STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5a005	A. BUILDING: _____ B. WING _____	C 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	**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 #: NJ00127609 CENSUS: 89 SAMPLE SIZE: 7 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 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;	A 357		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 357	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00127609 Based on observation, interview and review of records, it was determined that the facility failed to prevent a cognitively impaired resident from elopement. The facility failed to address the resident's changing psychosocial status and appropriately monitor and/or supervise [redacted] of [redacted] residents, Resident [redacted]. This deficient practice was evidenced by the following: On 8/28/19 at 10:00 a.m., the surveyor reviewed Resident [redacted]s medical record and observed that the resident was admitted to the facility [redacted] with a diagnosis of [redacted]. The "Resident Nursing Instructions" (RNI) documented that on [redacted] the resident was deemed an [redacted] and the resident had a [redacted] on the [redacted] The RNI also documented that the resident was able to [redacted] According to the "Progress Notes" (PN), on [redacted] a family meeting was held and the facility recommended a higher level of care due to the resident's [redacted] attempts. The resident was scheduled to be admitted to a behavioral unit on [redacted]. At 10:30 a.m. the surveyor, in the presence of the facility Executive Director (ED), toured the facility and observed that all doors within the secure [redacted] unit were equipped with [redacted] alarms. The ED demonstrated to the surveyor that all doors remained unlocked; however, if a	A 357		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5a005	A. BUILDING: _____ B. WING _____	C 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	**301 SICOMAC AVENUE WYCKOFF, NJ 07481**

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A 357	Continued From page 2 resident with a [redacted] approached the door, the door would lock and an audible alarm would sound. In addition to the audible alarm, the staff communication phones would alert with a red screen. The ED also stated that the alerts would continue until turned off by a staff member. Lastly, the ED demonstrated that the [redacted] alarms could be temporarily deactivated for a period of 10 to 15 seconds if an employee used a swipe pass. At 11:00 a.m., the surveyor reviewed [redacted] reports regarding Resident [redacted], both of which occurred on [redacted]. The first report of [redacted] documented that on [redacted]., Resident [redacted] was able to leave a secure area of the building and enter a non-secure area of the building without setting off [redacted] alarms. The facility investigated and the [redacted] and determined that the resident closely followed an employee through the door when the alarm was deactivated by the employee. The facility contacted the family and recommended a 24-hour private duty companion be put into place until the resident was transferred to a long term care facility. No additional safety precautions or monitoring were instituted. The surveyor then reviewed the report of the second [redacted] which documented that the resident was observed at dinner at 6:15 p.m. in the secure unit. At 6:36 p.m., the resident's wanderguard alarmed in another building located on the campus of the facility. The facility was called by the receptionist from the other building at 6:54 p.m. to notify the facility that the resident was physically present in another building. The resident was then escorted back to the Assisted	A 357		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 357	Continued From page 3 Living by security at 7:00 p.m. On 8/28/19 at 2:00 p.m., during the exit interview with the ED, the ED stated that the facility was not able to determine how the resident exited the building. The ED provided documentation that the alarms were working. The surveyor was not provided documented evidence of increased monitoring and/or supervision of Resident [redacted] after the first [redacted].	A 357		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
5a005 Y1	A. Building B. Wing Y2	10/11/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	301 SICOMAC AVENUE WYCKOFF, NJ 07481

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0357 Reg. # 8:36-4.1(a)(2) LSC	Correction Completed 09/30/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/28/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: X9NZ12

Christian Health Care Center
ESTABLISHED 1911

DATE: 09/13/19

TO: New Jersey Department of Health
Attn: Andrea Webb, Health Care Services Evaluator

FROM: Pamela J. Rooney, Administrator
The Longview Assisted Living Residence at the Christian Health Care Center

SUBJECT: DOH Visit 8/28/19 - #NJ00127609

Pursuant to your request and in follow up to the survey that was conducted in The Longview Assisted Living at The Christian Health Care Center on 08/28/2019.

Below is the Plan of Correction documentation for your review and consideration.

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**: Immediately following this occurrence, resident was assessed by the nurse and noted to be unharmed and with no adverse effects. Physician, family, psychiatrist, and MLTSS Case Manager notified. For Resident #1, we implemented a series of interventions and updated the General Service Plan (GSP) to ensure safety. As documented in chart, 1:1 distant supervision was provided by administrator until additional staff arrived to provide 1:1 as well as to accompany resident during transfer to the Psychiatric Unit. No other residents were affected by this event. All residents present on unit and safe. When residents are identified as needing additional oversight, recommendations will be made to the family for same. In the interim of awaiting for family action, we will implement increased safety measures.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice:**
   - **A Level of Care Assessment**, including review of behaviors/elopement risk, and a GSP review for each resident will be completed every 6 months or more frequently as needed, by the Director of Health Services or designated RN. Residents who are assessed to have elopement behaviors will be issued a wander guard.
   - **Inservices, communications and prominent signage to educate** both staff and visitors of elopement and tailgating risks were implemented; including emails with Elopement/tailgate Alert warnings to all Longview staff as well as support services leaders. Updated and prominent postings of elopement/tailgate alerts at both the front sign in book as well as at the entrance/exit to the Memory Care unit so it is visible to visitors and family.
   - **Every exit door from unit and entire building was physically checked and tested** with a test tag and will be tested daily through the month of September. When doors are found to be reliable, we will decrease daily testing to monthly through the month of December, then resume quarterly schedule per manufactures recommendation. If during testing, aberrations are found, or any other problems identified the issue will be addressed immediately and a more rigorous schedule will resume. We have improved our testing process by assuring that all components of the system are tested; including Information Services (IS) accompaniment during quarterly systems test.

- The two wooden doors will be replaced with two metal doors with audible tamper/push bar alarms.
- Safety and security plan include future plans to assess a camera in the breezeway.
- Details for clinical interventions noted below.

3. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** To ensure that all elopements are reported to the DOH the Elopement Alert policy and procedure was revised. It defines the systematic steps and interventions to be implemented for those residents who present an elopement risk and the reporting requirements. The following are also in place:
   Q2hr Census checks conducted by PCA/CMA staff for all residents designated as an elopement risk.
   Daily checks by clinical staff for presence and functionality of issued wander guards.
   Quarterly checks: Plant Operations (PO) ensures inspection and tests the Resident Wandering System as part of our computerized preventative maintenance program. This inspection includes a test of each exit being monitored, for each function of the system applicable, for that exit, by a contracted vendor in coordination with an Information Services (IS) employee. (As noted above, tested daily through the month of September. When doors are found to be reliable, we will decrease daily testing to monthly through the month of December, then resume quarterly schedule per manufactures recommendation). PO reports any malfunction of the system, which cannot be repaired immediately, to the Nursing department so that additional measures of security can be arranged.
   Semi-annual: A Level of Care Assessment, including review of behaviors/elopement risk, and a GSP review for each resident will be completed every 6 months or more frequently as needed, by the Director of Health Services or designated RN. Residents who are assessed to have elopement behaviors will be issued a wander guard.
   As needed: PO and IS monitors email notifications for low battery and hardware devices not reporting in to the alert system and as needed, setup communication of the new hardware to work with the hand-held SpectraLink phones and SARA server. PO inspects doors and door locks, and completes or coordinates repairs including hardware malfunctions.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes:** In addition to measures noted previously, to ensure correction, the following will be implemented by no later than **September 30, 2019**:
   - **Quality Manager/Clinical Educator** to provide in-services for all clinical and leadership staff to re-educate on the definition of elopement, elopement/tailgate precautions, review of occurrence reporting requirements and the revised elopement alert policy. Administrator to send reminder notification to all Longview staff and support service directors to alert of elopement precautions for our Memory Care unit and post visible signage for family/visitors exiting or entering the unit.
   - **Administrator conduct notices** including emails with Elopement/tailgate Alert warnings to all Longview staff as well as support services leaders. Updated and prominent postings of elopement/tailgate alerts at both the front sign in book as well as at the entrance/exit to the Memory Care unit so it is visible to visitors and family.
   - **VP of Residential Services** to continue to review the Elopement Alert policy annually. **Administrator, Director of Health Services and VP of Residential Services** to ensure compliance with the Elopement Alert policy and that revisions will be made to the policy as needs are identified.
   - **Director of Health Services and Clinical Education** to imbed information regarding elopement/tailgate precautions into the mandatory annual education module for Dementia.