

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5a005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/14/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 SICOMAC AVENUE WYCKOFF, NJ 07481</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments  Initial Comments: TYPE OF SURVEY: Complaint  COMPLAINT #: NJ00117149  CENSUS: 81  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	1. It is our policy to respect and follow the philosophy of assisted living, which emphasizes personal dignity, autonomy, independence, privacy, and freedom of choice. We strive to provide services and an environment that offers a balance between choice and safety in the least restrictive setting. At the time of this occurrence, the resident was living on the [REDACTED] with full freedoms (including documented requests from family insisting on full access to outdoors). Prior to occurrence, family was requested to consider a move to our [REDACTED] unit for increased structure, due to noted confusion. However, resident had not demonstrated a clear [REDACTED] risk nor did she meet our criteria to mandate a discharge to [REDACTED]. Given this, and coupled with family and resident insistence of rights outweighing risk, we abided to free use of outdoor areas and therefore, did not interpret this event an [REDACTED] Executive Order 26, 43. Immediately following this occurrence, resident was assessed by the nurse and noted to be unharmed with no adverse effect. Physician and family notified. Resident was reassessed and status was changed to an [REDACTED] risk. We implemented a series of interventions and updated her GSP to ensure her safety.  (Continued on page 2)	
A 563	8:36-5.10(a)(2) General Requirements  (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following:  2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and	A 563		

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

*[Signature]*  
TITLE: **CLIA Administrator**

*[Signature]*

(X6) DATE

**8/26/19**

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  5a005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/14/2019
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SICOMAC AVENUE WYCKOFF, NJ 07481		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 563	<p>Continued From page 1</p> <p>extent of damages;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ00117149</p> <p>Based on interview and record review it was determined that the facility failed to notify the Department of Health (DOH) of an [redacted] incident for [redacted] residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 8/14/19 at 10:00 a.m., the surveyor reviewed Resident [redacted]'s medical record which revealed that he/she was admitted to the facility of [redacted] and ambulated independently with the use of a [redacted]. Review of the "Progress Notes" (PNs) revealed that starting in [redacted] there were frequent documented incidents of wandering during nighttime hours and barricading the door to the apartment to prevent staff from entering.</p> <p>Also documented in the PNs was that the resident was seen by his/her Primary Care Physician on [redacted] and the behaviors were attributed to the diagnosis of [redacted]. Resident [redacted] General Service Plan dated 10/18/18 documented, "Need for increased oversight frequent, staff interventions and/or monitoring, e.g. wanderguard..."</p>	A 563	<p>Post this occurrence, the family was notified that a move to our [redacted] would be required due to Executive Order 26, 4.b, however, with no vacancy on our [redacted] at that time, we requested Private Duty Aides (PDA), added a wander guard and implemented safety checks daily per shift in addition to meal, care and med administration times. Family was in disagreement with recommendations and ultimately moved [redacted] to another facility (bringing [redacted] home w/PDA while awaiting an opening there).</p> <p>2. No other residents were affected by this event. To prevent future, similar events and to identify other residents who may be at risk, the Administrator, Risk Manager and Director of Health Services reviewed and revised our Executive Order 26, 4.b, Alert policy to include the DOH interpretation of elopements and notification requirements. Additionally, a Level of Care Assessment (including a review of behaviors/ Executive Order 26, 4, risk) will be conducted with the GSP review for each resident no less than every 6 months.</p> <p>3. Our Executive Order 26, 4, alert policy and procedure was revised. It defines the systematic steps and interventions to be implemented for those residents who present at [redacted] and the reporting requirements, to ensure that this does not occur in the future.</p> <p>4. To ensure that all elopements are reported to the DOH, in-services will be provided for all clinical and leadership staff to re-educate on the definition of Executive Order 26, 4.b, review of occurrence reporting requirements and the revised Executive Order 26, 4, alert policy. The Executive Order 26, 4, alert policy will be reviewed annually.</p>	<p>8/27/19</p> <p>8/27/19</p> <p>9/15/19</p>

*[Handwritten Signature]*  
8/26/19

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  5a005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/14/2019
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SICOMAC AVENUE WYCKOFF, NJ 07481		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 563	<p>Continued From page 2</p> <p>The surveyor observed documented within the PNs that on 10/23/18 at 3:52 p.m. the resident was observed by personnel in another building walking down the road with his/her walker. Facility staff responded and found the resident shivering due to the cold. The resident told the facility staff that he/she was walking home to Paterson. The resident was returned to the Assisted Living and [Executive Order 26, 4.3] interventions were implemented to prevent a repeat occurrence.</p> <p>During interview with the Administrator on 8/14/19 at 11:00 a.m., she confirmed that she did not report the [Executive Order 26, 4.3] to the DOH because the resident remained on the grounds of the facility. The surveyor referred the Administrator to the definition of [Executive Order 26, 4.3] contained within General Licensure Procedures and Standards Applicable to all Licensed Health Care Facilities N.J.A.C. 8:43-10.3, "Patient or resident [Executive Order 26, 4.3] means a situation in which a registered or admitted patient or resident, excluding competent adults, leaves a health care facility without staff being aware that the patient or resident has done so."</p> <p>The facility failed to report the resident [Executive Order 26, 4.3] to the DOH as required.</p>	A 563		

*Handwritten signature*  
8/26/19

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5a005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/14/2019</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  
**CHRISTIAN HEALTH CARE CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**301 SICOMAC AVENUE  
WYCKOFF, NJ 07481**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments  Initial Comments: TYPE OF SURVEY: Complaint  COMPLAINT #: NJ00117149  CENSUS: 81  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	1. It is our policy to respect and follow the philosophy of assisted living, which emphasizes personal dignity, autonomy, independence, privacy, and freedom of choice. We strive to provide services and an environment that offers a balance between choice and safety in the least restrictive setting. At the time of this occurrence, the resident was living on the independent side of our AL, with full freedoms (including documented requests from family insisting on full access to outdoors). Prior to occurrence, family was requested to consider a move to our Memory Care unit for increased structure, due to noted confusion. However, resident had not demonstrated a clear elopement risk nor did she meet our criteria to mandate a discharge to Memory Care. Given this, and coupled with family and resident insistence of rights outweighing risk, we abided to free use of outdoor areas and therefore, did not interpret this event an elopement. Immediately following this occurrence, resident was assessed by the nurse and noted to be unharmed with no adverse effect. Physician and family notified. Resident was reassessed and status was changed to an elopement risk. We implemented a series of interventions and updated her GSP to ensure her safety.  (Continued on page 2)	
A 563	8:36-5.10(a)(2) General Requirements  (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following:  2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and	A 563		

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

*[Signature]*  
TITLE: **CLIA Administrator**

(X6) DATE

**8/26/19**

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  5a005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/14/2019
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SICOMAC AVENUE WYCKOFF, NJ 07481		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 563	<p>Continued From page 1</p> <p>extent of damages;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ00117149</p> <p>Based on interview and record review it was determined that the facility failed to notify the Department of Health (DOH) of an <b>elopement</b> incident for <b>1</b> of <b>4</b> residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 8/14/19 at 10:00 a.m., the surveyor reviewed Resident <b>#3's</b> medical record which revealed that he/she was admitted to the facility on <b>9/2/15</b> and ambulated independently with the use of a <b>walker</b>. Review of the "Progress Notes" (PNs) revealed that starting in <b>February 2018</b>, there were frequent documented incidents of wandering during nighttime hours and barricading the door to the apartment to prevent staff from entering.</p> <p>Also documented in the PNs was that the resident was seen by his/her Primary Care Physician on <b>7/27/18</b> and the behaviors were attributed to the diagnosis of <b>dementia</b>. Resident <b>#3's</b> General Service Plan dated 10/18/18 documented, "Need for increased oversight frequent, staff interventions and/or monitoring, e.g. wanderguard..."</p>	A 563	<p>Post this occurrence, the family was notified that a move to our <b>Memory Care</b> would be required due to <b>elopement risk</b> however, with no vacancy on our <b>Memory Care</b> at that time, we requested Private Duty Aides (PDA), added a wander guard and implemented safety checks daily per shift in addition to meal, care and med administration times. Family was in disagreement with recommendations and ultimately moved <b>her</b> to another facility (bringing <b>her</b> home w/PDA while awaiting an opening there).</p> <p>2. No other residents were affected by this event. To prevent future, similar events and to identify other residents who may be at risk, the Administrator, Risk Manager and Director of Health Services reviewed and revised our Elopement Alert policy to include the DOH interpretation of elopements and notification requirements. Additionally, a Level of Care Assessment (including a review of behaviors/ elopement risk) will be conducted with the GSP review for each resident no less than every 6 months.</p> <p>3. Our elopement alert policy and procedure was revised. It defines the systematic steps and interventions to be implemented for those residents who present an <b>elopement risk</b> and the reporting requirements, to ensure that this does not occur in the future.</p> <p>4. To ensure that all elopements are reported to the DOH, in-services will be provided for all clinical and leadership staff to re-educate on the definition of elopement, review of occurrence reporting requirements and the revised elopement alert policy. The elopement alert policy will be reviewed annually.</p>	<p>8/27/19</p> <p>8/27/19</p> <p>9/15/19</p>

*[Handwritten Signature]*  
8/26/19

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  5a005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/14/2019
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SICOMAC AVENUE WYCKOFF, NJ 07481		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 563	Continued From page 2  The surveyor observed documented within the PNs that on 10/23/18 at 3:52 p.m. the resident was observed by personnel in another building walking down the road with his/her walker. Facility staff responded and found the resident shivering due to the cold. The resident told the facility staff that he/she was walking home to Paterson. The resident was returned to the Assisted Living and elopement interventions were implemented to prevent a repeat occurrence.  During interview with the Administrator on 8/14/19 at 11:00 a.m., she confirmed that she did not report the elopement to the DOH because the resident remained on the grounds of the facility. The surveyor referred the Administrator to the definition of elopement contained within General Licensure Procedures and Standards Applicable to all Licensed Health Care Facilities N.J.A.C. 8:43-10.3, "Patient or resident elopement" means a situation in which a registered or admitted patient or resident, excluding competent adults, leaves a health care facility without staff being aware that the patient or resident has done so."  The facility failed to report the resident elopement to the DOH as required.	A 563		

*Handwritten signature*  
8/26/19