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WATERS EDGE HEALTHCARE & REHAB	**512 UNION STREET TRENTON, NJ 08611**

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F 000	INITIAL COMMENTS Complaint #: NJ162088 Census: 145 Sample Size: 5 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey date: 03/07/2023-03/08/2023 It was determined the facility's past non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25(d)(2) Accidents/Supervision at a scope and severity of "J. " On 03/08/2023 at 5:38 PM, the Administrator, Director of Nursing, Corporate Consultant #2, Administration Consultant, and Social Service Consultant were informed of the past Immediate Jeopardy situation. The IJ was determined to have existed on 03/05/2023, when Resident #1 exited the building without staff knowledge and was found by law enforcement outside the facility, deceased. The facility developed and implemented a corrective action plan, and the IJ was determined to have been abated and the noncompliance corrected on 03/06/2023, prior to the survey entrance date.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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

Electronically Signed | 03/21/2023

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F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ162088 Based on observations, interviews, record reviews, document review, and facility policy review, it was determined the facility failed to ensure adequate supervision was provided to prevent [redacted] for 1 (Resident #1) of 5 sampled residents reviewed for [redacted] The lack of an effective audible alarm on an exit door and lack of adequate supervision resulted in Resident #1 [redacted] from the facility and being found [redacted] on a local highway on [redacted] The facility door alarmed when the resident exited; however, facility staff did not hear the alarm, allowing the resident to exit the facility without staff's knowledge. At the time of the survey, there were 3 residents identified as at risk for [redacted] It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25(d)(2) Accidents/Supervision at a scope and severity of "J." The IJ was determined to have existed on [redacted], when Resident #1 exited the building without staff knowledge and was found by law enforcement outside the facility, deceased. The	F 689	Past noncompliance: no plan of correction required.	

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facility [redacted] and implemented a corrective action plan, and the IJ was determined to have been removed and the noncompliance corrected on [redacted], prior to the survey entrance date.

On 03/08/2023 at 5:38 PM, the Administrator, Director of Nursing (DON), Corporate Consultant #2, Administration Consultant, and Social Service Consultant were informed of the Past Noncompliance Immediate Jeopardy situation.

Findings included:

Review of a facility policy titled, "Door Check," revised 10/2022, revealed, "Purpose: To ensure the security of facility residents and personnel and door closure integrity. Policy: Facility exit stairwell doors will be monitored monthly with door code changes by the Maintenance Department. Procedure: A. Maintenance personnel shall perform rounds of facility to evaluate the integrity/security of exit doors and stairwells on a monthly basis, or more often as necessary. B. Monthly rounds shall be documented on a log form with date and result. Comments will be added as necessary. Any problems must be reported on the log form and immediately reported to the Director of Maintenance and Administrator."

Review of an "Admission Record" revealed the facility admitted Resident #1 on [redacted] with diagnoses that included [redacted].

Review of an [redacted] Assessment," dated [redacted] revealed Resident #1 could follow instructions, was [redacted], could [redacted], had a history of [redacted] and

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had a diagnosis of NJ EX Order. 264b1 Review of the "Standard Assessments" screen in the resident's electronic medical record indicated Resident #1 scored on this t assessment. The scoring tool on the assessment indicated a score of indicated a low risk for

Review of "Progress Notes," dated at 4:58 PM, revealed Resident #1 was oriented to NJ EX Order. 264b1 frequently inside and outside of their room.

Review of a "Care Plan," dated as initiated revealed Resident #1 had memory loss. Interventions directed staff to cue, reorient, and supervise or assist the resident as needed and to continue to anticipate Resident #1's needs.

Review of "Progress Notes," dated at 4:14 PM, revealed Resident #1 was alert with some and around the floor at times.

Review of "Progress Notes," dated at 4:33 PM, revealed Resident #1 was alert and able to make their needs known. The resident was in their room most of day watching television, and would sometimes go into a room.

Review of "Progress Notes," dated at 3:19 PM, revealed Resident #1 was alert with some , walked around for a while, and stayed in their own room most of the shift.

Review of "Progress Notes," dated at 2:30 PM, revealed Resident #1 was and visited a room often.

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Review of a facility-reported incident report, dated [redacted], revealed Resident #1 [redacted] from the facility on [redacted] and was [redacted] and expired.

Review of "Progress Notes," dated [redacted] at 11:00 PM, revealed an entry written by Registered Nurse (RN) #1 that indicated Resident #1 was received in the resident's room watching television. The resident was [redacted] and [redacted]. Resident #1 walked back and forth from their room and a [redacted] room. Around 8:00 PM, Resident #1 was sitting in a chair watching television with a [redacted] RN #1's note indicated the medication nurse provided information that Resident #1 was sitting in a chair watching television with their [redacted] when the medication nurse provided a supplement to the resident's [redacted] around 9:00 PM, and Resident #1 had shown pictures to a nursing assistant around the same time. The note revealed two law enforcement officers arrived at "around 9:45 PM" and informed RN #1 of Resident #1's "unfortunate passing."

Review of the evening shift staffing schedule, dated [redacted], revealed Licensed Practical Nurse (LPN) #8, LPN #9, Certified Nurse Aide (CNA) #11, CNA #12, and RN #1 were on duty during the shift when Resident #1 [redacted] from the facility.

During an interview on 03/07/2023 at 3:16 PM, LPN #8 stated Resident #1 was [redacted] at times. The resident stayed in their room or their [redacted] room and watched television. LPN #8 stated there had been no issues with Resident #1 attempting to leave the floor or go out the exit

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doors to the stairwells. When asked the last time the LPN had observed Resident #1, she stated it was between 9:00 PM and 9:15 PM, and the resident was in a recliner in their relative's room. The LPN stated she then went to another floor to get some medication and did not hear an alarm when she returned to the floor. LPN #8 stated she was "shocked" when RN #1 told her what happened.

During an interview on 03/07/2023 at 4:00 PM, RN #1 stated she was the supervising nurse the night Resident #1 left the floor by going down the stairs. The RN stated the resident suffered from [redacted] and stayed in the resident's room or their [redacted] room, and on occasion would come as far as the nurses' station. The RN stated she supervised all floors and was not on the floor when the resident left the facility. RN #1 stated the guard at the front did not see anyone go out the front door. The RN stated the alarm worked but she could not hear it from the nurses' station when she came back onto the floor.

During an interview on 03/07/2023 at 4:22 PM, LPN #9 stated she was the charge nurse the night Resident #1 got out of the building. The LPN stated Resident #1 would [redacted] from the resident's room to their [redacted] room, and to the nurses' station. The LPN stated Resident #1 was at the nurses' station between 9:00 and 9:15 PM before the incident. LPN #9 stated Resident #1 was in their [redacted] room when medications were provided to the [redacted] about 9:30 PM by LPN #8. LPN #9 stated she could not hear the alarm when Resident #1 opened the door. LPN #9 indicated she talked with the two aides working on the hall, and they were providing care in other resident' rooms and did not hear the

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alarm. LPN #9 revealed she could not hear the door alarm from the nurses' station because the doors were too far away.

During an interview on 03/08/2023 at 9:36 AM, CNA #11 stated she was working the night Resident #1 left the building. The CNA stated she last saw Resident #1 between 9:00 PM and 9:15 PM watching television in their [redacted] room. CNA #11 stated she and CNA #12 were in another resident's room providing care and did not hear the alarm on the door sounding. The CNA stated they were in the other room [redacted] minutes and did not hear the alarm sound. CNA #11 stated she received training on [redacted] and residents who [redacted] upon being hired. The CNA stated when asked by the Administrator, she did let him know the CNAs could not hear the alarm sounding.

During an interview on 03/08/2023 at 9:55 AM, CNA #12 stated she worked on the 3:00 PM to 11:00 PM shift with Resident #1 on [redacted] The CNA stated the last time she saw Resident #1 was between 8:00 PM and 8:30 PM in the resident's [redacted] room watching television. CNA #12 stated she was in another resident's room providing care with CNA #11 between 9:30 PM and 10:00 PM. CNA #12 stated when they had completed care, LPN #8 was crying and told them what happened. The CNA stated she never heard the alarm sounding on [redacted].

On 03/07/2023 at 3:40 PM, the egress doors where Resident #1 exited the facility were observed with the Administrator present. The Administrator stated the resident had gone down the stairwell, out the egress doors, and through the unlocked gate. The Administrator stated the

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resident went along the building and through another fenced area where the dumpster and compactor were located. The Administrator pointed to the street to indicate the area where the incident with Resident #1 happened.

During an interview on 03/07/2023 at 4:40 PM, the Maintenance Director stated before the incident involving Resident #1, he would check the doors but did not document those checks anywhere. He stated the alarms were not loud enough to be heard at the end of the hallways with all the noise in the facility.

During an interview on 03/07/2023 at 4:55 PM, the Administrator stated he arrived at the facility at approximately 10:30 PM on [redacted], and the alarm was still sounding. The Administrator stated he entered the floor near the nurses' station and could not hear the alarm until he was right next to the door. He stated the staff could not hear the alarm when going into and out of rooms to provide resident care.

During an interview on 03/07/2023 at 7:05 PM, the Administrator stated the back patio was for barbecues and activities during the warm months. The Administrator stated he did not know if a lock had been in place on the gate in the past or if it was ever checked.

On 03/08/2023 at 8:45 AM, the area outside the compactor was observed. The area was approximately [redacted] from [redacted] There was a sidewalk from the compactor area that led to the street.

During an interview on 03/08/2023 at 9:25 AM, the Assistant Director of Nursing (ADON) stated

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the interdisciplinary team discussed the [redacted] risk for Resident #1 on admission and determined the resident [redacted] to and from their [redacted] room and had no exit-seeking behaviors.

On 03/08/2023 at 10:24 AM, the Maintenance Director clarified the facility's old policy for checking alarm doors. He stated the old policy was to check the doors once a month to make sure they sounded and change the code to open the door. The Maintenance Director stated the alarms all sounded the same, but he never went down the hall to see if it could be heard.

On 03/08/2023 at 11:00 AM, the compactor area was observed with the Administrator and the Maintenance Director. The Administrator stated the gate must have been ajar because the approximate six-inch gap the gate had when closed would not be wide enough for the resident to get through. The Administrator confirmed the speed limit on [redacted] where the incident occurred was [redacted] miles per hour.

On 03/08/2023 at 2:40 PM, the video surveillance footage from [redacted] was viewed with Corporate Consultant #2. The video showed Resident #1 walking across the concrete patio located on the [redacted] side of the building at 9:28 PM and 38 seconds. The resident left the camera view at 9:29 and 16 seconds. At 9:33 PM, the resident was observed on the inside of the gated area where the dumpster and compactor were located. Resident #1 stepped sideways and was outside the gated area. The resident turned left and walked toward [redacted]. Resident #1 was observed walking down the sidewalk towards [redacted] reaching the road, and crossing the

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road at 9:34 PM. Resident #1 turned right, headed [redacted] on the median, and went out of camera view. Resident #1 entered the camera view heading [redacted] on the median at 9:44 PM, attempted to cross the street again at 9:46 PM, and was struck by an [redacted]. Resident #1 was pushed approximately [redacted], landing on the road. Resident #1 was then struck by two additional cars.

On 03/08/2023 at 6:20 PM, the facility provided a copy of a corrective action plan that was developed and implemented beginning on [redacted] after Resident #1 got out of the facility. Review of the plan revealed the following:

"Trenton police notified facility in person at approximately 9:50 p.m. [PM] to speak with nursing supervisor [RN #1]- [redacted]

Nursing supervisor, [RN #1] contacted DON. DON notified Administrator. [redacted]

Full house resident census head count completed on all units. [redacted]

DON on site to commence investigation and conducted resident unit check, interview staff and obtain statements. [redacted]

DON met with [local] Police Office answering questions related to demographics. [redacted]

DON rounds with staff on all units. [redacted]

Increased supervision and monitoring of [redacted] floor unit by nursing staff and supervisors until door checks completed. started [redacted]

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F 689	Continued From page 10 Administrator on site [NJ EX Order: 2] around 10:30 pm [PM]. Third party door alarm vendor contacted at 11:45 p.m. on [NJ EX Order: 2] NJDOH [New Jersey Department of Health] notified approximately 11:50 p.m. on [NJ EX Order: 2] via phone call. Family notification by administrator approximately 12:15 a.m. on [NJ EX Order: 264b1]. Voice message notification left for MD [medical doctor] approximately between 12-1am [12:00 - 1:00 AM] on [NJ EX Order: 264b1]. Maintenance Director called in to facility to perform door checks 12:18 am [AM] [NJ EX Order: 2] arrived at facility around 12:30 am. Third party alarm company arrived to facility around 3:30 am on [NJ EX Order: 2] conducts full house audit of all unit, stairwell and door alarms and found all other door alarms to be sufficient volume. Maintenance Director conducted full house audit/check of all unit stairwell, door alarms and locking mechanism on [NJ EX Order: 2]. Secondary alarm installed on [NJ EX Order: 264] floor unit [NJ EX Order: 264b1] unit stairwell at around 4 am on [NJ EX Order: 2]. Initiation of exit door, stairwell alarm and door lock checks twice daily by maintenance started [NJ EX Order: 264b1]	F 689		

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Nurse practitioner contacted by DON approximately 6-7 am on [redacted].

DON contacted medical director at approximately 7:30 am on [redacted]

[redacted] starting at 6 am: Review of the following policies and procedures: [redacted] policy and procedure, exit door egress alarm policy and procedure, [redacted] risk assessment policy and procedure, [redacted] risk assessment on all in house residents, facility education on response to alarms policy and procedures for [redacted] purposeful rounding, [redacted]

Whole house [redacted] risk assessment completed on [redacted]

Ad hoc QAPI [Quality Assurance and Performance Improvement] meeting completed on [redacted]

Care plans for those residents deemed at risk for [redacted] reviewed and revised as necessary on [redacted].

Reportable event form submitted to NJDOH via email at 3:47 pm on [redacted]

Outdoor rounds completed on [redacted] and 03/7/23. Lock installed on patio gate on [redacted]

Audits to commence: New Admissions [redacted] Risk Audit commenced on [redacted].

Additional audits to be started included: Staff Knowledge of [redacted] Prevention and Management, Staff Knowledge to response to

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egress door alarms, Audit to monitor proper function for all egress doors and alarms.

Care plan agenda checklist reviewed and revised to include the quarterly elopement risk assessment.

One elopement drill per shift per month.

The surveyor conducted onsite verification on NJ EX Order: 28401 to confirm the facility had implemented all components of the corrective action plan. After conducting the following interviews and record/document reviews, it was determined the facility implemented all components of the action plan and the deficient practice was corrected on NJ EX Order: 28401 prior to the survey entrance.

Review of statements from RN #1, LPN #9, CNA #11, CNA #12, LPN #8, dated NJ EX Order: 28401 and NJ EX Order: 28401, revealed each staff member working on Resident #1's floor on the evening of NJ EX Order: 28401 provided a witness statement and signed it. The DON signed each statement.

Review of a third-party alarm company invoice dated NJ EX Order: 28401, indicated the company made an emergency service call at the facility and tested all the doors to ensure they were functioning properly.

Review of an email to the Administrator, dated 03/06/2023 at 6:47 AM, indicated a third-party alarm company arrived at the facility at 3:30 AM and performed a site inspection to make sure all the doors were working properly with the delayed egress and alarms. Further review of the email indicated all doors were tested and working as

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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) COMPLETION DATE
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they should with proper equipment on them as of 6:45 AM.

Review of a document titled, "Simulated NJ EX Order. 264b1 drill done on March 6, 2023 with Nursing staff" revealed between 1:30 AM and 5:00 AM, the facility reviewed the elopement policy with staff present in the facility, and the staff gave verbal feedback on what to do when a resident was missing and the importance of alarm response and rounding.

Review of in-service documents titled, NJ EX Order. 264b1 Risk Prevention: NJ EX Order. 264b1 and purposeful rounding," dated 03/2023, revealed staff received education on identifying NJ EX Order. 264b1 and NJ EX Order. 264b1. Staff members were given examples of NJ EX Order. 264b1 t and NJ EX Order. 264b1 prevention interventions and educated on practices that would promote resident safety and prevent NJ EX Order. 264b1 Facility staff members signed attendance forms indicating they attended the in-service.

During an interview on 03/07/2023 at 3:16 PM, LPN #8 stated after the incident with Resident #1, the facility provided in-services on NJ EX Order. 264b1 and knowing where the at-risk residents were located. The LPN further stated they were to go and check on an alarming door and go into the stairwell to check and make sure no residents had exited.

On 03/07/2023 from 3:24 PM through 3:31 PM, egress doors were observed with LPN #13. All three stairwell alarms were activated on the second floor, resulting in a loud audible alert. A red light also flashed when the doors were opened. Staff came to the door promptly to check

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	315324	A. BUILDING _____ B. WING _____	C 03/08/2023

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the alarm.

On 03/07/2023 at 3:40 PM, the egress doors where Resident #1 exited the facility were observed with the Administrator present. Outside the doors, there was a fence around a concrete platform. There was a locked gate on the left side of the patio.

During an interview on 03/07/2023 at 4:00 PM, RN #1 stated there had been training on NJ EX Order. 264b1 and checking the doors when they alarmed since the incident with Resident #1. The RN stated a louder alarm was added to the doors so it could be heard throughout the unit.

During an interview on 03/07/2023 at 4:22 PM, LPN #9 stated the facility provided training on NJ EX Order. 264b1 after the incident and what to do if the alarm went off. The LPN stated they must not only check the door but go into the stairway to check for residents. LPN #9 stated the alarms on the doors were now very loud.

During an interview on 03/07/2023 at 4:40 PM, the Maintenance Director stated louder alarms were installed on NJ EX Order. 264b1, so the alarms could be heard throughout the unit.

During an interview on 03/07/2023 at 7:05 PM, the Administrator stated a new lock was put on the patio gate.

During an interview on 03/08/2023 at 9:25 AM, the Assistant Director of Nursing (ADON) stated new NJ EX Order. 264b1 assessments were completed on all residents on NJ EX Order. 264b1 because of the incident with Resident #1.

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During an interview on 03/08/2023 at 9:36 AM, CNA #11 stated she received training on [redacted] and residents who [redacted] after the incident with Resident #1.

During an interview on 03/08/2023 at 9:55 AM, CNA #12 stated she had received training on [redacted] and door alarms sounding since the incident.

On 03/08/2023 at 10:24 AM, the Maintenance Director stated since the incident occurred with Resident #1, the facility's new policy for checking doors alarms was to check the alarms twice a day, document the findings, and make sure the alarms could be heard down the hall. The Maintenance Director stated the doors had booster alarms put in, so they were a lot louder. When asked about the open gate, he stated the gate had never been locked in the past, and they had placed a lock on it after the incident with Resident #1.

Review of the facility's new policy titled, "Exit Doors, Stairwell, and Egress Passageway Checks," dated 03/2023, indicated, "Policy: Facility exit and stairwell doors and egress passageways will be monitored on a daily basis by maintenance personnel to ensure that the doors are effectively secured and locking mechanisms and/or alarms in place and active." The policy also indicated, "Maintenance will document their findings on a daily log and any discrepancies, corrections, needed remediation will be documented in the comment section. Procedure: A. Maintenance personnel shall perform rounds of the facility to evaluate the security of the exit doors and stairwells daily and document their findings on the attached log. B.

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Rounds shall be documented daily to ensure that all door alarms and locks are in proper function, proper door locking release signage is present, and stairwell doors are secure on the forms entitled 'Exit Doors, Stairwells, Egress Passageways - Daily Log' & 'Door Alarm Daily Log/Egress Passageway Check'. The date and time of rounds will be entered by Maintenance Personnel, and a check mark placed in each box to indicate the door is secure and the door alarm/electronic maglock is in proper function. Any problems must be reported to the Director of Maintenance immediately for immediate follow up and repair/resolution and forwarded it to the administrator." Additionally, the policy indicated, "C. Any unsecured or obstructed egress area shall immediately be reported to the Director of Facilities for immediate resolution and the surrounding area searched for Residents or any potential unauthorized persons (i.e. [that is] if a door is found to be breached and or [an] alarm is sounding). The Nursing Supervisor must be notified to account for all residents in the event of any discrepancies."

Review of the "Door Alarm Daily Log/Egress Passageway Check," forms indicated all floors were checked on each shift on 03/06/2023 through 03/08/2023 to ensure doors were armed, the alarms modules were secure, the alarms would go off when the doors were opened, and the alarms would reset. Review of the forms indicated all problems were immediately addressed.

Review of the facility's "QA [Quality Assurance] Minutes," dated 03/06/2023 revealed a QA meeting was held and the committee examined the elopement and conducted a root cause

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