

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER Berlin Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Long-A-Coming Lane Berlin, NJ 08009	
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of medical records, and other pertinent facility documentation on [DATE], it was determined that the facility failed to provide adequate supervision to a cognitively impaired resident (Resident #2) with a known history of elopement who eloped from the facility on [DATE]. The deficient practice was identified for 1 of 3 residents (Resident #2). The resident had a history of exiting their unit on [DATE]. On [DATE] at approximately 6:01 P.M., Resident #2, while wearing a wander guard (security bracelet), left their unit on the second-floor and exited the facility through the main lobby front door. Staff became aware that the resident was missing from their unit when another nurse informed Resident #2's Licensed Practical Nurse (LPN #1) that when a staff member was coming into the facility, he saw someone that looked like Resident #2 on the road. At that time, LPN #1 looked for Resident #2 in their room, but could not find them. LPN #1 and other staff members went outside to search for the resident. Resident #2 was found approximately thirty minutes later, while walking with a walker on a nearby busy four-lane highway, and brought back to the facility at approximately 6:49 P.M. 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 [DATE] at 6:01 P.M., when Resident #1 eloped from the facility out of the main entrance doors until [DATE] at 6:49 P.M., when the resident was located by staff and brought back to the facility. The IJ was Past Non-Compliance (PNC). The facility's Administration was notified on the IJ on [DATE] at 6:28 P.M. The facility submitted an acceptable Removal Plan on [DATE]. The facility was back in compliance when the facility addressed the situation by locating the resident and immediately assessing them for injury upon return to the facility. Resident #2 was placed on one-to-one (1:1) monitoring; their care plan was revised; and the functioning of their wander guard was verified. The facility completed a head count to verify all residents were accounted for; conducted a house sweep using an interim elopement/wandering risk evaluation to check other residents for elopement risk; educated all staff on interventions to prevent elopement; and verified all binders that identified residents at risk for elopement were accurate and placed at the nurses' stations and the front desk. The Elopement/Missing Person policy was reviewed, and the Receptionist and off-shift staff were educated on the process for incoming and departing visitors. The Regional Plant Operations inspected doors and wander guard functionality; the door lock system was reviewed, and the timer was adjusted; adjustment was made to the frequency/sensitivity for the wander guard bracelet; and the front door system was switched to alert the front door's operator with a push/release mode only. The surveyor verified the completion of the Removal Plan was [DATE], during the on-site visit on [DATE], and determined the IJ was PNC. The evidence was as follows: A review of the facility's policy titled Wander Management and Prevention Updated-[DATE], under Policy Statement Indicated: The facility will maintain the safety of residents who wander and/or are at risk for elopement. Under Policy Interpretation and Implementation 4. The wander management system device will be used in conjunction with other resident-specific interventions for the management of unsafe wandering. 5b. Wander management system devices will be checked for functionality daily by nursing staff. 7. Doors with wander management system alarms will be checked for functionality daily by maintenance staff/designee. 8. Identified issues with wander management system alarms will be immediately addressed. A review of the facility's policy titled Wandering and Elopements under Policy Interpretation and Implementation 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary and c. Instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises. According to the Facility Reportable Event Record (FRE) dated [DATE], Resident #2 exited the second-floor nursing unit and eloped out of the facility through the facility's first floor lobby door on [DATE] at 6:01 P.M. According to the FRE, the Receptionist on duty at the time confirmed that she observed Resident #2 exit the building through the main front door but thought the resident was a visitor because the resident wore a [NAME] straw hat and was using a rollator. The FRE indicated that at around 6:22 P.M., a staff member who was returning to facility from his dinner break informed the nurse on the first-floor unit that he saw a person with a rollator (walker) outside the facility that looked familiar, like a resident. Staff then looked for Resident #2 in their room but could not locate the resident. A code yellow was called, and a search was initiated for the resident. The		