

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02A016	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/18/2022
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NAME OF PROVIDER OR SUPPLIER BRISTAL AT WOODCLIFF LAKE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 364 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ156409 CENSUS: 122 SAMPLE SIZE: 1 SURVEY DATE: 08/18/2022</p> <p>The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint survey.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p> <p>This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ156409</p> <p>Based on interview, record review, and review of</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 310	<p>Continued From page 1</p> <p>facility policy and training documentation, it was determined the facility failed to ensure the development and implementation of facility policies and procedures to ensure the safe usage and maintenance of personal medical equipment for one of one residents, Resident #1.</p> <p>Findings included:</p> <p>A review of Resident #1's "Move in Record," dated [REDACTED], revealed the resident had diagnoses which included EX Order 26 § 4b1 [REDACTED]</p> <p>Resident #1 was readmitted to the facility from a Rehabilitation facility on [REDACTED] with a privately owned [REDACTED] for transfers from one surface to another.</p> <p>A review of Resident #1's "Care Plan," last reviewed on 03/03/2022, revealed the facility developed a care plan related to transferring of Resident #1. The goal was for the resident to transfer safely with the assistance of two staff. The facility developed an intervention for two staff to assist the resident with a [REDACTED] [REDACTED]) at all times.</p> <p>On 05/12/2022 at 1:00 PM, the surveyor reviewed the "Reportable Event Record/Report" which identified that Resident #1 [REDACTED] from a [REDACTED] [REDACTED] during a transfer with two caregivers. Resident #1 was transferred to the Emergency Department (ED), where the resident later expired. According to the report, caregivers had been properly trained prior to use of the [REDACTED] [REDACTED]</p> <p>A review of Resident #1's "Progress Notes" dated 05/12/2022 at 1:07 PM revealed the resident was</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>██████ beside the bed. The note revealed two staff were present, a Private Duty Aide (PDA) and a "second aide" indicated the resident ██████ from the ██████. According to the note, the resident was ██████. The resident's ██████, and the resident was going to be transferred to a hospital.</p> <p>During an interview on 08/18/2022 at 9:47 AM, with Certified Nurse Aide (CNA) #1, the CNA who assisted with transferring Resident #1 on 05/12/2022, revealed the resident's PDA called her into Resident #1's room to assist with transferring the resident from a wheelchair to bed. CNA #1 stated she recalled the resident had a blue colored ██████ but had no recollection of the ██████ size nor the make and model of the ██████. CNA #1 stated the ██████ was positioned between the resident and the wheelchair. CNA #1 stated staff positioned the ██████ under the resident's upper back just below the armpit area and down to the back of the resident's knees. CNA #1 stated while she stood on one end of the ██████ to place the hooks of the ██████ on the ██████. Resident #1's PDA stood at the other end to do the same. Per CNA #1, upon successfully hooking the ██████ to the ██████, Resident #1's PDA went behind the ██████ and started pumping the ██████ such that the resident was lifted off their ██████. Per CNA #1, once Resident #1 was lifted from the ██████, she removed the ██████ from underneath the resident. CNA #1 reported that just as she moved the ██████ aside and before she returned to the resident, she heard a loud scream from Resident #1's PDA. She observed Resident #1 ██████. CNA #1 stated after Resident #1 ██████ from the ██████ the</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>█ was upright, and the █ was intact. CNA #1 affirmed she had been trained on how to conduct █ transfers and conducted a return demonstration before she was checked off as competent. Per CNA #1, she had repeatedly assisted Resident #1's PDA with transferring the resident over the course of the resident's stay at the facility.</p> <p>During an interview on 08/18/2022 at 10:39 AM, Resident #1's PDA stated she was not directly employed by the facility. The PDA stated she worked for a home health agency and had been trained on █. According to Resident #1's PDA, her training included a return demonstration of █ transfer process. The PDA reiterated the circumstances surrounding Resident #1's transfer and █ as described by CNA #1. The PDA stated she recalled the resident had a █. Per the PDA, she had no recollection of the make and/or model of the █ or the size of the █. The PDA described the position of the █ as upright and the █ as intact after Resident #1 █ from the █.</p> <p>A review Resident #1's Emergency Department (ED) physician note, dated 05/12/2022, revealed the resident presented at the ED following a █ from a █ sustained at the nursing home. The note revealed the resident was █ upon arrival at the ED.</p> <p>A review of the Computerized Tomography (CT) scan results of Resident #1's head revealed the hospital medical director interpreted the result on 05/12/2022 at 2:19 PM. Per the report, Resident</p>	A 310		

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A 310	<p>Continued From page 4</p> <p>#1 was noted with [REDACTED]</p> <p>[REDACTED]</p> <p>According to the ED Expiration Checklist dated [REDACTED] revealed Resident #1 expired at [REDACTED] on [REDACTED]. The cause of Resident #1's death was determined to be [REDACTED].</p> <p>On 08/18/2022 at 12:55 PM, the Director of Nursing (DON) reported to the surveyor during interview that Resident #1 ordered his/her own [REDACTED] and [REDACTED] and returned to the facility with it after the resident was temporarily discharged to a rehabilitation facility. Resident #1 was at the Rehab facility from [REDACTED] to [REDACTED]. The DON stated the facility assumed the rehabilitation facility assessed the resident for [REDACTED] usage before readmission to the facility. According to the DON, because the facility was an assisted living facility, the resident understood that the [REDACTED] portion of the resident's care was to be primarily conducted by the resident's PDA, while the facility staff served to only provide secondary support. Specifically, the DON stated when it was time to</p>	A 310		
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A 310	<p>Continued From page 5</p> <p>transfer the resident between surfaces, Resident #1's PDA directed the transfer, and once the resident was successfully transferred, the facility staff took over the resident's care. However, the DON stated direct care staff of the facility, including CNA #1, were trained how to conduct a proper [REDACTED] transfer prior to the resident's return to the facility. The DON stated she had no recollection of the make/model of Resident #1's [REDACTED], or the size of the [REDACTED] used for Resident #1. The DON verified the facility did not conduct a [REDACTED] assessment to include ensuring the resident had the right [REDACTED] size and did not have measures in place to check the safety and operability of Resident #1's [REDACTED]. The DON, however, acknowledged that the resident's care was the facility's responsibility, and the facility was responsible to ensure the general well-being of the resident as well as providing oversight of the resident's care.</p> <p>During an interview on 08/18/2022 at 1:48 PM, the DON from the home health agency (HHA) revealed the agency provided a PDA to assist Resident #1. The HHA DON stated once the facility was contacted to provide service in any capacity to a resident, a registered nurse was sent to assess the resident. Per the HHA DON, the home health agency's assessment of the resident did not include [REDACTED] usage nor determining the [REDACTED] size the resident required for a [REDACTED]. The HHA DON stated the HHA operated on the understanding that the facility had already completed that portion of the resident's assessment. The DON clarified that all nurse aides sent to facilities to serve in the capacity of a PDA had been trained how to conduct a [REDACTED] transfer. Specifically, the HHA DON stated Resident #1's PDA, who</p>	A 310		
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A 310	<p>Continued From page 6</p> <p>was assigned to the resident the morning of the fall, had been trained on [REDACTED] transfers. She stated after the incident, the agency had the PDA do a return demonstration of the transfer process carried out with Resident #1 on the morning of the resident's fall and did not find that the PDA did anything that was unsafe. The DON clarified that their company had no contractual agreement with the facility shifting the liability of the resident's [REDACTED] transfer to their agency.</p> <p>During an interview on 08/18/2022 at 2:39 PM, the Administrator also stated Resident #1 ordered his/her own [REDACTED] and [REDACTED]. Per the Administrator, the resident returned to the facility with [REDACTED] equipment after the facility discharged the resident to a rehabilitation facility. The Administrator stated the facility was of the understanding the rehabilitation facility assessed and cleared the resident on any safety concerns as well as the appropriateness of the [REDACTED] size before the resident was transferred back to the facility. The Administrator reiterated that direct care staff of the facility, including CNA #1, had been trained on [REDACTED] transfers prior to the resident's return to the facility. However, the Administrator stated that the facility had no information on the make and model of the [REDACTED] or the [REDACTED] the resident used during the resident's stay at the facility. The Administrator reiterated that Resident #1 understood that the [REDACTED] transfer portion of the resident's care was to be primarily handled by the resident's PDA, while the facility staff served to only provide secondary support. The Administrator, however, acknowledged that the resident was the facility's responsibility, and the facility was responsible to ensure the resident's general well-being as well as providing</p>	A 310		

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A 310	<p>Continued From page 7</p> <p>oversight for continuity of the resident's care at the facility. Further interview with the Administrator revealed the facility did not have a policy related to ██████ usage nor assessment of a resident prior to utilizing a ██████. The Administrator also stated the facility had no policy regarding safe usage and/or operability of equipment that a resident brought into the facility.</p> <p>A review of the facility's "Training/In-Service Documentation" for safe ██████ transfers dated 03/04/2022 revealed "This guide provides general safety recommendations and is not a replacement for the manufacturer's instructions. Refer to the manufacturer's instructions for specific use guidelines." Further review of the training revealed "Know Your Lift! Patient [resident] falls from lifts may cause injuries, including head trauma, fractures, and death." Further, the training indicated, "Choose size of ██████ based on manufacturer recommendation for patient's [resident] measurements. Choosing correct ██████ size is critical for safe patient transfer." In addition, "Using the wrong ██████ or attaching the ██████ incorrectly may cause serious injury to the caregiver or patient. Position center of ██████ under patient's [resident's] spine. Ensure patient's head and/or back is supported, if needed."</p> <p>A review of a facility policy titled, "Private Duty Aides," dated 03/01/2019, revealed, "Care provided by outside agency staff hired by the resident or resident's family/responsible party must: (a) be coordinated by the Resident Services Director (RSD) and Resident Relations Director (RRD) and home care representative; (b) be monitored by the RSD/RRD."</p>	A 310		

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A 310	Continued From page 8 The facility failed to establish policies/procedures to ensure staff utilized the [REDACTED] safely and the equipment was maintained in good working order in accordance with manufacturer's instructions. Resident #1 expired on [REDACTED] after sustaining a EX Order 26 § 4b1 [REDACTED] following a [REDACTED] from the [REDACTED] during a transfer at the facility.	A 310		
A 709	8:36-7.2(d)(1-18) Resident Assessments and Care Plans (d) Each health care assessment by the registered professional nurse shall include, at a minimum, evaluation of the following: 1. Need for assistance with "activities of daily living"; 2. Cognitive patterns; 3. Communication/hearing patterns; 4. Vision patterns; 5. Physical functioning and structural problems; 6. Continence; 7. Psychosocial well-being; 8. Mood and behavior problems; 9. Activity pursuit patterns; 10. Disease diagnoses; 11. Health conditions and preventive health	A 709		

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A 709	<p>Continued From page 9</p> <p>measures, including, but not limited to, pain, falls, and lifestyle;</p> <p>12. Oral/nutritional status;</p> <p>13. Oral/dental status;</p> <p>14. Skin conditions;</p> <p>15. Medication use;</p> <p>16. Special treatment and procedures;</p> <p>17. Restraint use;</p> <p>18. Outside service utilization.</p> <p>This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ156409</p> <p>Based on interview, record review and review of facility documents, it was determined the facility failed to conduct an assessment for the use of a [REDACTED] to identify appropriate measures to ensure the safety and operability of the [REDACTED] for 1 (Resident #1) of 1 resident reviewed for the use of a [REDACTED]</p> <p>Findings included:</p> <p>A review of Resident #1's "Move in Record," revealed the facility admitted the resident on 11/13/2013 with diagnoses which included EX Order 26 § 4b1 [REDACTED].</p> <p>Review of a typed timeline provided by the</p>	A 709		

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A 709	<p>Continued From page 10</p> <p>assisted living facility revealed Resident #1 was transferred to a hospital for surgery on 03/18/2019 and then transferred from the hospital to a rehabilitation (rehab) facility on 03/23/2019, and was readmitted to the assisted living facility on 05/02/2019.</p> <p>Review of a "Patient Discharge Summary/Instructions," dated 05/02/2019 from the rehab facility, revealed Resident #1 was discharged to the assisted living facility on 05/02/2019. The services and equipment that were ordered for the resident post-discharge included visiting nurse services and a [REDACTED]. The name and phone number of the medical equipment company was included on the summary.</p> <p>Review of a "Resident Care Evaluation/Level of Care" form, dated 02/02/2022, and a "Care Plan," dated as reviewed 03/03/2022, revealed the facility developed a care plan related to transferring Resident #1. The goal was for the resident to transfer safely with the assistance of two staff. A planned intervention was for two staff to assist the resident with transfers using a [REDACTED]. The care plan did not specify the size of the [REDACTED] the resident required. There was however no resident assessment for the use or maintenance of the [REDACTED].</p> <p>Review of a "Nursing Visit/Contact Form," dated 04/28/2022 at 3:04 PM from the home health agency (HHA), revealed Resident #1 had an issue with the [REDACTED] during two transfers conducted by the home health aide in which the [REDACTED] lowered fast instead of slowly. Per the notes on the form, Resident #1 had called the equipment company. Per the form, the home</p>	A 709		

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A 709	<p>Continued From page 11</p> <p>health Registered Nurse (RN) questioned Resident #1 about whether the equipment company intended to send out a representative to check the [REDACTED] or replace it, and Resident #1 stated, "No." The RN called a representative of the equipment company and was assured the company's representative would come to the facility on 04/29/2022 to check Resident #1's [REDACTED]. There was no further documentation regarding whether the equipment company representative went to the facility on 04/29/2022 to check or replace Resident #1's [REDACTED].</p> <p>Review of a "Reportable Event Record/Report" revealed on 05/12/2022 at 1:00 PM, Resident #1 [REDACTED] from a [REDACTED] [REDACTED] during a transfer with two caregivers. Resident #1 was transferred to the Emergency Department (ED), where the resident later expired. According to the report, caregivers were properly trained prior to use of the [REDACTED].</p> <p>Review of Resident #1's "Progress Notes," dated 05/12/2022 at 1:07 PM, revealed the resident was on the floor beside the bed. The note indicated two staff were present including the resident's Private Duty Aide (PDA) and a "second aide" who indicated the resident [REDACTED] from the [REDACTED]. According to the note, the resident was [REDACTED]. The resident's [REDACTED], and the note indicated the resident was going to be transferred to a hospital.</p> <p>During an interview on 08/18/2022 at 9:47 AM, Certified Nurse Aide (CNA) #1, identified as the CNA who assisted with transferring Resident #1 on 05/12/2022, revealed the resident's PDA called her into Resident #1's room to assist with transferring the resident from a wheelchair to bed. CNA #1 stated she recalled the resident had</p>	A 709		

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A 709	<p>Continued From page 12</p> <p>a [REDACTED] EX Order 26 § 4b1 but had no recollection of the [REDACTED] EX Order 26 § 4b1 size nor the make and model of the [REDACTED] CNA #1 stated the [REDACTED] EX Order 26 § 4b1 was positioned between the resident and the [REDACTED] EX Order 26 § 4b1 CNA #1 stated the [REDACTED] EX Order 26 § 4b1 was positioned to extend from under the resident's upper back, just below the armpit area, down to the backs of the resident's knees. CNA #1 stated while she stood on one end of the [REDACTED] EX Order 26 § 4b1 to place the hooks of the [REDACTED] EX Order 26 § 4b1 on the [REDACTED] EX Order 26 § 4b1, Resident #1's PDA stood at the other end to do the same. Per CNA #1, after connecting the [REDACTED] EX Order 26 § 4b1 to the [REDACTED] EX Order 26 § 4b1, Resident #1's PDA went behind the [REDACTED] EX Order 26 § 4b1 and started pumping the [REDACTED] EX Order 26 § 4b1 the resident off the [REDACTED] EX Order 26 § 4b1. Once Resident #1 was lifted from the [REDACTED] EX Order 26 § 4b1, CNA #1 removed the [REDACTED] EX Order 26 § 4b1 from underneath the resident. CNA #1 stated just as she moved the [REDACTED] EX Order 26 § 4b1 aside and before she returned to the resident, she heard a loud scream from Resident #1's PDA. She observed Resident #1 fall backward, hitting his/her head on the floor. CNA #1 stated after Resident #1 [REDACTED] EX Order 26 § 4b1 the [REDACTED] EX Order 26 § 4b1 remained upright, and the [REDACTED] EX Order 26 § 4b1 was intact. CNA #1 stated she had been trained on how to conduct [REDACTED] EX Order 26 § 4b1 transfers and conducted a return demonstration before she was checked off as competent with the procedure. Per CNA #1, she had repeatedly assisted Resident #1's PDA with transferring the resident over the course of the resident's stay at the facility. CNA #1 stated there was no other resident in the facility who relied on a [REDACTED] EX Order 26 § 4b1 to transfer.</p> <p>During an interview on 08/18/2022 at 10:39 AM, Resident #1's PDA stated she was not directly employed with the facility. The PDA stated she worked for a home health agency and had been trained on [REDACTED] EX Order 26 § 4b1. According to</p>	A 709		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02A016	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/18/2022
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NAME OF PROVIDER OR SUPPLIER BRISTAL AT WOODCLIFF LAKE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 364 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677
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A 709	<p>Continued From page 13</p> <p>Resident #1's PDA, her training included a return demonstration of the [REDACTED] transfer procedure. The PDA described the circumstances surrounding Resident #1's transfer and fall, as described by CNA #1. The PDA stated she recalled the resident had a blue colored [REDACTED]. Per the PDA, she had no recollection of the make and/or model of the [REDACTED] or the size of the [REDACTED]. The PDA described the position of the [REDACTED] as upright and the [REDACTED] as intact after Resident #1 [REDACTED].</p> <p>Review of an Emergency Department (ED) physician's note, dated 05/12/2022, revealed Resident #1 presented at the ED following a fall from a [REDACTED]. The note revealed the resident was EX Order 26 § 4b1 [REDACTED].</p> <p>Review of the Computed Tomography (CT) scan results of Resident #1's head revealed the hospital medical director interpreted the result on 05/12/2022 at 2:19 PM. Per the report, Resident #1 was noted with traumatic intracranial EX Order 26 § 4b1 [REDACTED].</p> <p>Review of an "ED Expiration Checklist," dated</p>	A 709		

New Jersey Department of Health

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A 709	<p>Continued From page 14</p> <p>05/12/2022, revealed Resident #1 expired at EX Order EX Order 26 § 4b1. The cause of Resident #1's EX Order 26 § 4b1 was determined to be EX Order 26 § 4b1.</p> <p>During an interview on 08/18/2022 at 12:55 PM, the Director of Nursing (DON) stated Resident #1 ordered his/her own EX Order 26 § 4b1 and EX Order 26 § 4b1 and returned to the facility with it after the resident returned from a rehabilitation facility. The DON stated the facility assumed the rehabilitation facility assessed the resident for EX Order 26 § 4b1 usage before readmission to the facility. The DON verified the facility did not conduct a EX Order 26 § 4b1 assessment to include ensuring the resident had the right EX Order 26 § 4b1 size and did not have measures in place to check the safety and operability of Resident #1's EX Order 26 § 4b1 prior to use. The DON stated that because the facility was an assisted living facility, the resident understood the EX Order 26 § 4b1 transfer portion of the resident's care was to be primarily handled by the resident's PDA while the facility staff served to only provide secondary support. Specifically, the DON stated that when it was time to transfer the resident between surfaces, Resident #1's PDA directed the transfer, and once the resident was successfully transferred, the facility staff took over the resident's care. The DON was unable to provide any documentation of an agreement or understanding with the resident or the home health agency related to the responsibility or liability related to use of the EX Order 26 § 4b1.</p> <p>During an interview on 08/18/2022 at 1:48 PM, the DON from the home health agency (HHA) revealed the agency provided a PDA to assist Resident #1. The HHA DON stated once the facility was contacted to provide service in any capacity to a resident, a registered nurse was</p>	A 709		
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New Jersey Department of Health

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A 709	<p>Continued From page 15</p> <p>sent to assess the resident. Per the HHA DON, the home health agency's assessment of the resident did not include an assessment for [REDACTED] usage nor determining the [REDACTED] size the resident required for a [REDACTED]. The HHA DON stated the HHA operated on the understanding that the facility had already completed that portion of the resident's assessment. She stated after the incident, the agency had the PDA do a return demonstration of the transfer process carried out with Resident #1 on the morning of the resident's fall and did not find that the PDA did anything that was unsafe. The DON confirmed the HHA had no contractual agreement with the facility shifting the liability of the resident's [REDACTED] transfers to the HHA.</p> <p>During an interview on 08/18/2022 at 2:39 PM, the Administrator stated Resident #1 ordered his/her own [REDACTED] and [REDACTED]. Per the Administrator, the resident returned to the facility with [REDACTED] equipment after discharge from a rehabilitation facility. The Administrator stated the facility was of the understanding the rehabilitation facility had assessed and cleared the resident on any safety concerns as well as the appropriateness of the [REDACTED] size before the resident was transferred back to the facility. The Administrator stated the direct care staff of the facility, including CNA #1, had been trained on [REDACTED] transfers prior to the resident's return to the facility; however, the Administrator acknowledged that the facility had no information on the make and model of the [REDACTED] or the [REDACTED] the resident used. Further interview with the Administrator revealed the facility did not have a policy related to assessment of a resident prior to utilizing a [REDACTED].</p>	A 709		

New Jersey Department of Health

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A 709	<p>Continued From page 16</p> <p>During a telephone interview with the equipment company's customer service representative on 09/16/2022 at 1:59 PM, the representative clarified that Resident #1 acquired the [REDACTED] originally on 05/06/2019 through a rent-to-own program. Per the equipment company's representative, Resident #1's insurance company paid off the [REDACTED] in May 2020. The representative stated on 03/11/2022, Resident #1 called the equipment company for a service request related to the complaint that the [REDACTED] header bar was hard to open or close. Per the equipment company's representative, Resident #1's service request on the [REDACTED] was denied because the [REDACTED] was considered to have been purchased out and was no longer covered for a service call per their policy. The representative added that their company's representative reached out to Resident #1's insurance to propose replacement of the [REDACTED] on 03/11/2022. Per the representative, their company received a verbal denial from Resident #1's insurance on 03/23/2022. The representative added that they received a prescription from the facility on 03/31/2022 requesting a new [REDACTED]. The representative clarified the request was denied because Medicare only covered the purchase of durable medical equipment once every five years; as such, Resident #1 was deemed not eligible. The representative concluded that Resident #1 was advised his/her only option, if the resident wanted a new [REDACTED] was to pay for one out of pocket. The representative stated Resident #1 did not proceed with acquiring a new [REDACTED] from the equipment company.</p> <p>During an interview on 09/16/2022 at 2:43 PM, the Administrator and the Director of Nursing (DON) stated that although the facility had four</p>	A 709		
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New Jersey Department of Health

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A 709	<p>Continued From page 17</p> <p>physicians who routinely visited the facility to review residents, the residents had choices to see a physician of their choice. The Administrator clarified that although he had only been employed at the facility for four days when the incident with Resident #1 occurred, the facility was not aware of the concerns with Resident #1's [REDACTED] as described by the equipment company representative. The DON added it was possible Resident #1 communicated his/her concerns directly to his/her physician who failed to inform the facility. The DON reiterated that Resident #1 was his/her own decision-maker and coordinated his/her own care related to the [REDACTED]. The DON clarified the facility's physician was not seeing the resident at the time of the incident and did not write a prescription for a new [REDACTED] for the resident. The Administrator added the equipment company possibly confused the facility for the home health agency who was responsible for the [REDACTED] transfer portion of the resident's care.</p> <p>During an interview on 09/16/2022 at 2:55 PM, the DON from the home health agency that provided Resident #1's private duty aide (PDA) acknowledged being aware of the concern with Resident #1's [REDACTED]. She stated the resident's concerns about the [REDACTED] were last communicated to the home health agency's Registered Nurse, who was at the facility to see the resident on 04/28/2022. The DON from the home health agency stated she believed Resident #1 acquired a new [REDACTED] and the [REDACTED] in use when the resident had the fall incident was not the same one reported to be faulty. She acknowledged there was no documentation in the resident's home health record to verify this information.</p> <p>During an interview on 09/16/2022 at 3:17 PM,</p>	A 709		

New Jersey Department of Health

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A 709	<p>Continued From page 18</p> <p>RN #1 from the home health agency stated she made a visit to the facility on 04/28/2022. Per RN #1, during her visit that day, HHA #1, the home health aide who was assigned to Resident #1 on 04/28/2022, complained that Resident #1's [REDACTED] dropped abruptly during transfer. RN #1 stated that although the abrupt drop of the [REDACTED] did not result in any negative outcome for the resident, she called the equipment company and was assured the company would be sending out a field technician to address the concern with the [REDACTED]. RN #1 acknowledged there was no follow-up documentation that addressed whether the equipment company's field technician showed up at the facility and whether the resident acquired or received a new [REDACTED].</p> <p>During an interview on 09/16/2022 at 3:25 PM, HHA #1 stated she recalled Resident #1's [REDACTED] dropped abruptly on at least two occasions. HHA #1 stated she recalled talking to RN #1 about this and believed Resident #1 got a replacement [REDACTED]. HHA #1 stated she believed Resident #1's replacement [REDACTED] came approximately a week prior to the resident's fall from the [REDACTED]. Per HHA #1, she believed the equipment company from which Resident #1 originally acquired the [REDACTED] took out the old [REDACTED] and replaced it with a new one. HHA #1 stated the old and replacement [REDACTED] were both manual lifts. According to HHA #1, she did not remember the make and model of the [REDACTED] that was in use for the resident. HHA #1 further clarified she did not work on the day of the fall incident with Resident #1 and was not able to provide information regarding the [REDACTED] that was used during the resident's transfer that day.</p> <p>Review of the facility's "Training/In-Service Documentation" for safe [REDACTED] transfers,</p>	A 709		

New Jersey Department of Health

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A 709	<p>Continued From page 19</p> <p>dated 03/04/2022, revealed, "This guide provides general safety recommendations and is not a replacement for the manufacturer's instructions. Refer to the manufacturer's instructions for specific use guidelines." Further review of the training revealed "Know Your Lift! Patient [resident] falls from lifts may cause injuries, including head trauma, fractures, and death." Further, the training indicated, "Choose size of [redacted] based on manufacturer recommendation for patient's [resident] measurements. Choosing correct [redacted] size is critical for safe patient transfer." In addition, "Using the wrong [redacted] or attaching the [redacted] incorrectly may cause serious injury to the caregiver or patient. Position center of [redacted] under patient's [resident's] spine. Ensure patient's head and/or back is supported if needed."</p> <p>The facility failed to conduct an assessment to esure that the use of the [redacted] was a safe and appropriate intervention for the resident and that the [redacted] was in proper working order. Resident #1 [redacted] and expired at the hospital on [redacted] following a [redacted] from the [redacted] during a transfer at the facility.</p>	A 709		
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 02A016	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 7/31/2023
NAME OF FACILITY BRISTAL AT WOODCLIFF LAKE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 364 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0709	Correction	ID Prefix _____	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-7.2(d)(1-18)	Completed	Reg. # _____	Completed
LSC _____	10/13/2022	LSC _____	10/13/2022	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/18/2022

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO



ASSISTED LIVING

We see *you* here

Complaint #: NJ156409

A310

8:36-3.4 (a) (1)

Administration

1. How will our corrective action be accomplished for those residents found to have been affected by the deficiency?

The facility conducted a review of the residents requiring transfer assistance to ensure no other residents needed transfer by a [REDACTED] lift. As no residents were identified as requiring the use of a [REDACTED] lift, no additional residents were affected. Impacted Resident #1 is no longer at the facility as resident expired.

2. How will our facility identify other residents having the potential to be affected by the same deficient practice?

The Resident Lifting Policy GNJ69 has been revised to reflect the following:

- Upon move-in or return from hospital/rehabilitation facility, the resident's transfer ability will be evaluated as part of the General Service Plan (GSP) review process and will take place with every 6-month assessment and change of condition assessment.
- If the resident is unable to transfer independently or with one person stand and pivot assistance, the Director of Wellness (DOW) or RN designee will coordinate with a physical therapist to evaluate the resident and determine the safest and most appropriate means of transferring the resident.
- If the physical therapy evaluation indicates that the resident requires a mechanical device for transferring and resident's needs can continue to be met at the Bristol, the DOW or RN designee will obtain an order from the resident's healthcare practitioner prior to the use of the equipment.
- If the resident is currently using a mechanical lift, the continued need for device will be assessed.
- The DOW or RN designee will reflect the need for the mechanical lift in the GSP including assistance level, provider, type of sling(s), device type and model number.

3. What measures have been put in place or systemic changes made to ensure that the deficient practice will not recur?

The Resident Lifting/Assisting Transfer Policy Number G NJ 69, which was created on November 27, 2019, revised on January 22, 2020, and was in effect at the time of the incident was revised to include emphasis on RN assessment frequency, physical therapy evaluation, and documentation regarding equipment specifications as indicated in above-response. Director of Wellness (RN), LPNs and care staff were educated on the updated policy. Policies are reviewed annually and revised as needed.



ASSISTED LIVING

We see *you* here

4. How will our facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the system changes?

The Resident Lifting Policy GNJ69 has been revised to reflect the following protocols to monitor corrective actions:

- Prior to initial use and weekly thereafter, the DOW or RN designee will:
 - ensure that each resident utilizing the mechanical lift has his/her own slings of type/size specified by physical therapist
 - inspect the sling and confirm that it is the appropriate size for the resident, is clean and in good repair
 - be responsible for monitoring weight changes and ordering a new sling if the resident requires one.
- The operators of the mechanical lift will inspect the lift and sling before each use.
- All mechanical lifts will be checked monthly and as needed by maintenance for integrity and function of all lift equipment prior to use in accordance with the manufacturer's instructions and a record of the equipment checks will be maintained by the maintenance department.
- The DOW or designee will be notified of broken or malfunctioning equipment and shall be removed from use.

Through the QAPI Program, the Director of Wellness (RN) remains responsible for monitoring and quarterly reporting compliance with correct action.

Completion date: 10/13/22