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
	35A001	A. BUILDING: ______ B. WING ______	C 10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL VILLAGE	455 HURFFVILLE-CROSSKEYS ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00139969 CENSUS: 87 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 301	8:36-3.2(k) Administration (k) An individual may apply for recertification without re-examination within three years of the certification renewal date and upon submitting a request for restoration of said certification, in writing, to the Certification Program. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00139969 Based on interview, record review and review of the facility's policy and procedure it was	A 301		

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

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A 301	Continued From page 1	A 301		

determined that the facility failed to follow its policy titled, "Move-in Process " for 1 out of 3 residents reviewed for elopement, Resident #2. This deficient practice was evidenced by the following:

This facility reportable event (FRE) was received via email to the Department of Health (DOH) on 10/1/20. The FRE indicated that Resident #2 eloped from the facility on 9/30/20.

On 10/13/20 the surveyor visited the community and met with the Executive Director (ED) and the Director of Nursing (DON) regarding Resident #2's [redacted] on [redacted]

The community has independent living (IL) on one side of the building and assistant living (AL) on the other side of the building. The receptionist area is a shared area between the IL and AL neighborhoods. According to the ED the receptionist leaves at 5 p.m. and no other staff members monitored the reception area.

The DON stated that Resident #2 was assessed as a risk for [redacted] and wore a wanderguard pendant. and that the [redacted] did not activate when the resident [redacted] out of the AL neighborhood.

The DON stated that when the wanderguard alarm system is activated it goes to the care managers beepers and indicates which door was activated. The DON further stated that when Resident #2 [redacted] the [redacted] system did not alarm.

The DON stated that on [redacted] Resident #2 eloped out of the facility and that the security guard at the healthcare facility behind the Al informed the Licensed Practical nurse (LPN) staff

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A 301	Continued From page 2	A 301		

that a resident had [redacted] and was at the healthcare facility with a nurse. The DON stated that the LPN escorted the resident back to the facility.

The DON along with the ED stated that on [redacted] the [redacted] system was checked by the Maintenance Director (MD) and he was notified of the [redacted] and system failure.

The ED further stated that the [redacted] alarm company was notified and an additional censor was installed to an area that may have had a dead zone and believed to have been the door that Resident #2 had accessed and [redacted] from the facility.

The surveyor met with the MD who stated that he checks the [redacted] system weekly and provided the surveyor with a copy of the wanderguard system checks. The MD stated that there are 12 doors equipped with the [redacted] system and that he checked all of the doors weekly. The surveyor reviewed the weekly log and the door that Resident #2 exited was last checked on [redacted] by the MD.

On 10/13/20 at 11:00 a.m., the surveyor interviewed the Home Health Aide (HHA) who stated that she was responsible for checking the [redacted] pendant batteries weekly and would change the battery if necessary. The HHA provided a list of residents with [redacted] pendants which revealed a total of [redacted] residents. During the time of the survey the AL census was 87. The surveyor reviewed the wanderguard pendant battery log and the HHA checked Resident #2's battery on [redacted]

On 10/13/20 at 12:30 p.m. the surveyor interviewed the LPN that worked during Resident

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A 301	Continued From page 3 #2's [redacted] from the facility and she stated that on [redacted] at 7:00 p.m., she last saw the resident in the hallway near the door while she was taking a break. The LPN also stated that 15 minutes had passed and that she did not see the resident again and at that time the security guard from the health care facility behind the building informed her that a resident had [redacted] and was at the healthcare facility. The LPN stated that she escorted the resident back to the facility and informed the DON. The LPN stated that the [redacted] system did not alarm when Resident #2 left the facility. The surveyor reviewed the medical records (MRs) for Resident #2 who moved into the facility in [redacted] with a diagnosis that included [redacted] According to the mini mental dated [redacted] completed by the Registered Nurse (RN) the resident scored a total of [redacted] points (a score of 9-11 points no or mild impairment, 5-8 points moderately advanced impairment and 0-4 points severe brain dysfunction.) The surveyor reviewed the "Quarterly Nursing Assessment" updated [redacted] by the DON which revealed that Resident #2 was [redacted], has [redacted] and ambulates alone. The surveyor reviewed the facility's policy titled Move-in Process which revealed, "...A safe, secure setting for visually, hearing or cognitively impaired individuals. The facility failed to keep Resident #2 in a safe and secure setting when he/she eloped from the facility and the facility's secured system failed.	A 301		