STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A017	A. BUILDING: _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD AT HAMILTON	2560 KUSER ROAD HAMILTON, NJ 08691

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00146650 CENSUS: 120 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 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/11/21

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint # NJ00146650

Based on observation, interview, record review and review of facility policies and procedures, it was determined that the facility administrator failed to ensure policies were implemented to decrease the risk of [redacted] for 1 of 3 residents, Resident [redacted] reviewed for [redacted]t. The deficient practice was evidenced by the following:

On 7/14/21, the Department of Health (DOH) received a Facility Reportable Event (FRE) regarding an [redacted] that occurred at the facility on [redacted]. According to the FRE dated [redacted] completed by the facility's Wellness Director (WD), between 3:45 a.m.-3:50 a.m., Resident [redacted]'s Private Duty Aide (PDA) reported that while in the bathroom, she heard the door to the room "slam" and upon exiting the bathroom, the resident was no longer in the apartment. In addition, the WD documented that the PDA searched for the resident in the nearby rooms and when she [PDA] was not able to locate the resident, the PDA went to the Wellness Office to notify the Licensed Practical Nurse (LPN) #1 on duty that the resident was missing.

On 7/17/21 at 9:30 a.m., the surveyor interviewed Resident #1 in his/her apartment regarding the elopement that occurred on [redacted]. The resident was [redacted] but was not able to recall the incident due to the resident's [redacted]. At 10:05 a.m., the surveyor reviewed Resident [redacted]'s medical record which revealed that the resident moved

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A 310	Continued From page 2 into the facility in [redacted] with diagnoses which included [redacted]. The WD obtained statements from employees present the night of the [redacted]. An aide reported that Resident [redacted] had been observed wandering in the hallway at 2 a.m. The aide reported that the resident returned to the room, but she did not escort the resident to the room because, "I know [redacted] aide was in the room, so I didn't go to the room with [redacted]." The PDA reported to the WD that approximately "3:45-3:50 a.m. I was in the bathroom. [redacted] (Res [redacted]) would open the door and check the hallway. [redacted] would do that all night. [redacted] doesn't sleep." The PDA continued, "I heard the door slam and another door slam. When I came out of the bathroom, [redacted] was not in the room, so I began looking for [redacted]." The PDA went to security who had not seen the resident. The PDA reported that she could not find the resident to the nurse on duty licensed practical nurse (LPN #1) who then got in her car to look for the resident. The WD obtained a statement from LPN #1 who was on duty at the time of the incident who stated that she went to the receptionist to see if she had seen the resident. LPN #1 stated that the receptionist had not seen the resident. The LPN said she then got in her car in search of the resident. Upon her return, the receptionist reported the police had called and they had custody of the resident. A review of the [redacted] Police Report noted that the resident was identified wearing pajamas and wandering around the lobby of the building the person was working in. The worker called the police who then transferred the to the hospital by EMS (emergency medical services) for evaluation.	A 310		

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A 310	Continued From page 3 According to Google map, the business building where the resident walked to was [redacted] miles from the facility where the resident resided. The resident walked in the dark on a four-lane road that has a speed limit of 40 miles per hour to this business building. The "Timeline" dated [redacted] revealed that Resident [redacted] was seen on the surveillance camera exiting the AL door at 3:54 a.m., and last seen at 3:59 a.m., walking out of the camera view of the Independent Living door towards the parking area. Resident [redacted] had diagnosis of [redacted] and being [redacted]. The surveyor interviewed the following employees who all corroborated the events of the [redacted] t: On 7/17/21 at 8:30 a.m., LPN #2 told the surveyor that Resident [redacted] had a PDA since the previous [redacted] on [redacted] The resident was awaiting placement onto the secured [redacted] (MC). LPN #2 told the surveyor that the PDA with the resident the night of the second [redacted] on [redacted] was asked to leave and was no longer taking care of the resident. At the surveyor's request, LPN #2 called the concierge and asked if there was identifying pictures of residents at risk for wandering at the front desk. The concierge reported that there was not such a list. The surveyor confirmed this information in an interview with Concierge #1 on 7/17/21 at 9:40 a.m. On 7/17/21 at 11:30 a.m., the surveyor interviewed the Wellness Director (WD). The WD confirmed the two [redacted] on [redacted] and [redacted] and the resident's need for PDA while awaiting an opening on the secured MC unit. The WD confirmed that the facility had received a call from the police at 4:55 a.m. stating	A 310		

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A 310	Continued From page 4	A 310		

that they had found the resident and were transferring the resident to the hospital. At this point, the surveyor asked the WD if she had instructed LPN #1 to contact the local police when she became aware of the [redacted] by LPN #1 at 4:51 a.m. which was past 30 minutes since the resident was confirmed missing. The WD told the surveyor that she had not asked the LPN to call the police.

On 7/17/21 at 11:50 a.m., the surveyor interview LPN #1 who was on duty the night of the elopement on [redacted]. LPN #1 stated that she last saw Resident [redacted] on 7/9/21 at 9 p.m. and did not check on the resident again during the shift since the resident had 1:1 PDA. LPN #1 stated that on [redacted] at 3:55 a.m. when she went down to the lobby to see if the concierge had seen the resident, she walked towards the door and the AL door opened. She stated that the door should have been locked but it was not locked. LPN #1 confirmed that she had not notified the police of the missing resident.

On 7/17/21 at 12:30 p.m., the surveyor interviewed Concierge #2 who was present at the time of the elopement. Concierge #2 confirmed the events that took place and confirmed that there was no list of residents at risk of wandering with pictures and identifiers at the front desk. Concierge #2 also confirmed that the door to the AL was not locked on the day and time of the elopement.

Surveyor review of Resident [redacted]s [redacted] assessment completed by the WD dated [redacted] and [redacted], indicated that Resident [redacted], [redacted]." In addition, Resident [redacted] had [redacted], on 1:1 supervision with PDA, and was awaiting placement in the [redacted] unit. However, Resident [redacted]s picture and name was

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A 310	Continued From page 5 not observed at the front desk on the date of the survey. The [redacted] Risk Assessment" form dated [redacted] and [redacted] after the resident's [redacted] revealed a score of [redacted] and [redacted]" which indicated that the resident was at risk for [redacted] and prevention protocols needed to be developed and implemented in the Wellness Plan(WP). On [redacted] the WP was updated to include the need for a Private Duty Aide, lab work and transfer to the [redacted] unit when it became available. The resident's [redacted]. On [redacted], the resident's WP was updated to include continue with 24-hour PDA, staff to increase room checks during the night and more frequent checks while awake while awaiting opening on MC unit. On [redacted], WP identified the resident was expected to be moving out to another community. Continue PDA until resident moves out. On 7/21/21, post survey, the surveyor received, "Timeline of Event" dated [redacted] via email which revealed that Resident [redacted] was seen on the surveillance camera leaving the facility through the Assisted Living door at 3:54 a.m. At 4:55 a.m., the facility received a phone call from a local PO that the resident was in their custody. However, the facility did not contact the local police after 30 minutes when the resident was confirmed missing. It was not until 4:55 a.m., that the local police notified the facility that the resident was with the local police. On 7/26/21 at 3 p.m., the surveyor interviewed the facility's Administrator regarding Resident [redacted]s elopement and the monitoring of the door. The Administrator stated that the resident exited the facility through the AL door and stated that there was no one assigned to the AL door from 8 p.m. to 8 a.m., after hours. She explained that the AL door should have been locked as stated in the	A 310		

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A 310	Continued From page 6 "Security Policy." The Administrator added that the facility later found out that the AL door had not been locked which enabled the resident to exit the facility. Surveyor review of the facility's policy and procedure titled, [redacted] Plan Policy #AL-019" revised 9/1/18 revealed, "Pictures of these Residents (identified as [redacted] risk) are kept at the front reception desk including the resident face sheet." Continued surveyor review of the policy indicated, "Steps to take within 30 minutes of inability to locate Resident" revealed, "Community staff will reference picture of Resident, which is located at the front desk, and information will be available regarding what clothing the person had on last." Further, the policy revealed, "Steps to take after 30 minutes of inability to locate Resident:" revealed, "General Manager to call police and cooperate fully with them. Provide police with a photo of the Resident and other identification information (time and location last seen, height, weight, distinguishing marks, what they were wearing, etc.)." In addition, the surveyor reviewed the policy and procedure titled, "Security Policy #ES-041" which indicated that the "The Environmental Services Director is responsible to enforce the following security measures:", "Twenty-four (24) hour response to systems." "A locked Community building from 8 p.m. to 8 a.m.; ..." "Door checks and safety checks during 11 pm to 7 am shift should be done by associates."	A 310		
A1179	8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance	A1179		

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A1179	Continued From page 7 (a) The facility shall provide and maintain a sanitary and safe environment for residents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00146650 Based on interview and record review it was determined that the facility failed to provide a safe environment for 1 of 3 residents reviewed for elopement, Resident [redacted] This deficient practice was evidenced by the following: On 7/17/21 at 9:30 a.m., the surveyor interviewed the resident in his/her apartment regarding the elopement that occurred on [redacted] The resident was alert and [redacted] but was not able to recall the incident due to the resident's [redacted] impairment. At 10:05 a.m., the surveyor reviewed Resident #1's medical record which revealed that the resident moved into the facility in [redacted] with diagnoses which included [redacted]. The [redacted] Assessment" form dated [redacted] and [redacted] revealed a score of [redacted] and [redacted]" which indicated that the resident was at a greater risk for [redacted]. The Nurse's Notes (NN) dated [redacted] at 7:47 a.m., written by LPN #1 documented that she was called to the parking lot by a staff member stating that Resident [redacted] was observed walking on ... Road. In addition, LPN #1 documented that the resident's family was notified and were in the process of providing a PDA for the resident.	A1179		

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A1179	Continued From page 8 The NN dated [redacted] at 6:56 a.m., written by LPN #1 documented that at about 3:55 a.m., she was notified by the resident's PDA that she could not find the resident when she [PDA] returned from using the bathroom. LPN #1 documented that she went downstairs to inquire from the front desk if she had seen Resident [redacted]. LPN #1 documented that the front desk stated that she also had gone to the bathroom and did not see the resident. LPN #1 documented that she then drove her car around the neighborhood twice and was not able to locate the resident. LPN #1 documented that she then notified the WD and later received a phone call from the local police. According to the NN dated [redacted] at 9:51 a.m. written by the DON, indicated that at approximately 4:51 [did not indicate a.m., or p.m.,] that they [staff] had been searching for the resident since 4:15 a.m., without success. The DON documented that she instructed LPN #1 to do a thorough search of resident rooms in the community. The DON documented that LPN #1 later called her [DON] at approximately 4:55 a.m., stating that she [LPN#1] received a phone call from the local Police confirming that they had Resident [redacted] in their custody and was transferring the resident to a local hospital. At 9:40 a.m., the surveyor interviewed Concierge #1 at the Independent Living front desk regarding the monitoring of the AL door. Concierge #1 stated that there was a 24-7 Concierge at the [redacted] desk but not the AL door. She stated that the AL door should have been locked after hours from 8 p.m. to 8 a.m. However, the AL door was not locked at the time of the [redacted] on [redacted]. At 11:30 a.m., the surveyor interviewed the WD when she arrived at the facility regarding the	A1179		

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A1179	Continued From page 9	A1179		

above incident. The WD stated that on [redacted], Resident [redacted] was found by the sidewalk of the main entrance of the facility by a staff member at approximately 7:30 a.m. and was brought back into the community. She stated that the resident was assessed for [redacted] risk but there was no bed available in the [redacted] a [redacted] unit. The WD explained that the resident's family provided 24 hours PDA for the resident until a bed was available at the [redacted] unit.

During continued interview, the WD stated that on [redacted], the resident again left the facility but had a PDA at the time of the second incident. The WD stated that Resident [redacted] left his/her apartment while the PA was in the bathroom. The WD stated that she received a phone call from LPN #1 at approximately 4:51 a.m., that the resident had not been seen since approximately 4 a.m. The WD stated that at approximately 4:55 a.m., she received another call from LPN #1 that the resident had been located by a local Police Officer (PO) but would not give the location of the resident. The surveyor then asked the WD about the security of the AL door and if the door was locked after hours. The WD stated that the door was not locked and that this is an AL facility and explained that there was a surveillance camera. The surveyor requested to view the video footage of the [redacted] event but the WD stated that she did not have access on the date of the survey.

At 11:50 a.m., the surveyor interviewed LPN #1 via telephone regarding the [redacted] that occurred on [redacted] on the 11-7 shift and inquired about the AL door after hours. During the interview, LPN #1 stated that when she came down to the lobby looking for the resident and walked towards the AL door, the door automatically opened. LPN #1 stated that the door was not locked but should have been

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A1179	Continued From page 10 locked. At 12:30 p.m., the surveyor interviewed Concierge #2 who was on duty the day of the above incident regarding Resident [redacted]'s elopement and monitoring of the AL door after hours. She stated that the resident's PDA came to the [redacted] front desk and asked if Resident [redacted] was seen at the lobby. Concierge #1 stated that she informed the PDA that she did not see the resident nor had she seen the resident leave the building. In addition, Concierge #2 stated that the door should have been locked from 8 p.m., to 8 a.m., but was not locked on the day of the incident. On 7/21/21. post survey, the surveyor received "Timeline of Event" dated [redacted] from the facility which revealed that Resident [redacted] was seen on the surveillance camera leaving the facility through the Assisted Living door at 3:54 a.m. On 7/26/21 at 3 p.m., the surveyor interviewed the facility's Administrator regarding Resident [redacted]s elopement and the monitoring of the AL door. The Administrator stated that the resident exited the facility through the AL door and stated that there was no one assigned to the AL door from 8 p.m., to 8 a.m., after hours. She explained that the AL door should have been locked as stated in the "Security Policy #ES-041" which indicated that the "The Environmental Services Director is responsible to enforce the following security measures:", "Twenty-four (24) hour response to systems." "A locked Community building from 8 p.m. to 8 a.m.; ... ." "Door checks and safety checks during 11 pm to 7 am shift should be done by associates." The Administrator added that the facility later found out that the AL door was not locked which enabled the resident to exit the facility.	A1179		

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A1179	Continued From page 11 On 7/27/21 at 11:50 a.m., post survey, the surveyor interviewed the Environmental Service Director (ESD) regarding the security policy of the AL door. She stated that after hours, the AL door should manually be locked by Associates and the call system engaged from 8 p.m., to 8 a.m. The ESD stated that to exit the building in an emergency, the emergency door which was located on the right hand side should be pushed to exit the building. The ESD added that after the elopement, there was a work order request for the AL door to be checked for malfunctioning. She stated that the door was checked and that there were no issues with the AL door. On 7/27/21 at 1:16 p.m., post survey, the surveyor received a police "CAD Report" [Computer-aided dispatch] dated [redacted] at 4:40 [a.m., or p.m., not specified]. The Police Officer documented that he responded to a call from an electrician of a building that an unknown elderly male/female [Resident [redacted]] who was dressed in pajamas was observed wandering around the lobby and roaming the hallway of a business building. In addition, the PO documented that the resident was transported to the local hospital for evaluation and that the resident's family was notified. According to Google map, the business building where the resident walked to was [redacted] miles [more than half a mile] from the facility where the resident resided. The "Timeline" dated [redacted] revealed that Resident [redacted] was seen on the surveillance camera exiting the AL door at 3:54 a.m., and last seen at 3:59 a.m., walking out of the camera view of the [redacted] door towards the parking area. Resident [redacted] had diagnosis of [redacted], and walked on a four lane road with a speed limit of	A1179		

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A1179	Continued From page 12 40 miles per hour to a business building while in the dark. Failure to lock the door from 8 p.m. to 8 a.m. in accordance with facility policy allowed the resident to exit the facility in darkness on a busy street into a building more than a half a mile from the facility. Refer to 8:36-3.4(a)(1)	A1179		