

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  Spring Grove Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  144 Gales Drive New Providence, NJ 07974	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43050</p> <p>C#NJ00168013</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure one resident (Resident (R) 8) out of three residents investigated for falls, remained free from accident hazards. This had the potential to cause serious harm to a resident with Alzheimer's disease.</p> <p>Findings include:</p> <p>Review of a policy provided by the facility titled Falls-Clinical Protocol, dated 03/2018, failed to address falls that were not caused by a medical condition. The policy stated, Falls often have medical causes; they are not just a nursing issue.</p> <p>Review of a document provided by the facility titled Profile Face Sheet, indicated R8 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, anxiety disorder, major depressive disorder (MDD).</p> <p>Review of a document provided by the facility titled Care Plan, dated 06/07/21 indicated that R8 was total dependent as to care due to impaired mobility secondary to contractures both upper and lower extremities. R8 has chronic incontinence to both urine and bowel and needs extensive assistance for his toileting needs, bed mobility, other activities of daily living, and transfers via Hoyer lift and two person assist. Care Plan, dated 04/01/24, indicated R8 had a witnessed fall in his room. Nursing assessment was performed with noted small abrasion on the anterior forehead. The intervention in place was to in-service staff on proper positioning and safety strategies when doing turning and repositioning total care residents.</p> <p>Review of R8's quarterly Minimum Data Set (MDS) provided by the facility with an Assessment Reference Date (ARD) of 04/14/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated the resident was severely cognitively impaired. The MDS also indicated the resident needed two staff persons for total assistance with care.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An incident report was provided by the facility stating that on 04/01/24 at 8:30 AM, Certified Nursing Assistant (CNA) 4 was rendering care to R8 when he/she accidentally fell on to the floor on a floor mat and sustained an abrasion on the anterior forehead. CNA 4 was using the bed control to lower the bed to the floor. R8's[spouse] was present in the room and called out to staff that My [spouse] is on the floor. Licensed Practical Nurse (LPN) 3 entered the room and found R8 face down on the floor mat and CNA 4 was at the bedside. The resident was assessed with no bruising or discoloration noted and was able to move all extremities. A small abrasion was noted on the forehead. The neuro check was initiated with Physician notification. Resident received one dose of hydralazine (blood pressure medication) for high blood pressure and Tylenol. No distress at present time.</p> <p>Interview on 05/09/24 at 9:41 AM with the Director of Nursing (DON) revealed that she wrote the incident report. The DON stated CNA 4 stated that she was putting a new brief on the resident. She was lowering the bed and had rolled [him/her] on [his/her] side. The resident rolled out of bed, face down on the floor mat. When the DON was asked why CNA 4 was providing care by herself when R8 is a two person assist, and the DON stated, CNA 4 liked to do things herself.</p> <p>Interview on 05/09/24 at 9:52 AM with the Regional Director of Operations (RDO) revealed I was in the facility at the time of the incident. The CNA stated that she was waiting for assistance when while lowering the bed, the resident became agitated with care. [He/She] fell out of bed. When the [spouse] entered the room and found [his/her] [spouse] on the floor, [he/she] started yelling for help.</p> <p>Review of CNA 4's personnel file provided by the facility revealed a hire date of 03/14/24 with orientation on 03/12/24 that included resident safety. On 04/01/24, CNA 4 was suspended and then discharged due to violation of company policy and code of conduct</p> <p>Phone interview with CNA 4 on 05/09/24 at 12:03 PM, revealed I was washing the resident and had finished [his/her] front side. I turned the resident to [his/her] side to wash [his/her] back and [he/she] started shaking and rolled out of bed onto the floor mat. [His/Her] [spouse] walked into the room and completely freaked out. I opened the door and hollered for help. When CNA 4 was asked what kind of assistance the resident needed, she stated [He/She] was a two person assist and used the Hoyer lift. When asked why she did not wait for help, she stated There is not enough help, and I just did it myself. I could not catch [him/her] when [he/she] fell because [he/she] was wet, and my hands were wet.</p> <p>Phone interview with LPN 3 on 05/09/24 at 2:34 PM revealed I heard the [spouse] of R8 screaming from [his/her] room that [his/her] [spouse] fell . I ran into the room and R8 was face down on the fall mat. The bed was in a low position. CNA 4 stated to me that R8 rolled off the bed. An assessment was completed and R8 had a scratch on [his/her] forehead.</p> <p>NJAC 8:39-27.1a</p>		