STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HACKENSACK MERIDIAN HEALTH PROSPECT HEIGHTS CARE C	**336 PROSPECT AVE HACKENSACK, NJ 07601**

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** Complaint # NJ 0 Based on interview, review of the medical record, and pertinent facility documentation on 8/26/20, it was determined that the facility failed to revise the comprehensive care plan based on the needs of the resident and in response to current interventions for 1 of 4 sampled residents, (Resident #2), deemed at high risk for falls who had three falls during a ten-day subacute admission, with two of the falls culminating with injuries. This deficient practice was evidenced by the following: The Face Sheet identified that Resident # 2 was admitted to the facility on [DATE], with primary [DIAGNOSES REDACTED]. According to the MDS, an assessment tool dated 2/9/20, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3 of 15, indicating that Resident #2 had severe cognitive impairment. A review of a facility document titled, Fall Risk Evaluation, an assessment tool dated 2/2/20, revealed that Resident #2 had a total score of 17. According to the Fall Risk, a resident with a Total score of 10 or above represents HIGH RISK. A review of the Daily Resident Status, an assessment tool dated 2/3/20, revealed that Resident #2 was confused and was totally dependent on staff for transfer/walking. A review of the Care Plan (CP) initiated 2/3/20, identified Resident #2 as having a history of falls at home, a fall risk with inclusion into the facility Falling Star Program. One of the interventions to prevent falls included Give verbal reminders/cues not to ambulate or transfer without assistance yet the Care Plan revision dated 2/4/20, identified Patient presents with impaired cognitive-communication deficits due to decreased ability to follow directions, verbalize wants/needs, and decreased safety awareness. There were no further additions or changes to the resident's CP after each fall. A review of the CP initiated 2/3/20 identified Resident #2's Generalized Weakness as a secondary risk for falls. The goal documented, decrease risk of injury related to falls. The Interventions included were low bed with floor mats and anti-tippers on wheelchair. There were no further additions or changes to the resident's CP after each fall. A review of the Incident/Accident Report dated 2/4/20 at 5:00 PM, documented that the resident attempted to get out of bed unassisted and was observed lying on the mat at the bedside, on the right side. The resident sustained [REDACTED].#2's Incident & Accident Investigation of the resident's fall dated 2/4/20 at 5:00 PM, revealed that the resident had a fall without injury and included, Immediate action taken to prevent further incidents: to do frequent rounding on patient and encouraged to use call bell. The Summary and Conclusion documented Resident with + confusion, short term compliance with redirection; episodes of combativeness/attempts to medicate as ordered disputed by resident. A review of Resident #2's Incident & Accident Investigation of the resident's fall dated 2/9/2020 at 1:58 PM, revealed that the resident had a witnessed fall when Resident #2 was seated in a wheelchair in the hallway and attempted to stand up and fell hitting the left side of the forehead. The resident was sent out to the hospital for a CT head scan. The documented Immediate action taken to prevent further incidents: Went to hospital, upon return, staff will frequently ambulate resident to prevent further fall incidents. The Summary and Conclusion documented, As per the witnessed staff, Resident stood up, attempting to ambulate, but the staff was too far to prevent the fall. The Comment added to the fall intervention included, Rehabilitation consult, continue TLC (tender loving care), reassurance, redirection, activities as tolerated, and continue to provide a calm environment. Administer as needed [MEDICATION NAME] as ordered when patient agitated, restless, and hard to direct. A review of Resident #2's Incident & Accident Investigation of the resident's fall dated 2/12/20 at 3:15 PM, revealed that the resident had a witnessed fall; Resident #2 was seated in a wheelchair in the dining room and attempted to stand up and fell hitting the right side of the forehead and sustained a left [MEDICAL CONDITION]. The resident was sent out to the hospital for a CT head scan. The documented Immediate action taken to prevent further incidents: Patient was transferred to the hospital emergency room for evaluation. The Summary and Conclusion noted alert confused patient with behaviors of agitation, physical aggression, restlessness and impulsiveness, and hard to redirect. Patient was being monitored by the staff and kept on trying to get up and lean forward when in wheelchair. Resident fell . It was witnessed that the resident hit his head. The Recommendations indicated, Rehabilitation ambulation due to the behavior of wanting to ambulate. A review of a Physician order [REDACTED]. When questioned, both parties stated that a lap belt, chair alarm, or pad alarm for the resident's wheelchair were not advisable because they felt that the noise or restraint would agitate the resident. When asked what interventions were put in place to prevent any further falls after the fall on 8/9/20, they responded that an as needed [MEDICATION NAME] was ordered for the resident if agitated, restless and hard to direct. A review of the physician's orders [REDACTED]. A review of a facility policy titled, Fall Management Program with an effective date of 12/2001 and revised 8/2012, revealed under Procedure section 11. Interventions implemented include but are not limited to the following: tab alarm, wheelchair/seat alarm, low beds, floor mats, bedside commode, wheelchair positioning assessment, etc. as determined by each individualized plan of care. A review of a facility policy titled Falling Star Program with an effective date of 1/1999 and revised on 9/2017, revealed under Procedure section 3. The staff will initiate, change, or modify interventions as needed. NJAC 8:39-11.2 (2)

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.