STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING ______ B. WING ______	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

(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) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT: # NJ 142207 CENSUS: 112 SAMPLE SIZE: 4 Based on observations, interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 01/08/21 and 1/13/21, it was determined that the facility failed to supervise, monitor and ensure the safety of a resident who had a history of [redacted] and [redacted] and had a physician order [redacted]" On [redacted] Resident #3 was able to [redacted] the facility unattended, without the staff's knowledge, and wandered off the facility grounds to a main road. While crossing the main road the resident was struck by an automobile and subsequently [redacted] and was transported to the hospital for medical treatment of the injuries. The facility was unaware of the whereabouts of the resident until informed by the resident's sister that he/she was taken to the hospital with injuries. The facility staff also failed to follow their policies titled: "[redacted] Policy," and "Out on Pass Unaccompanied," for 1 of 4 residents (Resident #3) sampled. This deficient practice placed Resident #3 and all other residents who were at risk, who had a known history of [redacted] behavior, in an Immediate	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/07/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Jeopardy (IJ) situation. The IJ was identified on 01/08/21 at 5:26 p.m., when the Director of Nursing (DON) was notified of the IJ situation, which ran from 12/19/20 until 01/08/21 at 7:15 p.m., when the facility provided an acceptable Removal Plan to remove the Immediacy.	F 000		
F 609 SS=D	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. §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 142207	F 609	• All residents are at risk to be affected	2/10/21

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F 609	Continued From page 2 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on [redacted] and [redacted], it was determined that the facility staff failed to report an [redacted] and Injuries of Unknown Origin to the New Jersey Department of Health (NJDOH), the facility staff also failed to follow their policies titled, "Abuse Investigation and Reporting" and "Reportable Events," for 1 of 4 residents (Resident #3) sampled. This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #3 was admitted to the Facility on [redacted], with diagnoses which included but were not limited to: [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that Resident #3 was cognitively [redacted]. The MDS also indicated Resident #3 was independent for Activities of Daily Living (ADLs). Review of the Care Plan (CP), with an initiated date of [redacted] revealed Resident #3 had a "Focus" of: ADL self-care performance deficit related to impaired dynamic standing balance, impaired coordination and impaired problem solving. The CP also revealed a "Focus" of:	F 609	by the deficient practice. • Resident #3's Investigation summary report was submitted to the Department of Health with fax confirmation on 2/2/21. • All facility staff were re-educated on the facility Abuse Investigation and Reporting policy. • DON and ADMIN re-educated on policy as well as preferred means of submission. Ie; E-fax so facility will have ease of access to fax confirmation. • DON/ADMIN will review all reportable events and ensure the policy is being followed and will report weekly to the facility's regional team. Corporate DON or designee will audit one reportable event file per month x 3 months for evidence of appropriate event reporting. • Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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F 609	Continued From page 3	F 609		

, and ," and makes inappropriate comments regarding parts, with an initiated date of .
Interventions included; distract and redirect the resident from wandering by offering diversions ....
The CP also revealed a "Focus" of: physical and aggressive behavior with poor impulse control and initiated on .

Review of the facility document titled Risk Scale" dated , revealed Resident #3 scored " possible points, which indicated that the resident was "at " related to being ambulatory, medical diagnosis of .

Review of the Physician Orders verified that Resident #3's Physician wrote an order; . Resident may not sign in or out of (facility name)," dated , and again on .

During an observation while on the elevator on 1/8/21 at 10:15 a.m., Resident #3 was observed in a wheelchair with the elevated and in place. The resident stated that he/she was hit by a car appropriately ago while walking to the store to get

During an interview on 1/8/21 at 10:17 a.m., Resident #3 reported that on , during the daytime, left the facility and was struck by an automobile. ....

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F 609	Continued From page 4	F 609		

.... ." In addition, Resident #3 stated that did not inform anyone was leaving the grounds.

Review of Resident #3's MR revealed a progress note written on at 2:25 p.m., by the Registered Nurse, stating she received a call from the resident's who reported that the resident was at the hospital for an evaluation and treatment after a fall outside of the facility.

Review of the MR revealed a progress note written on at 8:25 p.m., by the Licensed Practical nurse (LPN), reporting that Resident #3 returned from the hospital with .

During an interview on 01/08/21 at 10:30 a.m., the Unit Manager (UM) reported that Resident #3 was ambulatory and left the facility on , and was hit by a car while walking across a main road and

During an interview on 1/8/21 at 1:24 p.m., the Administrator (Admin) stated that the incident with Resident #3 on , was considered a "significant event," however, the facility staff never investigated it because it did not occur on the facility's property and it was unknown what had happened.

During an interview on 1/13/21 at 12:50 p.m., the Admin stated that Resident #3's notified them on , that the resident had slipped on ice. When the resident returned from the hospital on , with injuries, the facility staff was unaware at that time how they occurred. The Admin further stated that since the incident did

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F 609	Continued From page 5 not occur in the facility or on the facility grounds he did not report it, however, he did acknowledge that the incident was an "injury of unknown origin" which should be reported to the state. Review of the facility's policy titled "Abuse Investigation and Reporting," dated 12/2018, revealed the following under "Policy Statement:" All reports of resident abuse, neglect, exploitation, misappropriation of residents property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management.... According to the "Reportable Event Form," supplied to every facility by the New Jersey Department of Health (NJDOH): The facility shall notify the Department of Health immediately by telephone, followed by a written confirmation with 72 hours for the following: "Any elopement." N.J.A.C. 8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		2/10/21

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F 610	Continued From page 6 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 142207 Based on interviews, review of Medical Records (MR), and review of other pertinent facility documents on 1/08/21 and 1/13/21, it was determined that the facility failed to conduct a thorough investigation of an injury of unknown origin and failed to follow the facility policies titled; "Accidents and Incidents - Investigating and Reporting," and "Abuse Investigation and Reporting," and their [redacted] Policy," for 1 of 4 residents (Resident #3) sampled. This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #3 was admitted to the Facility on [redacted] with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #3 had a Brief Interview for Mental	F 610	• All residents are at risk to be affected by the deficient practice. • Resident #3's full investigation was formally written out and facility "incident report" in the electronic medical records was completed. • Resident #3 was placed on close monitoring as a result of the investigation. Resident also acknowledged [redacted] new "Out on Pass" contract. • Previous month of incidents reviewed to ensure all investigations were preformed correctly and correct actions taken. • All facility staff were re-educated on the facility Accidents and Incidents – Investigating and Reporting policy as well as [redacted] and AMA (Against Medical Advice) policy. • DON/ADMIN will review all incidents and ensure the policy is being followed and will report weekly to the facility's regional team. Corporate DON or designee will audit two incidents per month x 3 months for evidence of compliance with the policy. • Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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F 610	Continued From page 7	F 610		

Status (BIMS) score of [redacted], which indicated that Resident #3 was cognitively [redacted]. The MDS also indicated Resident #3 was independent for Activities of Daily Living (ADLs).

During an observation while on the elevator on 1/8/21 at 10:15 a.m., Resident #3 was observed in a wheelchair with the [redacted] elevated and [redacted] in place. The resident stated that he/she was hit by a car approximately [redacted] ago while walking to the store to get [redacted].

During an interview on 1/8/21 at 10:17 a.m., Resident #3 reported that on [redacted], during the daytime, [redacted] left the facility and was struck by an automobile. [redacted]" In addition, Resident #3 stated that [redacted] did not inform anyone [redacted] was leaving the grounds.

Review of the Physician Orders verified that Resident #3's Physician wrote an order; [redacted]. Resident may not sign [redacted] in or out of (facility name), dated [redacted], and again on [redacted]

Review of Resident #3's medical records revealed a progress note written on [redacted] at 2:25 p.m., by the Registered Nurse, stating she received a call from the resident's [redacted] who reported that the resident was at the hospital for an evaluation and treatment after a fall outside of the facility.

Review of the MR revealed a progress note written on [redacted] at 8:25 p.m., by the Licensed

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F 610	Continued From page 8	F 610		

Practical nurse (LPN) reporting that Resident #3 returned from the hospital with a [redacted] and [redacted]. The nurse notified the doctor who ordered [redacted] medication.

During an interview on 01/08/21 at 10:30 a.m., the [redacted] Unit Manager (UM), reported that Resident #3 was ambulatory and had let the facility on [redacted] and was hit by a car while walking across a main road and [redacted] [redacted].

During an interview on 1/8/21 at 12:27 p.m., the Director of Nursing (DON) reported that no investigation was done after the incident on [redacted], involving Resident #3 because it did not happen at the facility.

During an interview on 1/8/21 at 1:24 p.m., the Administrator (Admin) stated that the incident with Resident #3 on [redacted], was considered a "significant event," however, the facility staff never investigated it because it did not occur on the facility's property and it was unknown what had happened.

During an interview on 1/13/21 at 12:50 p.m., the Admin and the DON stated that when Resident #3 returned to the facility on [redacted], with his/her [redacted] and [redacted] wrapped it was an "injury of unknown origin" since they did not know, at that time, what had happened.

According to the Facility Policy titled, "Accidents and Incidents - Investigating and Reporting" dated 12/2018, under Policy Interpretation and Implementation 1: The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.

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F 610	Continued From page 9	F 610		
	Review of the facility's policy titled "Abuse Investigation and Reporting," dated 12/2018, revealed the following under "Policy Statement:" All reports of resident abuse, neglect, exploitation, misappropriation of residents property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management....			
	Under: Policy Interpretation and Implementation," 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Admin will assign the investigation to an appropriate individual.			
	A review of the facility's policy titled '[redacted] Policy" dated 9/18/19, included the following under "Policy;" It is the objective of this facility to ensure the safety and protection of wandering residents by preventing their exit from the building. Under Policy Interpretation and Implementation, section 7. After locating the resident, an incident report must be completed and document incident in the nurse's notes. 7c. An appropriate Care Plan will be developed to prevent a reoccurrence of elopement.			
	N.J.A.C. 8:39-4.1(a)5			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		2/10/21
	§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-			

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F 657	Continued From page 10 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ 142207 Based on interviews, Medical Record (MR) review and review of other pertinent facility documentation on 1/8/21 and 1/13/21, it was determined that the facility staff failed to develop, update, and/or implement, a Care Plan (CP) for a resident who was leaving the facility against medical advice when the physician had a written order in place [redacted]." The facility also failed to implement a Care Plan	F 657	• All residents are at risk to be affected by the deficient practice. • Resident #3's Care Plan was updated with appropriate goals and interventions. • Reviewed all out on pass and [redacted] use care plans to ensure appropriate goals and interventions in place. • All Nursing staff re-educated on "Care Plans, Comprehensive, Person-Centered "as well as AMA (Against Medical Advice) policy. • "Forbidden item "and [redacted]" policy initiated with new resident contracts.	

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F 657	Continued From page 11 addressing [redacted] after the resident tested positive [redacted] times for [redacted], as well as follow the facility policies titled "Care Plans, Comprehensive, Person-Centered." and [redacted] Policy." This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #3 was admitted to the Facility on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that Resident #3 was cognitively [redacted]. The MDS also indicated Resident #3 was independent for Activities of Daily Living (ADLs). Review of Resident #3's Care Plan (CP) revealed a "Focus" of: [redacted], and [redacted], with an initiated date of [redacted]. Interventions included; distract and redirect the resident from [redacted] by offering diversions .... The CP also revealed a "Focus" of: physical and aggressive behavior with poor impulse control and '[redacted]" initiated on [redacted]. Review of the facility progress notes dated [redacted] revealed communication with the	F 657	• MDS coordinator will audit care plans of all newly admitted residents and all residents with change in "Out on Pass" status and or new onset of non-compliance with facility "Forbidden item "and "[redacted] use" policy going forward x 3 months. Care plans will continue to be reviewed in their entirety for accuracy at each resident's quarterly care conference by the interdisciplinary team. • Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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F 657	Continued From page 12 physician documented by the nurse as follows: "Resident is 'NOT' allowed out on pass. Resident may 'NOT' sign himself/herself in or out of (facility name)." Review of the Physician Orders verified that Resident #3's Physician wrote an order; " . Resident may not sign in or out of (facility name)," dated and again on . The CP did not include this. Review of Resident #3's laboratory/blood work dated and , verified that Resident #3 was on the above dates. The CP did not include this. During an interview on 01/08/21 at 10:30 a.m., the Unit Manager (UM) reported that Resident #3 was ambulatory and left the facility on and was hit by a car while walking across a main road and sustained . On 1/8/21 at 10:30 a.m., the 3rd floor Unit Manager (UM) also stated that Resident #3 was not CP for a history of because the floor staff implemented the CP. In addition, the UM stated that the resident was not CP for elopement or leaving Against Medical Advice (AMA) because the who was the Power of Attorney (POA) gave permission for the resident to leave the facility and the UM felt the resident was competent to leave the grounds unaccompanied. During an interview on 1/8/21 at 12:27 p.m., the Director of Nursing (DON) verified that Resident #3 was not Care Planned for use or leaving the facility against medical advice (AMA),	F 657		

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F 657	Continued From page 13 and both issues should have been addressed on the CP. Review of the facility policy titled "Care Plans, Comprehensive, Person-Centered," dated 12/2018, revealed the following under "Policy Statement:" A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Under "Policy Interpretation and Implementation," Section #14; The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition. A review of the facility's policy titled [redacted] Policy" dated 9/18/19, included the following under "Policy;" It is the objective of this facility to ensure the safety and protection of wandering residents by preventing their exit from the building. Under Policy Interpretation and Implementation, section 7. After locating the resident, an incident report must be completed and document incident in the nurse's notes. 7c. An appropriate Care Plan will be developed to prevent a reoccurrence of elopement. N.J.A.C. 8:39-11.2(e),(f),(h)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		2/12/21

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F 658	Continued From page 14 by: COMPLAINT: # NJ 142207 Reference: New Jersey Statutes, Annotated Title 45 Chapter 11, Nursing Board. The Nurse Practice Act for the State of New Jersey states; "the practice of nursing as a Registered Professional Nurse is defined as diagnosing, and treating human response to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized Physician or dentist." Reference: "The practice of nursing as a Licensed Practical Nurse is defined as performing tasks, and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a Registered Nurse, or otherwise legally authorized Physician or Dentist." Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 1/8/21 and 1/13/21, it was determined that the facility's nursing staff failed to follow the Standards of Nursing Practice by not following a Physician Order for 1 of 4 residents (Resident #3) sampled. This deficient practice	F 658	• All residents are at risk to be affected by the deficient practice. • Resident #3 was placed on close monitoring to ensure his physician's order of restricting out on pass is followed. Resident #3 signed a new contract acknowledging the facility's "Out on Pass "policy as well as his physician's order restricting his out on pass privileges. • All residents "Out on Pass" contracts reviewed to ensure acknowledgments and to ensure there were no conflicting Physicians orders. • All nursing staff re-educated on "Standards of Nursing Practice - following physicians' orders". • All staff re-educated on the list and policy for residents that are allowed "Out on Pass" as well as residents that are restricted from going "Out on Pass". • All staff re-educated on Resident Rights policy as well as AMA (Against Medical Advice) policy and process for residents to leave "Against Medical Advice" if they are able to make that decision. • All staff re-educated on the facility [redacted] policy. • Security Guards placed on the patio to ensure that residents stay within the patio area. Security guards educated on facility "Out on Pass" policy as well as AMA (Against Medical Advice) policy and procedure. • DON/ Designee will perform weekly chart audits X4 weeks to ensure "Physician's orders" restricting "Out on Pass" are being followed. • DON/ Designee will preform an audit	

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F 658	Continued From page 15 was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #3 was admitted to the Facility on [redacted] with diagnoses which included but were not limited to: [redacted] nxiety Disorder, Epilepsy, and Traumatic Brain Injury. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that Resident #3 was cognitively [redacted]. The MDS also indicated Resident #3 was independent for Activities of Daily Living (ADLs). During an observation while on the elevator on 1/8/21 at 10:15 a.m., Resident #3 was observed in a wheelchair with the [redacted] elevated and [redacted] in place. The resident stated that he/she was hit by a car appropriately [redacted] ago while walking to the store to get [redacted]. On 1/8/21 at 10:17 a.m., Resident #3 reported that on 1[redacted] during the daytime, [redacted] left the facility and was struck by an automobile. [redacted]." In addition, Resident #3 stated that [redacted] did not inform anyone [redacted] was leaving the grounds. Review of the Physician Orders verified that	F 658	on all New Admission's "Physician's orders" to ensure they are being followed. • DON/ Designee with preform weekly chart audits of 2 residents per unit x4 weeks to ensure "Physician's orders " are being followed. • MDS Coordinator / Interdisciplinary team will review and audit each individual resident's "Physician's orders" quarterly to ensure they are being followed. • ADMIN/ Designee will perform weekly audits on the "Out on Pass" binder to ensure the policy and procedure is being done properly x 4 weeks and then monthly X 3 months. • Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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F 658	Continued From page 16 Resident #3's Physician wrote an order; [redacted]. Resident may not sign [redacted] in or out of (facility name), dated [redacted], and again on [redacted] During an interview on 1/8/21 at 10:30 a.m., the 3rd floor Unit Manager (UM) reported that Resident #3 was ambulatory and had let the facility on [redacted], and was hit by a car while walking across a main road and sustained [redacted]. During an interview on 1/8/21 at 3:02 p.m., the 3rd floor Unit Manager (UM) reported that the physician put an order in place that Resident #3 could not go out on pass [redacted] behaviors." The UM also stated that the resident continued to go "out on pass" because the Administrator had informed the staff, that because the resident is [redacted] ([redacted]) the staff could not impinge on the residents right to go out/leave. During an interview on 1/8/21 at 4:10 p.m., the Director of Nursing (DON) reported that she was aware that the physician had an order in place for Resident #3 [redacted]" and the order was not followed by the nursing staff "because the resident doesn't listen, we can't keep him/her here. He/she gets violent and acts out." N.J.A.C.8:39-11.2(b)	F 658		
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 -	F 689		2/10/21

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F 689	Continued From page 17 §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 142207 Based on observations, interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 01/08/21 and 1/13/21, it was determined that the facility failed to supervise, monitor and ensure the safety of a resident who had a history of [redacted] and had a physician order "Resident is not allowed out on pass." [redacted] Resident #3 was able to independently exit the facility unattended, without the staff's knowledge, and wandered off the facility grounds to a main road. While crossing the main road the resident was struck by an automobile and subsequently sustained [redacted] and was transported to the hospital for medical treatment of the injuries. The facility was unaware of the whereabouts of the resident until informed by the resident's [redacted] that he/she was taken to the hospital with injuries. The facility staff also failed to follow their policies titled: [redacted] Policy," and "Out on Pass Unaccompanied," for 1 of 4 residents (Resident #3) sampled. This deficient practice placed Resident #3 and all other residents who were at risk, who had a known history of [redacted] and/or [redacted], in an Immediate	F 689	• All residents with known history of wandering and or exit seeking behavior are at risk to be affected by the deficient practice. • Resident #3 was placed on close monitoring to ensure his physician's order of restricting out on pass is followed. Resident #3 signed a new contract acknowledging the facility's "Out on Pass "policy as well as his physician's order restricting his out on pass privileges. • Resident #3s Care plan was immediately revised and all nursing staff were educated on the updated care plan as well as his updated contract. • Chart audits were immediately initiated to identify all residents with wandering or exit seeking behaviors to ensure the care plans reflect the correct level of supervision required to ensure their safety. • All Nursing staff re-educated on following physicians order and facility policy for residents that are allowed "Out on Pass" as well as residents that are restricted from going "Out on Pass". • All staff re-educated on Resident Rights policy as well as AMA (Against Medical Advice) policy and process for residents to leave "Against Medical Advice" if they are able to make that decision. All staff educated on	

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F 689	Continued From page 18 Jeopardy (IJ) situation. The IJ was identified on 01/08/21 at 5:26 p.m., when the Director of Nursing (DON) was notified of the IJ situation, which ran from 12/19/20 until 01/08/21 at 7:15 p.m., when the facility provided an acceptable Removal Plan to remove the Immediacy. This deficient practice was further evidenced by the following: 1. According to the "Admission Record" (AR), Resident #3 was admitted to the Facility on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that Resident #3 was cognitively [redacted] The MDS also indicated Resident #3 was independent for Activities of Daily Living (ADLs). Review of the Care Plan (CP) with an initiated date of [redacted], revealed Resident #3 had a "Focus" of: ADL self-care performance deficit related to impaired dynamic standing balance, impaired coordination and impaired problem solving. The CP also revealed a "Focus" of: [redacted] an initiated date of [redacted]. Interventions included; distract and redirect the resident from wandering by offering diversions .... The CP also revealed a "Focus" of: [redacted] behavior with [redacted] control and [redacted]	F 689	[redacted] Policy. • Security Guards placed on the patio to ensure that residents stay within the patio area. Security guards educated on facility "Out on Pass" policy as well as AMA (Against Medical Advice) policy and procedure. • DON/ Designee will perform weekly chart audits X4 weeks and then monthly X 3 months to ensure residents with wandering and exit seeking behaviors plan of care is being met. • Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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F 689	Continued From page 19 [redacted] which was initiated on [redacted] Review of the facility document titled [redacted] Risk Scale" dated [redacted], revealed Resident #3 scored [redacted] possible points, which indicated that the resident was [redacted]" related to being ambulatory, medical diagnosis of [redacted]: diagnosis impacting gait/mobility or strength. During an observation, while on the elevator on 1/8/21 at 10:15 a.m., Resident #3 was observed in a wheelchair with the [redacted] elevated and [redacted] in place. The resident stated that he/she was hit by a car appropriately [redacted] ago while walking to the store to get [redacted]. During an interview on 1/8/21 at 10:17 a.m., Resident #3 reported that on [redacted], during the daytime, [redacted] left the facility and was struck by an automobile. [redacted]" In addition, Resident #3 stated that [redacted] did not inform anyone [redacted] was leaving the grounds. Review of Resident #3's MR revealed a progress note written on [redacted] at 2:25 p.m., by the Registered Nurse (RN), stating she received a call from the resident's [redacted] who reported that the resident was at the hospital for an evaluation and treatment after a fall outside of the facility. Review of the MR revealed a progress note written on [redacted] at 8:25 p.m., by the Licensed Practical Nurse (LPN), reporting that Resident #3 returned from the hospital with a [redacted]	F 689		

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F 689	Continued From page 20 Review of the Physician Orders verified that Resident #3's Physician wrote an order; . Resident may not sign in or out of (facility name), dated , and again on . The CP did not include this. During an interview on 01/08/21 at 10:30 a.m., the Unit Manager (UM) reported that Resident #3 was ambulatory and left the facility on , and was hit by a car while walking across a main road and sustained During an interview on 1/8/21 at 3:02 p.m., the 3rd floor UM reported that the physician put an order in place that Resident #3 could not go out on pass ." The UM also stated that the resident continued to go out unaccompanied because the Administrator (Admin) had informed the staff that since the resident is the staff could not impinge on the residents right to go out/leave. The UM stated that the physician was never notified that Resident #3 continued to go out despite order. In addition, the UM stated that Resident #3 would go out to the area and leave through an unlocked gate and the resident had done this several times. The Monitor ( ) would not report it and never called the nursing staff to let us know the resident left. When the UM was asked if she ever spoke to the about notifying the staff that the resident left the grounds the UM stated: "He knows that it's on	F 689		

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F 689	Continued From page 21 the policy." Review of the facility document titled: [redacted] Agreement," verified that Resident #3 signed a [redacted] contract on [redacted], that he/she was educated on the [redacted] regulations of the facility and failure to comply with these rules and regulations will result in the potential for loss of privilege to [redacted] up to and including receipt of a 30 day discharge notice. Review of the MR failed to show any evidence to address a behavior plan and/or contract regarding Resident #3 leaving the facility against medical advice (AMA) and the facility staff was unable to provide one. Review of the Sign Out sheet located at the front receptionist desk verified that the Resident #3 signed out of the facility on the following dates: [redacted], (twice) and once in [redacted]r (undated) and again on [redacted]. The Sign Out sheet did not show a signature/signed out for [redacted] During an interview on 1/8/21 at 12:10 p.m., the Social Worker (SW) reported that the procedure for a resident to go out on pass is determined by "the team." They review the resident's cognitive and physical ability and the ability to use a cell phone. However, the SW was unable to provide any documentation or progress note to verify that the team did in fact meet to review Resident #3's ability to leave the facility unaccompanied. During an interview on 1/8/21 at 12:27 p.m., the DON stated that the IDT (Interdisciplinary) team needs to meet to determine if a resident is "safe" to go out on pass. Behavior, cognition and physical ability are all reviewed to determine if the resident is safe to go out on pass. "We review	F 689		

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F 689	Continued From page 22	F 689		

everything before they can go out unaccompanied." The DON also stated that "a physician order is needed" for a resident to go out on pass. However, the DON was unable to verify if the IDT team did in fact meet to determine if Resident #3 was safe to go out on pass.

During an interview on 1/8/21 at 4:10 p.m., the DON reported that she was aware there was a physician order in place that Resident #3 "could not go out on pass" but the order was not followed by the nursing staff "because he/she doesn't listen, we can't keep him/her here. He/she gets violent and acts out." The DON also stated that Resident #3 was unsafe to [redacted] and towards others due to his/her aggressive behaviors.

Review of the facility document titled "30-Day Notice of Intent to Discharge/Transfer Resident," undated, revealed documentation by the staff that Resident #3 was to be discharged to another facility on [redacted], for the following reason: "The move is necessary for your own welfare and your needs cannot be met within the nursing facility." and "The safety and health of the individuals in the nursing facility would otherwise be endangered due to the clinical or behavioral status of the resident."

During an interview on 1/8/21 at 1:24 p.m., the Admin stated that Resident #3 was given a 30 day notice/letter in [redacted] due to the [redacted] and his/her behaviors. However, the resident refused to sign the notice and the family rejected the move due to the distance to travel. The Admin further stated that 20 to 30 other facilities denied him/her.

During an interview on 01/08/21 at 1:24 p.m., the

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F 689	Continued From page 23 Admin reported that Resident #3's physician put an order in place that the resident was not allowed out on pass because of "outburst and behaviors" which required sending him/her to crisis several times. The Admin also stated that they were not aware that Resident #3 was out of the building on , until the resident's called and reported that he/she was in an accident. According to the Admin he spoke several times to Resident #3 that the physician had an order in place that the resident was not to go out on pass, but the Admin could not provide documentation that the resident signed that he/she was informed. During an interview on 1/8/21 at 4:10 p.m., Resident #3 reported continuous in the after the accident, ". The Resident #3 also stated that he/she can not leave now since confined to a wheelchair. During an interview on 01/13/21 at 12:10 p.m., the Security monitor (SM) reported that he saw Resident #3 leaving the area on by exiting the gate and informed the resident, that he/she was not supposed to leave the premises and it was not safe because there was ice on the ground. According to the SM the resident responded "I can do whatever the (expletive) I want to do," and he/she continued out the gate. The SM stated that he did not report to anyone that Resident #3 left the facility grounds until about 15 minutes later when he went up to the floor and informed a nurse at the desk that the resident had left, and stated that the nurse was the only one he informed.	F 689		

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F 689	Continued From page 24	F 689		

Review of the document titled "New Jersey Police Crash Investigation Report," provided to the surveyor by the facility staff, listed the date of the accident as [redacted] at 1:43 p.m. Under "Crash Description/Narrative:" Driver of Vehicle #1 stated she was driving eastbound and had a green light. As she passed the intersection the pedestrian stepped off the curb into traffic. She attempted to stop but could not stop in time and struck the pedestrian. Minor damage to her front license plate and bracket of the car. The pedestrian (Resident #3) stated he/she was waiting to cross the street and thought the light had turned red and stepped off the curb into the traffic when he/she was struck by Vehicle #1. The pedestrian (Resident #3) stated it was his/her fault because the light was green and he/she thought it was red. Pedestrian complained of a possible [redacted] [redacted]. In addition, the Officer documented that there was no crosswalk where the pedestrian entered into traffic.

A review of the facility's policy titled "[redacted] Policy" dated 9/18/2019, included the following under "Policy;" It is the objective of this facility to ensure the safety and protection of [redacted] residents by preventing their exit from the building. Under Policy Interpretation and Implementation, section 7. After locating the resident, an incident report must be completed and document incident in the nurse's notes. 7c. An appropriate Care Plan will be developed to prevent a reoccurrence of elopement.

A review of the facility's policy titled "Out on Pass Unaccompanied." dated 9/2020, included the following under "Policy;" It is the mission of (facility name) to maintain our residents' highest practicable level of independence, resident rights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING ______ B. WING ______	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

(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) COMPLETION DATE
F 689	Continued From page 25 and safety with regards to leaving the facility unaccompanied. Under "Purpose" To facilitate residents' safety and respect for resident's rights. Under Procedure; Unless otherwise specified by a physician, a competent resident may exercise his or her right to leave the facility unaccompanied by staff.... This deficient practice placed Resident #3 and all other residents who were at risk, who had a known history of wandering and/or exit seeking behavior, in an Immediate Jeopardy (IJ) situation. The IJ was identified on 01/08/21 at 5:26 p.m., when the Director of Nursing was notified of the IJ situation, which ran from 12/19/20 until 01/08/21 at 7:15 p.m., when the facility provided an acceptable Removal Plan to remove the Immediacy, which included safety checks on Resident #3 every 15 minute, no "out on pass," unescorted, and staff education on identifying elopement and wandering behaviors. The Removal Plan was verified on 1/13/21, the second day of the survey. N.A.C.P. 8:39-33.1(d)	F 689		

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
	061314	A. BUILDING: ____ B. WING ____	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD** **FREEHOLD, NJ 07728**

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S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		2/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/07/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061314	A. BUILDING: ___ B. WING ___	C 01/13/2021

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S1680	Continued From page 1 This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ 142207 Based on interviews and review of the Nursing Staffing Reports for the week of 12/20/20 and 12/27/20, it was determined that the facility failed to provide at least minimum staffing levels for 3 out of 7 days for each week of 12/20/20 and 12/27/20. The required staffing hours and actual staffing hours are as follows: For the week of 12/20/20. Daily required per census: 330.00 Date: 12/20/20 Actual hours: 288.00 Difference: -42.00 hours. Date: 12/25/20 Actual hours: 280.00 Difference: -50.00 hours. Date: 12/26/20	S1680	• All residents are at risk to be affected by the deficient practice. • The facility will utilize internal and external resources to increase recruitment of direct staff and to ensure the availability of other staffing resources (e.g. contracted staff) in the event of staffing shortage. • The facility will add an additional holiday bonus pay to ensure the holiday weeks are staffed appropriately. • For the next month, the administrator or designee will review the projected staffing hours daily to ensure staffing hours above state minimum. • Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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	061314	A. BUILDING: ___ B. WING ___	C 01/13/2021

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S1680	Continued From page 2 Actual hours: 304.00 Difference: -26.00 hours. For the week of 12/27/20. Daily required per census: 327.25 Date: 12/27/20 Actual hours: 288.00 Difference: -39.25 hours. Date: 01/01/21 Actual hours: 288.00 Difference: -39.25 hours. Date: 01/02/20 Actual hours: 312.00 Difference: -15.25 hours. During an interview on 1/13/2021 at 9:24 a.m., the Administrator reported that if they have a call-out, first they call the Agencies to see if they have any staff last minute. They also have unit clerks who are Certified Nursing Assistants (CNAs) so they can help with care. The Restorative Aides also help when needed. Unit Managers are sometimes pulled to the cart. In addition, the current staff is asked to work over-time when needed and the facility also has a high differential pay for weekends.	S1680		