STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crest/Mountainview Gardens	4 Cedar Crest Village Drive Pompton Plains, NJ 07444

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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617 Based on interviews and review of electronic medical record, as well as review of pertinent facility documents on [DATE] and [DATE], the facility failed to ensure Certified Nursing Assistant (CNA#1) used a sit to stand lift and a two-person assist transfer in 1 (Resident #1) of 4 residents as determined necessary by the Resident's Holistic Care Plan (HCP). The failure to follow this intervention during the evening care transfer of Resident #1 by CNA #1 resulted in the Resident falling to the floor and became unresponsive subsequently requiring her/his immediate transfer to acute care hospital emergency room (ER) for further evaluation. In the ER, the Resident was found to have large bilateral subdural hematoma (a condition that indicates bleeding in the brain) and expired on [DATE]. The deficient practice was evidenced by the following: According to Resident #1's Face Sheet (FS), Resident was admitted with diagnoses which included but were not limited to Hydrocephalus, Alzheimer's Disease, Epilepsy, Osteoporosis, Major Depressive Disorder, Dementia with Behavioral Disturbances, Hypertension, and Dysphagia. The Minimum Data Set (MDS), an assessment tool that reflects Resident's care needs, revealed that Resident #1 was cognitively impaired and required assistance in her/his Activities of Daily Living (ADLs). A review of Resident #1 HCP with Date of Assessment of [DATE], indicated under 3b. Transferring - Functional Status: Level of Assistance, Resident required Extensive Assist with Two persons physical assist as support and with a Sit to Stand lift device. Resident #1's HCP further indicated under 3c. Walking - Functional Status: Resident do not ambulate and need the following device (wheelchair, manual). A review of Resident #1's Clinical Notes (CN) dated [DATE] at 11:40 PM (EST) [eastern] [evening] documented and E-Signed by Registered Nurse (RN#1), I was pushing the med cart to back hall, saw [CNA#1 name] asking for help. When I went to the room, I saw [Resident #1 name] lying on the floor, CNA [CNA #1] holding her head on a bed pad. Per CNA [CNA #1], while transferring the resident, the resident's body was sliding and she lowered her to the floor. Resident noted to be verbally unresponsive [vital signs], foaming mouth noted Undersigned called 911, notified NP [nurse practitioner name] with order to transfer to [acute care hospital name], notified daughter Transferred resident via stretcher to [acute care hospital name] at 8:10pm. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's Resident Incident Report Form (RIRF) on Resident #1 on [DATE], the RIRF revealed there was no description or entry notes of the sit to stand lift equipment malfunctioned. The RIRF further revealed under Conclusion of the Investigation and completed by RN #2 (Clinical Manager/Wellness/Nurse Manager), RN #2 documented that Per initial CNA [CNA #1] statement, while she was transferring the resident using the stand-pivot technique, the resident began to shake and lost her balance. She then attempted to lower the resident to the floor. Upon further interview the CNA [CNA #1] stated that she was unable to lower the resident and both fell to the floor. The resident landed on her back. CNA is unsure if the resident struck her head during the fall. Resident was then noted to be verbally unresponsive .foaming mouth noted. 911 was called .and resident was transferred to [acute care hospital] . A review of the facility's Investigative Summary/Conclusion (ISC) documented and completed by Director of Nursing (DON), under Incident, On the evening of February 16, 2024, at approximately 7:45 pm, CNA [CNA #1 name], was transferring [Resident#1 name] in her private apartment. At the time of transfer, [CNA#1 name] stated that the resident began to shake and she attempted to lower [Resident #1 name] to the ground. [CNA#1 name] immediately called for help and RN [RN #1] promptly responded . The ISC further revealed that on [DATE], the DON upon re-interview with CNA#1, CNA#1 reported that she had been transferring the Resident using the stand-pivot technique without additional staff assist. DON stated Resident #1 care plan indicated the need for a sit to stand lift. The ISC further revealed when the DON and the Nursing Home Administrator (NHA) took formal interview from CNA#1, CNA#1 explained that she attempted to transfer the Resident independently by holding her under the arm and back. CNA#1 stated Resident #1 began to shake and she then attempted to lower Resident #1 to the ground. When CNA#1 was asked for further clarification regarding her statement of lowering her to the ground, CNA#1 stated, I tried to lower her, but her body was too heavy, we both fell . CNA#1 was then asked if she had questions of a resident's care needs, such as transfers, where would she find this information. CNA#1 stated, I would ask my nurse or look at my assignment sheet. CNA#1 then stated that she did not read or look at her assignment sheet. The ISC, under Conclusion, It is concluded that at the time of the event, CNA#1 [name] was not following the outlined plan of care. During the tour of the [name] 3 Unit on [DATE] at 10:50 am [morning], in the presence of RN #2 Nurse Manager, surveyor asked RN#2 what were those binders on bedside desk in each room of resident in which RN#2 stated the binders contained the HCP of each resident in their room. She further stated the binder, aside from the HCP, it also entailed the ADLS of the resident in the room. RN#2 stated the nursing staff, nurses, and the CNAs, would get their reports from the nurses at start of shift and they would be updated on the HCP and ADLs of residents in the binders. The binders were being used as well during a care plan meeting or family meeting of staff with residents and their families in the room. She stated the binders were updated by her every three months or as needed if there were changes. RN#2 further stated the nursing staff would have their competency on mechanical lifts such as Hoyer or body lift, sit to stand lift, gait belt use upon orientation, as needed (once a week or monthly), and annually. During the interview with the DON and NHA on [DATE] at 3:29 pm [afternoon], they affirmed that the incident occurred because of CNA#1 not following the HCP of the Resident. They stated that CNA#1 was suspended and eventually terminated, and that the facility reeducated all licensed staff on care plan process and mechanical lift competencies. N.J.A.C. 8:,d+[DATE].1 (a)