that the resident was admitted to the facility on 6/30/17 with a diagnosis of dementia. The surveyor then reviewed the facility's, "Wandering Risk Scale" (WRS) dated 7/14/17 and 7/13/18 which documented that the resident di not have a diagnosis of dementia and was not at risk for wandering.         According to surveyor review of the resident's medical record, the surveyor observed hospital discharge note dated 6/9/17 which documented that the resident was brought to the emergency room by the local police department after he/she, "tried to check in at an assisted living facility without any prior arrangement." The hospital records also revealed that the resident took a bus to Wisconsin to find somewhere to live. The hospital records further disclosed that during the course of the hospital stay, the Physician diagnosed the resident was dangers and consequences of leaving the hospital without assistance or support."         Resident #4's medical record also contained a letter dated 8/14/17 from the resident's son which documented that the resident was diagnosed earlier that year with dementia and had a history of "running away" from wherever they get settled. The letter contruct that "In the past yearhas left four places where family/fireds have attempted to locate" There was also a note from a Clinical Neuropsychologist dated 3/1/19	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE	
the resident was admitted to the facility on 6/30/17 with a diagnosis of dementia. The surveyor then reviewed the facilitys, "Wandering Risk Scale" (WRS) dated 7/14/17 and 7/13/18 which documented that the resident did not have a diagnosis of dementia and was not at risk for wandering. According to surveyor review of the resident's medical record, the surveyor observed hospital discharge note dated 6/9/17 which documented that the resident was brought to the emergency room by the local police department after he/she, "Iried to check in at an assisted living facility without any prior arrangement." The hospital records also revealed that the resident took a bus to Wisconsin to find somewhere to live. The hospital records further disclosed that during the course of the hospital stay, the Physician diagnosed the resident with a severe cognitive impairment and documented that the resident lacked "insight into the potential dangers and consequences of leaving the hospital discharge or support." Resident #4's medical record also contained a letter dated 8/14/17 from the resident's son which documented that the resident was diagnosed earlier that year with dementia and had a history of "running away" from wherever they get settled. The letter contined that "the tays a on tote from a Clinical Neuropsychologist dated 3/1/19	A1073	Continued From page	e 10	A1073				
which documented that the consequences of         possible elopement and continued thoughts of         wanting to leave was discussed.         At 3:45 p.m. the surveyor interviewed the Director		Resident #4's medica the resident was adm 6/30/17 with a diagno surveyor then reviews Risk Scale" (WRS) da which documented th a diagnosis of demen wandering. According to surveyor medical record, the st discharge note dated that the resident was room by the local poli "tried to check in at without any prior arra records also revealed to Wisconsin to find s hospital records furth course of the hospital diagnosed the resided impairment and docu lacked "insight into th consequences of leave assistance or support Resident #4's medica letter dated 8/14/17 fr documented that the earlier that year with of "running away" from The letter continued th left four places where attempted to locate from a Clinical Neuro which documented th possible elopement a wanting to leave was	al record and observed that hitted to the facility on osis of dementia. The ed the facility's, "Wandering ated 7/14/17 and 7/13/18 hat the resident did not have tia and was not at risk for r review of the resident's urveyor observed hospital 6/9/17 which documented brought to the emergency ice department after he/she, an assisted living facility ngement." The hospital d that the resident took a bus comewhere to live. The er disclosed that during the I stay, the Physician nt with a severe cognitive mented that the resident e potential dangers and ving the hospital without t." al record also contained a rom the resident's son which resident was diagnosed dementia and had a history m wherever they get settled. that "In the past yearhas e family/friends have " There was also a note psychologist dated 3/1/19 that the consequences of and continued thoughts of discussed.					

STATEMEN	sey Department of Heal T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		60a005	B. WING		C 07/09/2019		
		17 SPRI	ADDRESS, CITY, STATE, ZIP CODE				
		MORRIS	TOWN, NJ 07960				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE	
A1073	of Nursing (DON) who time of the elopement not aware that the res dementia and elopem the DON the hospital resident's son and the Neuropsychological m that she had not seen past. The facility failed to re documentation availa record to accurately a	o stated that up until the t on 4/3/19 the facility was sident had a history of nent. The surveyor showed records, the letter from the e Clinical notes. The DON then stated in those documents in the eview existing ble within the medical assess the condition, ntions for Resident #4, in	A1073				