

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2025
NAME OF PROVIDER OR SUPPLIER Aristacare at Parkside		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W Stimpson Ave Linden, NJ 07036	

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>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>COMPLAINT #NJ00186243, NJ00186326</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 5/15/25 and 5/20/25, it was determined that facility staff allowed a severely cognitively impaired resident to exit the secured locked unit and then exit the facility while wearing a Wander Guard (WG) device. Staff also failed to follow the facility's Secure Care/Wanderguard System and Elopements policies on 5/11/25 for 1 of 3 residents (Resident #1).</p> <p>The resident was located at an off-site location by a relative and returned to the facility on 5/11/25 at approximately 9:30 P.M. This deficient practice placed all cognitively impaired residents who were at risk for elopement in an Immediate Jeopardy (IJ) situation. The deficient practice was evidenced by the following:</p> <p>A Facility Reportable Event (FRE) sent to the New Jersey Department of Health (NJDOH), dated 5/13/25, indicated that the Receptionist notified the Nursing Supervisor (NS) at 5:29 P.M. that the, . alarm at front door was sounding after multiple visitors exited the front door . The NS then proceeded to check the building and initiated a code gray. A code gray is a message alert for the facility staff a resident has left the building. The FRE further revealed that the resident was located at a nearby grocery store by a relative, unharmed. Resident #1 was escorted back to the facility by the relative at 9:30 P.M. The FRE did not indicate how the resident exited the 4th Floor secure unit nor the facility.</p> <p>Resident #1 was not at the facility at the time of the survey. A closed record review was conducted.</p> <p>According to the admission Record, Resident #1 was admitted to the facility with diagnoses which included but were not limited to: Alzheimer's Disease, Dementia, and unsteadiness on feet.</p> <p>A review of Resident #1's care plan (CP), revealed a Focus related to elopement, initiated on 5/9/25, that indicated, I am at risk for elopement [related to]: prior history of elopement, impaired judgement due to dementia [diagnosis], history of wandering, memory loss secondary to dementia [diagnosis], packing personal belongings, verbalization of such 'want to go home' etc. Further review of the elopement CP revealed a goal that indicated, I will not leave the building and its premises, dated 5/9/25.</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>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #1's Order Summary Report (OSR) for May 2025 revealed an active order for a WG placement at the right ankle, dated 5/9/25.</p> <p>Review of Resident #1's Treatment Administration Record (TAR) for May 2025, revealed an order for: Wanderguard at right ankle every shift -start date- 5/09/2025. The TAR revealed that Licensed Practical Nurse (LPN) documented that the resident was wearing the WG on the day shift on 5/11/25.</p> <p>A review of Resident #1's progress notes (PN) revealed a nursing note, dated 5/6/25, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the resident's cognition was severely impaired.</p> <p>Further review of the PN revealed a nursing note created by the NS on 5/11/25 at 11:04 P.M., which revealed, Patient is believed to have eloped from the building at around 5 pm - 5:30 pm. Staff at the front desk heard the alarm and saw the patient leave but did not believe it was a patient; she thought it was a visitor .</p> <p>The Director of Maintenance (DOM) stated during an interview with the surveyor on 5/15/25, at 10:45 A.M., that the 4th floor was designated as the dementia unit which he described as, [you] cannot leave unless you know the code or someone at the desk presses a button. He further stated that if someone wearing a WG entered the elevator, the elevator should not move, and an alarm should sound requiring a code to be entered. The DOM reported that he was informed of the incident the day after it occurred on 5/12/25. He stated that he came into the facility and checked the WG system and the doors and that everything was good. He further stated that he called the contracted provider and requested that they come to assess the system. The DOM provided an invoice from the contracted provider, dated 5/12/25, which revealed, inspection of the wanderguard control system. The inspection noted all tests performed found the system was working. The DOM further stated that he was not sure how the resident got out as the system was working. The DOM provided an email which confirmed this, dated 5/13/25. The email revealed that the [Contracted Provider] sent a technician out on 5/12/25 to test the doors. The technician tested every feature on the door. There are no repairs needed and everything is functioning properly.</p> <p>During an interview with the Director of Nursing (DON), Assistant Administrator (AA), Administrator, and Chief Clinical Officer (CCO) on 5/15/25 at 1:34 P.M., the AA stated that she arrived at the facility at approximately 7:15 P.M and that upon her arrival, the police and family were present, and the camera footage was reviewed. She stated that they observed the receptionist interacting with the resident in the vestibule and noted that the resident, exited the building at 5:30 P.M. She stated that the expectation was that if the alarm was sounding, staff should stop all people going out of the door to investigate. She further indicated that the footage showed the resident walking behind a group of people exiting the facility. The DON, the Administrator, and the CCO added that they all came in on the night of the incident and that the Administrator personally tested the WG system doors and elevators upon his arrival and found they were all working.</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>Note: The nursing home is disputing this citation.</p>	<p>In the presence of the AA and CCO, on 5/15/25 at 2:16 P.M., the CCO provided the camera footage from 5/11/25 for surveyor review. Both stated that the time stamp of the camera was off by 24 minutes. Surveyor noted that the camera footage started at 17:04 P.M., which they stated was actually 17:28 P.M. In the presence of the AA and CCO, the surveyor reviewed the footage which looked out into the lobby and a door was visible on the right hand side of the screen. The AA stated that beyond the door was a vestibule that had a double door that then lead to the outside of the facility. The following was noted: (Camera footage does not contain audio)</p> <p>-17:04 Receptionist was observed at the desk.</p> <p>-17:05:01 The AA identified to the surveyors Resident #1, by pointing at the screen when the resident appeared. Resident #1 was observed standing at the vestibule entrance with a visitor directly behind him/her pushing a person in a wheelchair. Resident #1 was wearing a straw hat, a pink long sleeve shirt, black pants, and pink shoes.</p> <p>-17:05:22 The door was observed opening</p> <p>-17:05:30 Resident #1 was observed walking out of the lobby behind the visitor and the person in the wheelchair into the vestibule. The receptionist was also observed getting up from the desk.</p> <p>-17:05:37 The receptionist was observed approaching the pin pad on wall to the left of the door. The AA stated that the receptionist punched in the numbers to silence the WG alarm.</p> <p>-17:06:03 Receptionist remained at the pin pad and footage ended.</p> <p>The AA further stated that the receptionist should not have let anyone in or out until it was determined why the (alarm) was going off.</p> <p>During an interview with the Receptionist on 5/15/25, at 3:51 P.M., she stated that receptionists are aware of the WG system and that, If a resident wearing a WG approaches the door, the alarm sounds and doors lock. The door can be opened via a button on the desk or a code entered on a pin pad next to the door. The Receptionist recalled the incident and stated that at around 5:30 P.M. she was at the [lobby] desk and the alarm went off. At that time, she recognized a visitor who was pushing a resident in a wheelchair. She pushed the button to open the door, and she heard the alarm sound while the door was opening. She immediately got up from the desk and walked over to the pin pad, where she saw the visitor with the wheelchair resident, and a gentleman/lady with a straw hat. She stated that she checked the resident in the wheelchair for a WG and she could not find one. She then observed the straw-hat's wrists and ankles and she did not see a WG. She further stated that she attempted to engage the person and asked if they were staying or leaving and the person stated leaving. She stated that the person then exited the building. The Receptionist stated that she immediately called the NS to report that the alarm sounded and was told that a search would be initiated. She stated that about an hour later she was asked if she had seen a resident and realized after inputting the name in the electronic system that she recognized Resident #1 as the person wearing the straw hat that exited the building. She further stated that Resident #1's picture was in the [elopement] binder and that, I should not have let anyone out and held the door until I checked that a resident was or wasn't there.</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>Note: The nursing home is disputing this citation.</p>	<p>During a telephone interview on 5/20/25, at 11:17 A.M., Certified Nursing Assistant (CNA) stated that she recalled observing a person near the elevator at around 5 P.M. and that he/she, did not look like a patient. The CNA stated that she asked the resident if he/she was okay, and did not engage any further. She stated that Resident #1 was not on her assignment, and it was after she returned from her break that she realized that it was Resident #1 that she saw by the elevator. The CNA denied hearing the alarm as well as entering the code on the pin pad. She further stated that she was agency and that she did not have the code.</p> <p>During a follow-up interview with the Administrator and the DON on 5/20/25, at 2:55 P.M., the Administrator stated that the 4th Floor unit was a Dementia locked unit, vigilance is required. The DON stated that, Residents should be monitored per their care plan. The Administrator also stated that he, Has yet to determine how the resident was able to leave the secure unit. He further stated that interviews were conducted of the staff that worked that night and all of them denied hearing an alarm [WG] or entering the code to bypass it. The Administrator provided copies of the witness statements to the surveyor.</p> <p>During a follow-up interview with the Administrator, the DON, and the CCO on 5/20/25, at 4:06 P.M., the Administrator stated that, The camera screen on the 4th Floor was not functioning and I was unable to view footage of the night of the incident. He further stated that the footage was not available for surveyor review.</p> <p>Review of the facility's undated Secure Care/Wanderguard System policy, revealed under Section 6 of the Procedure for Wanderguard Program, it reflected that the appropriate response for a resident who passed through a Secure Care/Wander Guard Doorway, was to redirect the resident.</p> <p>Review of the facilities Elopements policy, revised April 2023, revealed under Section 2 of the Policy Interpretation and Implementation, it reflected that if a staff member observed a resident leaving the facility that they should, Attempt to prevent the departure .</p> <p>A removal plan was provided to the surveyor on 5/22/25. The plan revealed what actions the facility took to prevent serious harm from occurring or reoccurring. The facility initiated a corrective action plan to remediate the deficient practice.</p> <p>The surveyor verified that the (IJ) F689 removal plan was implemented onsite on 5/27/25 at 2:42 P.M. The non-compliance continued from 5/11/25 for no actual harm with the potential for minimal harm that is not an IJ.</p> <p>The Removal Plan was as follows:</p> <ul style="list-style-type: none"> -On 5/11/25 at 11:10 P.M., a Telehealth visit was conducted upon Resident #1's return to the facility. -On 5/11/25 at 11 P.M., facility initiated 30 Minute Monitoring of Resident #1 -On 5/11/25 at 11 P.M., facility initiated 30 Minute Monitoring of the elevator -On 5/12/25, In-services for all staff were initiated on Door Alarms, Elopement, and Code Gray and if an alarm sounds staff were to investigate prior to entering a code. <p>(continued on next page)</p>		

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