

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2026
NAME OF PROVIDER OR SUPPLIER  Lincoln Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  499 Pine Brook Road Lincoln Park, NJ 07035	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, review of medical records, and review of other pertinent facility documents on 3/19/2026 and 3/24/2026, it was determined that the facility failed to maintain a safe environment to ensure adequate supervision to prevent the elopement of a resident (Resident #2). Resident #2, who was noted to exhibit in the presence of staff exit seeking behavior, was transferred to a secure unit on 03/04/2026. Resident #2 also had a Wander Guard in place since admission to the facility since 2024. This device would initiate an alarm and alert staff in the event of an attempt to leave the secured unit. This deficient practice was identified for 1 of 3 (Resident #2) reviewed for elopement. During the survey a finding that constituted an Immediate Jeopardy (IJ) was identified under CFR 483.12(a) (1) for F689. The facility failed to maintain a safe environment on a secured unit with adequate supervision to prevent an elopement of Resident #2 who was a known elopement risk. On 03/08/2026, between 9:00 PM-10:00 PM, Resident #2, who had a Wander Guard in place was able to exit their secured third floor nursing unit and exited through an exit door that was not supervised by staff. The resident left the facility which is in densely wooded area. The facility staff became aware that Resident #2 was missing at approximately 10:00 PM, when the licensed Practical Nurse (LPN #3) who was assigned on the second-floor nursing unit heard the door alarm sounding and activated Code Grey/ Resident/Guest Elopement Policy. LPN#1 and LPN#2 with the assistance of the Certified Nursing Assistant (CNA#1) searched the third-floor secured unit. A facility head count was completed, and Resident #2 could not be accounted for in the building and on the facility grounds. The Licensed Nursing Home Administration (LNHA) and the Director of Nursing (DON) were notified of the missing resident (Resident #2) at approximately 10:30 PM. The police were notified and a missing person report was filed at approximately 11:00 PM. Resident #2 was found 4.5 hours later on 3/09/2026 at approximately 2:00 AM by the police and transported by ambulance to the hospital. Resident #2 returned to the facility on [DATE] at approximately 5:00 PM. The facility's failure to maintain a safe environment on the secured unit with adequate supervision to prevent Resident #2 from leaving the facility without staff knowledge, placed this resident as well as all residents at risk for elopement, the risk of likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 03/08/2026. The LNHA and the DON were informed of the F689 IJ and were provided with the IJ template on 3/19/2026 at 7:08 PM. An acceptable Removal Plan (RP) was received on 3/23/2026 at 3:13 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The surveyor verified the implementation of the RP during the continuation of the on-site survey on 3/24/2026 and determined the immediacy was removed as of 03/19/2026. The evidence was as follows: The facility policy titled: policy and standard manual, Code Grey /Resident/Guest Elopement policy, with a reviewed date of 04/08/2025, Under Policy Statement, revealed that Code Grey Elopement is defined as an unannounced, unplanned departure from the facility boundaries. Under Mitigation, To lessen the likelihood and effects of resident elopement, a prevention plan contains protocols that are taught to all employees during orientation and reviewed on an annual basis. Under Prevention . Controlling the exit access of residents is (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2026
NAME OF PROVIDER OR SUPPLIER  Lincoln Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  499 Pine Brook Road Lincoln Park, NJ 07035	
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>essential to secure units and decrease the risk of a resident leaving the facility and wandering off the property .e. Each door has a code to leave the unit . The facility policy titled: Safety and Supervision of Residents, with a revised date of 01/25/2026, Under Policy Statement, Our facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. Under System Approach to Safety 2. Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision are determined by the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision vary among residents and over time for the same resident and are determined on a case-by-case basis. For example, resident supervision may need to be increased during temporary illness or a change in mental status/behaviors. Nursing staff will evaluate the need for supervision. A review of the Facility Reportable Event (FRE) dated 03/09/2026, that the facility submitted to the New Jersey Department of Health (NJDOH), revealed that at approximately 10:30 PM on 03/08/2026, an alarm was activated, prompting a Code Grey alert. A facility head count was conducted. During the head count, it was noted that Resident #2 was not in their room and was identified as missing. The FRE further revealed the local police were contacted and located Resident #2 approximately 4.5 hours later and transferred to the hospital. Resident #2 was returned to the facility at 5:05 PM on 03/09/2026.A Conclusion of event revealed: Despite all safety precautions and progressive interventions that were put in place, Resident #2 removed their Wander Guard after staff checked placement and function on the 3-11 shift and exited their unit. However, staff were alerted to Resident #2 egress by the door alarm. A review of the facility's Investigation Timeline (IT) includes the following: Resident #2's admission assessment in 2024, identified the resident as at risk for elopement and indicated that the resident had a Wander Guard (a wearable device that triggers alarms and/or locks) in place. The IT further indicated that the resident was placed in a non-secured unit at the time. The resident's family member was the main relative that was supportive to the resident. The relative visited and/or interreacted with the resident frequently. The resident's [family member] in 2026 reduced the frequency of visits with the resident. On 3/3/2026, the resident met with the facility Social Worker and requested a transfer to a facility closer to the relative.On 3/04/2026, Resident #2's behavior escalated with the resident attempting to leave the floor and was hard to redirect; and that the facility placed the resident on a one-to-one monitoring pending availability of a secured unit. The Director of Nursing (DON) stated during interview that the resident was then transferred to a secured unit on 3/4/2026 and discontinued the one-to-one monitoring.A review of the medical record revealed the following;According to the admission Record face sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: schizoaffective disorder (chronic mental health condition), major depression (a serious mental condition characterized by persistent sadness) and factitious disorder (a serious mental health condition where a person intentionally produces, feigns or exaggerates physical or psychological symptoms in themselves).According to the quarterly Minimum Data Set (MDS), an assessment tool dated 01/29/2026, Resident #2 had a BIMs score of 15 out of 15, which indicated the resident's cognition was intact. A review of Resident #2's Elopement/Wandering Risk Evaluation dated 03/04/2026 at 2:02 PM, indicated that Resident #2 was a high risk for elopement. The evaluation under behavior and mood noted that Resident #2 indicated yes to a history of actual/attempt of elopement and verbally expressed desire to go home or stay near exit door. Under cognition, it noted that Resident #2 was cognitively impaired with poor decision-making skills. A review of Progress Note (PN) dated 03/04/2026 at 7-3, which was written by the Assistant Director of Nursing (ADON), stated that resident #2 was showing possessive behaviors. and that psych met with the resident. A review of Resident #2's Care Plan (CP) revealed a focus initiated on 11/03/2024, with revision date of 12/30/2025 which stated that Resident #2 is an elopement risk, and a wanderer related to history of attempts to leave the facility unattended. The CP also stated that Resident #2 had a Wander Guard placed on their ankle and that the resident's behaviors should be monitored. The (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2026
NAME OF PROVIDER OR SUPPLIER  Lincoln Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  499 Pine Brook Road Lincoln Park, NJ 07035	
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>CP further stated that Resident #2 was noted to be actively exit seeking. The care plan included an intervention to do frequent monitoring. During interview with Resident #2 on 03/19/2026 at 11:10 AM, Resident #2 stated they exited the facility on 03/08/2026 wearing their Wander Guard on their ankle. Resident #2 stated they left the facility through the exit door on the unit and got onto the elevator to the front entrance, where they exited the building. Resident #2 also stated they walked to the bus stop which is close by the facility. Resident #2 stated they took the public transportation bus to go and visit their relative. Resident #2 stated while at their [family member] address, the police came and took them to the hospital. A telephone interview was conducted on 03/19/2026 at 12:43 PM. LPN#1 stated, she last saw Resident #2 at around 9:00 PM on 03/08/2026 after she provided their ordered snack (milkshake). Resident #2 said, I want a soda but then proceeded to their bedroom. At approximately 10:00 PM, I went in to check on Resident #2, I observed the milkshake on the bedside table sealed and untouched and observed Resident #2 was not present at that time in their room. I thought Resident #2 had gone to the soda machine on the other unit, so I went to the soda machine and did not see the resident (Resident #2). LPN #1 further stated, Resident #2 and other residents on the secured unit are allowed to go off the unit unaccompanied to the soda machine. During the same interview, LPN #1 stated, upon her return to the secured unit, she alerted CNA #1 and other staff members to conduct a thorough search in all the rooms, bathrooms and closet for Resident #2. After the head count and the resident was not accounted for and the Charge Nurse was notified. A Code Grey was activated for the missing resident. LPN #1 said there was no alarm sounding on the unit prior to code grey been activated. LPN #1 stated she did not see Resident #2's Wander Guard in the room during the search of the resident. An interview was conducted with CNA #1 on 03/19/2026 at 1:35 PM. CNA #1 stated she was assigned to Resident #2 on 03/08/2026. At 9:00 PM, I saw the resident (Resident #2) in their room and on the phone. At 10:00 PM, I went to do my last round and noticed Resident #2 was not in their room. I immediately told the nurse, and we checked everywhere, and Resident #2 was not found. CNA #1 said, No, I did not hear the alarm sounding. An interview was conducted with LPN #2 on 03/19/2026 at 3:50 PM. LPN #2 stated he was the nurse assigned to Resident #2 on 03/08/2026 the day the resident eloped. LPN #2 stated the process for leaving the secured unit is for the residents to always be accompanied by staff. On 03/08/2026, I checked the function and placement of Resident #2's Wander Guard during my shift. LPN #2 said, I saw Resident #2 at 9:00 PM in their room and at approximately 10:00 PM code grey was activated by a staff on another unit. A head count was done on the secured unit, and it was determined that Resident #2 was not on the secured unit or in the building. LPN #2 stated, I did not know Resident #2 was missing until code grey was activated at 10:00 PM. LPN #2 stated, no alarm sounded on the secured unit prior to code grey been activated. There were two nurses working on the secured unit on 03/08/2026 and we did not activate code grey. LPN #2 further stated a resident on the secured unit with a wander guard should not leave the unit unaccompanied. An interview was conducted with the DON in the presence of the Licensed Nursing Home Administrator (LNHA) on 03/19/2026 at 4:33 PM. The DON stated, a resident on a secured unit should not be able to leave unit unaccompanied by staff. An off-site telephone interview was conducted on 03/23/2026 at 2:38 PM with LPN #3, who stated he was the charge nurse for the second floor on 03/08/2023. LPN #3 said at 10:00 PM, he heard the door alarm sounding but did not recall which door was alarming. He activated the code grey. LPN #3 stated, once code grey was initiated, a head count was performed on each unit and it was at that time, Resident #2's nurse (LPN#2) informed him that Resident #2 was unaccounted for. LPN #3 stated, staff searched all rooms, buildings and grounds and were unable to locate Resident #2. He notified the DON and ADON of the missing resident (Resident #2). LPN #3 stated a resident on a secured unit should not leave the unit unaccompanied at any time. An acceptable Removal Plan (RP) was received on 03/23/2026 at 3:13 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice, including: On 03/08/2026, the DON and ADON provided immediate in-service training, and (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2026
NAME OF PROVIDER OR SUPPLIER  Lincoln Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  499 Pine Brook Road Lincoln Park, NJ 07035	
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>reeducation began regarding the safety and protocols for residents at risk for wandering and elopement. On 03/09/2026 at 5:00 PM, Resident #2 returned to the facility safely and was reassessed. A new wander guard with a secure band was placed on the resident's ankle, and the resident's room was moved adjacent to the nurses' station for monitoring. Resident #2 was placed on 1:1 monitoring for all shifts. On 03/19/2026, DON and ADON provided facility staff with education on the importance of monitoring residents' doors on secure units to prevent residents from exiting. On 03/19/2026, the DON and ADON serviced all staff on: A. Monitoring doors on secured units to prevent unauthorized exits; B. Residents living on the secured units need to be escorted by staff members when leaving the unit. On 03/19/2026, a test on all door alarms/door locks was completed and is working as designed by Northeast Protection Partners. B. The Wander Guard installer, Northeast Protection Partners, completed testing of all Wander Guard alarms and magnetic locks, and they are all working as designed. C. Effective immediately, as we evaluate the security of our secured unit doors, a trained staff member will be stationed on all shifts in the hallway of the secured unit to supervise doors to prevent unauthorized exit by all residents living on that unit. D. All staff who work on the secured units were in-serviced by the DON and ADONs on monitoring doors on secured units to prevent unauthorized exits. The surveyor verified the implementation of the Removal Plan on-site on 03/24/2026, and determined the immediacy was removed as of 03/19/2026. NJAC 8:39-27.1 (a)</p>		