New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A018	A. BUILDING: ________ B. WING ________	C 05/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING OF HAMILTON, THE	**1750 YARDVILLE-HAMILTON SQUARE ROAD** **HAMILTON, NJ 08690**

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00154510 CENSUS: 76 SAMPLE SIZE: 4 Report revised based on supervisory review. 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		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.	A1249		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A1249	Continued From page 1	A1249		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00154510

Based on observation, interview, and record review it was determined that the facility failed to provide a safe environment for residents to ambulate freely and failed to develop and implement a security policy and procedure for the exit doors allowing for safe passage coming and going within the Assisted Living (AL) units for 1 of 4 residents, Resident #4. This deficient practice was evidenced by the following:

On 5/9/2022 at 10:30 a.m., during an entrance conference with the Health Wellness Director (HWD), the surveyor inquired if there had been any incidents/accidents investigated by the facility in the past six months. The HWD told the surveyor that there had been none. Later, the surveyor was provided with a Reportable Event Report (RER) which identified Resident #4 had Ex.Order 26.4(b)(1) the facility on Ex.Order 26.4(b)(1) The surveyor then requested the resident's closed medical record for review.

At 11:30 a.m., the surveyor reviewed Resident #4's closed medical record. According to the "Face Sheet," the resident moved into the facility in Ex.Order 26.4(b)(1) 1 with diagnoses which included Ex.Order 26.4(b)(1) The "Progress Notes" (PN) dated from 2/1/2021 to 1/29/2022 indicated that Ex.Order 26.4(b)(1) . At 1:18 p.m., the surveyor interviewed

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A1249	Continued From page 2 a License Practical Nurse (LPN) regarding Resident #4. The LPN stated that on a good day, Resident #4 was alert and oriented to person, place and time. The LPN explained that Resident Ex.Order 26.4(b)(1) She stated that Resident #4 Ex.Order 26.4(b)(1) outside independently in a designated area but had never exited the building through the side exit doors. The surveyor's continued review of the medical record identified a PN dated 1/29/2022 at 5:48 a.m. written by the HWD which revealed, "At approx 3 am, res [resident] was observed by this writer walking up and down the hallways in AL. When asked if [the resident] was ok and if [the resident] needed anything, res [resident] stated [he/she] was just walking. At approx 3:30 am, I [HWD] received a call from the GM [General Manager] that the resident was outside and had fallen. This resident goes outside several times a day to Ex.Order 26.4(b)(1) Further, the HWD documented, "It appeared" that Ex.Order 26.4(b)(1) to the Ex.Order 26.4(b)(1) from the resident's Ex.Order 26.4(b)(1) were noted. The HWD documented that the Ex.Order 26.4(b)(1). The HWD documented that the resident stated that he/she was going for a walk. At 9:14 a.m., the HWD documented that the resident was admitted to the Ex.Order 26.4(b)(1) At 12:19 p.m., the HWD documented additional hospital admission diagnoses of Ex.Order 26.4(b)(1)	A1249		

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A1249	Continued From page 3	A1249		

Continued From page 3

At 11:55 a.m., the surveyor interviewed the HWD regarding the RER she had provided to the surveyor and her documentation of 1/29/2022. The HWD stated that she was on duty the date of the incident and that she saw Resident #4 at approximately 3 a.m walking down the hallway toward the exit door near room 117 where the resident had exited the facility. The HWD stated that the resident told her he/she was going for a walk. The HWD stated that she sent a text message to the Personal Assistant (PA) on duty to check on the resident while she (HWD) went to administer medication to residents on another unit.

During the interview, the HWD stated that at approximately 3:30 a.m., she received a telephone call from the GM, who arrived to work early due to a snow storm, and informed her that Resident #4 was outside lying in the snow. The HWD reported to the surveyor that she immediately went out and observed the resident lying on his/her back on the side walkway close to the exit door near room 1 Ex.Orde She explained that the resident was a Ex.Order 26.4(b r and was not sure if the resident had gone outside to Ex.Order 26.4(b)(1) and Ex.Order She stated that upon assessment, the resident was alert, oriented and responded to questions and repeated that he/she was going for a walk.

In addition, the HWD told the surveyor that she retrieved a Ex.Order 26.4(b)(1) r, placed the resident in it with assistance from a PA and covered the resident with a blanket and brought the resident back into the building for assessment. The HWD confirmed that it was a cold and blizzard night and identified that the resident was not wearing a coat or shoes at the time of the incident. She told

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A1249	Continued From page 4	A1249		

the surveyor that 911 arrived, cut off the resident's wet cloths and wrapped the resident in a silver heating blanket and transported the resident to a Ex.Order 26.4(b)(1)

On the same day at 12:15 p.m., the surveyor conducted a tour of the first floor Assisted Living (AL) unit with the HWD. The HWD showed the surveyor the exit door near room 117 where Resident #4 exited the building. The surveyor asked the HWD if exit doors including the exit door near room 117 were alarmed and she replied, "No." She explained that this is an Assisted Living (AL) facility and that the residents were,"Free to go and come." The HWD confirmed that the exit door near room 117 did not have a way of communication back into the building from outside. Therefore, the exit door did not alarm when the resident opened it to leave the facility. The door automatically locked preventing anyone from entering the facility once the door closed behind them. This failure in the door system allowed Resident #4 to exit the facility unnoticed and left the resident outside unable to reenter the building.

In addition, the surveyor asked the HWD if staff would have known Resident #4's whereabouts had the GM not come to the facility at the time [3:30 a.m.]. The HWD confirmed that staff would not have known the whereabouts of Resident #4 had the GM not come to work at that time due to the snow storm.

At 12:25 p.m., the surveyor interviewed the Plant Operation Supervisor (POS) regarding the exit doors. He stated that the exit doors were locked at all times except the front door and the back porch door which were unlocked from 8 a.m. to 8

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A1249	Continued From page 5	A1249		

p.m. He told the surveyor that the residents knew to use the front and back porch exit doors and indicated that a person can exit all other doors but cannot gain entrance back into the facility without someone opening the exit door from the inside. He confirmed that only the front door had a doorbell to regain entrance to the building after hours. The surveyor then requested the facility's security policy. The POS later informed the surveyor that the Assisted Living section of the facility did not have a security policy.

At 2:05 p.m., the surveyor interviewed a PA who provided care to Resident #4 on 1/29/2022 on the 11-7 shift. The PA stated that on 1/29/2022 at approximately 1:50 a.m., she saw Resident #4 walking down the hall with no shoes who stated that he/she was taking a walk. The PA stated that she redirected the resident back into the resident's apartment and went to the 2nd floor to continue with the residents' laundry. The PA stated that the resident was a smoker and used the front or back porch door to go out and smoke. The PA stated that the HWD later informed her [PA] that the resident fell on the snow. The PA stated that she assisted the HWD to put the resident into a wheelchair and brought the resident back into the building and where Resident #4 was t Ex.Order 26.4(b)(1)

On 5/19/2022 post survey, the surveyor interviewed the ED (Executive Director) by telephone who stated that on 1/29/2022, he came to work early due to a snowstorm. He continued to explain to the surveyor that he periodically drove around the premises to make sure everything was alright. The ED stated that at approximately 3:40 a.m., he saw what appeared to be a garbage bag but when he drove closer, he realized it was in fact a person lying on the snow.

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A1249	Continued From page 6 The ED stated that he got out of his car immediately and observed Resident #4 lying flat on the snow covered ground and identified that the resident was not wearing a coat, socks or shoes. The ED stated that he covered the resident with his winter coat and placed a telephone call to 911. During continued interview, the ED stated that he asked the resident what happened but the resident was not able to respond at the time. The ED stated that he then placed a call to the HWD inside the building who was working covering a shift. He stated that the resident was brought back into the building in a wheelchair and was transporte Ex.Order 26.4(b)(1) The ED confirmed that the exit door near room 117 was not alarmed and had no means of communication into the building from the outside. A Ex.Order 26.4(b)(report was received post survey on 6/2/2022 at 10:56 a.m. The surveyor reviewed the report dated from Ex.Order 26.4(b)(1) on admission through the 2 Ex.Order 26.4(b)(discharge date. According to the report dated Ex.Order 26.4(b)(1) at 05:02 EST, the Ex.Order 26.4(b)(1) . Additionally, the report revealed, "... year-old patient who came in by EMS [Emergency Medical Services] after [the patient] was found outside [the patient's} residence in the snow with Ex.Order 26.4(b)(1) The patient arrived with minimal response, temperature of 27 degrees [Centigrade equal to 80.6 degrees Fahrenheit]. The patient had multiple Ex.Order 26.4(b)(1) of Ex.Order 26.4(b)(1) as well as Ex.Order 26.4(b)(1) The patient was started on rewarming. ... CT [Computed Tomography] of the Ex.Order 26.4(b)(1) of	A1249		

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A1249	Continued From page 7 the Ex.Order 26.4(b)(1) The patient was brought back to the trauma room for further Ex.Order 26.4(b)(1). [The patient's] Ex.Order 26.4(b)(1) The patient's temperature improved to Ex.Order 26.4(b)(1) came back at 8 [a.m., Ex.Order 26.4(b)(1) r continued Ex.Order 26.4(b)(1)." Continued surveyor review of the hospital report revealed, "... year old [patient] presents to ... as a trauma alert for a Ex.Order Patient was found down in the snow after going outside to Ex.Order 26.4(b)(1) between two cars and someone found him/her an hour later. Patient arrives via Ex.Order 26.4(b)(1) in place. Patient only responding with sounds at this time. Patient alert and oriented and able to answer questions appropriately but questionable Ex.Order 26.4(b)(1) Party states [patient] has intermittent periods of Ex.Order 26.4(b)(1) at (the patient's) baseline and has Ex.Order 26.4(b)(1) outside before." The report indicated that on 2/7/2022, this a.m., [no time specified], 9 days after the Ex.Order that the patient was Ex.Order 26.4(b)(1) s and needed to be Ex.Order 26.4(b)(1). The report also indicated that the patient was started on treatment fo Ex.Order 26.4(b)(1) A late entry written by the RN in Resident #4's progress notes of the facility's medical record revealed, Ex.Order 26.4(b)(1), Late entry for Ex.Order 26.4(b)(1) Notified by GM [General	A1249		

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A1249	Continued From page 8 Manager] that resident had Ex.Order 26.4(b)(1)	A1249		

Plan of Correction for 5/9/22 Visit

A1271

- In order to accomplish the corrective action, The community conducted a root cause analysis related to the Department's findings that the community failed to provide a safe environment for residents to ambulate freely and failed to develop a security policy for the exit doors allowing for safe passage for coming and going.

  It was determined that the Plant Operations Supervisor was not aware that the community did have an established security policy which had been approved as part of the community's initial licensing and was in place and applied properly at the time of the incident.

  It was also determined that the Health and Wellness Director's (HWD) statement that residents were "free to come and go" was not clarified to explain that, while residents in the non-secured assisted living neighborhood are free to come and go, each resident's care plan identifies the resident's needs and preferences. Resident #4's mutually agreed on service plan identified that the resident was able to safely leave the community without supervision. Resident #4 had a wireless personal emergency pendant and was assessed as being independent with the community's call system operation.

  When the HWD encountered Resident #4 at 3:00 am on the date of the incident, she texted a Resident Assistant and requested Resident #4 be checked on. At 3:30 am, Resident #4 was located outside and had evidently fallen. Resident #4 was wearing the pendant when located outside but had not activated the device to summon assistance for re-entry to the community or for assistance after falling.

  The root cause analysis indicates that the community did not fail to provide a safe environment for ambulating or fail to have a policy for exit doors allowing for safe coming and going. As it was unusual for Resident #4 to be walking the hallways at approximately 1:50 am and again at 3:00 am, additional communication between staff at 1:50 am and additional intervention by the HWD at the time of her encounter with Resident #4 at 3 am or an expedited safety check by the RA at 3 am may have prevented the incident from occurring. Unfortunately, as this event occurred in the past, those actions cannot be accomplished to change or prevent the affected resident's incident.

- In order to identify other residents who may be affected, The community has provided training to all staff regarding the community's Policy and Procedure Manual that is required to be established and maintained in accordance with §8:36-5.7.

  Staff have received additional training regarding observing for and responding to behaviors/circumstances that may indicate a sudden or significant change of resident condition and that such situation must be verbally reported to the designated supervisor on duty immediately to ensure immediate interventions are enacted and a temporary care plan is established to monitor the resident.

- To ensure the deficient practice will not occur, the General Manager or their designee, will utilize the community's electronic "dashboards" to review recurring incident trends, unscheduled services, temporary care plans and other metrics that may indicate a gradual or sudden change of resident condition. This is in addition to evaluating individual incidents as they occur.

- In order to monitor the effectiveness of this plan, the General Manager will review the dashboard as part of their quarterly review.