STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Rehabilitation & Health Care Center	129 Morris Turnpike Newton, NJ 07860

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 - Actual harm Residents Affected - Few	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** 48617 Complaint #s: NJ00182470, NJ00182480 Based on interview, record review, and review of pertinent facility documents on 03/26/2025 and 04/01/2025, it was determined that the facility failed to (a) provide a safe environment for a wandering, ambulatory, and cognitively impaired resident (Resident #1) and (b) follow facility policy on thorough investigation of accident/incident. On 10/15/2024 Resident #1 was found stuck to the floor in an opened room where the floor was being redone. Resident #1 was found by a Certified Nursing Assistant (CNA) when she/he fell backwards and hit her/his head hard and started vomiting which resulted in Resident #1 being sent out to an acute care hospital #1[name] ER [emergency room] and later was transferred to acute hospital #2 [name] where she/he was found to have three (3) brain bleeds. Resident #1 was not in the facility during the survey. The Surveyor reviewed the closed medical records of Resident #1. This deficient practice was identified in 1 of 6 residents reviewed for incidents/accidents and was evidenced as follows: According to Resident #1's recent Resident Face Sheet (RFS), the Resident was readmitted to the facility with diagnoses that included but was not limited to Nontraumatic subarachnoid hemorrhage, nontraumatic subdural hemorrhage, Vascular dementia, Alzheimer's Disease, Essential Hypertension, Malignant Neoplasm of central portion of left breast, Acute ischemia heart disease, Osteoarthritis of knee, and Hyperlipidemia. Review of the Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of each resident's functional capabilities, dated 08/24/2024, Resident #1's Brief Interview for Mental Status (BIMS) score was 99 indicating that the Resident was unable to complete the interview. Under C1000 of Section C, Resident #1's Cognitive Skills for Daily Decision Making was coded as 3-severely impaired. The Resident's MDS further revealed in Section GG-Functional Abilities and Goals that the Resident was dependent on staff for the completion of her/his Activities of Daily Living (ADL). Review of Resident #1's Care Plan Activity Report (CPAR) reflected a list of Focus [health problem] that included but not limited to and as follows: (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Focus: Elopement: Wanders the unit at times; Wanders in and out of other residents' room; At risk of elopement. -Focus: Behavior: I [Resident] have behaviors such as constant pacing up and down the halls, wandering in other resident's rooms, declines to care and rummaging through drawers due to Alzheimer's dx [diagnosis]. -Focus: Falls: I [Resident] am at risk for falls. Review of Resident #1's Progress Notes (PN) dated 10/15/2024 at 7:05 pm [evening] and documented by [name redacted] (Nurse #1), that the resident was found in room [number] stuck to the floor. The room was accessible to the resident the floor is being redone. The CNA [certified nursing assistant] found Resident #1 had fallen backwards and hit his/her head. Vital signs and neurological checks were done by the nurse. The resident began to vomit when the staff sat him/her up. The resident's physician was notified and ordered the resident be evaluated in the Emergency Department (ED). The resident's daughter was notified, and the Nursing Supervisor was made aware. The resident left facility at 5:35pm on a stretcher. The PN further revealed Nurse #1 documented on 10/15/2024 at 10:38 pm, Call placed to [NMC] acute hospital, the Resident was transferred to [another hospital name] .She [Resident #1] has 3 brain bleeds. Review of Resident #1's Hospital Records [hospital name] ED [emergency department] to Hospital -admitted d 10/15/2024, Reason for Visit: Fall. Head Injury. A Neurosurgical Consultation documented by Neurosurgeon attending Dr. [doctor] [name redacted] revealed Reason for Consult: 1. S/p [status post, after] fall; 2. CT [computed tomography, a procedure that combined x-ray and computer technology image to view the inside of body] of head demonstrated a 1.1 cm [centimeter] focus of parenchyma hemorrhage [bleeding]/contusion in the right frontal lobe [right area of brain] with subarachnoid extension and .subdural [areas in inner brain] hematomas [bruising]. Review of the document titled, Incident Summary (IS), provided by the facility with Resident #1's [name, room number] with Date of Incident: 10/15/2024. According to the IS, under Incident, on 10/15/2024 at 5:50 pm [afternoon], resident [Resident #1's name] wandered into room [number] which was being remodeled, CNA#1 saw the resident and went to get the resident from the room. Resident #1 was trying to get their foot stuck from the glue on the floor. Resident #1 was trying to raise her/his foot and lost balance. CNA #1 tried to catch the resident from falling but was not able to catch him/her to prevent the fall. Resident #1 had fallen and landed on his/her buttocks first then hit his/her head on the floor. CNA#1 called for help and Licensed Practical Nurse (LPN) [name] came and assessed Resident #1. Resident #1 was alert lying on the floor, skin was intact, no bruises or bumps noted to his/her head. Resident #1 was assisted by 3 staff in the wheelchair when the Resident started vomiting twice. MD [doctor] was notified and ordered to transfer Resident to [acute hospital name] ED for evaluation and treatment. Resident #1 was admitted to [acute hospital name #1] and was found to have a small intracranial [within the skull] hemorrhage [bleeding]. Resident #1 was then transferred to [acute hospital name #2] for further evaluation. POA [Power of Attorney] [name redacted] was aware of the incident. [Resident #1] returned to facility on 10/16/2024. The Surveyor requested for the full Incident/Accident (I/A) Report of Resident #1 on 10/15/2024 from the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/01/2025 at 10:21 AM, in an interview with the Surveyor, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were not able to provide the IA of the Resident. The LNHA and DON stated they were new management and administration and had started on January of this year 2025. LNHA and DON were not able to provide the I/A and statements collected. The LNHA and DON further stated they could not locate the document but found the IS of the above-mentioned incident. Review of the facility policy titled, Accidents/Incidents, effective 04/01/2025, under Policy: Center staff will report, review, and investigate all accidents/incidents which occurred, or allegedly occurred, on or off Center property involving, or allegedly involving, a patient who is receiving services .; under Process: 3. Reporting: 3. 1 All accidents/incidents, witnessed or unwitnessed, will be reported to the supervisor. 3.1.1 Employees witnessing an accident/incident involving a patient will communicate a factual description of his /her findings to the supervisor or the nurse responsible on the unit .4. Follow-up/Investigation: .4.3 When conducting an investigation, the Administrator, DON, or designee will: .4.3.4 Conduct witness interviews from all staff and visitors who may have knowledge of the accidents/incident .4.3.6 Monitor that all aspects of the accident/incident and investigation involving patients are documented. N.J.A.C. 8:39-27.1(a)