STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A006	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS CHERRY HILL	1450 MARLTON PIKE CHERRY HILL, NJ 08034

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00123385 CENSUS: 117 SAMPLE SIZE: 3 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 753	8:36-7.3(c) Resident Assessments and Care Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00123385	A 753		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/13/19

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A 753	Continued From page 1 Based on interview and record review, it was determined that the facility failed to update and/or revise Service Plans for 2 of 3 residents reviewed for elopement, Resident #1 and Resident #3. This deficient practice was evidenced by the following: On 5/9/19 at 9 a.m., during the entrance conference with the Executive Director (ED), the surveyor asked the ED if there were any incidents/accidents investigated in the past three months. The ED replied, "No." At 9:30 a.m., the surveyor interviewed a Licensed Practical Nurse (LPN) and inquired about resident(s) with [redacted]. The LPN stated that Resident #2 was an [redacted] and had periods of [redacted]. She stated that the resident was observed outside of the front entrance a few times and was redirected back into the building by staff. She added that the resident stated he/she wanted to go to "[redacted]." At 9:45 a.m., the surveyor observed Resident #2 in his/her room seated on the bed. The surveyor asked the resident how he/she was doing and the resident replied, "ok, and goodbye." The surveyor then asked the resident if he/she attempted to go to [redacted] and the resident replied, "Wish I could but can't remember doing that, goodbye." At 11 a.m., the surveyor reviewed Resident #2's medical record and observed that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] of the [redacted]. The "Assisted Living Resident Evaluation & Level of Care v3" form, dated [redacted], documented that the resident was [redacted] and	A 753		

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A 753	Continued From page 2	A 753		

[redacted] had [redacted] and required [redacted] The surveyor also observed in the medical record that the resident was independent with Activity's of Daily Living (ADLs).

Continued surveyor review of the medical record revealed an electronic progress note dated [redacted] and timed at 17:42 [5:42] p.m., signed as written by a Registered Nurse (RN), which documented that the resident was more [redacted] than when previously assessed and the resident needed more [redacted].

On 3/12/19 at 14:09 [2:09] p.m., a RN documented that Resident #2 asked a valet at the front doors for directions to [redacted] and stated that he/she was "going there now." According to the medical record, the resident was easily redirected, staff were alerted, a [redacted] assessment was completed and safety checks were increased.

On 3/14/19 at 15:20 [3:20] p.m., a RN documented that the resident walked out of the front door [redacted] in past [redacted] and was redirected back inside the facility by the valet staff who alerted her (RN) to the situation. She documented that the resident acknowledged that he/she did something unsafe and multiple attempts were made to redirect the resident to the courtyard but, the resident refused. The RN documented that the resident's Power of Attorney (POA) was notified and agreed to getting a Private Duty Aide (PDA) and a psychiatry consult.

On 3/16/19 at 23:09 [11:09] p.m., an LPN documented that the resident approached her in the [redacted] and was [redacted] as to where to go and how to get back to his/her room. The

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A 753	Continued From page 3	A 753		

LPN documented that nursing escorted the resident back to the resident's room to watch television.

On 3/28/19 at 11:21 a.m., a RN documented that the resident was seen last night, [redacted] at 8 p.m. seated by the front desk. She documented that the resident [redacted] since the date of move-in and the POA was made aware of the [redacted] and about the [redacted] recommendation. Additionally, she documented that the POA stated that she would consider a [redacted] unit in the future but did not want to make a drastic change to the resident's life. The [redacted] note dated [redacted] documented that the POA was less concerned about the [redacted].

On 4/9/19 at 22:38 [10:38] p.m., a LPN documented that she observed the resident, "Standing out front" while she (LPN) was coming in for her shift. The resident stated to the LPN that he/she was getting some air.

On 5/15/19 at 3 p.m. the surveyor conducted a telephone interview with the LPN who stated that she observed the resident standing outside of the facility, by the front door at approximately 2:45 p.m., on the above date. The LPN stated that she redirected the resident back into the building.

During surveyor interview with the Executive Director (ED) on 5/9/19 at 2:05 p.m., regarding the above concerns, the surveyor inquired if the facility had a monitoring system in place for residents assessed to be at [redacted] and who live in the [redacted] section of the facility. The ED stated that it is an Assisted Living facility and the residents are allowed to go outside. The ED also stated that

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A 753	Continued From page 4 the facility did not have a system in place to monitor residents in non secured area, only in the [redacted] care unit. On 5/13/19 at 1:20 p.m., the surveyor conducted a telephone interview with a Concierge regarding Resident #2. The Concierge stated that the resident was an [redacted] and that they had his/her picture in a binder at the front desk to alert staff. The Concierge also stated that she observed the resident leave the building but could not recall the exact date. She explained that she immediately ran after the resident, who had already gotten down the steps and to the walk-way, "near the dining area." According to the Concierge, the resident stated that he/she wanted to take a walk. She also stated that she contacted nursing after she brought the resident back into the building. On 5/14/19 at 9:50 a.m., the surveyor interviewed the Director of Resident Care (DRC) regarding the resident's [redacted] r and she stated that the resident, "...liked to go between the doors and outside to look out but had not [redacted]." The DRC further stated that she spoke with the resident's POA regarding the resident's behavior and the POA stated that she was not ready to transfer the resident to the [redacted] unit. During interview, the DRC stated that a Private Duty Aide was initiated on [redacted] and was discontinued on [redacted] because the resident adjusted well and did not wander out of the building. However, Resident #2 had experienced a change [redacted] as evidenced by [redacted] and [redacted] and was observed outside on [redacted] by an LPN at 2:45 p.m.	A 753		

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A 753	Continued From page 5 Surveyor review of facility's policies and procedures titled, "[redacted]" documented, "Install or maintain monitoring systems or devices that provide continuous 24 hour/7 days week coverage." The resident's Service Plan (SP) initiated on [redacted] revealed that the resident was identified as an [redacted] related to [redacted] behavior and was disoriented to place. In addition, the SP documented that the resident would not leave the facility unattended through the review date of [redacted], and the interventions included that the POA employed a Private Duty Aide from 3 p.m.-7 p.m.. Surveyor review of the SP revealed no documented evidence that Resident #2's SP had been updated and/or revised to reflect intervention(s) to prevent the resident from leaving the building unattended on [redacted] and when the Private Duty Aide was discontinued on [redacted] 2. On 5/9/19 at 12:25 p.m., the surveyor reviewed Resident #3's medical record which documented that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted]. The "Assisted Living Resident Evaluation & Level of Care v3" form dated [redacted] documented that the resident was [redacted] only, [redacted] and had [redacted]. On 2/24/19 at 21:47 [9:47] p.m., a LPN documented that the resident was observed with his/her coat on and a bag and stated, "I was trying to go home because I wanted to make a peach pie. I got a taste for a good peach pie."	A 753		

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A 753	Continued From page 6 According to the electronic progress notes dated [redacted] and [redacted] Resident #3 was observed for [redacted] and an [redacted]. The facility identified the resident as an elopement risk and placed the resident's picture, face sheet and elopement identification form in a binder at the front desk. During surveyor review of the resident's Service Plan (SP) dated [redacted] and reviewed on [redacted] the surveyor did not observe documented evidence that a SP had been developed and/or updated to include the Resident #3's [redacted] risk. During interview with the ED regarding the above concerns, he stated that the resident had a SP for [redacted], however, the SP did not address the resident's [redacted] risk with intervention(s).	A 753		