New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75A001	A. BUILDING: _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERION GARDENS ASSISTED LIVING	315 MERION AVENUE CARNEYS POINT, NJ 08069

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00181478 CENSUS: 36 SAMPLE SIZE: 5 SURVEY DATE: 12/16/2024-12/19/2024 The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint Survey. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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

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This REQUIREMENT is not met as evidenced by:
NJ00181478

Based on record review, interview, and facility document and policy review, the facility failed to implement the facility's "Resident Elopement" policy and notify the Director of Wellness (DOW) and [NJ Exec Order] when 1 (Resident #1) of 5 sampled residents [NJ Exec Order 26.4b1]. On [NJ Exec Order 26.4b1], staff [NJ Exec Order 26.4] Resident #1 at approximately 8:00 PM. At approximately 10:30 PM on [NJ Exec Order 26.4b1], staff did not find Resident #1 in their [NJ Exec Order 26.4b1] The facility failed to initiate a [NJ Exec Order 2] for the resident until approximately 11:15 PM, did not notify the DOW until 11:53 AM, and did not notify the [NJ Exec Order] that the resident was [NJ Exec Order 26.] until 12:15 AM on [NJ Exec Order 26.4b1]. [NJ Exec Order] used a [NJ Exec Orde] and [NJ Exec Orde] Resident #1 at 7:10 AM on [NJ Exec Order 26.4b1] [NJ Exec O] and a [NJ Exec Order 26.4b1] from the facility, [NJ Exec Order 26.4b1]

It was determined that the facility's non-compliance with one or more requirements had caused or was likely to cause serious injury, harm, impairment, or death to residents.

On 12/19/2024, the New Jersey Department of Health determined the failed practice represented an immediate threat to residents' health and safety. The facility's Administrator was notified of the imminent danger and the immediacy of the situation involving the failure to implement/enforce facility policy, and a Removal Plan was requested.

Findings included:

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A 310	Continued From page 2 A facility policy titled "Resident Elopement," revised 05/25/2010, revealed, "It is the responsibility of all staff to provide a safe environment for all residents. The following guidelines will be followed in the event that a resident is missing." The policy revealed when a resident was determined to be [NJ Exec Order 26.4b] "Staff members will do a thorough search to locate the resident. If the resident is not located, proceed with the following instructions. The LPN [licensed practical nurse] or CMA [certified medication aide] on duty will notify the Director of Wellness. Staff members from other departments will search the entire facility and grounds prior to beginning the search, the residents photograph will be circulated to all involved in the search. The Director of Wellness will notify the Administrator and police if the resident is not found in the facility or on the grounds." Resident #1's "Resident Information" sheet revealed the facility admitted the resident on [NJ Exec Order 26.4b1]. Resident #1's physician '[NJ Exec Order 26.4b1] Notes" dated [NJ Exec Order 26.4b1] revealed the resident had a medical history that included diagnoses of [NJ Exec Order 26.4b1] The physician's note revealed Resident #1 took medications including [NJ Exec Order 26.4b1]). A facility '[NJ Exec Order 26.4b1] Drill Report" revealed administrative staff were notified on [NJ Exec Order 26.4b1] at 11:53 PM that Resident #1 was [NJ Exec Order 26.4b] and the DOW notified the Administrator at 11:54 PM. According to the report, the facility notified the [NJ Exec Order] that the resident was [NJ Exec Order 26.4] at	A 310		

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12:15 AM on NJ Exec Order 26.4b1, and the resident was NJ Exec Orde at 7:10 AM on NJ Exec Order 26.4b1. Per the report, nine staff participated in the NJ Exec Order 26 for the resident and staff responded in accordance with established policies and procedures.

Resident #1's 'NJ Exec Order 26.4b1 note dated NJ Exec Order 26.4b1 at 7:45 AM revealed the DOW documented that the facility received a call from the Administrator at 7:09 AM that Resident #1 was NJ Exec Order 26.4b1 at an NJ Exec Order 26.4b1.

An interview with Certified Nurse Aide (CNA) #8, who was also a certified medication aide, on 12/18/2024 at 4:22 PM revealed the CNA's shift started at 10:00 PM on NJ Exec Order 26.4b1 and the CNA looked inside Resident #1's room at 10:30 PM, noting the light was on. The CNA stated she went up front and asked if anybody NJ Exec Order 26.4b1 Resident #1. At that time, the CNA stated she was not concerned about Resident #1's NJ Exec Order 26.4b1 and gave Resident #1 until 11:15 PM (on NJ Exec Order 26.4b1) before she started checking Resident #1's friends' rooms.

An interview with the DOW on 12/16/2024 at 4:02 PM revealed CNA #8 called the DOW at 11:55 PM (on NJ Exec Order 26.4b1), approximately one and a half hours after she discovered that Resident #1 was NJ Exec Order 26.4b1. According to the DOW, she was at the facility within 10 minutes after receiving CNA #8's call. The DOW stated NJ Exec o was not contacted until the Administrator arrived at the facility and watched facility video camera footage.

An interview with the Administrator on 12/16/2024 at 4:29 PM revealed staff NJ Exec Order 26.4b1 for Resident #1 at approximately 10:30 PM, when a

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A 310	Continued From page 4 two-hour check was conducted, and the resident was NJ Exec Order 26.4b1. However, per the Administrator, staff did not notify her until approximately 11:45 PM on NJ Exec Order 26.4b1 that Resident #1 NJ Exec Order 26.4b1. During the survey, a Removal Plan was requested to address and correct immediacy of the deficient practice. The facility submitted a Removal Plan addressing: Safety, Elopement Policy revision, Nursing Policy and Procedure, and Staff Education.	A 310		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: NJ00181478 Based on record review, interview, and facility document and policy review, the facility failed to protect 1 (Resident #1) of 5 sampled residents' right to be NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 at approximately 8:00 PM, staff observed Resident #1 NJ Exec Order 26.4b1 of the facility. At approximately	A 389		

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A 389	Continued From page 5 10:30 PM, staff NJ Exec Order 26.4b1 Resident #1 in their NJ Exec Order 26.4b1 however, staff did not initiate a NJ Exec Order 26 for the resident until approximately 11:15 PM and did not notify administrative staff that the resident was NJ Exec Order 26.4 until 11:53 PM. Further, the facility did not notify the NJ Exec Order that Resident #1 was NJ Exec Order 26.4 from the facility until 12:15 AM on NJ Exec Order 26.4b1 NJ Exec Order 2 used NJ Exec Order 26 and NJ Exec Orde Resident #1 at 7:10 AM on NJ Exec Order 26.4b1 , NJ Exec and a NJ Exec Order 26.4b1 from the facility, NJ Exec Order 26.4b1 According to the resident's power of attorney (POA), the NJ Exec Order 26.4b1 showed Resident #1's cause of NJ Exec Orde was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 It was determined that the facility's non-compliance with one or more requirements had caused or was likely to cause serious injury, harm, impairment, or death to residents. On 12/19/2024, the New Jersey Department of Health determined the failed practice represented an immediate threat to residents' health and safety. The facility's Administrator was notified of the imminent danger and the immediacy of the situation involving the resident's NJ Exec Order 26.4b1 and a Removal Plan was requested. Findings included: A facility policy titled "Rights of [facility name] Residents," revised 06/29/2007, revealed "Policy: All residents are informed (in writing) of these rights upon admission to [the facility]. All employees are informed of these rights upon date of hire and at least annually thereafter. At a minimum, each Assisted Living Resident at [facility name] have these specific rights:" and	A 389		

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A 389	Continued From page 6 "16. The right to be free from physical and mental abuse and/or neglect." A facility policy titled, "One and Two hour Safety Checks," revised 10/15/2023, revealed, "The purpose is to proactively provide adequate supervision for individualized needs of the resident to improve quality of life." The policy revealed, "1. The licensed or certified healthcare staff will provide one or two hour safety checks for each resident as determined by the resident's individualized needs." The policy also revealed, "4. Two hour checks are the standard for [facility name] residents." A facility policy titled "Resident Elopement" revised 05/25/2010, revealed, "It is the responsibility of all staff to provide a safe environment for all residents. The following guidelines will be followed in the event that a resident is missing." The policy revealed, "When a resident is determined to be missing please follow steps below: - Note the time that the resident is/was determined missing. - Staff members assigned to the unit where the resident resides will verify [end of sentence]. - Staff members will do a thorough search to locate the resident. If the resident is not located, proceed with the following instructions. - The LPN [licensed practical nurse] or CMA [certified medication aide] on duty will notify the Director of Wellness. Staff members from other departments will search the entire facility and grounds prior to beginning the search, the residents photograph will be circulated to all involved in the search. The Director of Wellness will notify the Administrator and police if the resident is not found in the facility or on the grounds."	A 389		

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A 389	Continued From page 7 Resident #1's "Resident Information" sheet revealed the facility admitted the resident on NJ Exec Order 26.4b1 An undated 'NJ Exec Order 26.4b1 Checklist" completed by the Director of Wellness (DOW) revealed that Resident #1 was NJ Exec Order 26.4b1 . Per the checklist, the resident had no history of NJ Exec Order 26.4b1 and had made no attempts to NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 Checklist revealed there were NJ Exec Order 26.4b1 in Resident #1's NJ Exec Order 26.4b1 such as NJ Exec Order 26.4b1 . A 'NJ Exec Order 26.4b1 " dated NJ Exec Order 26.4b1 revealed the DOW documented that Resident #1 was able to NJ Exec Order 26.4b1 . The examination revealed Resident #1 knew the NJ Exec Order 26.4b1 The examination also revealed that Resident #1 recalled NJ Exec Order 26.4b1 According to the examination, Resident #1's total score was NJ Exec Order 26.4b1 out of NJ Exec Order 26.4b1 which indicated NJ Exec Order 26.4b1 Resident #1's physician 'NJ Exec Order 26.4b1 Notes" dated NJ Exec Order 26.4b1 , revealed the physician was following up with the resident for an NJ Exec Order 26.4b1 . The notes revealed the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 The physician's note revealed Resident #1 took medications that included NJ Exec Order 26.4b1 According to the physician's notes, Resident #1 was 'NJ Exec Order 26.4b1 ;" recent and	A 389		

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A 389	Continued From page 8 NJ Exec Order 26.4b1 ; NJ Exec Order 26.4b1 ; and the resident's NJ Exec Order 26.4b1 were NJ Exec Order A facility "Incident Report" dated NJ Exec Order 26.4b1 at 9:00 AM for Resident #1 revealed the DOW completed the report due to the resident's NJ Exec Order Per the report, staff called at 11:53 PM on NJ Exec Order 26.4b1 to report that they were unable to NJ Exec Order the resident NJ Exec Order 26.4b1. The report revealed the Administrator was notified immediately. The report revealed the DOW arrived at the facility and NJ Exec Order 26.4b1 and the Administrator arrived and reviewed facility camara footage. Per the camara footage, Resident #1 was NJ Exec Order 26.4b1 8:00 PM. According to the report, the facility notified NJ Exec O the resident's POA, and both alternative contacts. The report revealed the facility also contacted two NJ Exec Order 26.4b1 to ensure the resident NJ Exec Order 26.4b1. The report revealed the facility also contacted the NJ Exec Order in the NJ Exec Or where the resident NJ Exec Order 26.4b1. Per the report, the NJ Exec Order 26.4b1 arrived, took a NJ Exec Order 26.4b1 of what the resident was NJ Exec Order 26.4b and indicated they NJ Exec Order 26.4b1. The report revealed facility staff began NJ Exec Order 26.4b1 near the NJ Exec Order 26.4b1 According to the report, NJ Exec Orde returned and stated they NJ Exec Order 26.4b1 the resident and would be entering the resident into a database as a NJ Exec Order 26.4b1. The report revealed the resident's POA and family also arrived to assist in a NJ Exec Order 26.4b1. According to the report, at approximately 1:00 AM (on NJ Exec Order 26.4b1 NJ Exec Order brought in NJ Exec Order 26.4 NJ Exec Order 26.4b and NJ Exec Order 2 and NJ Exec Order 26.4b1, and staff, NJ Exec Order 2 and family continued a NJ Exec Order 26 NJ Exec Order 26.4 At 6:00 AM on NJ Exec Order 26.4b1 ; NJ Exec Order 26.4b1 and NJ Exec Order created a	A 389		

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NJ Exec Order 26.4b1 to NJ Exec Order the resident. The report revealed a NJ Exec Order 26.4b1 was able to NJ Exec Order Resident #1 NJ Exec Order 26.4b1

A facility "NJ Exec Order 26.4b1 " revealed the facility notified the NJ Exec Order at 12:15 AM on NJ Exec Order 26.4b1 that Resident #1 was NJ Exec Order 26.4b The report revealed the resident was NJ Exec Orde at 7:10 AM on NJ Exec Order 26.4b1. Per the report, nine staff participated in the NJ Exec Order 26 for the resident and staff responded in accordance with established policies and procedures.

An 'NJ Exec Order 26.4b1 note dated NJ Exec Order 26.4b1 at 7:45 AM revealed the DOW documented that the Administrator called at 7:09 AM and reported that Resident #1 had been NJ Exec Order 26.4b1 at an NJ Exec Order 26.4b1 .

A NJ Exec Order 26.4b1 revealed the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 from the facility and took approximately NJ Exec Order 26.4b1

NJ Exec Order 26.4b history according to a NJ Exec Order 26.4b and NJ Exec Or NJ Exec Order 26.4b1 revealed the NJ Exec Order 26.4b1 near the facility from 8:00 PM on NJ Exec Order 26.4b1 through 7:00 AM on NJ Exec Order 26.4b1 ranged from NJ Exec Order 26.4b1 , with NJ Exec Order 26.4b1 at 8:30 PM. The NJ Exec Order 26.4b history also revealed there were NJ Exec Order 26.4b1 at 9:51 PM on NJ Exec Order 26.4b1 .

An interview with Home Health Aide (HHA) #5 on 12/16/2024 at 2:42 PM revealed Resident #1 was a NJ Exec Order 26.4b1 . HHA #5 stated she did not see the resident NJ Exec Order 26.4b1. She stated she saw the resident NJ Exec Order 26.4b1 , and

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asked the resident how they were doing. Per HHA #5, the resident NJ Exec Order 26.4b1, and the resident seemed NJ Exec Orde as NJ Exec Order HHA #5 stated she was taking care of other residents when Resident #1 NJ Exec Order 26.4b1.

An interview with HHA #6 on 12/18/2024 at 4:52 PM revealed Resident #1 was NJ Exec Order 26.4b1) after 8:00 PM (on NJ Exec Order 26.4b1). HHA #6 stated she went to Resident #1's room after 9:00 PM and before 10:00 PM and the NJ Exec O was NJ Exec O and the light was on. She stated HHAs were told about wellness checks and instructed to always NJ Exec Order 26.4b the resident; however, HHA #6 stated she assumed Resident #1 NJ Exec Order 26.4b1 because Resident #1 was NJ Exec Order 26.4b1 the staff had to NJ Exec Order 26.4b1.

An interview with Certified Nurse Aide (CNA) #8 on 12/18/2024 at 4:22 PM revealed the CNA's shift started at 10:00 PM (on NJ Exec Order 26.4b1), and the CNA did a walk-though of the facility at the beginning of the shift. CNA #8 stated staff were NJ Exec Order 26.4b1 on Resident #1 every NJ Exec NJ Exec Orde and conduct a walk-through at the end of the shift. CNA #8 stated she looked inside Resident #1's room at 10:30 PM, and the light was on. The CNA stated she went up front and asked if NJ Exec Order 26.4b1 Resident #1. At that time, the CNA stated she was not NJ Exec Order 26.4b1 because Resident #1 was not in the system that indicated the resident wore a NJ Exec Order 26.4b1 , noting she then counted narcotics with the previous shift's nurse. She stated that Resident #3's door was shut, and she assumed Resident #1 was with Resident #3. She stated it was after 11:00 PM when the medications were put away, noting she gave Resident #1 until 11:15 PM on NJ Exec Order 26.4b1 before she started checking

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the resident's friends' rooms. According to CNA #8, residents had the right to go outside; however, the aides would have stopped Resident #1 from going outside at that time of night.

An interview with the DOW on 12/16/2024 at 4:02 PM revealed CNA #8 called the DOW at 11:55 PM (on NJ Exec Order 26.4b1 stating that they had not seen Resident #1. According to the DOW, she was at the facility within 10 minutes. The DOW stated the Administrator watched facility video camera footage and was able to determine that Resident #1 NJ Exec Order 26.4b1 at 8:11 PM. According to the DOW, Resident #1 was NJ Exec Order 26.4b1 and a NJ Exec Order 2 The DOW stated that, just prior to NJ Exec Order 2 the facility, video footage showed that Resident #1 and Resident #3 were seated on a couch. The DOW stated that, per the footage, Resident #3 NJ Exec Order 26.4b1 and an aide NJ Exec Order 26.4b Resident #3 to their room while Resident #1 NJ Exec Order 26.4b1. Per the DOW, the video footage revealed that Resident #1 was looking out the front window and two staff, HHA #4 and HHA #5, were in the area before Resident #1 NJ Exec Order 26.4b1. Per the DOW, the video revealed that no one NJ Exec O Resident #1 NJ Exec Order 26.4b of the facility. The DOW stated the facility did not have video camaras outside of the facility but could tell from the video that the resident NJ Exec Order 26.4b1 . According to the DOW, Resident #1 was NJ Exec Orde approximately NJ Exec Order 26.4b1 after NJ Exec Orde brought in NJ Exec Order 26.4 noting the resident had NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 of a NJ Exec Order 26.4b1

A follow-up interview with the DOW on 12/18/2024 at 5:15 PM revealed staff were required to do NJ Exec Order 26.4b1 and NJ Exec Order 26.4b residents every NJ Exec O hours. She stated staff were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75A001	A. BUILDING: _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERION GARDENS ASSISTED LIVING	315 MERION AVENUE CARNEYS POINT, NJ 08069

(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) COMPLETE DATE
A 389	Continued From page 12	A 389		

expected to knock if a resident's door was closed, and all staff had keys, if needed. According to the DOW, nursing staff were ultimately responsible for conducting rounds. Per the DOW, NJ Exec Order 26.4b1 [redacted] was common for Resident #1 and no one saw the resident NJ Exec Order 26

An interview with the Director of Finance (DOF) on 12/16/2024 at 2:12 PM revealed that, on NJ Exec Order 26.4b1 before the evening meal, Resident #1 had on NJ Exec Order and was NJ Exec Order 26 around NJ Exec Order 26.4b1 [redacted] but then went back to the resident's room. The DOF stated the facility's camera footage showed that Resident #1 NJ Exec at 8:15 PM. She stated the resident was NJ Exec Order approximately NJ Exec Order 26.4b1 [redacted]. According to the DOF, residents routinely sat up front at night and talked. The DOF stated the resident was allowed to go outside and used to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 but had not NJ Exec Order 26.4b1 [redacted]

An interview with the Administrator on 12/16/2024 at 4:29 PM revealed staff notified the Administrator at approximately 11:45 PM on NJ Exec Order 26.4b1 that Resident #1 NJ Exec Order 26.4b1. According to the Administrator, staff started NJ Exec Order 26 for Resident #1 at approximately 10:30 PM, when they completed a NJ Exec Order 26.4b1, and Resident #1 was NJ Exec Order 26.4b1. The Administrator stated Resident #1 was NJ Exec Order 26.4b1 [redacted]. Per the Administrator, anytime a resident NJ Exec Order 26.4b1, they conducted a NJ Exec Order 2 of the entire building, including all apartments and bathrooms, courtyards, and outside. The Administrator stated Resident #1 was also known to NJ Exec Order 26.4b1 [redacted]. According to the Administrator, Resident #1 was NJ Exec Order 26.4b1 whenever they wanted and could NJ Exec Orde and NJ Exe like NJ Exec Order 26.4b1.

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A 389	Continued From page 13 The Administrator stated that residents could not be kept NJ Exec Order 26.4b1 unless they were an NJ Exec Order 26.4b1 risk. She stated Resident #1 used to NJ Exec Order 26.4b1. Per the Administrator, Resident #1 had not had any NJ Exec O and was not an NJ Exec Order 26.4b1. She also stated that Resident #1 had NJ Exec Order 26.4b1, but no NJ Exec Order 26.4b1, and had shown NJ Exec Order 26.4b of NJ Exec Order 26.4b1. The Administrator stated the last staff member to NJ Exec R Resident #1 asked if Resident #1 was NJ Exec Or and Resident #1 answered NJ Exec Order 26.4b1. She stated she watched the facility's video camera footage, and prior to leaving Resident #1 was NJ Exec Order 26.4b1, looking at their NJ Exec Order2 and looking out the NJ Exec Order 26.4b1 as though they were NJ Exec Order 26.4b1. The Administrator stated that Resident #1 had a cell phone in the apartment but NJ Exec Order 26. The Administrator stated Resident #1 was NJ Exec Orde approximately NJ Exec O. According to the Administrator, Resident #1's family stated that the resident NJ Exec Order 26.4b1, because Resident #1 had NJ Exec Order 26.4b1. An interview with the resident's POA on NJ Exec Order 26.4b1 at 3:02 PM revealed the resident had moments of NJ Exec Order 26.4b1 usually in the NJ Exec Order 26.4b when the resident would think NJ Exec Order 26.4b1. The POA stated they had spoken to the resident at 11:00 AM on the day the resident NJ Exec Order 26.4b1 and the resident was NJ Exec O and had NJ Exec Order 26.4b1. The POA stated the resident had NJ Exec Order 26.4b1 and the resident NJ Exec Order 26.4b1 was completely NJ Exec Order 26.4b1. The POA also stated the resident NJ Exec Order 26.4b1 unless they NJ Exec Order 26.4b1. The POA stated the resident normally NJ Exec Order 26.4b1 around the facility, but NJ Exec Order 26.4b1. According	A 389		

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A 389	Continued From page 14 to the POA, the NJ Exec Order 26.4b1 of NJ Exec Orde according to an NJ Exec Order 26.4b was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 During the survey, a Removal Plan was requested to address and correct immediacy of the deficient practice. The facility submitted a Removal Plan addressing: Safety, Elopement Policy revision, Nursing Policy and Procedure, and Staff Education.	A 389		
A 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, any elopements; and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages; This REQUIREMENT is not met as evidenced	A 563		

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A 563	Continued From page 15 by: Based on record review, interview, and facility document and policy review, the facility failed to notify the Department when 1 (Resident #2) of 2 residents [redacted] from the facility. Findings included: A facility policy titled, "Resident Elopement," revised 05/25/2010, revealed "When a resident has been found the Director of Wellness or designee will follow steps below:" and "Contact the resident's responsible person, Family [sic] member and/or POA [power of attorney] and inform them of the status. Complete a [sic] Incident Report form ensuring that all staff involved has signed the form. Appropriate documentation is made to Twenty [sic] four hour communication log and in missing residents [sic] chart. Send the report to the Administrator." The Resident Elopement policy did not address notifying the Department of instances of elopement. Resident #2's "Resident Information" sheet revealed the facility admitted the resident on [redacted]. According to the Resident Information sheet, the resident had a medical history that included a diagnosis of [redacted] Resident #2's "Service Plan," dated [redacted] (print date), revealed the resident was at risk for [redacted] and directed staff to provide [redacted] and [redacted] to avoid and prevent [redacted] and to document and alert the Director of Wellness (DOW) if [redacted] occurred. Per the plan, Resident #2 was not [redacted] and there were no previous occurrences of [redacted]	A 563		

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A 563	Continued From page 16 An NJ Exec Order 26.4b1 "Incident Report" dated NJ Exec Order 26.4b1 revealed that, on NJ Exec Order 26.4b1 the Administrator received a call from a NJ Exec Order 26.4b1 that Resident #2 was NJ Exec Order 26.4b1, which was the NJ Exec Order 26.4b1 . The report revealed the DOW contacted Licensed Practical Nurse (LPN) #1 and staff NJ Exec Order 26.4b the resident. The report revealed the Administrator reviewed camara footage for NJ Exec Order 26.4b1 and Resident #2 was NJ Exec Order 26.4b1 after dinner and attempting to NJ Exec Order 26.4b1 however, the apartment door was locked. Per the report, the camara footage revealed the resident attempted to NJ Exec Order 26.4b1 to other NJ Exec Order 26.4b1 , including the NJ Exec O NJ Exec Order 26.4b1 , which the resident NJ Exec Order at 6:55 PM on NJ Exec Order 26.4b1 . Per the report, the resident NJ Exec Order 26.4b1 by 7:20 PM. Resident #2's 'NJ Exec Order 26.4b1 For [resident name]" notes, dated NJ Exec Order 26.4b1 at 9:45 PM, revealed Licensed Practical Nurse (LPN) #1 documented that the resident was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 The notes revealed Resident #2 was redirected into the NJ Exec Order 26.4b1 for NJ Exec Order reasons. According to the notes, Resident #2 was NJ Exec Order 26.4b1 why they were NJ Exec Order 26.4 NJ Exec Order 26.4b Resident #2's 'NJ Exec Order 26.4b1 notes dated NJ Exec Order 26.4b1 at 1:15 PM, revealed the DOW documented that the resident stated, NJ Exec Order 26.4b1 NJ Exec Order Per the notes, staff reminded Resident #2 that staff should NJ Exec Order 26.4b1 the resident outside due to NJ Exec Order 26 . The notes revealed a NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 the resident as a precaution. An interview with LPN #1 on 12/18/2024 at 9:34	A 563		

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A 563	Continued From page 17 AM revealed the LPN was passing medication when a NJ Exec Order 26.4b1. LPN #1 stated staff knew someone had NJ Exec Order 26.4b1. LPN #1 stated she had to look for an aide to NJ Exec Order 26.4b Resident #2. Per LPN #1, Resident #2 was NJ Exec Order 26.4b1 from the facility. An interview with Home Health Aide (HHA) #9 on 12/18/2024 at 11:00 AM revealed Resident #2 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. HHA #9 stated staff NJ Exec Order Resident #2 quickly, within five minutes. An interview with the Administrator on 12/18/2024 at 12:05 PM revealed staff NJ Exec Orde Resident #2 within five minutes. The Administrator stated she did not report Resident #2 as an NJ Exec Order 26.4b1 to the Department because the resident NJ Exec Order 26.4b1 the facility premises.	A 563		

MERION GARDENS ASSISTED LIVING
315 MERION AVENUE
CARNEYS POINT, NEW JERSEY 08069
856-299-0300
License number 75A001

8:36-3.4(A)(1) ADMINISTRATION

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Policy and procedure recreated on December 17, 2024 adding measures that will decrease opportunities of elopement and guidelines for staff to follow in the event of suspected elopement or when unable to locate a resident during rounds.

How the facility will identify other residents having the potential to be affected by the same deficient practice. Policy was updated on December 19, 2024 and now includes mini mental assessment to be conducted by DOW whenever a change of mental status is detected. Continue to complete General Service Plan Reviews for changes in status. Any resident residing on the traditional assisted living unit that exhibits exit seeking behavior will have a wander guard and LPN/RN and/or CMA will monitor and sign off that wander guard is in place and working correctly per shift, added a place for documentation on the electronic record.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Installation of keypad to the front entrance of the building that requires a 4-digit code to exit completed Friday, December 13, 2024. During the hours between 8PM-6AM keypad has restriction that must be unlocked by LPN/CMA on duty. No one will be able to exit the facility without LPN/CMA letting them out of facility. In the event of fire system alarm being triggered the system will override and release the door to prevent injury.

The One/Two Hour Safety Check Policy was updated on 12/19/2024 to include the importance of visually laying eyes on each resident while conducting one- and two-hour safety checks

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. Staff were reeducated on the importance of following policy and procedures, elopement signs and risk factors, One/Two-hour safety checks safety and well-being of all residents residing within Merion Gardens Assisted Living. Implemented on December 19, 2024. Education will continue with practice elopement drills.

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8:36-4(A)(16) RESIDENT RIGHTS

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Merion Gardens is a secure (locked) from the outside of the building 24 hours a day, seven days a week. No one can enter Merion Gardens without access to the 4-digit keypad code that unlocks the front and rear entrances. The sliding doors which open the main entrance are always to remain unlocked, this do not gain access to the facility, just the vestibule area. Residents, employees and visitors (who visit routinely) may have access to the 4-digit keypad code. Others may be advised of the access code based on administrative approval. Both entrances are also equipped with a Wander Guard Alarm System which protects residents who are at risk from wandering outside of the building. These entrances have an additional keypad and 4-digit code to bypass the Wander Guard Alarm. This 4-digit code is never to be shared with residents. When a resident is deemed to need wander guard by RN nursing assessment, this device overrides the main door code and keeps doors locked until code provided by staff grants access.

From the hours of 8PM-6AM the exit doors to the facility will be locked. LPN/CMA on duty will have to open the cover with key to allow any visitors to exit facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident that has a change of mental status or exhibits exit seeking behavior residing on the traditional unit of facility will have a mini mental completed by RN and wander guard placed if necessary; in event RN feels that wander guard is not sufficient resident will transition to the locked memory care unit.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Staff will conduct one/two-hour checks on each resident on their assignment throughout shift. Any resident that is not immediately located will be reported to LPN/CMA on duty and police will be notified followed by DOW and Administrator. During that time a complete search of property will be initiated until the police arrive on facility grounds.

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How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. LPN/CMA on duty will monitor that all exits/entrances are operating correctly with the use of wander guard in place for residents that utilize the safety measure. One/Two-hour checks will be conducted by support staff to ensure residents' safety.

8:36-5.10(A)(2) GENERAL REQUIREMENTS

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility will report to the Department of Health Survey and Field Operations immediately of any resident that leaves the facility unattended after notification to the local police department, DOW and Administrator.

How the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident that has a change of mental status or exhibits exit seeking behavior residing on the traditional unit of facility will have a mini mental completed by RN and wander guard placed if necessary; in event RN feels that wander guard is not sufficient resident will transition to the locked memory care unit.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Wander guard will be monitored by RN/LPN/CMA and signed off per shift that unit is working and placed correctly on resident.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. RN will monitor that one/two-hour checks are being conducted by support staff and LPN/CMA is signing off per shift that security measures are in place for any resident requiring wander guard monitoring.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
75A001		6/6/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERION GARDENS ASSISTED LIVING	315 MERION AVENUE CARNEYS POINT, NJ 08069

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 06/06/2025	ID Prefix A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 06/06/2025	ID Prefix A0563 Reg. # 8:36-5.10(a)(2) LSC	Correction Completed 06/06/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/19/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**