STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315158	A. BUILDING _____ B. WING _____	05/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIDGEWOOD CENTER	330 FRANKLIN TPK RIDGEWOOD, NJ 07450

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C#: [ST] 000 Based on interviews, and record review, as well as review of pertinent facility documents on 5/11/20, it was determined that the facility failed to update the care plan for 1 of 4 sampled residents (Residents #1) reviewed for care plans. This deficiency is evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated 1/30/20, Resident #1 had no cognitive impairment and required supervision and limited assistance from staff with Activities of Daily Living (ADLs). The Care Plan (CP), initiated on 1/31/20 and revised [DATE] showed that the Resident showed the potential to exhibit physical behaviors related to cognitive loss and Dementia. Intervention included but was not limited to: Resident was moved to a room closer to a nursing station initiated on 4/3/20. The facility's RMS (Risk Management Sustem) Event Summary Report (RMSESR) dated 3/28/20 showed that on 3/28/20 Resident #1 and Resident #4 were found in Resident #1's room. Resident #1 was fully clothed, however, Resident #4 was undressed from the waist down and Resident #1 was attempting to remove Resident #4's shirt. The Residents were immediately separated. New interventions included but were not limited to: moved Resident #1's room closer to nursing station and place motion sensor above Resident #1's doorway which was pending delivery. Review of Resident #1's Care Plan showed that it was not updated or revised to reflect the aforementioned incident and the interventions to prevent reoccurrence with the use of the motion sensor. The surveyor conducted an interview with Unit Manager (UM on the wing that Resident #1 resided on) on 5/11/20 at 10:12 am. The UM stated that he was not aware of any alarm or motion sensor interventions for Resident #1. He further stated that UM and Assistant Director Nursing (ADON) were responsible for updating CPs with new interventions. The surveyor conducted an interview with Assistant Director of Nursing (ADON) on 5/11/20 at 12:10 pm. The ADON stated that she was not aware of the motion sensor intervention for Resident #1. The surveyor conducted a telephone interview with a former Administrator (A #1, an Administrator during the aforementioned incident) on 5/11/20 at 2:09 pm. A #1 stated that the sensor alarm was one of the interventions discussed by the team to prevent the reoccurrence of the aforementioned incident. However, she did not get the chance to order the sensor motion online because of the [MEDICAL CONDITION] pandemic. The facility's policy titled Person-Centered Care Plan, effective on 11/28/16, reviewed on 6/12/19 and revised on 7/1/19 showed that: .7. Care plans will be: .7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals; . [ST]AC 8:39-11.2 (h)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C#: [ST] 002 Based on interviews, and record review, as well as review of pertinent facility documents on 5/11/20, it was determined that the facility failed to follow physician's orders [REDACTED].#1 and Resident #2) reviewed for physician's orders [REDACTED]. According to the Admission Record (AR) form, Resident #2 was originally admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated 3/9/20, Resident #2 had severely impaired cognition and required extensive assistance from staff with Activities of Daily Living (ADLs). The Care Plan (CP) initiated on 9/8/15 and revised on 12/15/17 showed that the Resident was at risk for falls. Intervention included but was not limited to: assess for changes in medical status, pain status, mental status and report to medical doctor as indicated. The RMS (Risk Management System) Even Summary Report (RMSESR) dated 12/2[DATE]9, showed that Resident #2 lost his/her balance and fell . The physician's orders [REDACTED].#2 had an order dated 12/2[DATE]9 for neurological checks every shift for five (5) days. The Progress Notes for Resident #2 for 12/19 showed that neurological checks were not performed on 1[DATE] during the evening (3:00 pm to 11:00 pm shift), on 12/27/19 during the evening shift, on 12/28/19 during the evening shift and on 12/29/19 during the night (11:00 pm to 7:00 am) shift. Review of Resident #2's Medication Administration Record [REDACTED]. 2. According to the Admission Record (AR), Resident #1 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated 1/30/20, Resident #1 had no cognitive impairment and required supervision and limited assistance from staff with Activities of Daily Living (ADLs). The Care Plan (CP), initiated on 1/31/20 and revised [DATE] showed that the Resident showed the potential to exhibit physical behaviors related to cognitive loss and Dementia. Intervention included but was not limited to: Resident was moved to a room closer to a nursing station initiated on 4/3/20. The Physician's Interim/Telephone Orders dated 3/28/20 at 11:00 pm showed that Resident #1 had an order for [REDACTED]. The ADON stated that neurological checks were documented in the progress notes. She was unable to give an answer as to why the neurological checks were not documented on the aforementioned dates. She was unable to provide an answer and documentation as to why the psychiatric consult was not done when it was ordered in March. The surveyor conducted an interview with Unit Manager (UM on the wing that Resident #1 and Resident #2 resided on) on 5/11/20 at 2:46 pm. The UM revealed that neurological checks were documented either on the Medication Administration Record [REDACTED].Neurological evaluation will be performed as indicated or ordered .PURPOSE To monitor patient for neurological compromise . [ST]AC 8:39-11.2(b)

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

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.