New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60a005	A. BUILDING: _____ B. WING _____	C 07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: COMPLAINT COMPLAINT #: NJ00122972, NJ00125734 CENSUS: 100 SAMPLE SIZE: 4 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #NJ00122972, NJ00125734 Based on interview and record review it was determined that the facility Executive Director (ED) failed to develop policies and procedures for the safety and security of residents,including the application, monitoring and removal of wanderguards (wanderguards are devices that are placed on a resident to alert staff when a resident attempts to leave a safe or designated area of the facility), for 3 of 4 residents, Resident #1, Resident #2 and Resident #4. This deficient practice was evidenced by the following: On 7/9/19 at 12:30 p.m. the Director of Nursing (DON) provided the surveyor with a list of residents that were at high risk for elopement. After the surveyor reviewed the document the surveyor conducted medical record reviews as follows: 1. At 1:00 p.m., the surveyor reviewed Resident #1's medical record and observed that the resident was admitted to the facility on 6/26/17 with a diagnosis of depression. The surveyor reviewed a facility document titled, "Wander Risk Scale" (WRS) for the following dates 6/26/17, 2/22/18, 8/15/18 and 2/11/19 and observed documented that Resident #1 was assessed to be at high risk to wander. The WRS revealed that the resident had a medical diagnosis of dementia. The WRS dated 8/15/18 revealed that the resident was "no longer wearing a wanderguard." Further review of the medical record revealed that	A 310		

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A 310	Continued From page 2	A 310		

there was no documented evidence that the resident had a diagnosis of dementia. Additionally, the medical record did not reveal any criteria for the application or removal of the wanderguard.

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.

3. On 7/9/19 at 1:30 p.m., the surveyor reviewed Resident #4's medical record and observed that the resident was admitted to the facility on 6/30/17 with a diagnosis that included dementia. According to surveyor review of the WRS dated 7/14/17 and 7/13/18, Resident #4 did not have a diagnosis of dementia and was not at risk for wandering. However, according to surveyor review of the medical record, Resident #4 did have a diagnosis of dementia and documentation contained within the record revealed that this resident had a history of elopements and continued verbalizations of wanting to leave.

According to surveyor review of the "Mental and Behavioral Health Visit Note" in the medical record, Resident #4 eloped from the facility on 4/3/19, and had a wanderguard applied. The "Progress Notes" (PN) dated 4/10/19 revealed that the resident cut off the wanderguard. On 4/14/19 the PN revealed that the resident again removed the wanderguard and on 5/6/19 the PN

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A 310	Continued From page 3 revealed that the resident placed it in his/her handbag. On 6/8/19 the PN revealed that the resident was last observed in the building at breakfast. Resident #4 was located at 1 p.m. by the local police and was returned to the building. The PN also documented that on 6/8/19 the facility reapplied the wanderguard and by 5 p.m. the resident again removed the wanderguard. On 7/9/19 at 3:56 p.m., the surveyor interviewed the Executive Director (ED) and the DON regarding the facility's policies and procedures for the use and monitoring of the safety of residents who wore wanderguards. The ED stated that she was not able to provide a policy or procedure for the use of these devices. The DON stated that she uses her nursing judgement on when to apply them but was not able to explain what the criteria was for the application or removal of the wanderguard.	A 310		
A 357	8:36-4.1(a)(2) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 2. The right to receive a level of care and services that addresses the resident's changing physical and psychosocial status; This REQUIREMENT is not met as evidenced	A 357		

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A 357	Continued From page 4 by: Complaint #NJ00122972, NJ00125734 Based on interview and 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 following: On 7/9/19 at 11:06 a.m., the surveyor interviewed the Director of Maintenance (DOM) who stated that all doors were equipped with magnetic locks and delayed egress bars, (hardware that prevents a door from being opened usually for 15 seconds and once opened an alarm that the door has been opened). The DOM stated that only 2 doors were equipped with the wanderguard receivers. The DOM stated that a resident eloped from the facility through a door that was not equipped with a wanderguard receiver. On 7/9/19 at 1:30 p.m., the surveyor reviewed Resident #4's medical record and observed that the resident was admitted to the facility on 6/30/17 with a diagnosis of dementia. According to the "Mental and Behavioral Health Visit Note," Resident #4 eloped from the facility on 4/3/19. The surveyor interviewed the Executive Director (ED) regarding the elopement who stated that the delayed egress alarm sounded and that the facility staff responded to the alarm but did not see anyone in the parking lot. The ED further stated that the resident exited the building through a door that was located directly outside the resident's apartment. According to continued interview, the ED stated that the facility staff did not know the resident was missing until the resident did not appear for morning medications	A 357		

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A 357	Continued From page 5 at approximately 9:30 a.m. The surveyor observed in the medical record that Resident #4 was found by police and was at the police department at 6 p.m. in New York State. The ED stated that the resident took a bus to this location after leaving the building. Upon the resident's return to the facility, a wanderguard was applied to the resident and he/she was placed on hourly safety checks. Surveyor review of the medical records revealed that the resident had a second elopement on 6/8/19. Continued interview with the ED revealed that on 6/8/19 the resident was last seen at breakfast and was located at 1 p.m. by the local police department approximately 1 mile from the building. The ED further stated that on 6/8/19 the resident left the building through the front door after he/she removed the wanderguard. Surveyor review of the "Progress Notes" (PN) dated 4/10/19 revealed that the resident cut off the wanderguard and attempted to leave the building at 6:40 a.m. On 4/14/19 the PN documented that the resident again removed the wanderguard and upon return to the building on 6/8/19, the wanderguard was reapplied, however, by 5 p.m. the resident again removed the device. The PN also documented that the resident was placed on 1:1 observation arranged by the resident's family. The "Wander Risk Scale" (WRS) completed on 6/12/19 revealed that the resident was a high risk to wander. The resident's Service Plan and assessment revealed that the resident was an elopement risk with interventions to provide the resident with a wanderguard and place the resident on safety checks.	A 357		

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A 357	Continued From page 6 On 7/9/19 at 3:45 p.m. the surveyor interviewed the ED and the DON. The DON stated that the family was not able to provide a 1:1 for safety monitoring for more than a few days and instead the facility provided hourly checks for the resident. The facility failed to provide appropriate monitoring for Resident #4 as the resident was assessed to be a high elopement risk, had a history elopement and a history of cutting off the wanderguard. There were no documented evidence that additional supervision or monitoring was added after the second elopement, in response to the changing needs of the resident.	A 357		
A 447	8:36-5.1(a) General Requirements (a) The assisted living residence, comprehensive personal care home or assisted living program shall provide and/or coordinate personal care and services to residents, based on assessment by qualified persons, in accordance with the New Jersey Nurse Practice Act, N.J.S.A. 45:11-23 and N.J.A.C. 13:37, this chapter, and the individual needs of each resident, in a manner which promotes and encourages assisted living values. This REQUIREMENT is not met as evidenced by: Complaint #NJ00122972, NJ00125734	A 447		

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A 447	Continued From page 7 Based on observation, interview and record review it was determined that the facility failed to consistently ensure a system was in place to maintain the security of all exit doors in order to assure resident safety for 1 of 4 residents reviewed, Resident #4, who eloped from the facility on 4/3/19 and 6/8/19. This deficient practice was evidenced by the following: On 7/9/19 at 11:00 a.m., during a tour of the facility, the surveyor observed that 2 of 6 exit doors in the facility were equipped with wanderguard receivers. One receiver was located at the front entrance to the building and the other receiver was located at the exit, to a fully enclosed secure patio area. The balance of the 4 doors exited into different locations in the parking lot. On 7/9/19 at 11:06 a.m., the surveyor interviewed the Director of Maintenance (DOM), who stated that all doors were equipped with magnetic locks and delayed egress bars, (hardware that prevents a door from being opened usually for 15 seconds and once opened an alarm that the door has been opened). Only 2 doors in the facility were equipped with the wanderguard receivers. On 7/9/19 at 1:30 p.m., the surveyor reviewed Resident #4's medical record which documented that the resident was admitted to the facility on 6/30/17 with a diagnosis which included dementia. The surveyor reviewed the "Progress Notes" (PN) section of the medical record and observed that Resident #4 eloped from the facility on 4/3/19. The surveyor then interviewed the Executive Director (ED) regarding the elopement and according to the ED, the resident exited the	A 447		

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A 447	Continued From page 8	A 447		

building through a door that was located directly outside his/her apartment. The ED stated that the delayed egress alarm sounded and the facility staff responded to the alarm, however, the staff did not see anyone in the parking lot. The ED also stated that the facility staff did not know that the resident was missing until the resident did not appear for morning medications at approximately 9:30 a.m.

The resident was located by the police department at 6 p.m. in New York State. The ED stated that the resident took a bus to the location after he/she left the building. Upon the resident's return to the facility, a wanderguard was applied to the resident and the resident was placed on hourly safety checks.

Surveyor review of the General Service Plan dated 4/11/19 revealed that the resident ambulated independently and was assessed to be an elopement risk. A wanderguard was placed on the resident and the staff were to check on the resident frequently. According to a PN dated 4/10/19, Resident #4 cut off the wanderguard. PN also documented on 4/14/19, 5/6/19, 5/22/19, 5/23/19 5/26/19 that the resident refused to wear the wanderguard.

On 6/8/19 the PN documented that the resident was last observed in the building at breakfast and 911 was called when the resident was unable to be found. The PN documented that Resident #4 was located by the local police at 1 p.m., approximately 1 mile from the building. The PN further documented that on 6/8/19 the facility reapplied the wanderguard, however, by 5 p.m. the resident had removed it. On 6/9/19 and 6/30/19 documented was that the resident refused to wear the wanderguard.

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A 447	Continued From page 9 The resident was sent to the hospital for a non-related issue on 7/4/19 with a plan to discharge the resident to a facility with a secure dementia environment. The facility failed to develop a system to maintain the security of exit doors for a resident who was at high risk for elopement, had a history of elopement, and who consistently removed the wanderguard device.	A 447		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Complaint #NJ00122972, NJ00125734 Based on interview and record review it was determined that the facility failed to accurately document in the medical record the condition, treatment and coordination of care in accordance with the standards of professional practice for 1 of 4 residents reviewed, Resident #4. This deficient practice was evidenced by the following: On 7/9/19 at 1:30 p.m., the surveyor reviewed	A1073		

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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 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, "...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 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 diagnosed earlier that year with dementia and had a history of "running away" from wherever they get settled. The letter continued that "In the past year...has left four places where family/friends have attempted to locate..." There was also a note from a Clinical Neuropsychologist dated 3/1/19 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

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A1073	Continued From page 11 of Nursing (DON) who stated that up until the time of the elopement on 4/3/19 the facility was not aware that the resident had a history of dementia and elopement. The surveyor showed the DON the hospital records, the letter from the resident's son and the Clinical Neuropsychological notes. The DON then stated that she had not seen those documents in the past. The facility failed to review existing documentation available within the medical record to accurately assess the condition, treatment and interventions for Resident #4, in accordance with standards of professional practice.	A1073		