

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2021
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NAME OF PROVIDER OR SUPPLIER JUNIPER VILLAGE AT WILLIAMSTOWN, WELLSPRING	STREET ADDRESS, CITY, STATE, ZIP CODE 1648 S. BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094
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(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	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00144653</p> <p>CENSUS: 21</p> <p>SAMPLE SIZE: 3</p> <p>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.</p>	A 000		
A 563	<p>8:36-5.10(a)(2) General Requirements</p> <p>(a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following:</p> <p>2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages;</p>	A 563		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 563	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00144653</p> <p>Based on interview and record review it was determined that the facility failed to notify the Department of Health (DOH) of an elopement incident for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 4/15/21 at 10:30 a.m., the surveyor reviewed the medical record of Resident #2, who was transferred from the facility's assisted living to the memory care facility on [REDACTED], and according to the document titled, "MOVE IN RECORD," had diagnoses which included [REDACTED].</p> <p>The surveyor reviewed a document in the medical record titled, "Resident Evaluation and Level of Care Determination - V 8," dated [REDACTED], which revealed that the resident was a [REDACTED] but did not require an assistive device.</p> <p>The surveyor reviewed Resident 2's Progress Notes (PNs), which revealed that on [REDACTED], and [REDACTED] the resident successfully exited the building through [REDACTED] hall exit doors and on [REDACTED] the resident exited the building twice.</p>	A 563		

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A 563	<p>Continued From page 2</p> <p>On 4/15/21 at 11:15 a.m., the surveyor interviewed Staff Member (SM) #1 who stated that Resident #2 has gone out of the facility [REDACTED] times and that the resident was always looking to leave the building.</p> <p>On 4/15/21 at 11:30 a.m., the surveyor interviewed SM #2 who stated that on [REDACTED] Resident #2 exited the building and was found in the facility's parking lot. SM #2 stated that she assisted the resident back to the building.</p> <p>On 4/15/21 at 11:50 a.m., the surveyor interviewed SM #3 who stated that she assisted Resident #2 back to the building on [REDACTED] with another co-worker.</p> <p>On 4/15/21 at 12:30 p.m., the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she was aware that Resident #2 had gone outside. The LPN further stated that the resident was found in the parking lot and that she did not consider that an [REDACTED]. The LPN further stated that when the exit doors open, an alarm will sound and the staff would check the alarm panel to acknowledge the location of the opened door, and alert staff members of the location via the radio.</p> <p>On 4/15/21 at 2:30 p.m., the surveyor interviewed the Registered Nurse (RN) who stated that she was aware that Resident #2 exited the building but did not consider the occurrence an event which needed to be reported to the Department of Health (DOH) since the resident did not leave the campus.</p> <p>On 4/15/21 at 2:45 p.m., the surveyor met with the ED who stated that the facility was working with the family to find placement for Resident #2 but that as of this point, there were no</p>	A 563		

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A 563	<p>Continued From page 3</p> <p>arrangements made.</p> <p>On 4/15/21 the surveyor interviewed the Health Care Provider (HCP) who stated that Resident #2 remained at [REDACTED] and would benefit from having a private Aide.</p> <p>At 3:00 p.m. the surveyor informed the ED that the resident remained at [REDACTED] and requested the ED to provide the surveyor with a removal plan.</p> <p>At 4:15 p.m., the surveyor met with the ED who agreed with the surveyor that the incidents should have been reported immediately to the DOH as an [REDACTED]. The ED further stated that Resident #2 would be provided with a private Aide until discharged from the facility.</p> <p>The surveyor observed that the facility's location was off of a four-lane highway, with the speed limit being 50 miles per hour.</p> <p>The surveyor reviewed the facility's policy titled, "Reportable Events," which indicated that occurrences that are required by state, local and federal agencies shall be reported. The facility failed to report [REDACTED] to the DOH when Resident #2 was able to get outside of the secured locked neighborhood to areas that were not locked, including outside of the building, without staff's knowledge that the resident was leaving the secured locked area.</p> <p>On 4/23/21 the surveyor revisited the facility and was informed by the ED that the resident was transferred to the hospital on [REDACTED] had a private Aide until the resident was transferred, and the resident will not return to the facility, but would be transferred to a skilled nursing facility.</p>	A 563		