STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315037	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TEANECK NURSING CENTER	1104 TEANECK ROAD TEANECK, NJ 07666

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #NJ 639 Based on observation, interview, and record review, it was determined that the facility failed to assess a resident's status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care accurately. This deficient practice was identified for 1 of 5 residents reviewed, Resident #1. This deficient practice was evidenced by the following: On 8/6/20 at 9:10 AM, the surveyor observed Resident #1 inside their room, lying in bed with the call bell within reach. The resident informed the surveyor that he/she had a fall incident in the facility. The resident was unable to remember the exact details of the fall incident. A review of the resident's Face Sheet, an admission summary, revealed that Resident #1 had [DIAGNOSES REDACTED]. A review of the resident's MDS dated [DATE] and 4/4/20, showed that the resident's score for cognitive skills for daily decision making was two, indicating moderate cognitive impairment. Further review of both the 1/15/20 and 4/4/20 MDS, revealed that the resident had a fall incident with no injury documented. A review of the resident's fall Care Plan (CP), dated 1/15/20, revealed the resident had a fall incident in the resident's bathroom and sustained swelling to the left upper eyebrow. The CP Intervention revealed, Sent to ER for eval. Further review of the CP showed that the resident had another fall incident on 3/29/20 with interventions to complete body assessment, resident encouraged to call for assistance and therapy screen. A review of the 1/14/20 Incident/Accident (I/A) Report showed that Resident #1 had a fall incident and sustained slight swelling on the left eyebrow with an order to transfer to the hospital for further evaluation. Review of the 3/29/20 I/A Report revealed that the resident had a fall incident with no injury. A review of the Clinical Notes dated 3/29/20 at 11:00 PM after the fall incident revealed that the resident had complained of back pain and was medicated with Tylenol, which was determined to be effective. On 8/6/2020 at 11:35 AM, the surveyor interviewed the Licensed Practical Nurse/MDS Nurse (LPN/MDS Nurse), who informed the surveyor that she was responsible for completing the MDS assessment with oversight from the Director of Nursing (DON) who was a Registered Nurse. The LPN/MDS Nurse indicated that it was the DON who signed and acknowledged the MDS assessment was correct and completed. She further stated that the DON who signed the 1/15/20 and 4/4/20 MDS was not the current DON. At that same time, the LPN/MDS Nurse informed the surveyor that the 1/15/20 MDS should have captured the fall with injury, and the 4/4/20 MDS should have captured the back pain. She further stated, I followed the Resident Assessment Instrument (RAI) manual. On 8/6/20 at 12:11 PM, the LPN/MDS Nurse informed the surveyors that she rechecked the RAI Manual and acknowledged that she incorrectly coded the 1/15/20 and 4/4/20 MDS. On 8/6/20 at 1:03 PM, the survey team met with the Administrator, DON, and Regional Nurse to discuss the above concerns. A review of the CMS's RAI Version 3.0 Manual updated October 2019 provided by the LPN/MDS Nurse titled, J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment documented under Page J-32 Definitions of No injury-no evidence of any injury is noted on the physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall, and Injury except major-includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain. NJAC 8:39-11.2(e)1; 27.1(a)

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