| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315343 | A. BUILDING _____ B. WING _____ | C 05/18/2023 |

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| **BROADWAY HOUSE FOR CONTINUING** | **298 BROADWAY NEWARK, NJ 07104** |

| (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) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>Complaint #: NJ00164204<br><br>Census: 63<br><br>Sample Size: 3<br><br>The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. | F 000 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint #NJ00164204<br><br>Based on interviews and a review of the medical records (MRs) and other facility documentation on 5/18/23, it was determined that the facility staff failed to implement interventions to prevent an elopement and follow the facility's policy for 1 of 3 sampled residents (Resident #1) reviewed for elopement. This deficient practice is evidenced by the following:<br><br>Review of the facility policy titled "Facility Passes & Pass Violation" revised 5/16/22, included but was not limited to: "Passes are given after 14 | F 689 | F689<br><br>1.Resident affected by deficient practice:<br><br>Resident #1 who was affected by the deficient behavior is no longer a resident at the facility. He did not choose to remain at Broadway House Continuing Care and signed out against medical advice (AMA). | 6/26/23 |

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

Electronically Signed | 06/26/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 689 | Continued From page 1<br>days admission ...All escorts must be an adult ...4 different types of passes are given out at the discretion of the medical director, primary physician, or nurse practitioner. Residents are granted 1 independent pass a day ...Each pass is color coded. If escorted, resident is granted 2 passes a day to be with loved ones. Store pass (red form) means the resident must return to the facility within 1 hour. Day pass (yellow form) means that a resident must return back to the facility by 9PM. Medical pass means that a resident must return back to the facility once that appointment is finished and cannot wander away, this is an escorted pass ...Staff cannot escort any resident for day pr store passes".<br><br>1. According to the Face Sheet, Resident #1 was admitted to the facility on Ex.Order 26.4[illegible].<br><br>The physician progress notes (PNs) dated Ex.Order 26.4[illegible] revealed diagnoses which included but were not limited to: Ex.Order 26.4(b)(1) [illegible].<br><br>The admission nursing assessment dated Ex.Order 26.4[illegible] revealed that Resident #1 was Ex.Order 26.4(b)(1) [illegible] The resident was able to Ex.Order 26.4(b)(1) [illegible] assistance.<br><br>Review of Resident #1's baseline care plan (CP), dated Ex.Order 26.4(b)(1)[illegible] revealed that Resident #1 was scheduled for Ex.Order 26.4(b)(1) three times a week at a Ex.Order 26.4(b)(1) [illegible] There were no goals or interventions indicated in the CP.<br><br>Review of Resident #1's Physician Order (PO) did not reveal a PO for Ex.Order 26.4(b)(1). | F 689 | 2.Identifying other residents who could be affected by the deficient practice:<br><br>All residents who have medical appointments outside of the facility could be affected.<br><br>The Transportation Coordinator will set-up a schedule which includes: Resident's name, clinic appointment, departure time from the facility, and name of transport aide to accompany the resident.<br><br>No resident with a medical appointment is to leave the facility unescorted without a physician order.<br><br>Security is to call nursing Manager/DON (Director of Nursing) of any resident attempting to leave the facility unescorted.<br><br>3.Measures or systemic changes to ensure that the deficiencies will not recur:<br><br>CNA will be assigned to accompany residents who have appointments outside of the facility.<br><br>New admission orders will be checked for clinic appointments to prevent this and will be forwarded to the Transportation Coordinator to ensure that transportation and escort services was completed.<br><br>All admission orders will be reviewed by | |

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| F 689 | Continued From page 2<br>The Resident Master Listing (RML) document dated Ex.Order 26.4(b)(1) included a list of residents and their "pass status". Resident #1's "pass status" indicated a medical hold or medical pass for the first 14 days of admission which required the resident to be escorted by a staff member for a medical appointment and must return to the facility after an appointment. The Director of Nursing (DON) explained during an interview on 5/18/23 at 11:34 AM, that the master list is updated every Friday or when the facility admitted a new resident. The updated list is given to the security staff. Security and nursing staff are required to verify the "pass status" each time a resident would request to leave the facility.<br><br>The Resident Appointments calendar (RAC) from 5/8/23-5/12/23 included a list of residents and the appointment details including destination, time of appointment, and assigned escort. However, Resident #1's RT appointments on Ex.Order 26.4(b)(1) and Ex.Order 26.4(b) were not included in the calendar. The Director of Nursing (DON) explained during an interview on 5/18/23 at 11:34 AM that the weekly calendar is handed to the security staff every Monday. She added security personnel (SP) and nursing staff must not allow any resident to leave the facility for an appointment unless it was scheduled in the calendar.<br><br>Review of an elopement incident Reportable Event Record/Report (RER) sent to the New Jersey Department of Health (NJDOH) on Ex.Order 26.4(b) included that Resident #1 left the facility on Ex.Order 26.4 3 at 2:12 PM for an Ex.Orde appointment.<br><br>Review of the undated summary of investigation revealed that an elopement incident occurred on Ex.Order 26.4(b) at 2:12 PM when the unit manager (UM) | F 689 | Manager to identify any discrepancies and make corrections<br>accordingly and report findings to DON daily.<br><br>Transport Coordinator will give security and nursing department scheduled appointments weekly.<br>Facility will complete a facility-wide Elopement in-service.<br><br>4.Monitoring the continued effectiveness of the systemic change<br><br>DON will review transportation schedule weekly to identify any discrepancies and correct them on an<br>ongoing basis.<br><br>Master List which includes pass and code status will be updated daily and distributed to the security<br>desk and units daily on an ongoing basis.<br><br>DON will complete monthly QAPI (Quality Assurance Performance Improvement) report and present<br>findings to the QAPI committee meeting and Quarterly QAPI meeting through the first Quarter of 2024. | |

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| F 689 | Continued From page 3 | F 689 | | |

acted independently and allowed Resident #1 to leave the facility without an escort for [redacted] appointment. The initial interventions the facility put in place after the elopement included: contacting the [redacted] and the resident, filing a police report, and implementing the facility's protocol for elopement.

A statement from the Registered Nurse/UM (RN/UM) revealed that on [redacted], the RN/UM allowed Resident #1 to leave the facility for [redacted] appointment without an escort.

A statement from SP #1, who was responsible for supervising residents who sit in front of the facility, revealed on [redacted] SP #1 allowed Resident #1 to leave the facility unaccompanied because she presumed the resident did not need an escort since the RN/UM approved the resident to leave without an escort for the same appointment earlier that week.

Review of the nursing PNs dated [redacted] at 12:08 PM indicated that Resident #1 informed RN #1 he/she was scheduled for [redacted] three times a week at 12:30 PM, and transportation had been pre-arranged and on the way. There was no indication in the PN that RN #1 verified the resident's "pass status" or checked the RAC.

Further review of the nursing PNs dated [redacted] at 10:43 PM revealed that RN #1 notified the RN/nursing supervisor (RN/NS) when Resident #1 did not return from [redacted] appointment. RN #1 reached out to the resident, but the cellphone was not in service. At 8:45 PM, the SP on duty confirmed the resident did not call. It was indicated in the nursing PNs the RN/NS completed a facility search and confirmed with

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| F 689 | Continued From page 4 | F 689 | | |

the transportation provider the resident canceled the service at 1:38 PM pick up from the facility to Ex.Order 26.4 Additionally, the RN/NS notified the physician and the DON and left a voice message on his/her cellphone at 9:45 PM. The RN/NS made an inquiry to nearby hospitals and notified the police. The police responded at 5:50 AM on Ex.Order 26.4(b)(1

During an interview with the surveyor on 5/18/23 at 11:34 AM, the DON explained she could not get in touch with the Ex.Order 26 staff until Ex.Order 26.4(b) because of the weekend closure. She stated the resident could not be reached after leaving the facility. She then went to Ex.Order 26.4(b)(1) and spoke with the resident about returning to the facility. However, the resident declined and signed out against medical advice (AMA).

The AMA form dated Ex.Order 26.4(b), signed by Resident #1, the DON, and a witness, included that the medical risk/benefits were explained and understood by the resident.

During an interview with the surveyor on 5/18/23 at 1:15 PM, SP #1 confirmed on Ex.Order 26.4(b)(1) she did not check the RAC if Resident #1 was scheduled for an appointment or the RML for the "pass status". She allowed Resident #1 to leave the facility unaccompanied for Ex.Order 26 appointment on Ex.Order 26.4(b) because the RN/UM approved the same appointment on Ex.Order 26.4(b). The SP acknowledged she should have asked the nursing staff and not assumed the resident did not require an escort.

During an interview with the surveyor on 5/18/23 at 9:00 AM and 11:08 AM, the RN/UM stated that newly admitted residents must be escorted by facility staff to medical appointments. However,

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| F 689 | Continued From page 5 | F 689 | | |

the RN/UM approved Resident #1 to leave the facility for a medical appointment without an escort on Ex.Order 26.4(b) because the resident's Ex.Order 26.4(b)(1) RN/UM acknowledged she failed to follow the facility's policy and should have let an aide escort the resident to the appointment. Additionally, the RN/UM was unable to explain why the appointment calendar was not updated to include Resident #1's Ex.Order appointments on Ex.Order 26.4(b) and Ex.Order 26.4(b)(1)

During an interview with the surveyor on 5/18/23 at 2:34 PM, RN #1 who was the assigned nurse for Resident #1 on Ex.Order 26.4(b) stated she was unsure of the escort requirements for medical appointments but confirmed she allowed Resident #1 to leave for a medical appointment unaccompanied on Ex.Order 26.4(b)(1). She added she allowed it because the resident had Ex.Order 26.4(b)(1) However, RN #1 agreed she failed to follow the facility's policy and stated she should have verified the escort requirements with the administration staff.

During an interview with the surveyor on 5/18/23 at 11:34 AM, the DON stated that the RN/UM, RN #1, and SP #1 should have followed the facility's policy and not allowed Resident #1 to leave for a medical appointment without an escort. The resident required an escort regardless of having Ex.Order 26.4(b)(1). She further stated they should have verified the resident's pass status.

During an interview with the surveyor on 5/18/23 at 3:03 PM, the Administrator stated that all staff are expected to follow the facility's pass or escort requirements procedure.

Review of the facility policy titled "Code

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| F 689 | Continued From page 6<br>Gray-Missing Resident-Resident Elopement-Management of Missing Resident" dated 12/16/21 included but was not limited to: "It is the responsibility of all personnel to report any resident attempting to leave the premises unauthorized, or is suspected of being missing, to the security department and the nursing department immediately".<br><br>NJAC 8:39-27.1(a) | F 689 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 315343 Y1 | A. Building<br>B. Wing Y2 | 6/28/2023 Y3 |

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| BROADWAY HOUSE FOR CONTINUING | 298 BROADWAY<br>NEWARK, NJ 07104 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0689 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 483.25(d)(1)(2) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 06/26/2023 | 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 | |
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| 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 | |
|---|---|
| 5/18/2023 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |