STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18A113	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT HILLSBOROUG	351 ROUTE 206 HILLSBOROUGH, NJ 08844

(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 #: NJ 00142326, NJ 00142442 CENSUS: 83 SAMPLE SIZE: 4 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 03/18/21

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This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00142326, NJ 00142442

Based on observation, interview, and record review on 1/19/21 and 1/20/21 it was determined that the facility failed to ensure a safe environment and implementation of its policy and procedure on "Elopement" and "Door Alarms/Checks" for Resident #1, [redacted] residents reviewed for elopement. This deficient practice was evidenced by the following:

On 1/11/21 and 1/14/21, the Department of Health (DOH) received a Facility Reportable Event (FRE) regarding an elopement that occurred at the facility on January [redacted] and January [redacted]

On 1/19/21 at 9:40 a.m., the surveyor interviewed the Executive Director (ED) regarding the elopements that occurred on [redacted] separate occasions. The surveyor inquired from the ED if the facility had residents that were at risk for elopement. He stated that there were [redacted] residents and he provided the surveyor [redacted] residents names which included Resident #1.

At 10:30 a.m., the surveyor reviewed Resident #1's medical record and according to the "Face Sheet," the resident moved into the facility [redacted] with diagnosis which included but was not limited to [redacted] The "Progress Notes" (PN) dated [redacted] written by a Registered Nurse (RN) revealed that the resident was [redacted], and

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[redacted] with [redacted]. The RN documented that the resident ambulated independently.

During continued interview with the ED, he stated that Resident #1 was not at the facility on the date of the survey and that Resident #1 was admitted to the hospital on [redacted] with [redacted]. He stated that on [redacted] at approximately 12:30 p.m., the facility received a telephone call from a Police Officer (PO) who recognized Resident #1 from a previous 911 call to the facility. The ED continued that the facility was informed by the PO that the resident was at a [restaurant] located at approximately [redacted] mile from the facility. The ED stated that he viewed the camera and that Resident #1 left the facility at approximately 11:30 a.m., through [redacted] door [redacted] facing the [redacted] and proceeded to a restaurant.

The ED stated that the Manager on Duty (MOD), a Licensed Practical Nurse (LPN) who received the telephone call went to the restaurant to bring the resident back to the facility. He explained that Resident #1 stated that he/she wanted to call his/her [redacted] but his/her cell phone was not working properly. The ED stated that upon bringing Resident #1 back to the facility, the resident was placed in the [redacted] unit, a secured unit for observation. The ED added that at approximately 9 p.m., the same day, Resident #1 was returned to his/her [redacted] and was monitored hourly and in addition, he [ED] stated that he recommended a less complicated cell phone for the resident.

Further, the ED stated that the [redacted] elopement occurred on [redacted] at approximately 12:20 p.m. The ED stated that at approximately 3 p.m., Resident #1's Power of Attorney (POA) contacted

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the facility that the resident was at a local hospital being evaluated. He explained that the resident left the facility through the same [redacted] door [redacted] and proceeded down the [redacted] to a stationery store next to the same restaurant about [redacted] mile from the facility. The ED stated that a staff member at the stationery store called 911 because the resident appeared [redacted] and was taken to the Emergency Room (ER) for evaluation.

During the interview, the ED confirmed that the facility was not aware of the resident's whereabouts on [redacted] and [redacted] until the PO and the resident's POA notified the facility of the resident's whereabouts. The surveyor then requested the facility's elopement policy for review.

On the same day at 10 a.m., the two surveyors toured the Assisted Living (AL) unit with the Resident Care Director (RCD) and she showed the surveyors [redacted] door [redacted] facing the [redacted] where Resident #1 eloped from. The surveyor asked the RCD if [redacted] door [redacted] was alarmed and she replied, "No, this is Assisted Living facility." She added that a person can exit but cannot gain entrance without someone opening the [redacted] door from the inside.

In addition, the surveyor asked the RCD how staff was alerted when a resident who was at risk for elopement left the building through a [redacted] door. She stated that there was a camera installed in the ED's office to view the four [redacted] doors. Also, the RCD stated that the doors transmitted a signal to the tablets that the care givers carry with them. She explained that the signal alerted the staff the [redacted] door that was opened and a staff

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member would immediately respond to that stairwell door. The RCD and the surveyors were at [redacted] door [redacted] for five minutes and no staff responded to the door when the RCD opened it.

At 10:30 a.m., surveyor continued review of the medical record observed PN dated [redacted] at 3:05 p.m., written by the LPN revealed, "Received a call from [local] police dept that resident was at a [restaurant] and needed to be picked up. Writer immediately notified ED, and drove to restaurant to pick the resident up. Resident stated that [he/she] left because [he/she] needed to make a phone call and couldn't on [his/her] phone." The LPN documented that the resident stated, "It was quite easy I followed the exit signs and started walking. I knew it was a [redacted] so I was careful, I will do it again if I am not able to make a phone call." According to the LPN documentation, the resident's POA was contacted and updated regarding the resident's elopement and that the resident was currently in [redacted] until bedtime.

The PN dated [redacted] at 6:49 p.m., written by an LPN indicated, "resident seen [redacted] around [redacted] a [redacted] behaviors, pushing doors until alarm goes off."

The PN dated [redacted] at 8:40 p.m., written by the RCD revealed, "Writer was notified resident eloped out of community tonight. Resident will remain in [redacted] for safety at this time and will be on one hour checks staff is updated on elopement risk at this time and will monitor resident closely."

During a post survey telephone interview on 2/1/21 at 1:52 p.m., with Concierge #1, she stated that she was on duty on [redacted]. She stated that

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she received a telephone call [could not recall exact time] from a PO that Resident #1 was at a restaurant a few miles down the [redacted]. Concierge #1 stated that she was not informed by any staff that the resident was [redacted] prior to the resident's elopement. She added that she was not aware when the resident left the facility through [redacted] door [redacted]. She explained that the front entrance door was the only door in use and that the door was always locked.

The PN dated [redacted] at 12:19 p.m., "Late Entry" for [redacted] written by the RCD indicated, "Writer was notified from ER that resident was in the ER being evaluated that[he/she] was picked up at a [stationery] store down the block from the community."

At 11 a.m., the surveyor interviewed the RCD regarding above documentation and asked her the intervention(s) that was put in place after Resident #1 eloped on [redacted] to reduce further risk of elopement. She stated that the resident was placed in the [redacted] unit for observation and that at approximately 9 p.m., same day the resident was transferred back to his/her [redacted] and was placed on hourly checks. She added that a monitoring log was started to monitor the resident's whereabouts from [redacted] after the resident's [redacted] elopement to [redacted] before the resident's [redacted] elopement. The surveyor then requested the completed monitoring log by staff for review.

At 11:25 a.m., the surveyor interviewed the ED regarding [redacted] door [redacted] He stated that the four [redacted] doors were alarmed and connected to employees' tablets [iPad] on the units. The ED informed the surveyor that on [redacted], when he found out that [redacted] door [redacted] was not

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functioning properly, he directed the LPN to reset the door. In addition, the ED stated that on [redacted] after the [redacted] elopement, he asked the Director of Maintenance (DOM) to recheck [redacted] door [redacted]. The ED stated that on [redacted] the DOM reached out to the alarm company and stairwell [redacted] door was adjusted and was functioning properly.

At 11:40 a.m., the surveyor interviewed the LPN regarding the elopement that occurred on [redacted] and her documentation. The LPN confirmed that she was on duty and was the MOD. The LPN stated that she received a telephone call from the receptionist that a PO was holding on the line regarding Resident #1. The LPN stated that after speaking with the PO and the ED, she went to pick up the resident from the restaurant where the resident eloped to. She stated that the resident informed her [LPN] that he/she wanted to make phone calls and followed the exit signs in the building to leave.

Further, the LPN stated that the resident stated that he/she was aware of the [redacted] and if he/she [Resident] needed to do it, will do it again. The LPN stated that she followed instruction from the ED to place the resident in the [redacted] unit for observation including an hourly monitoring when the resident returned to his/her [redacted]. The LPN stated that she evaluated the resident upon returning to the community and that the resident's skin was intact and there was no change in the resident's cognition. The LPN added that the resident was appropriately dressed for the cold weather and that the resident wore pants, a buttoned-up shirt/jacket, and shoes.

The LPN explained that she asked Concierge #1

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to create a monitoring log for use when the resident returned to his/her [redacted]. The LPN stated that she did not follow up because her shift ended at 4 p.m. on that day.

During continued interview, the surveyor asked the LPN if she checked [redacted] door [redacted] and if she was instructed by the ED or anyone to reset the door after she brought Resident #1 back to the facility. The LPN stated that she did not check [redacted] door [redacted] neither was she instructed to reset the alarm to the door. The surveyor requested the "24 Hour Checks" log for review. The "24 Hour Checks" log revealed three columns with, "Date, Time (hourly) and employee sign off" were blank.

At 11:50 a.m., the surveyor interviewed a Certified Medication Aide (CMA) who provided care to Resident #1 on [redacted] and 1/12/21 on the 7-3 shift. The CMA stated that on [redacted] at approximately 10 a.m., that Resident #1 appeared [redacted] and was looking for his/her family/[redacted]. The CMA stated that she redirected the resident, but the resident did not want to go back to his/her [redacted] but was encouraged to do so. The CMA stated that she notified Concierge #1 at the front desk that the resident was [redacted]. Also, the CMA added that staff on the unit were aware of the resident's [redacted] behavior. The CMA stated that she was later notified by the LPN/MOD that the resident had eloped and was found at a nearby restaurant.

The CMA continued that on 1/12/21 at approximately 9 a.m., she medicated the resident and that the resident appeared calm in his/her [redacted] She stated that the staff on the unit monitored the resident hourly and completed an

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A 310	Continued From page 8 hourly log of the resident's whereabouts. The CMA stated that she was later notified that the resident had eloped and was taken to a local hospital. The surveyor requested the resident's completed hourly log for review and the surveyor was later informed by the staff that they could not locate the completed log. On 1/19/20 at 12:15 p.m., the surveyor interviewed a Certified Home Health Aide (CHHA) who provided direct care to the resident on [redacted] on the 7-3 shift. The CHHA stated that she monitored the resident hourly and documented the resident's whereabouts on a monitoring log. She stated that she last saw the resident at approximately 2:50 p.m., in his/her apartment before she [CHHA] ended her shift at 3 p.m. At 12:55 p.m., the surveyor interviewed the DOM regarding the door alarms. He stated that he was notified on [redacted] that [redacted] door [redacted] was not functioning properly. The DOM stated that he attempted to reset the doors through a computer system but was unable to do so. He stated that he then reached out to the alarm company to assist him with resetting [redacted] door [redacted]. He explained that stairwell door #4 was reset and was functioning. He added that all [redacted] doors were alarmed and would alert at the front desk if someone was exiting through the doors. During continued interview with the DOM, he stated that he checked the [redacted] doors every two months for functioning. The surveyor then requested documented evidence or a report that the doors were checked every two months for functioning. The DOM informed the surveyor that the door alarm checks were performed visually and that there was no report or documentation.	A 310		

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A 310	Continued From page 9 On 1/20/21 at 9:45 a.m. next day of survey, the surveyor asked the ED to test [redacted] door [redacted] alarm for functioning and staff response. At 9:48 a.m., the ED opened [redacted] door [redacted]. The sensor on [redacted] door [redacted] alarmed on the ED's cell phone from 9:48 - 9:54 a.m. [6 minutes]. However, the two surveyors did not observe staff member(s) respond to [redacted] door [redacted]. The ED acknowledged that no staff member responded when [redacted] door was opened and stated, "That's a concern." At 11:05 a.m., the surveyor interviewed Concierge #2 at the front desk regarding the facility's protocol on elopement when a resident at risk for elopement was attempting to leave the building. She stated that residents with elopement risk were identified on the daily Census list and the list was kept at the front desk. Concierge #2 provided the surveyor a Census list dated [redacted]. However, the Census list did not identify the four residents that were earlier identified by the ED as elopement risk. During interview with Concierge #2, the surveyor did not observe the four resident pictures at risk for elopement hung at the front desk with an "elopement risk warning" as documented on the "Elopement" policy. Concierge #2 confirmed that there were no residents' pictures hung and/or binder at the front desk. At 12:40 p.m., the surveyor informed the ED of the concerns. The ED acknowledged that the four residents' pictures were not hung at the front desk. In addition, he acknowledged that the facility was not aware of Resident #1's whereabouts on [redacted] from 11:30 a.m. to 12:30 p.m., [one hour] later; and on [redacted] from 12:20	A 310		

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p.m. to 3 p.m., [2 hours and 40 minutes] later until a telephone call from a Police Office and the resident's POA. The ED stated that he was aware of the security issues and would be addressed.

A police report #1 was received post survey on 2/9/21 at 3:26 p.m. The surveyor reviewed the police report titled, "CAD Abstract Report" [Computer Aided Dispatch] dated [redacted] at 4:10 p.m. The report indicated that a Patrol Officer responded to a call and met with Resident #1 at a restaurant who appeared to be "very disoriented and suffers from [redacted]." According to the report, the Patrol Officer then contacted the facility and the resident was picked up from the location by the facility's LPN.

Surveyor review of police report #2 dated 1/12/2021 at 2:07 p.m., revealed that a Patrol Officer responded to a call to a store. The Police Officer indicated that Resident #1 stated that his/her children of high school age and were kidnapped. According to the police report, the resident continued to [redacted] from one story to another and stated that he/she was 34 years old. The report indicated that the resident was then transported to a local hospital for evaluation.

The surveyor reviewed the facility policy and procedure titled, "Elopement" which was "Revised 3-2019" and revealed, "The community makes the resident's safety and well being a priority and will make reasonable attempts to prevent elopements. Elopement is when a resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired, wander/walks/runs away, escapes, or otherwise leaves the community unsupervised, unnoticed, and/or prior

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A 310	Continued From page 11 to the scheduled discharge." Further review of the policy and procedure indicated Procedure: ... 3., "If a resident is found to be an elopement risk: The resident's picture will be hung at the concierge desk with an elopement risk warning." Surveyor continued review of the Policies and Procedures titled, "Door Alarms/Checks" which was "Revised 3-19 revealed, " Secured and alarmed doors leading in and out of [redacted] will be inspected on a weekly basis. Doors and alarmed doors in traditional AL will be inspected on a monthly basis." Under "Procedure: 1. Maintenance/designee will inspect all secured and alarmed doors in [redacted] weekly and as needed. 2. Maintenance/designee will inspect all secured and alarmed doors in traditional AL on a monthly basis and as needed. 3. If for any reason a door alarm fails to sound or the alarm does not trigger on the call bell system, the Executive Director and Director of Maintenance will be notified immediately. 4. If door alarm cannot be fixed immediately by maintenance/designee, employees will be assigned to monitor exits to ensure resident safety until the alarm is functioning. 5. The maintenance director/designee will submit a report of all door alarm audits to the QA committee."	A 310		
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.	A 753		

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This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00142326, NJ 00142442

Based on interview and record review it was determined that the facility failed to provide documented evidence of the implementation of Service Plan for Resident #1, 1 of 4 residents reviewed for SP. This deficient practice was evidenced by the following:

On 1/19/21 at 10:30 a.m., the surveyor reviewed Resident #1's medical record and according to the "Face Sheet," the resident moved into the facility [redacted] with diagnosis which included but was not limited to [redacted]. The "Progress Notes" (PN) dated [redacted] written by a Registered Nurse (RN) revealed that the resident [redacted]. The RN documented that the resident ambulated independently.

The surveyor reviewed the Progress Notes (PN) dated [redacted] at 3:05 p.m., written by a Licensed Practical Nurse (LPN). The LPN documented, "Received a call from [local] police dept that resident was at a [restaurant] and needed to be picked up. Writer immediately notified ED and drove to restaurant to pick the resident up. Resident stated that [he/she] left because [he/she] needed to make a telephone call and couldn't on [his/her] phone. "It was quite easy I followed the exit signs and started walking. I knew it was a [redacted] so I was careful, I will do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18A113	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT HILLSBOROUG	351 ROUTE 206 HILLSBOROUGH, NJ 08844

(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 753	Continued From page 13	A 753		

it again if I am not able to make a phone call." The LPN documented that the resident was currently in the [redacted] care, a [redacted] unit until bedtime.

The PN dated [redacted] at 6:49 p.m., written by an LPN revealed, "resident seen [redacted] around [redacted], [redacted], pushing doors until alarm goes off."

The PN dated [redacted] at 8:40 p.m., written by the RN indicated, "Writer was notified resident eloped out of community tonight. Resident will remain in [redacted] for safety at this time and will be on one hour checks staff is updated on elopement risk at this time and will monitor resident closely."

The PN dated [redacted] at 12:19 p.m., "Late Entry" for [redacted] written by a RN indicated, "Writer was notified from emergency room (ER) that resident was in the ER being evaluated that [he/she] was picked up at a [stationery] store down the block from the community."

The surveyor reviewed the Service Plan dated [redacted] and under "Safety Check: Freq. [frequent]. Wandering" indicated the following safety hourly checks: 12AM, 1AM, 2AM, 3AM, 4AM, 5AM, 6AM, 7AM, 8AM, 9AM, 10AM, 11AM, 12PM, 1PM, 2PM, 3PM, 4PM, 5PM, 6PM, 7PM, 8PM, 9PM, 10PM, 11PM."
"Notes: Monitor for [redacted] activity. Report if resident is [redacted] or [redacted] community"

During surveyor interview with the Resident Care Director (RCD) at 11 a.m., the surveyor inquired about the safety hourly checks and the intervention(s) that was put in place after Resident #1 eloped on [redacted]. She stated that

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A 753	Continued From page 14	A 753		

the resident was placed in the [redacted] unit for observation. She stated that at approximately 9 p.m., same day the resident was transferred back to his/her [redacted] and was placed on hourly checks. She added that a monitoring log was started to monitor the resident's whereabouts from [redacted] after the [redacted] elopement to [redacted] when the resident eloped again. The surveyor then requested the completed monitoring log by staff for review.

The surveyor interviewed the Executive Director, Resident Care Director, Licensed Practical Nurse, Certified Medication Aide, and Certified Home Health Aide. All four staff members stated that Resident #1 was closely monitored and that the whereabouts of the resident was documented on [redacted] through [redacted] by the staff members assigned to the resident.

The RCD later informed the surveyor that the facility was not able to provide the surveyor the completed log to show that Resident #1 was closely monitored hourly to prevent the resident from eloping the [redacted] time on [redacted]

On 1/10/21, the facility was aware that Resident #1 was [redacted] prior to the resident's first elopement. In addition, after Resident #1's [redacted] elopement on [redacted] 1, the resident informed a Licensed Practical Nurse at the facility that he/she [Resident] would leave the facility again if he/she was not able to make a telephone call. On [redacted] at 12:20 p.m., Resident #1 left the facility again without staff awareness until the facility was alerted by the resident's Power of Attorney (POA) that the resident was at the Emergency Room.

The facility was not aware of the resident's

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A 753	Continued From page 15 whereabouts on [redacted] from 11:30 a.m. to 12:30 p.m., and on [redacted] from 12:30 p.m. to 3:30 p.m. Refer to 8:36-3.4(a)(1)	A 753		