STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315047	A. BUILDING _____ B. WING _____	C 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077**

(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 # NJ115525, NJ122780, NJ125813, NJ126030, NJ126297, NJ126298, NJ126299, NJ126302, Based on observations, interviews, medical record (MR) review, and review of other pertinent facility documentation on 7/24/19 and 7/26/19, it was determined that the facility failed to protect and ensure that a [redacted] resident who had a known history of wandering in the facility, was safe from elopement and was appropriately monitored and/or supervised by the facility staff to prevent elopement for 1 of 6 sampled Residents (Resident #1) reviewed for elopement. On [redacted], Resident #1 exited the facility via a rear exit door (door #4) that did not alarm. The facility implemented a search in the building but was unable to find the Resident. Resident #1 was missing from the facility from 6/16/19 at 3:10 a.m. to 6/16/19 at 3:30 a.m., approximately 20 minutes. The Resident was found across the street away from the facility by a Licensed Practical Nurse (LPN #4) and was returned to the facility on 6/16/19 at 3:30 a.m. Also, on 7/24/19, the facility failed to ensure the Wander Guard system functioned properly to prevent Residents with a history of wandering and pacing did not exit the facility unescorted for 1 of 6 sampled Residents (Resident #9). On 7/24/19, during a test of the Wander Guard system, Resident #9 who was [redacted] and had a known history of wandering in the facility, with a Wander Guard device to his/her right ankle was escorted to the front doors accompanied by a Certified Nurse's Assistant (CNA #1). Upon exiting the front door of the facility with Resident	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/03/2019

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 #9, the Wander Guard system did not alarm and did not lock. The facility further failed to ensure Residents' Wander Guard devices were functioning properly to prevent elopement for 2 of 6 sampled Residents (Resident #10 and Resident #11). This placed Resident #1, Resident #9, Resident #10 and Resident #11 at risk for elopement, as well as all residents with a history of elopement in an Immediate Jeopardy (IJ) situation. The IJ was identified on 7/24/19 at 4:31 p.m., the Administrator, Director of Nursing (DON) and owners of the facility were notified of the IJ. The IJ ran from 6/16/19 at 3:10 a.m. through 7/24/19 at 4:31 p.m., and was lifted the same day at 5:15 p.m., when the facility implemented an acceptable Removal Plan.	F 000		
F 658 SS=E	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 by: COMPLAINT# NJ 126297, NJ 126299 Based on interviews, record review and review of pertinent facility documents on 7/24/19 and 7/25/19, it was determined that the facility staff failed to follow Physician's Orders (POS) for 4 of 5 sampled Residents (Resident #1, 9, 10, and 11). The facility staff also failed to transcribe a Physician's Order correctly for 1 of 5 sampled Residents (Resident #7). The facility staff further	F 658	Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.	7/31/19

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F 658	Continued From page 2 failed to follow policy's titled "Physician Orders", "Medication Administration" and "[redacted] Management" for 5 of 5 sampled residents (Resident #1, 7, 9, 10 and 11). This deficient practice was evidenced by the following: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview for Mental Status (BIMS) score o[redacted] The MDS also indicated that Resident #2 needed assistance with Activities of Daily Living (ADLs). Review of Resident #1's "Order Summary Report (OSR)" (Physicians Order Sheet) dated 6/2019, revealed the following: Check function of Wander Guard placed to [redacted] every shift for safety, dated 6/9/19. Check placement of Wander Guard to [redacted] every shift for safety, dated 6/9/19. Review of Resident #1's "Treatment Administration Record (TAR)" dated 6/19, showed that there was no documentation to indicate that the Wander Guard to the [redacted] was checked for function and/or placement as follows: On 6/16/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. On 6/23/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. On 6/23/19, for the 7:00 a.m. to 3:00 p.m. shift,	F 658	Resident #1 and Resident #9 were discharged from the facility. Resident #10 and #11 Medication Administration Records were maintained using Medical Record Process. Resident #7□s Physician order was clarified and transcribed by a licensed nurse on 7/16. All residents have the potential to be affected. A medical Record audit was completed for the completion of MAR□s for all current residents. Licensed Nurses were educated on the completion of the Medication Administration Record (MAR) policy and procedure on 7/26. Audits of MAR will be completed weekly for 4 weeks then monthly times 3 months by Director of Nursing or licensed Nurse. Results will be presented to the Quality Assurance Performance Improvement Committee Quarterly for 6 months.	

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F 658	Continued From page 3 for placement. On 6/24/19, for the 7:00 a.m. to 3:00 p.m. shift, for function. 2. According to the AR, Resident #9 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to the MDS, an assessment tool dated [redacted], Resident #9 had a BIMS score of [redacted] The MDS also indicated that Resident #9 needed assistance with ADLs. Review of Resident #9's Physical Restraint Device Assessment dated 6/28/19, indicated the Resident required a Wander Guard device due to wandering and pacing. Review of Resident #9's POS dated 6/2019, revealed the following: Check function of Wander Guard placed to [redacted]) every shift. Document yes or no to functioning, dated 6/28/19. Check placement of Wander Guard to ([redacted]) every shift for safety, dated 6/28/19 Review of Resident #9's TAR dated 7/19, showed that there was no documentation to indicate that the Wander Guard to the [redacted] was checked for function and/or placement as follows: On 7/23/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement. On 7/23/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. 3. According to the AR, Resident #10 was admitted to the facility on [redacted], with	F 658		

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F 658	Continued From page 4 diagnoses which included but were not limited to: [redacted] According to the MDS, an assessment tool dated [redacted] Resident #10 had a BIMS score of [redacted] The MDS also indicated that Resident #10 needed assistance with ADLs. Review of Resident#10's POS dated 7/2019, revealed the following: Check function of Wander Guard placed to wheelchair every shift, dated 6/24/19. Check placement of Wander Guard to wheelchair every shift, dated 6/24/19. Review of Resident #10's TAR dated 7/19, showed that there was no documentation to indicate that the Wander Guard to the wheel chair was checked for function and/or placement as follows: On 7/2/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement. On 7/2/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. On 7/9/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement. On 7/9/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. On 7/11/19, for the 11:00 p.m. to 7:00 a.m. shift, for function. 4. According to the AR, Resident #11 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]	F 658		

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F 658	Continued From page 5 [redacted]. According to the MDS, an assessment tool dated [redacted], Resident #11 had a BIMS score of [redacted]. The MDS also indicated that Resident #11 needed assistance with ADLs. Review of Resident #11's POS dated 7/2019, revealed the following: Check function of Wander Guard placed to left ankle every shift. Document yes or no to functioning every shift dated, 6/24/19. Check placement of Wander Guard to left ankle every shift, dated 6/24/19. Review of Resident #11's TAR dated 7/19, showed that there was no documentation to indicate that the Wander Guard to the [redacted] was checked for function and/or placement as follows: On 7/2/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. On 7/9/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement. On 7/9/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. On 7/11/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement. On 7/11/19, for the 11:00 p.m. to 7:00 a.m. shift, for function. During an interview on 7/24/19 at 12:35 p.m., Certified Nurses Assistant (CNA #1) stated "I tell the nurse I saw the Wander Guard and the nurse will document the placement of the Wander Guard." CNA #1 further stated "Residents wear a Wander Guard to prevent them from escaping and eloping."	F 658		

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F 658	Continued From page 6 During an interview on 7/24/19 at 12:40 p.m., Licensed Practical Nurse (LPN #1) stated "we only check for placement of the Wander Guard on the 7:00 a.m. to 3:00 p.m. shift, and 3:00 p.m. to 11:00 p.m. shift. The 11:00 p.m. to 7:00 a.m. shift checks the function." During an interview on 7/25/19 at 3:00 p.m., LPN #2 stated "a blank on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) means it was not done." 5. According to the "Admission Record (AR)," Resident #7 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]. According to the MDS, dated [redacted], Resident #7 had a BIMS score of [redacted], which indicated Resident #7's [redacted] The MDS also indicated that Resident #7 required extensive assistance with ADLs. A review of Resident #7's undated Care Plan showed the "Focus".. [redacted] Under "Interventions," Administer pain medication as ordered. Observe for signs and symptoms of [redacted] and intervene accordingly. Render treatment as ordered."	F 658		

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F 658	Continued From page 7 Review of Resident #7's OSR with an order date range from 7/1/19 to 7/26/19, included the following orders: 1. [redacted]." Order date 7/11/19, start date 7/12/19, order status "Discontinued." 3. "[redacted]." Order date 7/16/19. start date 7/17/19, order status "Active." Review of resident #7's Treatment Administration Record (TAR) dated 7/1/19 - 7/31/19 revealed the order for [redacted]. Order date 7/11/19, start date 7/12/19 was administered from 7/12/19 to 7/16/19. A review of the [redacted] Consultation orders dated 7/10/19, the physician indicated the following recommendations: 1. [redacted]. This should be changed daily. A review of the facility incident report for medication error dated 7/17/19 indicated the following: "Resident [#7] returned from ... [redacted] appointment with new orders for [redacted] orders inappropriately transcribed from consult sheet. "[redacted] Resident received inaccurate wound care to right	F 658		

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F 658	Continued From page 8	F 658		

heel for two days before being discovered. Resident with no adverse effects noted to [redacted] care orders clarified. PCP [Primary Care Physician] notified of error. Resident is own responsible party." The surveyor observed that according to the TAR, resident #7 received the treatment for 5 days. The surveyor notified the Director of Nursing (DON) regarding the discrepancy in the incident report.

A review of Resident #7's progress notes indicated the resident went to [redacted] appointment on 7/10/19. A note dated 7/16/19 indicated: "Order clarified to cleanse right heel with NSS [redacted] Attempted to call [redacted]] to confirm clarification, no answer, left message. MD aware.

During an interview with the DON on 7/31/19 at 2:48 p.m., the DON stated that the 2-day statement on the incident report was incorrect. The resident received the treatment for 5 days and a correction would be made. The DON stated that the resident did not suffer any ill effects as a result of the incorrect treatment. The DON further stated that the nurse Registered Nurse (RN #1) received education regarding the transcription error and treatment order clarification.

Review of the facility's policy titled "Medication Administration" dated August 1, 2017, revealed the following:
Under "Purpose" To provide practice standards for safe administration of medications for residents in the facility.
Under "Procedure" The licensed nurse will chart the drug, time administered and initial his/her name with each medication administration and

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sign full name and title on each page of the Medication Administration Record (MAR).
Under "Documentation" A. The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment.
B. Recording will include the date, the time and dosage of medication or type of the treatment.
C. Initials may be used. provided that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record.

A review of the facility "Physician Orders", policy dated 8/1/17 indicated the following:
Policy
The Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary.
VIII. Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order.
IX. Medication/treatment orders will be transcribed onto the appropriate resident administration record.

A review of the facility [redacted] Management" policy dated 11/1/17 indicated the following:
Purpose
To provide a system for the treatment and management of residents with [redacted] including [redacted].
Policy
A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new [redacted] from developing.
[redacted] Management

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F 658	Continued From page 10 A. The attending Physician will be notified to advise on appropriate treatment promptly. E. A Licensed Nurse will develop a care plan for the resident based on recommendations from Dietary, Rehabilitation and the Attending Physician. F. Per Attending Physician order, the Nursing Staff will initiate treatment and utilize interventions for pressure redistribution and wound management. NJAC 8:39-11.2(a); 27.1(a)(b); 29.2(b)	F 658		
F 689 SS=K	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 126299 Based on observations, interviews, medical record (MR) review, and review of other pertinent facility documentation on 7/24/19 and 7/26/19, it was determined that the facility failed to protect and ensure that a [redacted] resident who had a known history of wandering in the facility, was safe from elopement and was appropriately monitored and/or supervised by the facility staff to prevent elopement for 1 of 6 sampled Residents (Resident #1) reviewed for	F 689	Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. Resident #1 was returned to the facility without adverse effects. Maintenance tested the front door and it	7/31/19

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F 689	Continued From page 11 elopement. On 6/16/19, Resident #1 exited the facility via a rear exit door (door #4) that did not alarm. The facility implemented a search in the building but was unable to find the Resident. Resident #1 was missing from the facility from [redacted] at 3:10 a.m. to 6/16/19 at 3:30 a.m., approximately 20 minutes. The Resident was found across the street away from the facility by a Licensed Practical Nurse (LPN #4) and was returned to the facility on [redacted] at 3:30 a.m. Also, on 7/24/19, the facility failed to ensure the Wander Guard system functioned properly to prevent Residents with a history of wandering and pacing did not exit the facility unescorted for 1 of 6 sampled Residents (Resident #9). On 7/24/19, during a test of the Wander Guard system, Resident #9 who was [redacted] and had a known history of wandering in the facility, with a Wander Guard device to his/her right ankle was escorted to the front doors accompanied by a Certified Nurse's Assistant (CNA #1). Upon exiting the front door of the facility with Resident #9, the Wander Guard system did not alarm and did not lock. The facility further failed to ensure Residents' Wander Guard devices were functioning properly to prevent elopement for 2 of 6 sampled Residents (Resident #10 and Resident #11). This placed Resident #1, Resident #9, Resident #10 and Resident #11 at risk for elopement, as well as all residents with a history of elopement in an Immediate Jeopardy (IJ) situation. The IJ was identified on 7/24/19 at 4:31 p.m., the Administrator, Director of Nursing (DON) and owners of the facility were notified of the IJ. The IJ ran from 6/16/19 at 3:10 a.m. through 7/24/19 at 4:31 p.m., and was lifted the same day at 5:15 p.m., when the facility implemented an acceptable Removal Plan. This deficient practice	F 689	functioned correctly. Resident #9's wanderguard was tested as well and was also functioning properly, however bracelet was replaced. Resident #10 and #11□s Wanderguard Bracelets were immediately replaced. All wandering residents have the potential to be affected. All residents who utilize a wanderguard bracelet were evaluated □ checked for functioning and placement. All exit doors were checked to ensure for functionality, and all are operating correctly. Staff was educated on the elopement prevention program policy/procedure on 6/17/19 and another education on 7/24. The Director of Nursing / Maintenance / or licensed nurse will audit both bracelets and doors for functionality weekly for 4 weeks; then monthly for 3 months. Results will be presented to the Quality Assurance Performance Improvement Committee Quarterly for 6 months.	

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was evidence by the following:

1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted]

According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] The MDS also indicated that Resident #1 needed assistance with Activities of Daily Living (ADLs).

Review of Resident #1's Care Plan (CP) prior to exiting the facility included the following:
Under "Focus": Wandering/pacing to point of exhaustion, dated 4/17/19.
Under "Interventions": Monitor resident closely during acute episodes of behavior to keep the resident and others safe, dated 4/17/19.

Review of Resident #1's "Order Summary Sheet (OSR)" (Physician's Order Sheet (POS)) dated 6/2019, showed the following:
Check function of Wander Guard placed to ([redacted]) every shift for safety, dated 6/9/19.
Check placement of Wander Guard to [redacted]) every shift for safety, dated 6/9/19.

Review of Resident #1's "Treatment Administration Record (TAR)" dated 6/19, showed that there was no documentation to indicate that the Wander Guard to the [redacted] was checked for function as follows:
On 6/16/19, for the 3:00 pm. to 11:00 p.m. shift.

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Review of the Facility's Reportable Event Record (FRE) dated 6/19/19, indicated on 6/16/19 at 3:10 a.m., while making rounds, assigned Certified Nurses Assistant (CNA #1), at approximately 3:05 a.m., noticed the Resident were not in his/her bed. The charge nurse and supervisor were notified. A room to room search of the South Unit was initiated. At approximately 3:15 a.m., "Code Gray" was initiated. The supervisor and CNAs continued to search inside the building while two Licensed Practical Nurses (LPNs #6 and #7) conducted a search outside the building. At approximately 3:30 a.m., while making rounds outside of the building, the LPN charge nurse (LPN #6) noticed the Resident sitting across the street. Resident #1 was without injuries and returned to building without incident.
The FRE also revealed Resident #1 had a CP for wandering behavior and included interventions of a Wander Guard to the [redacted].
Investigational findings included the following:
"It was determined with high probability that the Resident exited through this door (door #4) as it is the closest to the Resident's room and all other doors alarmed when tested, including the [redacted] exit door (Door #4). It is unclear if the door did not alarm at the time of the Resident's exit due to a malfunction or an employee error of not resetting the alarm properly...."

According to the "Elopement" form dated 6/19/19 at 9:16 a.m., under "Immediate Actions Taken":
Resident #1's Wander Guard checked for function and working but, changed for safety.
New elopement risk assessment completed.
Elopement CP initiated and Wandering CP updated.
Under "Mental Status": Oriented to person only.

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F 689	Continued From page 14 Under "Predisposing Physiological Factors": Confused, and Impaired Memory. Under "Predisposing Situation Factors": Wanderer. Review of Resident #1's "Progress Notes" dated 6/16/19 at 08:23 a.m., included; Supervisor notified staff that Resident was not in bed. Staff immediately patrolled the entire facility. Staff checked Resident's Wander Guard device on left ankle with transmitter and it was functional however; the Resident was wheeled to back door and front door, no alarm activation occurred. The Wander Guard device was changed. Maintenance was notified. The door is now functioning and alarming. Every (q) 1-hour checks were initiated x 3 days. A head to toe assessment was completed with no signs of head contusions, no skin integrity issues. Vital Signs Stable (VSS). Notified [redacted].... Review of Resident #1's "Elopement Risk Evaluation" dated 6/16/19, indicated the Resident scored a 20, indicating the Resident was at risk for elopement from the facility. Under #3 "Mental Status:" Disoriented at all times. Under #4 "Cognitive Processes": Purposeful exit seeking. 2. According to the "Admission Record (AR)," Resident #9 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #9 had a Brief Interview for Mental Status (BIMS) score of [redacted]. The MDS also indicated that	F 689		

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F 689	Continued From page 15 Resident #9 needed assistance with Activities of Daily Living (ADLs). Review of Resident #9's "Physical Restraint Device Assessment" dated 6/28/19, indicated the Resident required a Wander Guard due to wandering and pacing. Review of Resident #9's POS dated 6/2019, included: Check function of Wander Guard placed to ([redacted]) every shift. Document yes or no to functioning, dated 6/28/19. Check placement of Wander Guard to ([redacted]) every shift for safety, dated 6/28/19 Review of Resident #9's "Treatment Administration Record (TAR)" dated 7/19, showed that there was no documentation to indicate that the Wander Guard was checked for function and/or placement as follows: On 7/23/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement. On 7/23/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. Review of Resident #9's CP undated, revealed the following: Under "Focus": The Resident is an elopement risk/wander related (r/t) impaired safety awareness. Under "Interventions": Wander Alert: Wander Guard to right ankle. Check for placement and function every shift. Replace as needed. 3. According to the "Admission Record (AR)", Resident #10 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]	F 689		

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[redacted]

According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #10 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #10 had [redacted]. The MDS also indicated that Resident #10 needed assistance with Activities of Daily Living (ADLs).

Review of Resident #10's "Physical Restraint Device Assessment" dated 6/24/19, indicated the Resident required a Wander Guard device due to wandering and pacing.
Under Psychological - Contributing factor considerations: Confusion and pacing/wandering.

Review of Resident #10's POS dated 7/2019, included:
Check function of Wander Guard placed to wheelchair every shift, dated 6/24/19.
Check placement of Wander Guard to wheelchair every shift, dated 6/24/19.

Review of Resident #10's "Treatment Administration Record (TAR)" dated 7/19, showed that there was no documentation to indicate that the Wander Guard to the wheelchair was checked for function and/or placement as follows:
On 7/2/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement.
On 7/2/19, for the 3:00 p.m. to 11:00 p.m. shift, for function.
On 7/9/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement.

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F 689	Continued From page 17 On 7/9/19, for the 3:00 p.m. to 11:00 p.m. shift, for function. On 7/11/19, for the 11:00 p.m. to 7:00 a.m. shift, for function. Although the Resident #10's POS has orders for a Wander Guard device to wheelchair Resident #10's CP undated, revealed the following: Under "Focus": Resident is an elopement risk/wander, as evident by history of attempts to leave facility unattended, impaired safety awareness. Under "Interventions": Wander Alert: Wander Guard to left ankle. Check for placement and function every shift. Replace as needed. All staff should be aware of Residents tendency to wander, including receptionist. Notify Social Services of persistent attempts to leave the building and if Resident is not responding to redirection. Distract Resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and/or a book. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is Resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Wander Alert: Wander guard to left ankle. Check for placement and function every shift. Replace as needed. 4. According to the "Admission Record (AR)," Resident #11 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #11 had	F 689		

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a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #11 [redacted] The MDS also indicated that Resident #11 needed assistance with Activities of Daily Living (ADLs).

Review of Resident #11's 'Physical Restraint Device Assessment" dated 6/28/19, indicated the Resident required a Wander Guard device due to wandering.
Under Psychological - Contributing factor considerations: Confusion, anxious and pacing/wandering.

Review of Resident #11's POS dated 7/2019, included:
Check function of Wander Guard placed to left ankle every shift. Document yes or no to functioning every shift, dated 6/24/19.
Check placement of Wander Guard to left ankle every shift, dated 6/24/19.

Review of Resident #11's "Treatment Administration Record (TAR)" dated 6/19, showed that there was no documentation to indicate that the Wander Guard was checked for function and/or placement as follows:
On 7/2/19, for the 3:00 p.m. to 11:00 p.m. shift, for function.
On 7/9/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement.
On 7/9/19, for the 3:00 p.m. to 11:00 p.m. shift, for function.
On 7/11/19, for the 3:00 p.m. to 11:00 p.m. shift, for placement.
On 7/11/19, for the 11:00 p.m. to 7:00 a.m. shift, for function.

Review of Resident #11's CP undated, revealed

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the following:
Under "Focus": Resident is an elopement risk/wander, as evident by history of attempts to leave facility unattended, impaired safety awareness, Resident wanders aimlessly.
Under "Interventions": Wander Alert: Wander Guard to left ankle. Check for placement and function every shift. Replace as needed.
Provide structured activities: Toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.
Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is Resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.

During a tour on 7/24/19 at 9:00 a.m., accompanied by Maintenance staff, 9 of 9 doors were tested for function of the Wander Guard system. Two of the nine doors had Wander Guard systems that activated by alarming and locking when a Resident attempt to exit the facility, while the remaining seven doors activate only by alarming when opened.

On 7/24/19 at 10:00 a.m., in the presence of Maintenance staff person; a test of Resident #10's and Resident #11's Wander Guard device were conducted. Resident #10's and Resident #11's Wander Guard were not functioning. The Maintenance person removed the nonfunctioning Wander Guard device and replaced it with a new Wander Guard device.

On 7/24/19 at 11:00 a.m., a test of the Wander Guard system was conducted. Resident #9 with a Wander Guard device to the right ankle was escorted to the front doors accompanied by an owner of the facility, Maintenance staff and CNA

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#1. Upon leaving the facility with a Wander Guard device, the Wander Guard system did not activate/alarm allowing Resident #9 to exit the facility. The Wander Guard device was tested with a transponder and found to be functioning. A repeat test of the Wander Guard system at the front door was completed on 7/24/19 at 11:05 a.m., with Resident #9 and the Wander Guard system was non-functioning.

During an interview on 7/24/19 at 12:35 pm., CNA #1 stated "the supervisors check the function of Wander Guard devices, but I only observe the Wander Guard. I tell the nurse I saw the Wander Guard and the nurse will document the placement of the Wander Guard device." CNA #1 further stated; "Residents (Residents #1, Resident #9, Resident #10, and Resident #11) wear a Wander Guard device to prevent them from escaping and eloping."

During an interview on 7/24/19 at 12:40 p.m., LPN #1 stated "we check every shift for placement, we only check for placement on the 7:00 a.m. to 3:00 p.m. shift and 3:00 p.m. to 11:00 p.m., shift. The 11:00 p.m. to 7:00 a.m., shift checks the function."

During an interview on 7/24/19 at 12:45 p.m., LPN #2 stated; "the Resident (Resident #1) was assessed for elopement. He/she had a Wander Guard device." LPN#2 further stated "my last in-service regarding elopement was around the time the Resident eloped, I have not been in-serviced prior to the elopement."

During an interview on 7/24/19 at 12:55 pm., Maintenance staff stated; "I check the Wander Guard system are active and the doors lock. I

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check the system twice a day. 2 of the 9 doors alarm and lock, while the other doors only alarm. The nurse checks the function and placement of the Wander Guard devices. The Resident (Resident #1) exited out of door #4. The doors are always locked. When you push against the door the door opens and the alarm sounds." Maintenance further stated "I, the Administrator and supervisors have a key to alarm and disarm the doors."

During an interview on 7/24/19 at 1:38 pm., the Administrator stated; "Prior to the elopement the Resident (Resident #1) was not an elopement risk. The Resident was found across the street. A nurse found him/her. No injuries were noted. The Resident was last seen when the aide did rounds at approximately 2:15 a.m. The Resident was outside for approximately 30 minutes. Once he/she was found the supervisor brought a wheel chair to bring him/her back to the facility. The Resident had always had a wheel chair, but no wheel chair was with the Resident when found. Wander Guard devices are on for precaution. He/she was confused and wandering throughout the facility." The Administrator further stated, "door #4 did not sound."

Review of the "Closed Circuit Camera (CCC)" on 7/24/19 at 2:33 p.m., with Maintenance staff was conducted. The CCC are stationed on the [redacted] side of the building with no cameras on the [redacted] side of the building. Door # 4 is located on the [redacted] side.

During a phone interview on 7/26/19 at 3:00 p.m., LPN #2 stated "I was notified by the CNA that the Resident was not in his/her room. We started a search looking for him/her, but we could not find

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him/her. He/she was not in the building. I saw him/her across the street in the parking lot. He/she had a Wander Guard device on." LPN #2 further stated "I checked the door he/she went out of, it was not working but the Resident's Wander Guard device was working."

Review of the facility's Quality Assurance & Performance Improvement (QAPI) titled "Elopement Prevention and Compliance" undated, revealed the following:
Under "Root Cause": Two Residents were identified with having Wander Guard devices that did not function when tested. While auditing the TARs it was identified there were missing administration signatures.
Facility actions taken were as follows:
Facility wide audit to be completed for all Residents with Wander Guard devices to ensure all are functioning.
Education to be completed for staff on the policy and procedures for elopement.
Treatment Administration Record (TAR) to be audited to ensure orders being followed.

Review of the facility's policy titled "Wandering & Elopement" dated August 1, 2017, revealed the following:
Under "Purpose": To enhance the safety of Residents of the facility. Under "Policy" The facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement.
Under "Procedure": The resident's risk for elopement and preventative interventions will be documented in the resident's medical record, and will be reviewed and re-evaluated by the "Interdisciplinary Team (IDT)": upon admission, readmission, quarterly, and upon change n

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F 689	Continued From page 23 condition... Under "Response to Resident Elopement": A. The facility staff member who finds that the Resident is missing will alert facility staff. B. The charge nurse will call "CODE GRAY" and organize a search. Facility staff will search areas of the facility, including common areas, bathrooms, showers, outside areas etc. Under "Return of a Resident." B. The licensed Nurse will initiate or update the Resident's CP and implement immediate intervention(s) to prevent further wandering/elopement by the resident. Review of the facility's policy titled "Elopement Risk Reduction Approaches" dated August 2017, revealed the following: Under 'Planning": D. Ensure that Residents are able to move about freely, are monitored and remain safe. Under "Environment": H(ii). Install non-intrusive alert systems that alert staff to Resident exiting. N.J.A.C 8:39-33.1(d)	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		7/31/19

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F 880	Continued From page 24	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 25 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: NJ115525, NJ126297 Based on observation, staff interviews and review of facility's policy, it was determined that the facility staff failed to implement hand washing techniques in accordance to the facility's policy and accepted standard of infection control practice. The surveyor observed the Licensed Practical Nurse (LPN) perform a wound care treatment for 1 of 12 sampled residents (Resident #7) without hand washing after removing gloves during the treatment. This deficient practice was evidenced by the following: The surveyor reviewed the medical record of Resident #7 on 7/26/19. The resident "Admission Record" revealed that Resident #7 was admitted to the facility in [redacted] with diagnoses which included but were not limited to: [redacted]	F 880	Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. Resident #7 had no adverse effects noted. All residents have the potential to be affected. No other residents were affected by the practice. Licensed Nurses were educated on hand washing and dressing change practices to ensure infection control standards are maintained. The DON or licensed nurse will perform observational audits weekly on random dressing changes for 4 weeks	

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F 880	Continued From page 26 [redacted] A Minimum Data Set (MDS), an assessment tool, dated [redacted], showed a Brief Interview for Mental Status (BIMS) score of [redacted]. The MDS also indicated that Resident #7 required extensive assistance with Activities of Daily Living (ADLs) and transfers. A Physician Order Sheet (POS) dated 7/17/19 showed the following order: [redacted] On 7/26/19 at 9:55 a.m., the surveyor with the permission from Resident #7 and in the presence of LPN #3 requested to observe the [redacted] treatment. The following observations were made by the surveyor: LPN #3, with the permission of Resident #7, cleared Resident #7's belongings off the overbed table. LPN #3 then gathered the treatment supplies from the treatment cart and placed them on the overbed table. LPN #3 then washed her hands for 10 seconds, donned clean gloves, opened the drape and placed the drape on the overbed table. The LPN failed to wash the overbed table surface prior to placing the drape. LPN #3 then placed the [redacted] LPN #3 then placed Resident #7's [redacted] LPN #3 then cut the existing	F 880	then monthly for 3 months to ensure compliance. Results will be presented by DON or Licenses Nurse to the Quality Assurance Performance Improvement Committee Quarterly for 6 months.	

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F 880	Continued From page 27 kling dressing and took off the soiled dressing. The nurse then took off the gloves, washed her hands for 10 seconds and donned clean gloves. LPN #3 then sprayed the [redacted] with a [redacted] The surveyor stopped the nurse from applying the treatment as the nurse was about to apply the [redacted], secondary to the nurse failed to wash her hands after cleansing the [redacted]. The nurse went out of the room to get gloves and on return washed her hands again for 10 seconds and donned clean gloves. LPN #3 then squeezed the [redacted], then squeezed the [redacted]. She then placed [redacted] and wrapped it with kling. The nurse then asked if the resident had any pain to which the resident replied, "It is OK." LPN #3 then initialed and dated the tape and applied it to the dressing. The surveyor continued to observe LPN #3 discarded the plastic bag with the trash, took off the tubes of the [redacted] off the overbed table and returned them to the treatment cart. LPN #3 then returned and washed her hands for less than 10 seconds and returned to Resident #7's bedside. Resident #7 requested LPN #3 place the [redacted]. The nurse failed to wash the overbed table after she discarded the soiled dressing items in the plastic bag. The nurse failed to wash her hands after donning the resident's [redacted] and exited Resident #7's room. During an interview with the surveyor on 7/26/19 at 10:13 a.m., LPN #3 stated that she forgot to wash the surface of the overbed table. She further stated that she should have washed her	F 880		

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F 880	Continued From page 28 hands after cleaning Resident #7's [redacted] with [redacted], after donning Resident #7's [redacted] During an interview with the surveyor on 7/26/19 at 1:30 p.m., the Director of Nursing (DON) stated that LPN #3 should have washed her hands during Resident #7's treatment as observed by the surveyor. The DON further stated that LPN #3 has been re-in-serviced on proper hand washing and infection control after the [redacted] care treatment on 7/16/19. The surveyor requested the facility's policy on Dressings - Application & Technique." According to the policy supplied by the facility, dated with effective date of 8/1/17, which included but was to limited to: Purpose To ensure cleanliness and prevent infection by protecting the skin's surface and to promote resident comfort and [redacted] healing. Policy The Licensed Nurse will use non-sterile or "clean" dressing technique for all changes unless otherwise indicated by physician order or manufacturer guidelines. Procedure 1. General C. Wash hands before and after each procedure, and out on gloves. D. Gather equipment needed. E. Explain procedure to resident and provide privacy. F. Position resident for comfort to expose only the wound site.	F 880		

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F 880	Continued From page 29 II. Application of Dressing A. "Clean Technique" i. Prepare a clean, dry work area at bedside. The work surface may be prepared by: a. Using a disinfectant solution; or b. Using a non sterile moisture barrier drape. ii. Bring all dressings, solutions and items to be used and place on prepared work surface. Place a plastic bag within easy reach of the work area. iii. Don non sterile gloves. iv. Prepare/open dressing items on the prepared work surface. If dressings need to be cut to size, use clean or sterile scissors. Open packages and cut tape. Place initials and date on a piece of tape or on the dressing. v. Position resident for comfort to expose area to be dressed. vi. remove dressing(s) and discard into plastic bag. a. If dressing adheres to wound, moisten with sterile solution. vii. Continuously monitor the resident throughout procedure for response to interventions and episodes of pain. viii. Remove and discard non sterile disposable gloves in plastic bag at bedside. ix. Wash hands and reapply non sterile gloves. Proceed with cleansing the wound. a. Clean wound with normal saline or prescribed cleanser. b. Pat the tissue with a clean gauze pad. c. Discard into plastic bag. xii. Remove and discard non sterile disposable gloves in plastic bag at bedside. xiii. Wash hands and reapply non sterile gloves. xiv. Apply a liquid barrier film or moisture barrier to peri wound area. xv. Apply topical agents to wound as prescribed. xvi. Discard gloves.	F 880		

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F 880	Continued From page 30 xvii. Affix the dressing in place. xviii. Close plastic bag and dispose of it in accordance with infection control procedures. A review of the facility policy, "Hand Hygiene" dated 8/1/17 included but was not limited to the following: Purpose To ensure that all individuals use appropriate hand hygiene while in the facility. Policy The facility considers hand hygiene the primary means to prevent the spread of infections. Procedure i. Facility staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. iii. Facility staff follow the hand hygiene procedure to help prevent the spread of infections to other staff, residents, and visitors. v. Facility staff, visitors and volunteers must perform hand hygiene procedures in the following circumstances. A. Wash hands with soap and water. v. After contact with intact and non-intact skin...even if gloves are worn. viii. In between glove changes. Washing hands B. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty (20) seconds under a moderate stream of running water, at a comfortable temperature. C. Rinse hands thoroughly under running water. NJAC 8:39 - 19.4(a)1	F 880		

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F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ126299, NJ115525, NJ126302, NJ126297, NJ126298, NJ122780, NJ125813, NJ126030 Based on observation and interviews and other facility documentation, it was determined that the facility failed to provide a safe environment, specifically a cluttered electrical room located in the hallway on a unit and accessible to all facility residents. This deficient practice was evidenced by the following: During a tour on 7/24/19, the surveyor observed an electrical room with a sign on the outside of the room and on each circuit breaker panel cover indicating, "DANGER ELECTRICAL ROOM NO STORAGE PERMITTED." The surveyor observed the room contained a bed mattress, a folding table, several folding chairs, a 3-foot ladder, and a recliner which were blocking off the access to the electric panels. After the surveyor notified administration, the maintenance staff responded and proceeded to take out the items from the electrical room. During an interview with the surveyor on 7/24/19 at 1:05 PM, the Maintenance staff stated that the folding table, folding chairs, recliner and ladder should not be stored in the electrical room. During an interview with the Administrator on	F 921	Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. The electrical room was cleared of all extraneous items. All residents have the potential to be affected. Staff were in-serviced on the appropriate storage of items. Maintenance or Administrator will audit the electrical room to ensure that no items are stored there weekly for 4 weeks then monthly for 3 months. Results will be presented by Maintenance or Administrator to the Quality Assurance Performance Improvement Committee Quarterly for 6 months.	7/31/19

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F 921	Continued From page 32 7/24/19 at 1:38 PM, the Administrator stated that the room should not be used as a storage room and all items would be removed. NJAC 8:39 - 31.1(c)	F 921		