

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
H 000	<p>Initials Comments</p> <p>Type of Survey: Complaint</p> <p>Complaint #: NJ00168633</p> <p>Census: 109</p> <p>Sample Size: 3</p> <p>The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities. 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 the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	H 000		
H2630	<p>8:43E-10.6(a)(2) Reporting Serious Preventable Adverse Events</p> <p>Adult and pediatric day health care services facilities and facilities that provide home-based services, that is, home health care facilities, hospice facilities, assisted living residences, comprehensive personal care homes, and assisted living programs, shall report only those serious preventable adverse events that are within the control of the facility or directly caused by, or related to, services of the facility.</p>	H2630		

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

TITLE

(X6) DATE

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
H2630	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00168633</p> <p>Based on interview and document review, it was determined that the facility failed to notify the Department of Health (DOH) of an [REDACTED] from the program which occurred on [REDACTED] for 1 of 3 participants, Participant #2. This deficient practice was evidenced by the following:</p> <p>On 10/27/23 at 1:27 p.m., the surveyor interviewed Participant #2's [REDACTED] who stated the participant [REDACTED] from the facility on two different occasions. The participant's [REDACTED] stated the first incident occurred [REDACTED], but she could not recall the month/date [REDACTED]. The participant's [REDACTED] explained after the first [REDACTED] the facility called Participant #2's [REDACTED] to inform the [REDACTED] Participant #2 was [REDACTED]</p> <p>On 11/02/23 at 12:24 p.m., the surveyor interviewed the Administrator, who confirmed Participant #2 [REDACTED] from the facility on two different occasions. The Administrator stated on the participant's [REDACTED] day as a [REDACTED] at the program, the participant [REDACTED] through a [REDACTED] which was [REDACTED]. The Administrator stated the incident was reported to the [REDACTED], who [REDACTED] Participant #2 one hour later [REDACTED]. The Administrator confirmed the first incident which occurred on [REDACTED], was not reported to the Department of Health.</p> <p>On 11/13/23 at 11:38 a.m., the surveyor interviewed the Administrator, who confirmed Participant #2 received services such as transportation, activity, and meals while at the program on [REDACTED]. The surveyor also reviewed</p>	H2630			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
H2630	<p>Continued From page 2</p> <p>the "Daily Transport Log" dated [NJ Ex Order 26.4b1], which revealed Participant #2 was picked up at 11:46 a.m. by Driver #1.</p> <p>On 11/08/23 at 11:35 a.m., the surveyor received and reviewed the [NJ Ex Order 26.4b1] for the first [NJ Ex Order 26.4b1] dated/timed [NJ Ex Order 26.4b1] at 3:38 p.m., which revealed a staff member at the facility reported Participant #2 was [NJ Ex Order 26.4b1] and told the [NJ Ex Order 26.4b1] that the Participant [NJ Ex Order 26.4b1] "20 minutes prior to the [NJ Ex Order 26.4b1] arrival. At 5:50 p.m., a [NJ Ex Order 26.4b1] was generated for Participant #2. At 6:47 p.m., Participant #2 was [NJ Ex Order 26.4b1] [NJ Ex Order 26.4b1], and returned [NJ Ex Order 26.4b1] three hours and 29 minutes later.</p> <p>The surveyor review of the facility policy titled, "Patient Elopement," which revealed, "... In the event of an unexpected occurrence involving the elopement of the patient the following will occur...5. Reportable event procedure is followed."</p> <p>Additionally, the surveyor reviewed the facility policy titled, "Reportable Events," which showed, "The facility shall notify the Department immediately...for most reportable events that occur in the facility. The Administrator or his designee will notify the Department of Health immediately by phone. An incident report will be completed immediately and be given to the Administrator who will report the event to DHSS of [sic] the following events...P. Missing residents..."</p> <p>Reference: 8:43F-3.1(b)(1-7) M-0223 8:43F-17.2 M-0827</p>	H2630		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 000	Continued From page 3	M 000		
M 000	Initial Comments Type of Survey: Complaint Complaint #: NJ00168633 Census: 109 Sample Size: 3 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 223	8:43F-3.1(b)(1-7) Administration (b) The administrator shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including participant rights; 2. Planning and administering the managerial, operational, fiscal, and reporting components of the facility; 3. Participating in the quality improvement program for participant care and staff	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	<p>Continued From page 4</p> <p>performance;</p> <p>4. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job descriptions;</p> <p>5. Ensuring the provision of staff orientation, staff education, and ongoing staff training in accordance with N.J.A.C. 8:43F-6.3;</p> <p>6. Establishing and maintaining liaison relationships and communication between facility staff and services providers and with participants and their caregivers; and</p> <p>7. Verifying that each Medicaid-eligible participant is eligible to receive services available at the adult day health services facility prior to the participant's entry into the program. For the purposes of this section, the administrator shall be entitled to rely on any prior authorization performed by the Department for the participant in accordance with N.J.A.C. 8:86.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00168633</p> <p>Based on observation, interviews, record, and document review, it was determined that the Administrator failed to ensure the implementation</p>	M 223			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	<p>Continued From page 5</p> <p>and enforcement of all policies and procedures, including "Security and Accountability During Transportation," "Use of Wonder Guard [Wanderguard]," "Patient Elopement," and "Reportable Events" for 2 of 3 Participants reviewed, Participant #1 and Participant #2. This deficient practice was evidenced by the following:</p> <p>On 10/26/23 the surveyor reviewed the medical record (MR) of Participant #2 which revealed the participant was admitted to the program on [REDACTED] with a diagnosis of [REDACTED]. The surveyor also reviewed Participant #2's initial assessment, which revealed a [REDACTED] Assessment [REDACTED] NJ Ex Order 26.4b1," which indicated the participant was a [REDACTED] NJ Ex Order 26.4b1". The assessment also indicated the Administrator was made aware of the [REDACTED] NJ Ex Order 26.4b1, and the participant was to wear a [REDACTED] NJ Ex Order 26.4b1 while at the program. (The Medi Channel: [REDACTED] NJ Ex Order 26.4b1 is a technology designed to keep [REDACTED] NJ Ex Order 26.4b1 from [REDACTED] NJ Ex Order 26.4b1. The system relies on three components: [REDACTED] NJ Ex Order 26.4b1 that residents wear [REDACTED] NJ Ex Order 26.4b1, and a [REDACTED] NJ Ex Order 26.4b1 [REDACTED] NJ Ex Order 26.4b1. When a resident with a [REDACTED] NJ Ex Order 26.4b1 [REDACTED] NJ Ex Order 26.4b1.)</p> <p>On 10/26/23 at 11:44 a.m., the surveyor interviewed the Administrator, who stated she received a phone call on [REDACTED] NJ Ex Order 26.4b1 from a [REDACTED] NJ Ex Order 26.4b1 who informed her Participant #2 was reported [REDACTED] NJ Ex Order 26.4b1 by his/her [REDACTED] NJ Ex Order 26.4b1 on [REDACTED] NJ Ex Order 26.4b1 at about 6:30 p.m. when Participant #2 did not [REDACTED] NJ Ex Order 26.4b1 from the program. The Administrator stated she informed the [REDACTED] NJ Ex Order 26.4b1 Participant #2 was not [REDACTED] NJ Ex Order 26.4b1 on [REDACTED] NJ Ex Order 26.4b1, but she would check the [REDACTED] NJ Ex Order 26.4b1 list again to confirm. The Administrator stated she checked the [REDACTED] NJ Ex Order 26.4b1</p>	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	<p>Continued From page 6</p> <p>list and Participant #2 was NJ Ex Order 26.4b1. The Administrator also stated she was later informed by Participant #2's NJ Ex Order 26.4b1 that the participant was handed to the participant's driver on NJ Ex Order 26.4b1.</p> <p>In addition, the Administrator stated she then called Driver #1, who confirmed on NJ Ex Order 26.4b1 he picked up Participant #2 [at 11:35 a.m.] from his/her NJ Ex Order 26.4b1 and handed off the Participant to the nursing staff NJ Ex Order 26.4b1 on arrival to the program. The Administrator stated the transportation log from NJ Ex Order 26.4b1 revealed Driver #1 picked up Participant #2 from his/her NJ Ex Order 26.4b1 at 11:35 a.m. The Administrator stated the NJ Ex Order 26.4b1 did not pick up any footage from NJ Ex Order 26.4b1 that showed Participant #2 was present at the facility. The Administrator explained when the nursing staff received Participants with NJ Ex Order 26.4b1 from the Drivers, they would immediately apply a NJ Ex Order 26.4b1 and a NJ Ex Order 26.4b1.</p> <p>At 11:59 a.m., the surveyor observed two NJ Ex Order 26.4b1 Participants with a NJ Ex Order 26.4b1 on, but no NJ Ex Order 26.4b1 were applied. The surveyor interviewed a Certified Nursing Assistant (CNA), who stated the NJ Ex Order 26.4b1 were broken, and the Administrator planned to order new ones.</p> <p>At 12:04 p.m., the surveyor interviewed the Director of Nursing (DON) to inquire about the NJ Ex Order 26.4b1 protocol. The DON stated the protocol was for the nursing staff to apply NJ Ex Order 26.4b1 to Participants at NJ Ex Order 26.4b1 once the Participants were received by the Drivers. The DON also stated NJ Ex Order 26.4b1 were not used at the program.</p>	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	<p>Continued From page 7</p> <p>At 12:08 p.m., the surveyor observed a Driver bring Participant #1 to the CNA in the rear of the facility, who then applied a [REDACTED] to the Participant, however, no [REDACTED] was applied.</p> <p>At 1:57 p.m., the surveyor interviewed the CNA and Medical Assistant (MA) #1 to inquire about why [REDACTED] participants did not have the [REDACTED] on. The CNA and MA #1 both stated the [REDACTED] did not work properly and have had a delayed alarm for seven to ten days. The CNA and MA #1 both stated the drivers would bring [REDACTED] participants to the nursing staff, who would then apply the [REDACTED] and attach the [REDACTED] to the [REDACTED]. The CNA stated she did not observe Participant #2 at the program on [REDACTED].</p> <p>At 2:51 p.m., the surveyor interviewed Driver #1, who stated on [REDACTED] he picked up Participant #2 from his/her [REDACTED] [at 11:35 a.m.] and handed the participant to a Licensed Practical Nurse (LPN) [REDACTED] upon arrival to the facility. Driver #1 stated he did not observe Participant #2 again after the Participant was dropped off at the program. Driver #1 stated the nursing staff were supposed to inform the receptionist of [REDACTED] participants who were present at the facility. Driver #1 explained his shift ended at 3:00 p.m., and Driver #2 transported the participants from the second session to home.</p> <p>At 3:54 p.m., the surveyor interviewed Driver #2, who stated he [REDACTED] Participant #2 at the program on [REDACTED]. Driver #2 stated he asked the receptionist [REDACTED] Participant #2, however, the receptionist stated she had [REDACTED] the participant.</p>	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	<p>Continued From page 8</p> <p>On 10/27/23 at 1:27 p.m., the surveyor interviewed Participant #2's [redacted] who stated the [redacted] on [redacted] was the second time the participant had [redacted] from the program. The participant's [redacted] stated the first incident happened [redacted], but she could not recall the month/date. The participant's [redacted] stated after the first [redacted] the program called Participant #2's [redacted] to inform the [redacted] Participant #2 was [redacted].</p> <p>During the interview, the participant's [redacted] stated the second [redacted] occurred on [redacted]. The participant's [redacted] explained Participant #2 was put on the facility bus between 11:30 and 11:40 a.m. by the health care worker of Participant #2's [redacted]. The participant's [redacted] stated on [redacted] at 6:40 p.m., she received a call from Participant #2's [redacted] who stated she could not reach the facility and Participant #2 had [redacted]. The participant's [redacted] explained she then called the program and Driver #1, but there was no answer with either call. The participant's [redacted] stated on [redacted], the family called the [redacted] to report Participant #2 [redacted] and Participant #2 was [redacted] by the [redacted] on [redacted] around 8:30 p.m. at a [redacted].</p> <p>On 11/02/23 at 12:17 p.m., the surveyor interviewed the LPN at the program, who stated Driver #1 did not hand over Participant #2 to her, and the participant was [redacted] at the program on [redacted]. The LPN also stated the staff who received an [redacted] participant from a driver was responsible for the [redacted] placement. The LPN stated the facility did not use [redacted].</p>	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	<p>Continued From page 9</p> <p>On 11/02/23 at 12:24 p.m., the surveyor interviewed the Administrator again, who confirmed Participant #2 [redacted] twice. The Administrator stated the first [redacted] occurred [redacted], however she could not recall the month/date of the [redacted]. The Administrator stated Participant #2 was a visitor and [redacted] from the program on the second day of his/her visit [redacted] which was [redacted]. The Administrator stated the incident was reported to the [redacted], and an [redacted] the participant one hour later [redacted]. The Administrator stated the first [redacted] which occurred on [redacted] was not reported to the Department of Health.</p> <p>On 11/03/23 at 9:04 a.m., the surveyor received and reviewed a police report dated/timed [redacted] at 6:48 p.m. The report revealed an [redacted] met with Participant #2's [redacted] who reported the participant [redacted]. The report also indicated the [redacted] called the facility on [redacted] and there was no answer. The report revealed the officer then contacted the [redacted] health care worker who stated [between 11:30 a.m. and 11:40 a.m.] she walked Participant #2 to the bus and watched as Participant #2 and another participant boarded Driver #1's bus.</p> <p>The [redacted] indicated on [redacted] at 11:35 a.m., the [redacted] called the Administrator at the center, who stated the staff at the center [redacted]. Participant #2 at the program on [redacted]. The report indicated the [redacted] contacted Driver #1, who stated on [redacted] he picked up Participant #2 [at 11:35 a.m.], walked the participant to [redacted], and handed the participant to a nurse. The report revealed on [redacted] the [redacted] called another</p>	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	<p>Continued From page 10</p> <p>NJ Ex Order 26.4b1 to inquire if they had seen Participant #2. The report revealed, "On NJ Ex Order 26.4b1 the NJ Ex Order 26.4b1 requested NJ Ex Order 26.4b1 for a NJ Ex Order 26.4b1 who possibly NJ Ex Order 26.4b1. The request was made at approximately 15:35 hours [3:35 p.m.] and the location was for the NJ Ex Order 26.4b1." The report indicated Participant #2 gave the NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 as he/she was transported to a local hospital. The report indicated the NJ Ex Order 26.4b1 went to the hospital to confirm the identity of Participant #2, and the NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1 at 11:10 a.m.</p> <p>On 11/08/23 at 11:35 a.m., the surveyor received and reviewed the NJ Ex Order 26.4b1 for the first NJ Ex Order 26.4b1 dated/timed NJ Ex Order 26.4b1 at 3:38 p.m., which revealed a staff member at the facility reported Participant #2 was NJ Ex Order 26.4b1 and told the NJ Ex Order 26.4b1 that the Participant NJ Ex Order 26.4b1 20 minutes prior to the NJ Ex Order 26.4b1's arrival. At 5:50 p.m., a NJ Ex Order 26.4b1 was generated for Participant #2. At 6:47 p.m., Participant #2 was NJ Ex Order 26.4b1 and returned NJ Ex Order 26.4b1 three hours and 29 minutes later.</p> <p>The surveyor reviewed the "History and Physical Notes" from Participant #2's hospital admission on NJ Ex Order 26.4b1, which revealed, "[Participant #2] was NJ Ex Order 26.4b1 at 1600 [4:00 p.m.] today at the bus stop having NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.... [Participant #2 has a] NJ Ex Order 26.4b1 NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1." Participant #2 was admitted on NJ Ex Order 26.4b1, with diagnoses of NJ Ex Order 26.4b1 (Mayo Clinic: NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 It results in NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 (Healthline: NJ Ex Order 26.4b1</p>	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	<p>Continued From page 11</p> <p>NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1).</p> <p>The surveyor reviewed the facility policy titled, "Security and Accountability During Transportation," which indicated, "The facility shall develop and implement plans for security and accountability for the participant and the participant's personal possessions while transportation services are being provided...4. All participants will be escorted off the bus by a program aid or [an] employee of the medical center."</p> <p>The surveyor reviewed the facility policy titled, "Use of Wonder Guard [Wanderguard]," which indicated, "It is the policy of [the facility] to place the wonder guard [wanderguard] on all participants who are at risk and have been assessed to be a potential for elopement."</p> <p>The facility failed to follow their facility policy titled, "Patient Elopement," which indicated, "...In the event of an unexpected occurrence involving the elopement of the patient the following will occur: 1. The building is searched for the patient. 2. Staff is dispatched to search for [the] patient outside [of] the facility. 3. Local Police is notified. 4. Patient family/care provider is informed. 5. Reportable event procedure is followed".</p> <p>The surveyor reviewed the facility policy titled, "Reportable Events," which showed, "The facility shall notify the Department immediately...for most reportable events that occur in the facility. The Administrator or his designee will notify the Department of Health immediately by phone. An incident report will be completed immediately and be given to the Administrator who will report the event to DHSS of [sic] the following events...P. Missing residents..."</p>	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 223	Continued From page 12 Reference: 8:43E-10.6(a)(2) H-2630 8:43F-17.2 M-0827	M 223		
M 827	8:43F-17.2 Transportation Services The facility shall develop and implement plans for security and accountability for the participant and the participant's personal possessions while transportation services are being provided. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00168633 Based on observation, interview, record, and document review, it was determined that the facility failed to ensure the security and accountability of a Participant during transportation for 1 of 3 Participants reviewed, Participant #2. This deficient practice was evidenced by the following: On 10/26/23 the surveyor reviewed the medical record (MR) of Participant #2 which revealed the participant was admitted to the program on [NJ Ex Order 26.4b1] with a diagnosis of [NJ Ex Order 26.4b1]. The surveyor also reviewed Participant #2's initial assessment, which revealed a [NJ Ex Order 26.4b1] Assessment [NJ Ex Order 26.4b1], " which indicated the participant was a [NJ Ex Order 26.4b1] ". The assessment also indicated the Administrator was made aware of the [NJ Ex Order 26.4b1] and the	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 13</p> <p>participant was to wear a [REDACTED] while at the program. (The Medi Channel: [REDACTED] is a technology designed to keep [REDACTED] ..The system relies on three components: [REDACTED], sensors that [REDACTED], and [REDACTED] [REDACTED] When a resident with a [REDACTED] [REDACTED] NJ Ex Order 26.4b1, the system [REDACTED] .)</p> <p>On 10/26/23 at 11:44 a.m., the surveyor interviewed the Administrator, who stated she received a phone call on [REDACTED] from a [REDACTED] who informed her Participant #2 was [REDACTED] NJ Ex Order 26.4b1 by his/her [REDACTED] on [REDACTED] at about 6:30 p.m. when Participant #2 did [REDACTED] from the program. The Administrator stated she informed the [REDACTED] Participant #2 was [REDACTED] NJ Ex Order 26.4b1 on [REDACTED], but she would check the [REDACTED] list again to confirm. The Administrator stated she checked the [REDACTED] list and Participant #2 was [REDACTED] NJ Ex Order 26.4b1. The Administrator also stated she was later informed by Participant #2's [REDACTED] NJ Ex Order 26.4b1 that the participant was handed to the participant's driver on [REDACTED] NJ Ex Order 26.4b1.</p> <p>In addition, the Administrator stated she then called Driver #1, who confirmed on [REDACTED] he picked up Participant #2 [at 11:35 a.m.] from his/her [REDACTED] and handed off the Participant to the nursing staff [REDACTED] NJ Ex Order 26.4b1 on arrival to the program. The Administrator stated the transportation log from [REDACTED] NJ Ex Order 26.4b1, revealed Driver #1 picked up Participant #2 from his/her home at 11:35 a.m. The Administrator stated the [REDACTED] NJ Ex Order 26.4b1 did not pick up any footage from [REDACTED] NJ Ex Order 26.4b1 that showed Participant #2 was [REDACTED] NJ Ex Order 26.4b1. The</p>	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 14</p> <p>Administrator explained when the nursing staff received Participants with NJ Ex Order 26.4b1 from the Drivers, they would immediately apply a NJ Ex Order 26.4b1 and a NJ Ex Order 26.4b1.</p> <p>At 11:59 a.m., the surveyor observed two NJ Ex Order 26.4b1 participants with a NJ Ex Order 26.4b1 on, but no NJ Ex Order 26.4b1 were applied to the participants. The surveyor interviewed a Certified Nursing Assistant (CNA), who stated the NJ Ex Order 26.4b1 were broken, and the Administrator planned to order new NJ Ex Order 26.4b1.</p> <p>At 12:04 p.m., the surveyor interviewed the Director of Nursing (DON) to inquire about the NJ Ex Order 26.4b1 protocol. The DON stated the protocol was for the nursing staff to apply a wander vest to all participants at NJ Ex Order 26.4b1 the participants were received from the drivers. The DON added that NJ Ex Order 26.4b1 were not used at the program.</p> <p>At 12:08 p.m., the surveyor observed a driver bring Participant #1 to the CNA, who then applied a NJ Ex Order 26.4b1 to the participant. However, the surveyor did not observe the CNA apply a NJ Ex Order 26.4b1 to Participant #1.</p> <p>At 1:57 p.m., the surveyor interviewed the above CNA and Medical Assistant (MA) #1 to inquire about why the NJ Ex Order 26.4b1 participants did not have NJ Ex Order 26.4b1 applied. The CNA and MA #1, both stated the NJ Ex Order 26.4b1 did not function properly and had a delayed alarm for seven to ten days. The CNA and MA #1, both stated the drivers would bring the NJ Ex Order 26.4b1 participants to the nursing staff, who would then apply the NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The CNA and MA #1 also stated the NJ Ex Order 26.4b1.</p>	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 15</p> <p>were supposed to be attached to the back of the NJ Ex Order 26.4b1. The CNA confirmed she did NJ Ex Participant #2 at the program on NJ Ex Order 26.4b1.</p> <p>At 2:02 p.m., and 2:07 p.m., the surveyor interviewed the Food Service Director, Receptionist, Administrative Assistant, and MA #2. The four staff members confirmed that they NJ Ex Order 26.4b1 Participant #2 at the program on NJ Ex Order 26.4b1. Additionally, the receptionist stated she observed everyone who entered and exited the facility on NJ Ex Order 26.4b1, and everyone signed in. The receptionist explained the entrance door remained locked and she had to let people in and out of the facility. The surveyor reviewed the "Daily Check-In sheet" dated NJ Ex Order 26.4b1, which revealed Participant #2 was NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1.</p> <p>At 2:26 p.m., and 2:32 p.m., the surveyor interviewed two unsampled participants from Participant #2's transportation log. Unsampled Participant #1, stated on NJ Ex Order 26.4b1, he/she observed Participant #2 on the bus, but NJ Ex Order 26.4b1 NJ Ex Order 26.4b1. Unsampled Participant #2 stated he/she observed Participant #2 on the bus and NJ Ex Order NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1.</p> <p>At 2:51 p.m., the surveyor interviewed Driver #1, who stated he picked up Participant #2 from his/her home on NJ Ex Order 26.4b1 and handed the participant to a Licensed Practical Nurse (LPN) in the rear of the facility upon arrival to the facility. Driver #1 stated he did not observe Participant #2 again after the participant was dropped off at the program. Driver #1 stated the nursing staff were supposed to inform the receptionist of NJ Ex Order 26.4b1 participants who were present at the facility. Driver #1 explained his shift ended at 3:00 p.m.,</p>	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 16</p> <p>and Driver #2 took the participants from the second session to home. Driver #1 also stated it was the responsibility of Driver #2 to check the "Daily Trip Log" to ensure all participants who were brought to the facility that morning were accounted for prior to departure.</p> <p>In addition, Driver #1 stated the Administrator called him on [REDACTED] to inquire about Participant #2 and that he explained to the Administrator he picked up the participant from his/her [REDACTED] on [REDACTED] [at 11:35 a.m.]. Driver #1 then stated he called Driver #2 to inquire about Participant #2's last whereabouts who stated he [REDACTED] Participant #2 on [REDACTED] at the program.</p> <p>At 3:23 p.m., the surveyor interviewed the Director of Transportation (DOT), who stated he [REDACTED] Participant #2 on [REDACTED] at the program. The DOT also stated he in-serviced all drivers on [REDACTED] participants who needed to be escorted to the nursing station on arrival. The DOT stated all drivers were given a "Daily Trip Log" which listed all participants on their bus route at the end of each day, with those scheduled to attend the center the following day highlighted.</p> <p>Further, the DOT stated the drivers recorded the participant's pick-up and drop-off time on the "Daily Trip Log". The surveyor inquired about how Driver #2 knew which Participants were to be transported [REDACTED] on [REDACTED]. The DOT stated Driver #2 was given Driver #1's "Daily Trip Log" from the morning of [REDACTED] to refer to. The DOT explained he used Driver #1's morning "Daily Trip Log" to create Driver #2's afternoon "Daily Trip Log".</p>	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 17</p> <p>The surveyor reviewed the highlighted "Daily Trip Log" given to Driver #1 on [REDACTED] for [REDACTED], which revealed Participant #2 was scheduled to attend the center on [REDACTED]. The surveyor also reviewed Driver #1's "Daily Trip Log" dated [REDACTED], which confirmed Participant #2 was picked up at 11:35 a.m. The surveyor then reviewed Driver #2's "Daily Trip Log" dated [REDACTED], which revealed all the participants Driver #1 picked up in the morning were highlighted. However, the surveyor did not observe the participant's pick-up times on the log.</p> <p>At 3:54 p.m., the surveyor interviewed Driver #2, who stated he [REDACTED] Participant #2 on [REDACTED]. Driver #2 stated he asked the receptionist where Participant #2 was, and the receptionist stated she [REDACTED] the participant. Driver #2 confirmed he knew the highlighted participants on the list were to be transported home. Driver #2 added that he was not given a list of participants who were at [REDACTED], but he knew who the participants were, which included Participant #2.</p> <p>On 10/27/23 at 1:27 p.m., the surveyor interviewed Participant #2's [REDACTED] who stated the [REDACTED] on [REDACTED] was the second time the participant had [REDACTED] from the program. The [REDACTED] stated the first [REDACTED] happened [REDACTED], but she could not recall the month/date. The [REDACTED] stated after the first [REDACTED] the program called Participant #2's [REDACTED] to inform the [REDACTED] Participant #2 was [REDACTED] and the participant [REDACTED] through an [REDACTED].</p> <p>Further, the participant's [REDACTED] stated the second incident occurred on [REDACTED] and stated Participant #2 was put on the facility bus between</p>	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 18</p> <p>11:30 and 11:40 a.m. by the health care worker of Participant #2's [REDACTED] The participant's [REDACTED] stated on [REDACTED] at 6:40 p.m., she received a telephone call from Participant #2's [REDACTED] who stated she could not reach the facility and Participant #2 had not [REDACTED]. The participant's [REDACTED] stated she then called the center and Driver #1, and there was no answer with either call. The participant's [REDACTED] stated on [REDACTED], the family called the department to report Participant #2 [REDACTED] and Participant #2 was [REDACTED] by the [REDACTED] on [REDACTED] around 8:30 p.m. at a [REDACTED].</p> <p>On 11/02/23 at 12:17 p.m., the surveyor interviewed the LPN at the program, who stated Driver #1 did not hand off Participant #2 to her, and the participant was [REDACTED] at the program on [REDACTED]. The LPN also stated the staff who received an [REDACTED] participant from a driver was responsible for the [REDACTED] placement. The LPN stated the facility did not use [REDACTED].</p> <p>On 11/02/23 at 12:24 p.m., the surveyor interviewed the Administrator again, who confirmed Participant #2 [REDACTED] on two different occasions. The Administrator stated the first [REDACTED] occurred [REDACTED], however she could not recall the month/date of the [REDACTED]. The Administrator stated Participant #2 was a visitor and [REDACTED] from the program on the second day of his/her visit through the [REDACTED] which was [REDACTED]. The Administrator stated the incident was reported to the [REDACTED] and the participant was [REDACTED] within one hour [REDACTED]. The Administrator stated the first [REDACTED] which occurred on [REDACTED] was not reported to the Department of Health.</p>	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 19</p> <p>On 11/03/23 at 9:04 a.m., the surveyor received and reviewed a [NJ Ex Order 26.4b1] dated/timed [NJ Ex Order 26.4b1] at 6:48 p.m. The [NJ Ex Order 26.4b1] indicated an [NJ Ex Order 26.4b1] met with Participant #2's [NJ Ex Order 26.4b1] who reported the participant [NJ Ex Order 26.4b1]. The [NJ Ex Order 26.4b1] also revealed the [NJ Ex Order 26.4b1] called the program on [NJ Ex Order 26.4b1] and no one answered. The report revealed the [NJ Ex Order 26.4b1] contacted the participant's [NJ Ex Order 26.4b1] health care worker who stated she walked Participant #2 to the bus and watched as Participant #2 and another participant boarded Driver #1's bus.</p> <p>In addition, the report revealed that on [NJ Ex Order 26.4b1] at 11:35 a.m., the [NJ Ex Order 26.4b1] called the Administrator of the program, who stated the staff [NJ Ex Order 26.4b1] Participant #2 at the program on [NJ Ex Order 26.4b1]. The report indicated the officer contacted Driver #1, who stated on [NJ Ex Order 26.4b1], he picked up Participant #2 [at 11:35 a.m.], walked the participant to the [NJ Ex Order 26.4b1], and handed off the participant to a nurse. The report indicated on [NJ Ex Order 26.4b1], the [NJ Ex Order 26.4b1] called another [NJ Ex Order 26.4b1] to inquire if Participant #2 had been seen.</p> <p>According to the police report, "On [NJ Ex Order 26.4b1] the [NJ Ex Order 26.4b1] requested [NJ Ex Order 26.4b1] mutual aid for a [NJ Ex Order 26.4b1] who possibly [NJ Ex Order 26.4b1]. The request was made at approximately 15:35 hours [3:35 p.m.] and the location was for the [NJ Ex Order 26.4b1]." The report indicated Participant #2 gave the [NJ Ex Order 26.4b1] to the [NJ Ex Order 26.4b1] as he/she was transported to a local hospital. The report indicated the [NJ Ex Order 26.4b1] went to the hospital to confirm the identity of Participant #2, and the [NJ Ex Order 26.4b1] on [NJ Ex Order 26.4b1] at 11:10 a.m.</p>	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 20</p> <p>The surveyor reviewed the "History and Physical Notes" from Participant #2's hospital admission on [REDACTED], which revealed, "[Participant #2] was [REDACTED] by EMS at 1600 [4:00 p.m.] today at the [REDACTED] having [REDACTED] and [REDACTED].... [Participant #2 has a] [REDACTED], and [REDACTED]." Participant #2 was admitted on [REDACTED], with diagnoses of [REDACTED] (Mayo Clinic: [REDACTED]) It results in [REDACTED] and [REDACTED] (Healthline: [REDACTED]).</p> <p>On 01/02/24 at 10:11 a.m., the surveyor interviewed the Administrator who stated staff at the front desk were responsible for signing-in all participants, including [REDACTED] participants. The Administrator explained if participants were not able to sign, the front desk staff would sign on their behalf, and write "unable to sign". The Administrator stated all participants signed-in at the front desk as soon as they entered the facility. The Administrator stated Participant #2 would sign-in sometimes, and the front desk staff would sometimes sign him/her in.</p> <p>The surveyor reviewed the distance from the facility to the [REDACTED] where Participant #2 was [REDACTED] which revealed the participant [REDACTED] approximately [REDACTED] from the program (approximately a [REDACTED] to a [REDACTED]). (Reference: Apple Maps)</p> <p>The surveyor also reviewed the weather from [REDACTED], which indicated there was a high of 63 degrees, a low of 58 degrees, and it rained. (Reference: Weather-The Weather Channel:</p>	M 827		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/26/2023
NAME OF PROVIDER OR SUPPLIER 2ND HOME UNION CITY, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087		
(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
M 827	<p>Continued From page 21</p> <p>weather.com).</p> <p>The surveyor reviewed the facility policy titled, "Security and Accountability During Transportation," which indicated, "The facility shall develop and implement plans for security and accountability for the participant and the participant's personal possessions while transportation services are being provided... 4. All participants will be escorted off the bus by a program aid or [an] employee of the medical center."</p> <p>The surveyor reviewed the facility policy titled, "Use of Wonder Guard [Wanderguard]," which revealed, "It is the policy of [the facility] to place the wonder guard [wanderguard] on all participants who are at risk and have been assessed to be a potential for elopement."</p> <p>Additionally, the surveyor reviewed the "Job Description: Driver," which indicated, "Provide transportation of clients to and from the center and provide escort service as needed to ensure client safety."</p> <p>Reference: 8:43F- 3.1(b)(1-7) M-0223 8:43E-10.6(a)(2) H-2630</p>	M 827			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 408111	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/26/2023
NAME OF FACILITY 2ND HOME UNION CITY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H2630	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43E-10.6(a)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/18/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/26/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 408111	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/26/2023
NAME OF FACILITY 2ND HOME UNION CITY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3610 PALISADES AVENUE UNION CITY, NJ 07087	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0223	Correction	ID Prefix M0827	Correction	ID Prefix	Correction
Reg. # 8:43F-3.1(b)(1-7)	Completed	Reg. # 8:43F-17.2	Completed	Reg. #	Completed
LSC	01/18/2024	LSC	01/18/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/26/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			