STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315439	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Bristol Glen	200 Bristol Glen Drive 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** Complaint # NJ 2565649Based on observation, interview, review of medical records, and other pertinent facility documents, it was determined that the facility failed to provide a safe environment and follow fall prevention interventions as written on the individual comprehensive care plan (ICCP) for 2 of 2 residents, (Resident #2 and Resident #5). Resident #2 was transferred with the use of a mechanical lift by one staff member, fell, sustained a head injury that required an emergency transfer to a hospital, and was admitted for 8 days with a laceration of the head that required 3 staples. This deficient practice was evidenced by the following: 1. Resident #2 was not in the facility during the survey. The surveyor reviewed the closed medical record for Resident #2. A review of Resident #2’s admission Record reflected the resident was admitted to the facility on [DATE] with diagnoses which included but were not limited to; a displaced fracture of the second cervical vertebra (break in the bone with fractured pieces moved out of their normal alignment), traumatic brain injury (damage to the brain) and hemiplegia (paralysis of one side of the body). A review of the most recent Minimum Data Set (MDS), an assessment tool dated 7/31/25, reflected that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated that the resident had severe cognitive impairment. A review of Section GG assessed that the resident required the assistance of two staff members for transfers. A review of Resident #2’s Care Plan Report reflected a care plan dated 6/20/25, with a focus area that indicated that the resident required assistance with bathing, hygiene, dressing, and grooming related to cognitive impairment, impaired mobility, and incontinence, with interventions that included but were not limited to; mechanical lift (a lift that uses a sling to safely transfer individuals with limited mobility from one location to another) for transfers with 2 persons; apply a neck collar for neck fracture that should be worn whenever out of bed or when transferring. A review of a nurses’ note dated 7/16/25 at 7:02 PM, reflected that a Certified Nursing Assistant (CNA #1) called out from the resident’s room, “I need help”. The nurse went to the room and observed the resident on the floor, next to the bed, with their head resting on the leg of the mechanical lift. CNA #1 stated that the resident “just slid out”. The back of the resident’s head was bleeding and direct pressure, and an ice pack was applied. Additional staff arrived to assist the resident back to bed and the Director of Nursing (DON) was notified. The nurses' note did not indicate that the resident had their neck brace in place. (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	Further review revealed that an ambulance service was called and arrived at 7:25 PM and a neck collar was placed on the resident by EMS and the resident was transferred to the hospital at 7:40 PM. A review of the New Jersey Universal Transfer Form dated 7/16/25, with no documented time of transfer, revealed the reason for the transfer to the hospital, was the resident sustained an occipital (back of the head) wound with bleeding from the head post fall. A review of the Registered Nurse (RN) assessment nurses note dated 7/16/25 at 10:07 PM (late entry), revealed that CNA #1 attempted to transfer the resident with a mechanical lift alone without assistance. A review of the Facility Incident/Accident Report dated 7/16/25, indicated a Certified Nursing Assistant (CNA #1) transferred Resident #2 with a mechanical lift alone without assistance. The resident sustained a laceration to their head, and CNA #1 had been terminated. A review of CNA #1's Total Mechanical Lift Competency dated 3/20/25, reflected that CNA #1 received training and performed the Mechanical Lift Operation appropriately, which included: Ensuring two caregivers are present during the transfer . A review of the nurse's note dated 7/24/25 at 10:48 PM, reflected that Resident #2 was readmitted to the facility at 5:15 PM post fall, with 3 staples to the left occipital area of the head with a neck collar in place. On 8/25/25 at 11:58 AM, during an interview with the surveyor, the DON stated that the nurse called her on 7/16/25, at approximately 8:00 PM, and informed her of the incident. The DON suspended CNA #1 while an investigation was completed. On 8/25/25 at 12:30 PM, the survey team discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA), the Administrator in Training, and the DON. The LNHA confirmed that all mechanical lift transfers require two staff members to be present. A review of the facility policy, “Safe Handling” with a revised date of 8/8/25, reflected…The facility is committed to a culture of safety. All residents will be handled safely using zero manual lifts for mechanical lifting, transferring, and repositioning…The purpose is to ensure residents receive assistance appropriate for their functional level, physical characteristics, level of cooperation, medical condition, and cognitive status while promoting safety and comfort…to increase the quality of care for the resident…examples include but are not limited to bed to chair transfers…A direct care teammate shall consider their own ability, the environment and the resident status prior to any lift/transfer…Follow care plan lift/transfer recommendation. 2. On 8/20/25 at 12:06 PM, the surveyor observed Resident #5 who was dressed and groomed and was seated in a wheelchair in the dining room, waiting for lunch to be served. The resident was seated in the dining room with other residents and was seated next to a table. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #5’s admission Record reflected the resident was admitted to the facility on [DATE], with diagnoses which included but were not limited to; spinal stenosis (the spaces inside the bones of the spine get too small), cervicalgia (pain in the neck and shoulder that varies in intensity), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). A review of the most recent Minimum Data Set (MDS), an assessment tool dated 7/02/25, reflected that Resident #5 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. A review of Section GG assessed that the resident required maximum assistance for transfers. A review of Resident #5’s Care Plan Report reflected a care plan with a focus area that indicated that the resident required assistance with bathing, hygiene, dressing, and grooming related to impaired mobility, which was initiated on 6/24/25. Interventions included “transfer with moderate assist of 2 and use of a rolling walker and/or grab bar. Gait belt should be used for safety.” A review of the nurse’s note dated 8/25/25 at 4:29 AM, titled as “Incident Note, reflected… a Certified Nursing Assistant (CNA #2) reported that while attempting to transfer a resident out of bed that the resident sat/fell on their buttocks. The nurse wrote that when she saw the resident, they were sitting on the floor with legs out in front. The note continued that the resident denied injury and was successfully lifted by three staff members including a CNA #3 from another unit. Interventions were put in place to assure that the resident had the proper shoes and socks, and that the CNA #2 was in-serviced that the resident required two staff members for transfers, and that the CNA #2 needed to ask for assistance before transferring resident out of bed. A review of the “Daily Assignment Sheet” dated 08/26/25, revealed that Resident #5 was a transfer x 2 with Roller walker and gait belt. On 08/26/25 at 10:00 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who was aware of the incident and stated that the resident was a 2 person assist for transfers from bed or chair and that CNA #2 should have asked for help before trying to transferring the resident by herself. The LNHA acknowledged that CNA #2 was previously educated on transferring residents and that she was re-educated after the incident. On 8/26/25 at 12:40 PM, the surveyor interviewed CNA #2 who stated that she was aware that the resident was a 2-person transfer and that she should have requested help from another staff member. CNA #2 further stated that she was previously in-serviced on properly transferring residents and that she was re-educated after the incident. On 8/26/25 at 12:55 PM, the surveyor discussed the above concern with the LNHA and the Director of Nursing. No further information was provided. NJAC 8:39-27.1 (a)