STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315253	A. BUILDING ______ B. WING ______	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER AT SOMERSET, INC	**15 DELLWOOD LANE SOMERSET, NJ 08873**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 11/26/19 CENSUS: 104 SAMPLE SIZE: 23 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to perform a rehabilitation screen and conduct an interdisciplinary meeting to reevaluate fall prevention interventions for a resident who sustained a fall, in accordance with the facility's policy. This deficient practice was identified for 1 of 1 resident reviewed for falls (Resident #28) and was evidenced by the following: On 11/21/19 at 11:49 AM, the surveyor observed Resident #28 seated in the dining room in a wheelchair with blue padding on either side of the	F 689	F 689 Submission of this plan does not constitute an admission or agreement by the provider of the truth of the information set forth in the statement of deficiencies, The Plan of Correction is prepared and submitted because of the requirements under State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance. F 689 Free of Accidents / Hazards It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate	12/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/13/2019

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.

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F 689	Continued From page 1 resident. The resident was pleasant and was receiving feeding assistance by staff. The surveyor noted the resident had a large area of Review of the Admission Record revealed that Resident #28 was re-admitted to the facility on after hospitalization with diagnoses which included The document also indicated that the resident also had diagnoses which included). Review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated , identified that Resident #28 had a Brief Interview for Mental Status (BIMS) score of The MDS also included that the resident required extensive assistance of two persons for physical assistance with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed). Review of a "Change of Condition SPN," dated 11/04/19 at 4:56 AM, written by Registered Nurse (RN) #1, detailed that Resident #28 had an unwitnessed fall and was found on the floor laying on his/her left side, by the bed. The resident was assessed and was found to have a raised area on the left forehead and complained of a headache. The physician was notified and the resident was transferred to the hospital at 5:00 AM.	F 689	supervision and assistant devices to prevent accidents. 1) Resident #28 was re-assessed for fall risk. The IDT team met and reviewed the fall events of 11/4 and 11/6. Recommendations for fall prevention included bilateral mats next to the bed on the floor, bed alarm, low bed, positioning wedge, and side rails were all updated in resident care plan and implemented to mitigate potential risk of fall. The team met with the resident and family and reviewed the fall prevention strategies. The resident was referred for rehab services for strengthening and positioning. 2) All residents identified as high risk for falls have the potential to be affected. All residents with high risk scores were re-assessed to determine current status. IDT team reviewed care plan recommendations and interventions to ensure sufficient supervision and assistant devices were in place. All new admissions determined to be high risk for falls will be evaluated by the IDT team and appropriate interventions put in place. All fall events will be reviewed by IDT team as soon as possible to determine root cause. Interventions will be put in place to assure fall risk is reduced. Post fall incident reports will be concluded within 7 days per policy. 3) Systemic measures / changes: Post fall protocols were updated to include actions to be taken at the time of a fall event; Reporting structure for managers,	

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F 689

Continued From page 2

Review of a Nurse Note (NN), dated 11/04/19 at 7:00 AM, revealed that RN #1 indicated that a "thorough report" regarding Resident #28's fall was given to the Supervisor/Unit Manager and the possibility of replacing the resident's bed side rails was discussed. Further review of the record revealed that the resident returned to the facility from the emergency room status post fall with no new orders on [redacted].

Review of a NN, dated [redacted] at 10:29 PM, written by RN #2, revealed that at approximately 8:10 PM, Resident #28 stated, "Mummy, please help me!" RN #2 entered the resident's room and observed the resident lying on the floor on his/her left side. The resident reportedly explained that he/she tried to pull the curtain and rolled out of bed and hit his/her head. The resident's mattress was noted to be lifted and displaced partially on the frame. On assessment, the resident had a [redacted] The physician was notified and the resident was sent to the emergency room for imaging at approximately 9:00 PM.

Review of a NN, dated [redacted], the resident was discharged from the hospital and received at the facility at 10:15 PM on [redacted]. The NN also revealed that an air mattress and floor mats were in place.

On 11/22/19 at 9:09 AM, the surveyor observed Resident #28 lying in bed on an air mattress with the head of the bed elevated. The resident was accompanied by Certified Nursing Assistant (CNA) #1 who provided the resident with feeding

F 689

referrals to rehab for assessment, the accident policy was reviewed with all staff to ensure compliance. Incident reports will be reviewed daily by nurse managers to ensure a thorough investigation is completed. Staff will be educated regarding completing post fall incident reports and statements timely and fall prevention strategies. RN Manager/designee will be educated regarding implementing appropriate immediate interventions for post fall events. All fall events will be reviewed by IDT to determine causal factors and resident specific related interventions. RN Manager/designee to ensure care plans are reviewed frequently for accuracy of fall prevention strategies in place for high risk residents.

4) Auditing and Monitoring.
The RN Manager will audit post fall reports daily until completion. The DON / Designee will audit a minimum of 5 high fall risk resident care plans and all post fall incident reports weekly X 4 weeks; Bimonthly X 8 weeks and monthly thereafter to ensure compliance. Any negative patterns will be addressed immediately, and any trends will be presented to QAPI monthly for further review and recommendations.

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F 689	Continued From page 3 assistance. CNA #1 stated that the resident was impulsive and forgetful and thought that he/she could still walk independently. CNA #1 further stated and demonstrated that approximately two weeks ago, the facility implemented a [redacted] that was placed on the bed against the resident's left side to prevent leaning. The facility also implemented side rails on both sides of bed, bed pad alarm and cushioned fall mats which were placed on the floor on both sides of the resident's bed. She further stated that prior to the resident's recent falls, the resident had smaller side rails. On 11/22/19 at 9:18 AM, the surveyor interviewed RN #3, who stated that she always knew Resident #28 to be impulsive since she started working at the facility [redacted]. RN #3 stated that the resident previously had half rails and a bed pad alarm in place for safety to prevent falls but noted that they were discontinued prior to the resident's recent falls due to state regulations. RN #3 further stated that once the half rails were removed the air mattress was applied to the bed. On 11/25/19 at 9:28 AM, the surveyor interviewed the Social Worker (SW) who stated that Social Work was involved with care planning for falls. She further stated that since she began working at the facility in May 2019, Resident #28 had a low bed, a fall mat on the right side of the bed, and both bed and chair alarms. The SW stated that the facility previously used half rails but "struggled" with them as they could be used as a restraint. She further stated that the facility was looking into alternatives that would give the resident something to hold onto. She did not believe that any interventions were discontinued. The SW concluded by stating that some families	F 689		

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F 689	Continued From page 4 wanted side rails, but she wasn't sure about Resident #28's family. On 11/25/19 at 9:39 AM, the surveyor interviewed the Unit Manager (UM) who stated that on 11/04/19, Resident #28 slid off the bed and onto the left side and that was how the resident, [redacted] [redacted]." She stated that the bed was in the low position and frequent room observations were in place. The UM further stated that a fall mat was not used on the left side of the resident's bed and that was why the resident had so much [redacted]. The UM explained that the resident's side rails and bed pad alarm were removed from the resident's bed not too long before the resident's first fall on 11/04/19 but was unsure of the exact date. The UM stated that a bed pad alarm may have alerted staff prior to the resident's second fall on 11/06/19, as the resident pulled the curtain and fell off the bed onto the left side. The UM added that both quarter rails and a bed pad alarm were added after Resident #28's second fall. The UM further stated that the facility policy mandated that at the time of a resident fall the assigned nurse and the supervisor discussed what was in place and how it happened, and the following day, the Interdisciplinary Team which consisted of the UM, Rehabilitation Department Head, Director of Nursing (DON) and Assistant Director of Nursing would meet to discuss the fall. The UM stated, after the first fall on 11/04/19, the DON may have met with Resident #28's family, but wasn't sure. The UM further stated that after the second fall the DON and the doctor met with the resident's family at the bedside. On 11/25/19 at 11:33 AM, in the presence of the	F 689		

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F 689	Continued From page 5	F 689		

survey team, the surveyor interviewed the DON who stated that on 11/11/19 both she and the physician met with the Resident #28's family to discuss interventions and goals of care. At that time, it was decided that resident would be removed from [redacted] and opted for [redacted] The DON stated that side rails and a bed pad alarm were recently discontinued prior to both of the resident's recent falls on 11/04/19 and 11/06/19. The DON did not offer that once the side rails and bed alarm were discontinued prior to the first fall, that additional interventions were implemented in place of the side rails and bed pad alarm.

The DON stated that on 11/06/19, Resident #28 rolled out of bed after he/she attempted to pull the curtain and that she realized after a Mock Survey was completed at the facility, a few weeks ago, that the facility was supposed to conduct an Interdisciplinary (IDT) Meeting immediately after a fall. The DON confirmed that an IDT meeting was not held after Resident #28's first fall on 11/04/19 but was completed after the second fall occurred on 11/06/19.

On 11/25/19 at 11:54 AM, the surveyor met with the Rehabilitation Director (RD), who identified herself as an Occupational Therapist. The RD stated Resident #28 had a [redacted] and leaned to both the [redacted] and had cushions in place in the wheelchair to prevent leaning. The RD stated the facility had Risk Management Software that alerted therapy of falls and a post fall meeting would then be held to discuss interventions. The RD stated that she learned of Resident #28's fall on 11/04/19. She stated she did not assess the resident, but on 11/05/19, she recommended a positioning wedge which was

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F 689	Continued From page 6	F 689		

provided to the resident on 11/12/19.

Review of the resident's Care Plan (CP) revealed the resident was at risk for falls with a goal to be free from falls and injuries. The CP interventions included, but was not limited to:
a. Keep bed in lowest position, low bed, initiated on 02/21/18.

b. Staff to check on resident frequently, initiated on 02/28/18, revised on 11/12/19, and resolved on 11/12/19.

c. Floor mat to both sides of the bed when the resident was in bed initiated on 11/06/19.

d. Side rails applied to both sides of bed, initiated on 11/06/19.

e. Bed alarm and chair alarm, initiated on 02/21/18, revised on 03/01/18, and resolved on 03/01/18. The bed alarm was dated at re-initiated on 11/12/19.

f. Positioning wedge while in bed, initiated on 11/18/19.

On 11/25/19 at 1:08 PM, the surveyor interviewed the Director of Social Work who stated she was not involved in a post fall meeting to discuss the falls that Resident #28 sustained and stated that was something that the facility planned to do "going forward."

On 11/26/19 at 9:23 AM, in the presence of the survey team, the surveyor interviewed the DON who stated on 11/04/19, Resident #28 slid out of bed onto the floor and was sent to the emergency room for an evaluation, and returned hours later.

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F 689	Continued From page 7	F 689		

The DON stated it was decided that pillows would be placed on the side of the resident to prevent falls from bed. This intervention was not documented within the medical record.

The DON stated that per facility policy a resident was supposed to be referred to therapy immediately following a fall. The DON could not speak to why therapy was not consulted after Resident #28's fall on 11/04/19. The DON stated that the facility realized that they needed to look at their interventions and care plans related to falls.

The surveyor reviewed the facility policy, "ACCIDENT/INCIDENT POLICY" (Revised July 1, 2018) which revealed the following procedures for fall accidents:

A comprehensive care plan for the resident at risk will be developed to include relevant environmental and resident risk factors, measurable goals, and person-centered interventions that may include needs for supervision and/or assistive devices as appropriate.

The interdisciplinary team will review resident (elder) and/or representative preferences by considering the impact of these choices on individual well-being, other residents, and on the Home's obligation to protect resident (elders) from harm to develop a care plan in which staff honors the choice while mitigating risks.

Interdisciplinary team members will conduct a systematic review of the event to eliminate or reduce the incidence of further falls. The interdisciplinary team will review and modify

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F 689	Continued From page 8	F 689		

resident(s) elder(s) care plan interventions as indicated based on the findings of the systematic review.

Post fall management may include interventions such as changes in the resident's (elder's) medications, environmental modifications, and/or additional staff training.
A rehabilitation screen will be conducted after a fall to screen for the need for therapy to improve gait and balance.

NJAC 8:39-27.1(a)

New Jersey Department of Health

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	061812	A. BUILDING: ______ B. WING ______	11/26/2019

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S1575	8:39-21.2 Mandatory Laundry Services If the facility has an on-premises laundry, it shall provide a receiving, holding, and sorting area with hand-washing facilities. The walls, floors, and ceilings of the area shall be clean and in good repair. The flow of ventilating air shall be from clean to soiled areas, and ventilation shall be adequate to prevent heat and odor build-up. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to provide hand-washing facilities within the on-site laundry area. This deficient practice was evidenced by the following: On 11/22/19 at 10:46 AM, the surveyor toured the laundry department with the Laundry Aide (LA #1). LA #1 was observed using the washing machines and upon interview stated she was washing resident clothing. LA #1 stated that she received the dirty clothing and that it was kept	S1575	S1575 Submission of this plan does not constitute an admission or agreement by the provider of the truth of the information set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because of the requirements under State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance. 1) There was no one affected due to not having a handwashing facility within the on-site laundry area.	11/29/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/13/19

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S1575	Continued From page 1 separate from the clean clothing. She continued to state that she would wash clothing that would be stained with urine or fecal matter and that the staff would remove any solids. She also stated that if a resident was on isolation precautions, the certified nurse aide (CNA) would inform her if the clothing was from a resident on isolation precautions and those clothes would be done separately. The surveyor observed a table toward the rear of the laundry department and a floor type basin with a garden hose and nozzle adjacent to the table. LA #1 identified the table as the clothing sorting table. The surveyor interviewed LA #1 regarding handwashing facilities located within the laundry department and she stated there was not a handwashing sink located within the laundry department. She stated she would leave the department to use the employee restroom, which was around the corner in another hallway, or she would use the handwashing sink located in the facility kitchen across the hall. On 11/25/19 at 1:42 PM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) and Director of Nursing (DON) regarding the expectations for hand-hygiene after laundry staff wash resident's soiled clothing. They stated when the laundry person washes resident's clothing that may have fecal matter or soiled with urine, the staff must wash hands. On 11/25/19 at 1:49 PM, the surveyor toured the laundry department with the ADON/IP and DON who stated they were unaware there was not a sink in the laundry department. At 1:50 PM, the Director of Support Services (DSS) joined the tour and the DON asked the DSS where the	S1575	2) All residents could have been affected by not having a handwashing facility within the on-site laundry area. 3) A sink was purchased, installed and fully operational on 11/29/2019 in the on-site laundry area. Laundry staff will be educated on proper handwashing protocol. 4) Corrective action will be monitored by daily cleaning by the laundry aid and inspecting the sink in the on-site laundry area for proper operation. Any time the sink is observed to be not functioning properly, it will be repaired immediately by the maintenance staff. Audits on proper handwashing will be conducted by DON/Designee weekly for one month, then monthly for three months on laundry staff and reported into QAPI on a monthly basis.	

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S1575	Continued From page 2	S1575		

laundry staff washed their hands. The DSS stated they would put a hairnet on and go into the kitchen or go to the staff bathroom to wash their hands.

On 10/25/19 at 2:25 PM, two surveyors toured the laundry department and interviewed LA #2, who stated that she would remove gloves, put on a hair net and enter into the kitchen where she would wash her hands. Both surveyors observed the closest kitchen hand-washing sink which was approximately six to eight feet inside the kitchen, and located within a close proximity to the food preparation area.

On 11/26/19, in the presence of the survey team and DON, the Administrator provided the surveyor with an Environmental Services Policy, effective 11/26/19. The policy revealed, "this policy is to ensure that team members follow the proper procedures for gloves, hand sanitizer and hand washing to minimize risk for infection and when handling soiled and clean clothes." Procedure number 4 indicated, "Hand hygiene should be performed per policy" and procedure number 5 reflected, "Laundry staff is encouraged to use the following sinks for hand washing: sink in multi-purpose room between meals; staff bathroom; kitchen sink near dirty dish area-hair nets required."

Review of the Hand Washing/Hand Hygiene Policy, revised November, 2017 revealed that hands should be washed with soap and water for the following situations, "a. When hands are visibly soiled; and b. after contact with a resident with infections [REDACTED] including, but not limited to infections caused by [REDACTED]