STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING ______ B. WING ______	C 05/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK REHABILITATION & HEALTHCARE CENTER	**600 LINCOLN PARK EAST CRANFORD, NJ 07016**

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F 000	INITIAL COMMENTS COMPLAINT # NJ 136403 CENSUS: 56 SAMPLE: 1 Based on observations, interviews, review of the "Medical Record" (MR), and other pertinent facility documentation on 5/26/2020, it was determined that the facility failed to ensure a resident with [redacted] as well as failed to secure the resident's window for safety to prevent accidents for 1 of 1 residents sampled, (Resident #1). On [redacted], Resident #1 was observed by the Recreation Director (RD) hanging out the [redacted] floor window, the RD and the Licensed Practical Nurse (LPN #1), redirected the resident, however, the nurse failed to check the window for safety and ensure that the window was secured shut. The resident was able to open the unsecured window, tied sheets together, and subsequently fell to the ground from the [redacted]-floor and was sent to the Emergency Room (ER) via 911 and admitted for a [redacted]. This deficient practice placed Resident #1 and all other residents with [redacted] who were at risk or who had a known history of wandering and/or elopement, in an Immediate Jeopardy (IJ) situation. The IJ was identified on 5/26/2020 at 5:48 p.m., when the Administrator and the Director of Nursing (DON), were notified of the IJ and were provided the IJ template. The IJ ran	F 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 06/16/2020

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 from 5/18/2020, through 5/26/2020 at 12:00 p.m., and was lifted when the facility provided an acceptable Removal Plan.	F 000		
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 - §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 136403 CENSUS: 56 SAMPLE: 1 Based on observations, interviews, review of the "Medical Record" (MR), and other pertinent facility documentation on 5/26/2020, it was determined that the facility failed to ensure a resident with [redacted] as well as failed to secure the resident's window for safety to prevent accidents for 1 of 1 residents sampled, (Resident #1). On 5/18/2020, Resident #1 was observed by the Recreation Director (RD) hanging out the [redacted] floor window, the RD and the Licensed Practical Nurse (LPN #1), redirected the resident, however,	F 689	F 689 Element One - Corrective Actions 1. The window in the room of the Resident#1 was fixed and secured on May 18th 2020 2. Maintenance Director conducted environmental and safety inspections on all windows of the facility to ensure that all windows were safe and secure on May 26th 2020 3. on May 27th 2020 LPN#1 was counseled and re-educated on Elopement Risk Policy; Monitoring and Supervision of elopement risk residents; Policy on Hazard Area, Devices and Equipment to ensure resident□s safety 4. Resident #1 has not returned to the facility. 5. Recreation Director was counseled and re-educated on Elopement Risk Policy; Policy on Hazard area, Devices and Equipment; Reporting to Administrator for immediate safety concern and following thru to ensure the	5/27/20

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F 689	Continued From page 2 the nurse failed to check the window for safety and ensure that the window was secured shut. The resident was able to open the unsecured window, tied sheets together, and subsequently fell to the ground from the [redacted]-floor and was sent to the Emergency Room (ER) via 911 and admitted for a fractured hip. This deficient practice placed Resident #1 and all other residents with [redacted] in an Immediate Jeopardy (IJ) situation. The IJ was identified on 5/26/2020 at 5:48 p.m., when the Administrator and the Director of Nursing (DON), were notified of the IJ and were provided the IJ template. The IJ ran from 5/18/2020, through 5/26/2020 at 12:00 p.m., and was lifted when the facility provided an acceptable Removal Plan. This deficient practice was further evidenced by the following: 1. According to the "Admission Record," Resident #1 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 Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] The MDS also indicated Resident #1 needed limited assistance for Activities of Daily Living (ADLs). Review of the Care Plan dated 5/11/2020, revealed Resident #1 was an [redacted]. The Goals listed included but were	F 689	resident□s safety Element Two - Identification of at Risk Residents All residents with [redacted] have the potential to be affected by this practice Element Three - Systemic Changes 1. Nursing staff were re-educated by ADON/Designee on completion of elopement risk assessments and updating of care plans, Elopement Risk Policy; Policy on Hazard areas, Devices and Equipment; and -Monitoring and Supervision of elopement risk residents. This education was also integrated into the orientation program for nursing staff. 2. An Elopement Drill was conducted by Safety Director/Designee 3. Safety and Environmental rounds are conducted by Maintenance Director /Designee weekly for 3 months and monthly thereafter and include checking the security of all windows. 4. Elopement Risk Assessments will be completed for residents on admission, quarterly as appropriate by licensed staff. All new admissions/re-admissions will be assessed for elopement risk within 24 hours upon admission by a licensed staff 5. IDCP Team will review care plan for all residents who exhibit exit seeking behavior or verbalizing of leaving the facility weekly x 3 months and monthly thereafter Element Four □ Quality Assurance Monitoring 1. DON/Designee audit completion of Elopement Risk assessments and care plans of residents who exhibit exit seeking behavior monthly for the next quarterly and quarterly thereafter and findings will	

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F 689	Continued From page 3 not limited to: The resident's safety will be maintained through the review date. The resident will not leave the facility unattended through the review date. The "Target date" was [redacted]. The interventions listed included but were not limited to: [redacted] Also listed under "Interventions", the resident's triggers for wandering/eloping are agitation. The resident's behaviors are de-escalated by gently redirecting. Further review of the Care Plan dated 5/11/2020, revealed Resident #1 had a potential to be physically aggressive and takes things off the wall when frustrated, related to anger. The Goals listed included but were not limited to: The resident will demonstrate effective coping skills through the review date. The resident will not harm self or others through the review date. The interventions listed included but were not limited to: Administer medications as ordered. Monitor and document for side effects and effectiveness. Analyze times of day, places, circumstances, triggers and what de-escalates behavior and document. According to the "Admission Review Sheet" dated [redacted], Resident #1 had left the Assisted Living (AL) Facility he/she was living in Against Medical Advice (AMA), because they would not let him/her go out to [redacted]. They also documented the resident was on 1:1 for monitoring. Review of the facility's progress notes dated 5/4/2020 at 9:15 p.m., the nurse documented the following: Resident seen walking out the door to the parking lot, nurse and recreation aide	F 689	be submitted to the Administrator monthly and discussed during the quarterly QA committee meeting. 2. Monthly Safety and Environmental rounds will be conducted by Maintenance Director/Designee to include checking all windows on an ongoing basis. Findings will be submitted to the administrator by the Maintenance Director/designee and discussed during the quarterly QA meeting. 3. An Elopement Drill will be done by Safety Officer /Designee and the report will be submitted to the Administrator to be discussed during the quarterly QA committee meeting.	

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F 689	Continued From page 4 followed resident and tried to redirect [redacted] back to the facility, resident refused saying "I'm going to the bus stop, I got things to do today." The nurse and recreation aide followed the resident to the street and continued to encourage the resident to come back to the facility. After a few minutes the resident returned to the facility. The doctor was notified of the resident's behavior and gave an order to send the resident to the hospital for an evaluation. The resident was admitted to the hospital for "[redacted]" and was readmitted to the facility on [redacted]. Review of the facility's progress notes dated 5/10/2020 at 6:07 p.m., the nurse documented the following: Patient wandering, still risk of elopement, medicated for [redacted] [redacted]... will continue to monitor. Review of the facility's progress notes dated 5/14/2020 at 9:00 a.m., the nurse documented the following: The resident was walking around the room and stated, "I'm leaving right now, I have a taxi coming it's almost here.... Resident [redacted] when approached unable to redirect. .. [redacted] given as ordered-effective." At 11:00 a.m., the nurse reported the resident was aggressive towards the staff but redirectable. Safety and fall precautions maintained. At 1:00 p.m., the resident was alert with noted confusion, continues to yell and curse at the staff with effective redirection. Safety and fall measures in place. At 4:00 p.m., the "resident was [redacted] [redacted]." The nurse was unable to effectively redirect the resident and documented [redacted] [redacted]	F 689		

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F 689	Continued From page 5 [redacted]) given - continues to walk around unit but no [redacted] noted." At 6:00 p.m., the resident attempted to leave the facility ... redirected by the staff effective. Short intervals of calmness achieved with verbal engagement between resident and staff. "Constant monitoring maintained. Remains alert and stable." Review of the facility's progress notes dated 5/15/2020 at 1:27 p.m., the DON documented she spoke with the [redacted] Nurse Practitioner (NP) about Resident #1's medications and the following recommendations were made and will be reviewed with the Primary Medical Doctor. Discontinue [redacted], increase [redacted] and standing [redacted]. Review of the facility's progress notes dated 5/15/2020 at 2:22 p.m., the DON documented the resident pulled the fire alarm and stated "they did not take me out as fast as I wanted. I don't care that this was wrong. I will do it again if I do not get my way." The DON counseled the resident on safety and how to make [redacted] needs known in a non-dangerous manner. Review of the facility's progress notes dated 5/15/2020 at 6:45 p.m., LPN #1 documented Resident #1 was sitting in the common area (dayroom) looking out the [redacted] floor window when the resident became agitated and stated, "I'm waiting for the police to come." LPN #1 then heard a loud noise and observed Resident #1 with the window open and ejecting his/her limbs out of the window and cursing at staff members who were down in the parking lot below. The LPN attempted to redirect the resident, and documented "was not easily redirected and became harmful to himself/herself." The nurse	F 689		

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F 689	Continued From page 6	F 689		

called the doctor to inform him of the resident's state. The doctor ordered to send the resident to crisis for an evaluation. There was no documentation indicating the nurse checked the window for safety or secured the window shut.

According to the progress notes the nurse documented Resident #1 returned to the facility on [redacted] at 6:55 a.m., with diagnoses of [redacted]. She also documented, the resident was alert with confusion. Vital signs were checked, and the nurse reported: "Will continue to monitor."

According to the Facility's Reportable Event (FRE) , reported to the NJ Department of Health (NJDOH) on 5/20/2020, with a "Date of Event" of 5/18/2020, and a "Time of Event" of 6:45 p.m., indicated that prior to the event Resident #1 was in his/her room, the resident tied bed sheets together into a rope and tried to climb out of the window. The resident was found outside on the ground, sitting upright against the wall of the building by the therapy room. The resident was crying out for help. Resident was alert, awake and verbally responsive with clear speech. Several sheets tied in knots were underneath the resident.

Review of the nursing progress notes attached to the FRE, indicated on 5/18/2020 at 5:00 p.m., the nurse saw the resident in the hallway and the resident stated to the nurse "I want to get out of here, I will pull the fire alarms or call 911." The nurse documented she redirected the resident and the resident returned to their room. At 6:00 p.m., the nurse documented "nurse was made aware by Activity Director that resident (Resident #1) was attempting to eject his/her limbs out of room window." She further documented when

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F 689	Continued From page 7 approached and asked, "what are you doing, it is not safe opening up the window." The resident replied, "I'm getting the "F" out of here." The staff documented that they were able to redirect the resident and the resident was encouraged to come out of the room, however, the resident declined. The nurse documented "upon staff exiting room resident noted not in window area." At 6:45 p.m., the nurse documented she received a call from the therapy department who informed her that Resident #1 was outside on the ground. Staff immediately responded and 911 emergency were notified. There was no documentation indicating the nurse checked the window for safety or secured the window shut. According to the FRE "Conclusion" undated, the DON documented the following: "Resident sustained a [redacted] from the [sic] trying to leave the building by climbing out of the window using tied sheets which was not anchor [sic] properly and caused him/her to fall to the ground together with the tied sheets." During a facility tour on 5/26/2020 at 10:30 a.m., accompanied by the DON and the Assistant Director of Nursing (ADON), the surveyor's observation of Resident #1's room revealed a semi-private room with 2 single beds. The DON reported Resident #1 does not have a roommate secondary to [redacted] behavior. Three windows were observed in the center of the room which were grouped together. The center window had an air conditioner in place and was sealed shut by a board screwed to the edge of the window and the air conditioner was secured by screws in place on the upper and lower edges of the window. The window on the left side was observed closed with 2 screws approximately 3 inches above the window and a screw and bolt above the 2 screws.	F 689		

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F 689	Continued From page 8 The window on the right had 2 metal brackets in place above the lower window on each side which were held in place with 2 screws which prevented the window from opening at all. During the tour on 5/26/2020 at 10:35 a.m., the DON stated, Resident #1 opened the window by using a knife as a screwdriver to open the window, however, no knife was found. During an interview on 5/26/2020 at 11:49 a.m., the Recreation Director (RD) reported, on 5/18/2020 between 6:30 and 7:00 p.m., she was sitting in the ██ wing dayroom" and observed through the window on █ wing Resident #1 "he/she stuck his/her head and arms out of the window.... The window was open about one foot, twelve inches." The RD stated she immediately went to the resident's room. From the doorway she said to Resident #1, "don't stick your head out it's not safe." The resident closed the window and stayed in the room. The RD reported the resident was agitated and stated aggressively, "don't tell me what to do." The RD reported the incident to the nurse on the unit. "I told them [LPN #1 and the Certified Nursing Assistant (CNA #1)] the resident had his head and arms out of the window and he was very agitated. The RD reported she then went to the room with the nurse and the CNA and the resident was still in the room and was still agitated and yelling saying, "respect my privacy." When the RD left, the nurse and the CNA were still with the resident. The RD stated the window was closed when she left. During an interview on 5/26/2020 at 1:10 p.m., the Director of Social Services (DSS) reported, Resident #1 was initially on the ██ floor on an unlocked unit, however, he/she attempted several times to exit the building. In addition, the resident was able to walk around, and people were afraid	F 689		

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F 689	Continued From page 9 because he/she would talk about hurting others, therefore, the resident was moved to the [redacted] floor locked unit. The DSS also stated, she did not feel Resident #1 was safe to make decisions because of his/her aggression. During a phone interview on 5/26/2020 at 2:32 p.m., LPN #1 reported, she was notified by the RD that Resident #1 "was waving his/her arms out of the window." She reported when she went to the room the windows were closed and she observed screws in place above the window. "I saw screws in place on the left side, so I did not try to open the windows to see if there were any issues with the windows." When she left, Resident #1 was in their room on the bed and appeared calm, the resident stated to LPN #1, he/she understood, and was not going to do anything and the resident stated, "I'm okay." According to LPN #1 she paged maintenance to check the windows, however, maintenance never responded to the page and she did not call maintenance again. According to LPN #1, she rechecked the resident about 15 minutes later and observed the resident in their room washing clothes. According to LPN#1, she did not send Resident #1 to crisis because the resident never stated he/she wanted to leave or talk about hurting himself/herself and the resident was calm when he/she left. She later was alerted by the therapy department that the resident was outside. She called 911 then went outside to assess the resident. During an interview on 5/26/2020 at 11:03 a.m., the Maintenance Director (MD) reported that he was not in the building on 5/18/2020, when Resident #1 climbed out of the window since his shift ended at 3:00 p.m., however, he was called to return to the facility around 6:00 p.m. "They	F 689		

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F 689	Continued From page 10 said there was an accident here. Someone had jumped out of the window and I was called to come fix the window." According to the MD the resident had 3 windows in his room grouped together the MD stated, the resident "jumped out the window on the right side, the window was wide open, glass was not broken, he/she forced the screws out." When he returned to the facility on [redacted], he observed the window in Resident #1's room on the far right to be "wide open" which was over 12 inches. The MD also reported that prior to the incident there was "2 L brackets on the window, one on each side." When he arrived after the incident one L bracket was bent, the other one was off completely. According to the MD all windows on the second floor are checked monthly by the maintenance department, however, the MD reported no logs were kept of the inspections. In addition, the MD reported L brackets were added to Resident #1's windows about 1 month prior to the accident since the bolts were loose. Review of the Facility document dated 4/30/2020, titled "Elopement Risk Assessment Form" for Resident #1, dated 4/30/2020, under "Definitive Risk Factors:" Marked "Yes" for the questions: Is the resident cognitively impaired with poor decision-making skills (i.e. intermittent confusion, cognitive deficits, disoriented) Under "Summary of Assessment," The nurse documented; "Resident is not at risk for elopement at this time." Under "Scoring:" Three or more "Resident status/Potential Risk Factors" and/or one or more "Definitive Risk Factors" indicate a resident at risk for elopement. During an interview on 5/29/2020 at 10:00 a.m., the DON verified that the Elopement Risk Assessment Form completed on 4/30/2020, was	F 689		

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F 689	Continued From page 11	F 689		

completed incorrectly by the nurse because Resident #1 did have one "Definitive Risk Factor."

A review of the facility's policy titled "Elopement" dated 9/18/2019, 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.

A review of the facility's policy undated, titled "Hazardous Areas, Devices and Equipment," under "Policy Statement:" All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Under "Identification of Hazards" section 1., A hazard is defined as anything in the environment that has the potential to cause injury or illness. Section 1.d. Open area or items that should be locked when not in use. Section 1.k. Disabled locks, latches or alarms.

Under "Assessment and Analysis of Hazards:" section 2. Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous. Under section 3. Resident vulnerability is based on risk factors including the individual resident's functional status, medical condition, cognitive abilities, mood and health treatments (e.g., medications).

Resident #1 was observed by the Recreation Director (RD) hanging out the window and she reported the unsecured window to the nurse on the unit, however, the nurse failed to check the window for safety and the resident was able to open the unsecured window, tied sheets together, and exited the building, and subsequently fell to the ground from the [redacted] -floor and was sent to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING ______ B. WING ______	C 05/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK REHABILITATION & HEALTHCARE CENTER	**600 LINCOLN PARK EAST CRANFORD, NJ 07016**

(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 12 the Emergency Room (ER) via 911 and admitted for a [redacted] This deficient practice placed Resident #1 and all other residents with [redacted] [redacted] who were at risk or who had a known history of wandering and/or elopement, in an Immediate Jeopardy (I) situation. The IJ was identified on 5/26/2020 at 5:48 p.m., when the Administrator and the Director of Nursing (DON), were notified of the IJ and provided the IJ template. The IJ ran from 5/18/2020, through 5/26/2020 at 12:00 p.m., and was lifted when the facility provided an acceptable Removal Plan. A revisit to verify the Removal Plan occurred on 5/29/2020. N.J.A.C. 8:39-33.1(d)	F 689		