

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315297	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2021
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NAME OF PROVIDER OR SUPPLIER ALLEGRIA AT THE FOUNTAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 114 HAYES MILL ROAD ATCO, NJ 08004
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F 000	INITIAL COMMENTS Complaint #: NJ148292; NJ147724; NJ147726 and NJ146614 Census: 52 Sample Size: 8 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, facility document reviews, and facility policy review, it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents for one (Resident [REDACTED] of three residents reviewed for adequate supervision. Specifically, the facility failed to ensure a two person transfer for Resident [REDACTED], who sustained a [REDACTED] to the resident's [REDACTED]. This had the potential to affect 16 residents whom the facility identified needed assistance of two persons for transfer. Findings included:	F 689	1. The CNA for resident [REDACTED] was re-educated for the need to follow the plan of care re: safe transfer needs for each resident and to acquire additional assistance when required/necessary. The CNA for resident [REDACTED] underwent a transfer competency to demonstrate safe transfers skills 2. 16 residents have the potential to be affected. All residents requiring transfer assistance will be identified with the type of assistance required on the CNA	10/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/14/2021
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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.

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F 689	<p>Continued From page 1</p> <p>1. According to the [REDACTED] computerized physician order, Resident [REDACTED] was admitted with diagnoses that included [REDACTED]</p> <p>A review of Resident [REDACTED]'s quarterly Minimum Data Set (MDS), dated [REDACTED], indicated the resident was [REDACTED] impaired with a Brief Interview for Mental Status (BIMS) score of [REDACTED]. The resident required two-persons physical assistance with bed mobility and transfer. The resident required one-person physical assistance with locomotion, dressing, eating, toilet use, and personal hygiene.</p> <p>A review of Resident [REDACTED]'s care plan, dated [REDACTED], indicated the resident had deficit with self-care related to activities of daily living and directed for staff to transfer the resident with assistance of two nursing staff. The resident had no record of making a false claim against nursing staff.</p> <p>A review of Resident [REDACTED]'s medical record indicated a nursing note documented on [REDACTED] which indicated that at approximately 2:00 PM of the same day, Resident [REDACTED] complained of [REDACTED]. The record noted that upon a nursing staff assessment of the resident, the resident was noted with a [REDACTED] to the [REDACTED], and the surrounding area of the [REDACTED] was described as having a [REDACTED]. The record indicated that the facility sent Resident [REDACTED] to the hospital for evaluation.</p>	F 689	<p>assignment sheet. CNAs will be re-educated by the ADON/designee that failure to follow safe transfer practices will receive progressive disciplinary actions.</p> <p>3. All CNAs will be re-educated by the ADON/designee to be aware of each assigned resident's transfer status and the need to acquire additional assistance when required/necessary. Transfer competencies by therapy provider/ADON/designee will be completed on all CNAs.</p> <p>4. 10 resident's requiring transfer assistance will be randomly audited by the ADON/designee throughout all three shifts for four weeks then monthly. Audit findings will be reported to the QA committee.</p>	

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F 689	<p>Continued From page 2</p> <p>A review of Resident █'s hospital record dated █ indicated the resident's admitting diagnosis from the emergency room was a █. The record indicated no █ to the resident's █. The record did not indicate that Resident █ suffered any other complication.</p> <p>A review of the facility's incident investigation report dated █ indicated that the report reiterated the observation with Resident █ as indicated above. The report indicated that Resident █ was unable to effectively explain how the resident sustained the injury to their █. The report indicated that the facility interviewed Certified Nurse Aide (CNA) #2, the CNA who provided care to Resident █ on the evening the resident was suspected to have sustained the injury. Per the report, CNA #2 acknowledged that she transferred Resident █ alone but was unaware an injury occurred during the transfer. The conclusion portion of the report indicated the facility determined that Resident █ banged the resident's █ on the side of the bed during the transfer, which resulted in a █. The report added that Resident █'s use of the medication █ may have contributed to the █ of the injury. Per the report, CNA #2 and other direct care staff were re-educated on safe transfer and the need to strictly adhere to the transfer status assessed and considered safe for the residents.</p> <p>During an interview on 09/28/2021 at 12:10 PM, Resident █ stated that they had requested to be put back in bed during the 11:00 PM to 7:00 AM shift on █. The resident stated that CNA #2 transferred the resident without getting the assistance of another nursing staff. Resident █ stated that CNA #2 hit the resident's █.</p>	F 689			

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F 689	<p>Continued From page 3</p> <p>against the base of the resident's bed in the course of transferring the resident alone. The resident clarified that they were not [REDACTED] immediately following the incident. Per Resident [REDACTED], the resident could not tell if CNA #2 realized the resident hit their leg during the transfer. Resident [REDACTED] clarified that the facility attended to the [REDACTED] immediately. Resident [REDACTED] concluded that the resident was sent to the hospital for evaluation.</p> <p>During an interview on 09/28/2021 at 3:01 PM, CNA #2 stated she recalled that she was asked to put Resident [REDACTED] back in bed at approximately 11:10 PM the day Resident [REDACTED] was suspected to have sustained the injury to the resident's [REDACTED]. She acknowledged she transferred the resident alone without seeking assistance of another staff as the resident's care plan dictated. She stated she knew that the resident required assistance of two nursing staff for transfer but did not call for help. CNA #2 stated that she was educated to adhere strictly to the transfer needs of residents as indicated in the care plan following the incident with Resident [REDACTED].</p> <p>During an interview on 09/28/2021 at 4:23 PM, the Director of Nurses (DON) stated safety was always a top priority for both staff and residents at the facility. Per the DON, CNAs had access to the transfer status of each resident assigned to them. The DON clarified that the facility's investigation identified that Resident [REDACTED] most likely sustained the injury to the resident's [REDACTED] when the resident was transferred by CNA #2. The DON stated that CNA #2 did not follow the care plan assessed and considered safe for Resident [REDACTED]'s transfer, which dictated to transfer with assistance of two nursing staff. The DON stated that CNA #2 should not have transferred Resident</p>	F 689		

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F 689	Continued From page 4 <p>█ alone. The DON stated that she continued to educate nursing staff across the facility about ensuring necessary safety measures were in place related to residents' transfer status.</p> <p>Review of the "Safe Lifting and Movement of Residents" facility policy, provided by the DON on 09/28/2021 at 5:10 PM, indicated in part " ...In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents ..."</p> <p>New Jersey Administrative Code §8:39-27.1(a)</p>	F 689			