STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315262	A. BUILDING _____ B. WING _____	**09/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARROGATE	**400 LOCUST STREET LAKEWOOD, NJ 08701**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, medical record review and review of other pertinent facility documentation, it was determined that the facility failed to consistently implement and modify Care Plan safety interventions to prevent falls on a resident who was identified as a high fall risk. This deficient practice was identified for Resident #23, 1 of 3 sampled residents reviewed for incident and accidents, and was evidenced by the following: On 09/24/2020 at 11:30 AM, during facility tour, Resident #23 was observed seated in a chair in the activities room. The surveyor was unable to interview due to the resident's cognitive loss. The surveyor reviewed Resident #23's medical record: According to the Admissions Record, the resident was admitted to the facility with Irritable Bowel Syndrome (IBS), Cognitive Communication Deficit, and Diabetes Mellitus (DM). The significant change Minimum Date Set (MDS), an assessment tool dated 07/30/2020, indicated that the resident had moderate cognitive impairment and required limited assistance with toileting, transfers and ambulation. The MDS also indicated that the resident had a history of [REDACTED]. On 09/28/20 11:32 AM, the surveyor reviewed the facility Incident and Accidents Reports (IAR) dated: 06/26/2020, 07/30/2020, 08/08/2020, 08/20/2020, 08/24/2020, 08/31/2020, and 09/05/2020 which revealed that Resident #23 had fallen on each one of these dates and that the CP was not updated to include new interventions to reduce the risk for falls after each fall was identified. The Care Plan (CP), dated 04/23/2020, reflected that the resident was at risk for falling related to (r/t) deconditioning, gait and balance problems. The CP listed dates of actual fall without injury on 06/26/2020, 07/07/2020, 07/30/2020 and an unwitnessed fall on 08/06/2020 that resulted in a bruised nose. There was no revision to the CP to include the date of the resident's fall, as identified in the IARs dated 08/20/2020, 08/24/2020, 08/31/2020, and 09/05/2020, nor was there documentation of an intervention after each of these fall incidents. The Plan of Treatment for Outpatient Rehabilitation form, dated 07/29/2020, reflected that Resident #23 had several falls in the past 12 months and demonstrated gross physical and mobility dysfunction resulting in gait impairment. The form also indicated that when the resident ambulated near and around objects the resident lacked the proper safety awareness and unsafe speed. The Physical Therapy (PT) Discharge Summary, dated 09/10/2020, reflected that Resident #23 reached maximum functional potential and displayed a decreased safety awareness, impulsive behavior and was an overall increased risk for falls. On 09/28/2020 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN UM) who stated that Resident #23 was cognitively impaired and had poor safety awareness. She stated the resident had a [DIAGNOSES REDACTED]. She stated that the resident had a frequent falls when he/she lived in assisted living and that when the resident attempted to walk in his/her room without assistance, he/she would lose balance and fall. She added that the resident was incontinent at times and that most of his/her falls were related to his/her bowel issues. The LPN UM explained the process for completing the IARs. She said that the nurse, who identified the fall, would complete the IAR. The report would then go to the DON for review and the DON would write up a summary. The DON would then bring the IAR to the morning meeting to review possible new interventions to prevent continued reoccurrences of the resident falling. The following disciplines attended the meeting: Activity Director, LPN UM, Assistant Director of Nursing (ADON), Director of Nursing (DON), Social Worker (SW), Director of Rehabilitation, MDS Coordinator, and Dietician. The LPN UM stated, We go over the incident to see what we could have done better and talk about possible interventions we could put into place to help and reduce the risk for falls. The nurse that fills out the incident report collects statements and would put an intervention to reduce the risk of fall on the CP. On 09/28/2020 at 12:14 PM, the surveyor interviewed the DON who stated that the process for IAR investigations included: the nurse who identified the incident or accident was supposed to fill out the incident report, obtain statements and update the care plan with new interventions that were put into place to prevent further reoccurrences. The IAR packet would then be submitted to the DON for review and compliance. I look at the whole packet for completion and then it is taken to morning meeting for review. The DON confirmed that not every IAR report investigation or CP was completed with new interventions to prevent a further reoccurrence of falls for Resident #23. I could usually argue the point, but I cannot argue that there were no documented interventions on every fall for Resident #23. On 09/29/2020 at 08:24 AM, the surveyor interviewed the DON who stated that she was aware that fall interventions were not documented on the resident's CP after each fall and stated she takes full responsibility for the lack of documentation for fall interventions on the Resident #23 care plan. On 09/29/2020 at 09:40 AM, the surveyor interviewed the primary care Certified Nursing Assistant (CNA) who stated that Resident #23 was cognitively impaired and was impulsive with poor safety awareness. She stated that Resident #23 was a fall risk secondary to unsteady gait and required extensive assistance with toileting and ADLs. She also added that he had occasional incontinence of bladder and bowels and wore protective briefs for vanity and hygiene. She stated that she tried to keep him on a schedule and tries to keep an eye on him because he attempts to get up without assistance and has an unsteady gait. On 09/29/2020 at 11:21 AM, the surveyor interviewed the Licensed practical Nurse (LPN #1) who stated that if a resident falls, We then update the CP and come up with a new intervention to prevent further accidents. LPN #1 revealed that he was caring for Resident #23 when he/she fell on [DATE] at 3:42 PM, and did not know why he did not put in a new intervention on the residents CP to reduce the risk for falls. On 09/29/2020 at 12:09 PM, the surveyor attempted to conduct a telephone interview with LPN #2 but there was no answer. A message was left. The facility policy titled, Fall Risk Assessment, dated March 2018, indicated that the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The facility policy titled, Falls-Clinical Protocol, dated March 2018, indicated that if an individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. The facility policy titled, Falls and Falls Risk, Managing, dated March 2018, indicated that based on previous evaluations and current date, the staff will identify interventions related to the resident's specific risk and causes to try and prevent the resident from falling and try to minimize complications from falling. NJAC 8:3.9-27.1(a)

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.