

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2025
NAME OF PROVIDER OR SUPPLIER Careone at Wellington		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Union Street Hackensack, NJ 07601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Complaint #: NJ186848</p> <p>Based on observation, interviews, and review of pertinent facility documents on 6/2/25, it was determined that the facility failed to provide adequate supervision to a cognitively impaired resident (Resident #1) with a known history of elopement which resulted in the resident eloping on 5/26/25. This deficient practice was identified for 1 of 4 residents reviewed for risk for elopement (Resident #1).</p> <p>Resident #1, a cognitively impaired resident who wore a wander guard to alert staff of possible elopement, was last seen by staff on 5/26/25 at 3:45 PM. The Licensed Practical Nurse (LPN #1) reported that the resident wanted to go downstairs for dinner, and she disarmed the elevator's wander guard system to allow the resident to self-propel themselves in their wheelchair downstairs. Observation of video footage revealed that the Receptionist (R#2) disengaged the lobby's rear exit door's wander guard alarm, and Resident #1 exited the facility through that door at 3:48 PM. At 6:45 PM, during rounds, the Registered Nurse (RN) Supervisor noted that Resident #1 did not eat their dinner tray, and asked LPN #1 to find the resident. At 6:50 PM, LPN #1 could not locate the resident and the facility initiated their elopement protocol. The resident was located at 9:45 PM in a parking lot of a tire shop in a nearby town, and was brought back to the facility by staff at 10:13 PM.</p> <p>The facility's failure to provide adequate supervision to a cognitively impaired resident who was at risk for elopement and eloped posed a likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation which ran from 5/26/25 at 3:45 PM, when LPN #1 allowed Resident #1 to leave the unit unescorted, until 5/26/25 at 10:13 PM, when the resident was found in a nearby town and brought them back to the facility by staff. The IJ was Past Non-Compliance (PNC).</p> <p>The facility's Licensed Nursing Home Administrator was notified of the IJ on 6/2/25 at 6:35 PM. The facility submitted an acceptable Removal Plan on 6/3/25 at 12:40 PM.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility was back in compliance when the facility addressed the situation by locating the resident and immediately assessing the resident upon return to the facility; the Director of Nursing (DON) provided in-servicing to LPN #1 on the policies on elopement risk, wandering residents, accidents and incidents, and routine resident checks; the vendor assessed and repositioned the wander guard alarms on the rear entrance door and confirmed the system was fully functioning; and a facility wide in-service and re-education on resident rounding and the escorting of residents at high risk of elopement, elopement drill, transporting of residents at high risk for elopement, monitoring of the facility entrance and exits with the proper use of wander guard alarming system deactivation. The surveyor verified the completion of the Removal Plan was 5/30/25, during an on-site survey on 6/10/25, and determined the IJ was PNC.</p> <p>The evidence was as follows:</p> <p>A review of the facility's Wandering and Elopements policy dated revised March 2019, included under Policy Interpretation and Implementation: 1) If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety .</p> <p>A review of the Facility Reportable Event (FRE) submitted by the facility to the New Jersey Department of Health (NJDOH) on 5/27/25, included an Investigation Summary and Conclusion (ISC) with date of incident: 5/26/25. The ISC indicated that Resident #1 was assessed as cognitively impaired and at risk for elopement with a security bracelet (wander guard) applied. The resident utilized a wheelchair for mobility, and on 5/26/25, at approximately 3:45 PM, LPN #1, their primary nurse, reported that the resident wanted to go downstairs in preparation for dinner, which was their usual behavior. At approximately 6:45 PM, the RN Supervisor was rounding on the third-floor unit and noticed the resident's dinner tray in their room was untouched. The RN Supervisor immediately reached out to LPN #1 and inquired why the tray was still in the room. LPN #1 thought the resident was downstairs in the main dining room having their dinner. Staff went downstairs, but the resident was not in the dining room which prompted the RN Supervisor to start searching for the resident thinking they may have completed their meal and was wheeling themselves around the unit as per their normal activity after dinner. When the RN Supervisor was unable to locate the resident, the RN Supervisor immediately initiated the missing person protocol and notified the DON, Assistant Director of Nursing (ADON), and the Licensed Nursing Home Administrator (LNHA).</p> <p>The ISC also included a conclusion which indicated that the resident exited from the unit when they went in the elevator. Their wander guard alarmed and held the elevator on the third-floor, and LPN #1 put in the code to disengage the elevator hold which allowed the resident to head down to the lobby in elevator alone. Once the resident arrived at lobby, they went toward the rear exit door. At rear exit door, the wander guard system alarmed and R#2 entered the code to disable the alarm as visitors and residents were gathered at the front of the building. Resident #1 was then able to continue out of the rear exit door. Both the front and rear exit doors were equipped with the wander guard system, and the exits and wander guards were inspected and operating properly prior to the event with no malfunctions noted. The wander guard company was called in immediately after the event and tested the system and verified it was functioning properly. The ISC indicated in the conclusion, the point of egress was the rear exit door. The wander guard system was in place and functioning. The resident was assessed with no injury.</p> <p>The ISC further included the following timeline of events on 5/26/25:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - At 3:45 PM, the resident was noted entering the elevator. - At 3:48 PM, the resident arrived from elevator to the lobby and exited through the back door exit. - At 6:45 PM, the RN Supervisor noted Resident #1's dinner tray was untouched and requested LPN #1 go to the first floor to retrieve the resident. - At 6:50 PM, LPN #1 notified the RN Supervisor that the resident was not on the first floor. The RN Supervisor immediately initiated the missing person protocol and continued to search for the resident. - At 7:39 PM, the DON, ADON, and LNHA were notified of the missing resident. The DON notified authorities and the NJDOH. The DON and LNHA immediately headed to the facility. - At 8:03 PM, the DON and LNHA arrived at facility along with the department heads to increase search. - At 8:05 PM, the Police Officer [name redacted] arrived at the facility. - At 9:45 PM, the resident was visually located outside of the facility. - At 9:51 PM, the resident was met in person by facility staff, picked up, and driven back to the facility. - At 10:13 PM, the resident safely arrived back to the facility escorted by facility staff with the Police Officer present at arrival. <p>A review of the admission Record face sheet (admission summary), revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to; dementia, difficulty walking, muscle weakness, hyperlipidemia, hypertensive heart disease, and chronic pain.</p> <p>A review of the Minimum Data Set (MDS), an assessment tool dated 5/2/25, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated a severely impaired cognition. The MDS further revealed that the resident required assistance from staff in their completion of activities of daily living (ADLs).</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 4/27/25, that the resident was at risk for elopement due to change in environment and had a history of wandering with an actual missing person incident per spouse. Interventions included for staff to accompany to meals and scheduled activities with date initiated 4/27/25.</p> <p>On 6/2/25 at 2:07 PM, the surveyor requested and reviewed the video footage of the incident on 5/26/25. The surveyor noted the camera monitors showed the lobby areas, but there was no video footage by the third-floor nursing unit. The camera monitors in the lobby revealed the following:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - At 3:47:57 PM, the resident was seen coming out from Elevator #1 in front of the reception area by themselves. The resident was seen self-propelling in their wheelchair wearing a dark sweatshirt, gray pants, and black sneakers. No distress was noted. - At 3:48:03 PM, the resident was seen in their wheelchair near the right side of the reception area towards the rear exit sliding doors. - At 3:48:21 PM, Receptionist (R#1) was seen coming out from the left side of the reception area and went around the reception desk. - At 3:48:32 PM, the resident was in their wheelchair near the rear exit sliding doors and started propelling towards the exit. - At 3:48:36 PM, the resident, in their wheelchair, was seen propelling towards the rear sliding doors. - At 3:48:39 PM, R#2 was seen with her left hand on the keypad on the wall. It was also noted that R#2's back was towards the rear exit sliding doors. - At 3:48:52 PM, the resident was seen in their wheelchair exiting the opened sliding doors and turned left. - At 3:49:41 PM, the resident was seen in their wheelchair passing by the left side of the outside of the building at the rear. - At 3:49:59 PM, the resident was seen self-propelling in their wheelchair towards the fenced gate on the left side area of the parking lot at the back of the facility. - At 3:50:19 PM, the resident was seen in their wheelchair through the fenced gate and made a left towards the street side and was then out of camera view. <p>On 6/2/25 at 2:37 PM, the surveyor interviewed R#1, who stated that on 5/26/25 at around 3:45 PM, when R#2 came in, she went to the restroom before endorsing (discussing pertinent information from shift) to her. When she came back to the reception area, she went around the desk to sit and called staff regarding some issues and started giving the report to R#2 after that. R#1 stated that she heard the alarm, and she saw R#2 pressing the keypad while they were endorsing. R#1 further said she did not see the rear doors because R#2 was on her right side blocking her view. R#1 did not recall seeing the resident in their wheelchair exiting the rear exit sliding doors.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/2/25 at 3:14 PM, the surveyor conducted a telephone interview with R#2, who stated on 5/26/25 at around 3:45 PM, the morning receptionist (R#1) went to the restroom as her shift was about to end, and while waiting for R#1 at the reception desk, she saw Resident #1 coming out from the elevator in front of the reception area. R#2 further stated that she greeted the resident and was speaking to them when R#1 came back from the restroom. R#2 then got up while R#1 went around the desk and had their endorsement. R#1 was giving the report to R#2. R#2 said she was facing R#1 and the entrance sliding doors (left side in the camera) during the report and had her back towards the resident and the rear sliding doors. The surveyor asked R#2 if she entered the code on the keypad or pressed the button, and R#2 stated she could not remember as she was talking to R#1. The surveyor then asked if she heard the alarm sound, and she said she did and that she was facing the entrance doors and she thought there were no residents or family members. R#2 could not remember pressing the code. The surveyor informed R#2 that in the video footage she was seen pressing the keypad, and R#2 provided no further information.</p> <p>On 6/2/25 at 3:48 PM, the surveyor interviewed LPN #1, who stated that she saw the resident in their wheelchair going in the elevator. LPN #1 confirmed she was aware the resident had a wander guard and it alarmed. LPN #1 said she deactivated the code because she knew the resident always went down for dinner at 4:00 PM. LPN #1 also said she was aware that the resident was supposed to be accompanied by staff. LPN #1 further said the resident usually went downstairs, and she did not think something would happen to them because the lobby and dining room downstairs were secured. LPN #1 stated she knew the resident was not seen when the RN Supervisor came up and asked her if she saw the resident. LPN #1 said the resident was usually administered their medication after their dinner when the resident came up at around 6:00 PM to 6:15 PM. LPN #1 further said it never occurred to her that the resident would leave as they went down to dinner every day.</p> <p>On 6/2/25 at 4:28 PM, the surveyor interviewed the LNHA and DON. The DON stated they had protocols on missing persons and elopement and staff were educated before and after the incident. The DON and LNHA stated that they implemented measures right away after the incident and educated all staff right away that night.</p> <p>The facility submitted an acceptable Removal Plan on 6/3/25 at 12:40 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include: the facility located the resident and was immediately assessed upon return to the facility; the DON provided in-servicing to LPN #1 on the policies on elopement risk, wandering residents, accidents and incidents, and routine resident checks; the vendor assessed and repositioned the wander guard alarms on the rear entrance door and confirmed the system was fully functioning; and a facility wide in-service and re-education on resident rounding and the escorting of residents at high risk of elopement, elopement drill, transporting of residents at high risk for elopement, monitoring of the facility entrance and exits with proper use of the wander guard alarming system deactivation. The facility self-corrected the deficient practice and it was determined that the IJ was Past Non-Compliance (PNC), and the facility corrected their non-compliance on 5/30/25.</p> <p>The surveyor verified the implementation of the Removal Plan on-site on 6/10/25.</p> <p>NJAC 8:39-27.1(a)</p>		