STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. Building B. Wing	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 NJ Complaint #156759 Based on observation, interview, record review, and other pertinent facility documentation, it was determined that the facility failed to ensure residents were free from abuse after a resident (Resident #24) was prevented from leaving an abusive situation by Certified Nursing Aide (CNA #1) who continued to work with other residents following no investigation. This deficient practice was identified for 1 of 5 residents reviewed for abuse (Resident #24). Resident #24, who had diagnoses which included anxiety, depression, and Post Traumatic Stress Disorder (PTSD) (A mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations), reported on 07/30/22 an Agency Nurse (Licensed Practical Nurse (LPN #1) became verbally abusive with him/her when their scheduled Percocet (pain medication) and Xanax (anxiety medication) was requested. The resident reported LPN #1 closed the door to his/her room which triggered the resident's PTSD. The resident indicated that they had a history of imprisonment, which caused the feeling of entrapment with closed doors and feelings of anxiety. Resident #24 reported that when they tried to exit the unit to find help, LPN #1 prevented them from leaving by holding the handlebars of the wheelchair (w/c). He stated that CNA #1 further prevented him/her from escaping the anger that LPN #1 exhibited towards him/her, by blocking the exit doors and preventing him from leaving. The resident reported that this made them angry because all they wanted was to leave, and the resident could not understand why they were not permitted to leave the unit to find help. During a review of video surveillance footage, it was observed that the resident self-propelled in the wheelchair, and LPN #1 moved alongside the resident towards the closed exit doors of the unit. CNA #1 was seen exiting from Resident room [ROOM NUMBER] and stood in front of the resident blocking them from proceeding forward, and then stood in front of the exit door blocking the exit. (continued on next page)

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.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of CNA #1's written statement regarding the incident included that she was stopping the resident from leaving the unit. The facility's failure to ensure all residents were free from abuse, including verbal, physical, restraints, and involuntary seclusion by not investigating the actions of CNA #1 after a written statement acknowledged she stopped the resident from leaving the unit as well as video footage confirming she blocked the exit door preventing the resident from leaving the unit posed a serious and immediate threat for abuse which can cause serious physical and emotional harm or impairment. This resulted in an Immediate Jeopardy (IJ) situation that began on 07/30/22 after CNA #1 blocked Resident #24 from leaving the unit and continued to work seven additional shifts until the surveyor inquiry. The facility Administration was notified of the IJ on 08/25/22 at 02:55 PM. The facility submitted an acceptable Removal Plan (RP) on 08/26/22 at 01:55 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 08/26/22. Part A On 08/18/22 at 10:38 AM, the surveyor interviewed Resident #24, who stated on 07/30/22, they received Percocet and Xanax every six hours and asked an aide to find the nurse to administer the medications. An Agency Nurse (LPN #1) entered my room and informed me that they would administer my medications and take my vital signs and proceeded to leave the room and closed the door. The resident stated that they proceeded to use the call bell and LPN #1 came back into the room to tell me to stop pushing the call bell; pulled down her mask and attempted to bite my finger as I pointed at her. The resident continued that he/she got out of bed to get away from LPN #1, LPN #1 lunged her nurse's cart at me three times and hit his/her left foot causing a wound to re-open. The resident stated that he/she was trying to get away from LPN #1 and get to the Registered Nurse Supervisor (RN Supervisor). The resident stated as they were attempting to leave the unit in the hallway, the nurse assaulted them by pulling the wheelchair (w/c) 2-3 times, which positioned the resident on only two back wheels and the two front wheels were lifted off of the floor. The resident stated that there was a (CNA #1) there, but he/she could not recall the name who tried to calm the crazy nurse down. The resident stated that the RN Supervisor escorted LPN #1 out of the building and a State Trooper came last week who viewed the surveillance footage and confirmed LPN #1 assaulted the resident. The resident stated that they had severe PTSD and that this event had triggered an episode. The surveyor reviewed Resident #24's medical record. A review of the Resident Facesheet (an admission summary) reflected that the resident was admitted to the facility in September of 2021 but did not include admitting diagnoses. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 08/10/22, reflected a brief interview of mental status (BIMS) score of 15 out of 15, which indicated the resident was fully cognitively intact. It further reflected the resident had verbal behavioral symptoms directed toward others that occurred four to six days in the last seven days of assessment. Section I Active Diagnoses included the resident had hypertension (high blood pressure), anxiety, depression, psychotic disorder, and PTSD. It further included in a seven-day look back period, the resident received daily antianxiety, antidepressant, and opioid medications. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the individualized comprehensive Care Plan (CP) included a problem area initiated on 04/8/22, for at risk for altercation in mood/behavior; history of major depressive disorder, anxiety, use of Seroquel (antipsychotic medication) for agitation, use of Xanax for anxiety, and Remeron for anxiety/depression/mood with interventions that included to observe for efficiency of medications; monitor for target behaviors or behaviors not easily redirected; refer to nurse if noted behaviors worsening, unable to redirect; keep the room well lit, open blinds for sunlight; and give medications Remeron, Xanax, Seroquel as ordered. A further review of the CP included a diagnosis of PTSD, however, did not include a problem area or interventions pertaining to the resident's diagnosis of PTSD. A review of the Interdisciplinary Progress Notes included a Nursing Note dated 07/30/22 at an illegible time, which reflected at around 05:10 AM; a CNA approached the writer who was on the other side of the unit to report an altercation between an Agency Nurse (LPN #1) and the resident. The writer went over to Resident #24 and brought them back to their room, and conducted a body check. The note reflected that the writer reassured Resident #24 that everything would be okay. On 08/18/22 at 11:49 AM, the surveyor requested from Administration all investigations for Resident #24 from 07/01/22 until present. On 08/18/22 at 12:48 PM, the surveyor interviewed the RN Supervisor via telephone, who stated on 07/30/22, she was called to the unit the Agency Nurse (LPN #1) and Resident #24 were having an argument, and the nurse was very aggressive. The resident had told the CNA that he/she wanted his medications, and LPN #1 came into the room to tell the resident she would get the medications. The RN Supervisor stated that ten minutes had passed and the resident had not received their medications so they pressed the call bell and LPN #1 came into the room and asked why he/she was calling her. LPN #1 then proceeded to close the door, which the resident did not like, and he/she went to call the Supervisor, but LPN #1 took the phone, so the resident could not call. LPN #1 then blocked the resident's room with her medication cart so they could not leave and then pulled the resident's w/c so the resident could not leave the unit. The RN Supervisor stated the aides told LPN #1 to stop, and RN #1, who was on the other side of the unit, called the RN Supervisor, who had LPN #1 leave the facility, and an investigation was initiated. The RN Supervisor stated the resident reported LPN #1 attempted to bite their finger but no injury was observed. There was surveillance video footage reviewed and statements were taken. The RN Supervisor stated Resident #24 gets really upset sometimes due to pain so the nurses usually responded to him/her right away. On 08/18/22 at 01:06 PM, the surveyor requested the Licensed Nursing Home Administrator (LNHA) to provide all investigations conducted for Resident #24 from 07/01/22 to present. On 08/19/22 at 11:25 AM, the surveyor interviewed the Director of Nursing (DON) who stated she had been on vacation for the past two weeks so the Assistant Director of Nursing (ADON) completed the investigation and the final report. The DON confirmed she watched the video surveillance footage which revealed LPN #1 abused Resident #24. On 08/19/22 at 11:31 AM, the surveyor interviewed the ADON who stated that she completed an investigation for the incident on 07/30/22 which she reported to the New Jersey Department of Health (NJDOH), Ombudsman, the Veteran's Affairs [NAME], Office of Inspector General, Physician, family, and later the State Police after the resident alleged LPN #1 assaulted him/her with her medication cart. The ADON stated when she reviewed video footage, it was clear LPN #1 was holding the handlebars on the back of Resident #24's wheelchair as well as a verbal altercation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/19/22 at 11:59 AM, the surveyor interviewed LPN #1 via telephone who stated she was an Agency Nurse assigned to the facility that day (07/30/22) and received no information from the facility prior to the start of her shift. LPN #1 stated to a degree she understood that the resident was right, but the resident made racist remarks to her and weaponized their wheelchair rolling over her feet. LPN #1 stated that the medication cart was in front of his/her room since she was trying to administer the resident's medication and he/she started pushing the medication cart at the nurse. LPN #1 stated a nurse informed her Resident #24 had to receive their medication on time and she apologized that the medication was a few minutes late and she started to prepare the medications. The resident proceeded to press the call bell and started yelling and cursing at her to administer the medications and he/she was going to call administration. LPN #1 stated that she tried to calm the resident down but he/she started making derogatory racial remarks to her telling her that she was yelling at them. The resident then got out of bed and charged in their wheelchair at the medication cart yelling and cursing. LPN #1 stated that she told the aides to get the Supervisor. LPN #1 stated she was unaware if the resident had any behaviors and the two CNAs were telling her to stop the resident from leaving the unit and she had no idea why the resident could not leave the unit; if the unit was a lockdown unit or the resident was on COVID-19 restrictions, but she was the closest staff to the resident so she grabbed the back of the wheelchair to stop the resident. LPN #1 further stated that she did not know the two CNAs' names, but they were yelling at her to stop the resident from leaving the unit, so she grabbed the back of his/her wheelchair. On 08/19/22 at 12:52 PM, the surveyor in the presence of the DON, Employee Relations/Legal Specialist, and survey team observed the surveillance video from 07/30/22 and observed the following: At approximately 05:13 AM, Resident #24 was observed self-propelling in a wheelchair alongside of LPN #1 and proceeded up the hallway in the direction of the closed exit doors; LPN #1 was observed at some point holding her left arm up with their left hand positioned upward in a motion to stop that was directed towards the resident. CNA #1 was observed exiting Resident room [ROOM NUMBER] which was located on the right side directly next to the closed exit doors and proceeded to position herself directly in front of the resident. There was no audio, but it could be determined that there was a verbal exchange between the resident and staff. LPN #1 then grabbed the back of the handlebars of Resident #24's wheelchair, which changed the resident's direction from facing forward towards the exit doors to now facing towards Resident room [ROOM NUMBER]. The resident was trying to get away but was being restrained by LPN #1, who was still holding onto the back of the wheelchair, which caused the front wheels to lift off the ground, causing the resident to recline in the w/c. CNA #1 then stood in front of the exit door and blocked the resident from having access to exit. CNA #2 was observed walking up the hallway towards LPN #1, CNA #1, and the resident and it can be observed CNA #2 was engaging in the conversation. Then, CNA #3 came through the closed exit door and proceeded to wheel the resident away from LPN #1 and CNA #1. RN #1 was seen walking up the hallway towards the resident and CNA #3 and it appeared that they were attempting to calm the resident as they were bringing the resident towards their room. On 08/19/22 at 1:23 PM, the surveyor interviewed CNA #1 via telephone who stated she could not recall the incident but she had provided a statement, so the surveyor should read their statement. On 08/19/22 at 1:31 PM, the surveyor attempted to interview CNA #2 via telephone about the incident, and CNA #2 would only repeat the word yes in response to interview questions and offered nothing further. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/22 at 10:00 AM, the surveyor reviewed the facility provided an investigation report for Resident #24's incident which occurred on 07/30/22. A review of the staff statements included a statement provided by CNA #2, which detailed that they were taking care of a resident when they heard a noise in the hallway and came out into the hallway and saw Resident #24 trying to leave the floor. She stated that, I stopped him/her from leaving the floor. CNA #2 stated that both she and another CNA called the charge nurse, but I did not know what was going on. CNA #2's statement appeared to be what the surveyor witnessed CNA #1 do in the surveillance video. There was no statement included from CNA #1 in the investigation report provided. On 08/22/22 at 10:31 AM, the surveyor reviewed the surveillance video with the Assistant Licensed Nursing Home Administrator (ALNHA) #1, Employee Relations/Legal Specialist, and another surveyor, and the Employee Relations/Legal Specialist confirmed CNA #1 was the aide who was blocking the door and CNA #2 was the aide observed later walking up the hallway towards LPN #1, CNA #1, and the resident during the altercation. At this time, the surveyor reviewed the investigation packet with ALNHA #1 who confirmed there should have been a statement from CNA #1 included in the investigation report. On 08/22/22 at 11:28 AM, the surveyor asked the DON if there was any surveillance video footage from the camera by the nurse's station from the incident and the DON reported that the camera was not working during the incident. The surveyor also informed the DON that they attempted to interview the CNAs and was told to read their statements, but there was no statement provided for CNA #1. On 08/23/22 at 10:59 AM, the DON provided the surveyor with CNA #1's statement dated 07/30/22 which was the exact same statement provided by CNA #2. At this time, the surveyor asked the DON to read both CNA #1 and CNA #2's statements, and she confirmed that both statements were the same but was signed by the corresponding CNA. At this time, the surveyor requested to watch the video footage again with the DON. On 08/23/22 at 11:10 AM, the surveyor with the DON, Employee Relations/Legal Specialist, and another surveyor viewed the video footage. The surveyor asked the DON, when comparing the surveillance footage with the statements if the statements clearly reflect what had happened. The DON reported that she completed a three-page reportable to the New Jersey Department of Health (NJDOH) and told RN #1 to watch the video to see if anything should be added to her statement, and then the DON reported she left for vacation. The DON stated that the ADON had watched the video with RN #1 who did not want to change her statement. The DON stated the purpose of an investigation was to determine a root cause analysis and confirmed these statements were not clear. The DON stated when she returned from vacation, the investigation was completed by the ADON and she did not review it even though she was responsible for oversight of all aspects of nursing. The DON confirmed the resident had the right to leave the unit and no staff, including the two CNAs should have stopped the resident from leaving the unit. The surveyor reviewed the video with the DON. The DON acknowledged CNA #1 was standing in front of the exit door blocking Resident #24 from exiting the unit, which was an issue because this was considered a restraint. The DON stated that even if the resident was confused, which Resident #24 was not, staff could not stop the resident from leaving. The DON stated staff had to ensure the resident's safety and could follow the resident from a distance, but staff could not prevent the resident from leaving the unit. The DON stated the ADON was currently on vacation but confirmed the investigation was not complete, and she had to re-open the investigation to clarify the statements and determine why CNA #1 stood in front of the door. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/23/22 at 11:50 AM, the surveyor requested from the LNHA all nursing schedules from 07/31/22 until present. On 08/23/22 at 12:09 PM, the surveyor reviewed the education for CNA #1 and CNA #2, which revealed both aides received abuse training prior to the event on 04/11/22 and 12/20/21 respectively. On 08/23/22 at 01:14 PM, the surveyor re-interviewed Resident #24 who stated CNA #1 was stopping LPN #1 from verbally abusing him/her, but confirmed CNA #1 was preventing him/her from leaving the unit and told them they were not allowed to leave the unit. The resident stated CNA #1 could have done more since she was not letting them leave and he/she did not know why. On 08/24/22 at 10:30 AM, the surveyor reviewed the nursing schedules since 07/31/22, which revealed CNA #1 worked seven shifts at the facility after the incident. On 08/24/22 at 11:35 AM, the surveyor interviewed the DON regarding the process for investigating abuse. The DON stated that for abuse, you take the person off the floor immediately and get their statement. When asked why you removed them from the floor, the DON responded that you have to remove them from the floor because it was a concern of abuse, you would not leave the residents with that person until you determined it was not abuse. When asked what constitutes abuse, the DON stated there were different types of abuse including physical, verbal, monetary, emotional, sexual, seclusion, and restraining against ones will. The DON stated she called CNA #1 yesterday and spoke to her over the phone regarding her statement that she stopped the resident from leaving, and CNA #1 stated after everything was done, the RN Supervisor gave an in-service that if a resident wanted to leave, they cannot stop anyone from leaving the floor, and they can follow them from afar. The DON stated that the situation was looked at initially that CNA #1 was trying to calm the resident down and not by the statement which the video confirmed that CNA #1 was trying to prevent the resident from leaving the unit. An additional review of the investigation report included an in-service/education attendance sheet dated 07/31/22, the day after the incident, with a program topic of the resident should be allowed to leave the unit if [they] wish. Do not stop the resident from leaving the unit by holding [their] chair, re-direct verbally. If they insist on going leaving the unit allow them to leave, and can follow behind to make sure the resident is safe. The in-service was presented by RN Supervisor to four staff members CNA #1, CNA #3, LPN #2, and RN #2. The in-service was not given to CNA #2 or RN #1, who were both present at the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the investigation report included in the Final Investigation dated 08/11/22, for actions taken: staff intervened separating the Agency Nurse (LPN #1) from [resident]; provided emotional support and notified Nursing Supervisor (RN Supervisor) immediately of their observations and [resident's] allegations; Agency Nurse was removed from the nursing unit and asked to provide a statement. She was subsequently dismissed from the remainder of her shift; [Agency] was notified of incident and request was made for the staff member not to return to facility; MD (Physician) was notified with order for body check every shift for five days and vital signs every shift for five days; [resident] reported that the nurse did not make physical contact with [his/her] person, only restricted [him/her] by holding [his/her] wheelchair; Social Worker will continue to provide emotional support. The summary included: the ADON reviewed the footage, which showed [Resident #24] was near the end of the door of the unit, the Agency staff was holding [their] wheelchair handle preventing [them] from leaving the unit. It was apparent on the video that staff members intervened and came to diffuse the situation. Hand gestures were made by Charge Nurse noted to put her hand up in a stop motion to Agency Nurse (LPN #1) as she appeared to follow [Resident #24] up the hall making verbalizations. Conclusion: evidence of verbal abuse and intent to involuntarily seclude a resident was consistent in staff members' statements and observations made by the ADON on the video footage. Verbal abuse and attempt to involuntarily seclude were substantiated. The Final Investigation summary did not include that CNA #1 involuntarily secluded the resident or that any action was taken towards CNA #1. On 08/24/22 at 12:33 PM, the DON informed the survey team that in light of CNA #1 blocking door, she was reporting it to the NJDOH. On 08/25/22 at 09:51 AM, the surveyor interviewed Resident #24 who stated he/she was imprisoned for twenty months and preferred the door to their room remain open because the closed door triggered their PTSD causing anxiety. The resident stated on 07/30/22, they were waiting for LPN #1 to administer their routine Percocet and Xanax medication so they could go back to sleep. LPN #1 closed his/her room door and then started yelling at him/her, and the resident reported they just wanted to escape LPN #1 who grabbed their wheelchair almost tipping the chair over. Resident #24 stated that he/she remembered the aide (CNA #1) saying their name and that he/she knew her and he/she could not leave but Resident #24 stated they could not determine who the aide was at the time. Resident #24 stated they just wanted the RN Supervisor, which made them feel angry because they were being prevented from escaping from LPN #1, and CNA #1 was not helping the situation. CNA #1 could have opened the door to let me leave but she would not let me leave which made me mad. The resident stated he/she had never been prevented from leaving the unit before so they could not understand why that was happening. The facility's failure to ensure all residents were free from abuse, including verbal, physical, restraints, and involuntary seclusion by not investigating the actions of CNA #1 after a written statement acknowledged she stopped the resident from leaving the unit as well as video footage confirming she blocked the exit door preventing the resident from leaving the unit posed a serious and immediate threat for abuse which can cause serious physical and emotional harm or impairment. This resulted in an Immediate Jeopardy situation. The IJ was identified on 08/25/22, and the LNHA, ALNHA #1, ALNHA #2, DON, and Director of Veterans Health Care Services were notified of the IJ at 02:55 PM. A written Removal Plan was accepted and verified on-site on 08/26/22, which included staff members will be immediately relieved from their duties; to ensure safety of the residents a comprehensive investigation will commence at the time of the event to ensure a thorough and complete review of all contributing factors have been conducted; all staff in-serviced on the Abuse and Neglect Policy. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/22 at 10:34 AM, the surveyor interviewed the DON who confirmed that the investigation regarding CNA #1 should have started upon review of the CNA's statement and video footage. The DON stated that after surveyor inquiry, she had called on the telephone both CNA #1 and CNA #2 to clarify their identical written statements. The DON stated CNA #1 had better English than CNA #2 so CNA #2 copied CNA #1's statement. The DON acknowledged that CNA #2 should not have copied CNA #1's statement and CNA #2 provided the DON with a new written statement and the DON received a verbal statement over the phone from CNA #1. On 08/26/22 at 11:00 AM, the DON provided the surveyor with a copy of the Statement of Clarification dated 08/23/22. A review of this statement included a revised statement of CNA #1 given via telephone to the DON and the MDS Coordinator. The statement indicated CNA #1 was taking care of a resident in room [ROOM NUMBER] when she heard Resident #24 and the nurse's voices in the hallway. When she came out, she observed the nurse holding the resident's wheelchair while he/she was trying to leave the floor. I stayed in front of the door, and tried to talk to him/her and said, You cannot leave the floor so we are going to get the charge nurse for you. This statement contradicts video footage of LPN #1 grabbing the back of the resident's wheelchair after CNA #1 had exited Resident room [ROOM NUMBER]. On 09/06/22 at 02:35 PM, the surveyor conducted an interview via telephone with the DON. The surveyor asked the DON to review the Statement of Clarification dated 08/23/22. The DON read the statement and the surveyor asked if the statement confirmed what the video footage revealed. The DON stated she watched the video three times with the surveyor and the video confirmed that CNA #1 was blocking the door preventing the resident from leaving which was the part she was focused on. When asked if LPN #1 grabbed the back of Resident #24's wheelchair before CNA #1 exited Resident room [ROOM NUMBER] or after, and the DON stated she could not speak to that. The DON confirmed she did not review the video again after receiving the statement because it was the CNA's statement and she admitted to blocking the resident from leaving the room. When asked if it was important to verify the written statement matched the video footage, the DON confirmed yes. On 09/06/22 at 02:50 PM, the DON, in the presence of two surveyors, watched the video surveillance footage which showed CNA #1 stepped out of Resident room [ROOM NUMBER] before LPN #1 and Resident #24 reached the closed exit doors, and CNA #1 stood in front of the exit doors. The video then revealed after CNA #1 was in front of the doors, LPN #1 grabbed the back of Resident #24's wheelchair in the presence of CNA #1. This contradicted CNA #1's revised statement that she walked out of Resident room [ROOM NUMBER] and observed LPN #1 was holding the back of Resident #24's wheelchair at that time. On 09/06/22 at 03:15 PM, the DON followed-up with the surveyor via telephone and confirmed that she watched the video footage again. The DON confirmed that the video footage showed that LPN #1 did not grab the back of Resident #24's wheelchair until after CNA #1 was outside of Resident room [ROOM NUMBER] in front of the door which contradicted the CNA's statement. The DON continued the statement taken was what CNA #1 informed her of what had happened. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Resident Safety Policy and Procedure Resident Abuse Certification dated 06/08/22, included it is policy to promote and maintain a work and living environment that is professional and free from threat, and/or occurrences of harassment, mistreatment, abuse (verbal, physical, mental or sexual), neglect, corporal punishment, involuntary seclusion and misappropriation of property .Residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals . Procedure . identify, correct and intervene in situations in which mistreatment, abuse, neglect and/or misappropriation of resident property [in] more likely to occur. This shall include but is not limited to: the supervision of staff to identify inappropriate behaviors such as using derogatory language, rough handling, ignoring residents while giving care, speaking to a resident in a scolding manner, etc. A review of the facility's Abuse Investigation policy, includes the facility will investigate all alleged and/or suspected events, occurrences, patterns, or trends that may constitute abuse. An investigative report of the findings, disposition of the victim, conclusions, and subsequent administrative actions filed as a matter of record . Procedure . Investigations pertaining to employee to resident . incidents involving employees shall require the employee be assigned to another work area or released from duty with pay pending on the outcome of the investigation. The employee shall not have contact with the resident throughout the course of the Administrative Investigation . NJAC 4.1(a)(5) F600 remains a deficiency at a scope and severity level of a D based on the following: Part B Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure an Agency Nurse received abuse training according to facility policy prior to working in the facility. This was identified for 1 of 3 staff members (LPN #1) reviewed for an abuse investigation of 1 of 5 residents (Resident #24) and was evidenced by the following: On 08/18/22 at 10:38 AM, the surveyor interviewed Resident #24 who stated on 07/30/22, he/she received Percocet (pain management medication) and Xanax (anxiety medication) every six hours and asked an aide to find the nurse to administer the medications. An Agency Nurse (Licensed Practical Nurse (LPN #1)) entered my room and informed me that they would administer my medications and take my vital signs and proceeded to leave the room and closed the door. The resident stated that he/she proceeded to use the callbell and LPN #1 came back into the room, to tell me to stop pushing the callbell; pulled down her mask and attempted to bite my finger as I pointed at her. The resident continued that they got out of bed to get away from her and LPN #1 lunged her nurse's cart at me three times and hit my left foot that reopened a wound. The resident stated that he/she was trying to get away from LPN #1 and get to the Registered Nurse Supervisor (RN Supervisor). The resident stated as he/she was attempting to leave the unit in the hallway, the nurse assaulted me by pulling my wheelchair 2-3 times which caused my wheelchair's (w/c) two front wheels to be in the air which positioned me only on the two back wheels. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident stated that there was a Certified Nursing Aide (CNA #1) there but he/she cannot recall their name who tried to calm the crazy nurse down. The resident stated that the RN Supervisor escorted LPN #1 out of the building and a State Trooper came last week who viewed the surveillance footage and confirmed LPN #1 assaulted me. The resident stated that he/she had severe Post Traumatic Stress Disorder (PTSD) and this event had triggered an episode. The surveyor reviewed the medical record for Resident #24. A review of the Resident Facesheet (an admission summary) reflected that the resident was admitted to the facility in September of 2021 but the document did not include admitting diagnoses. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 08/10/22, refl [TRUNCATED]

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 27193 Complaint # NJ00157129 B. Based on interviews, and record review, it was determined that the facility failed to ensure that care plan interventions were being followed and that direct care staff were consistently following the person-centered care plan. This deficient practice was identified for Resident #29 one of 2 residents reviewed for abuse and was evidenced by the following: On 08/16/22 at 11:45 AM the surveyor observed Resident #29 in bed. The head of the bed was elevated, Resident #29 was alert and able to answer some simple questions. On 08/19/22 at 11:00 AM, the surveyor conducted an interview with the Certified Nursing Assistant (CNA) assigned to Resident # 29. The CNA stated that Resident #29 was a total care, does not get out of the bed by choice, had behavior of being accusatory toward staff. She further stated that Resident #29 must have two staff in the room at all times to provide care. The CNA showed the daily assignment to the surveyor. The surveyor reviewed Resident #29's medical record on 08/19/22. The Admission Face sheet revealed that Resident #29 had diagnoses which included but not limited to: Major depressive disorder, cardiac dysrhythmias, atrial flutter, muscle weakness essential hypertension. The Minimum Data Set (MDS) an assessment tool to prioritize care dated 08/01/22 revealed that Resident #29 was able to make his needs/ her needs known. Resident #29 scored 11 on the Brief Interview for Mental Status (BIMS.) normal score 15. A care plan dated 05/10/21 last revised 08/24/22, identified the following problem :I have a habit of accusing others of misconduct towards me The Goal was for Resident #29 to not accusing others of misconduct for the next 90 days. The intervention implemented was for two staff to care for Resident #29 at all times. On 08/23/22 at 12:30 PM an interview was conducted with the Director of Nursing. The surveyor requested all investigative reports for Resident #29. The DON provided a reportable incident dated 08/10/29 regarding an allegation of abuse. 08/24/22 02:30 PM, the surveyor conducted an interview with the (Registered Nurse Unit Manager) RNUM. The RNUM confirmed that Resident # 29 had behavior of being accusatory toward staff, and the behavior was addressed in the care plan. The surveyor reviewed the care plan with the RNUM and noted that the behavior was not addressed on the current care plan. However the behavior was addressed on the CNA's daily assignment. The CNA daily assignment read, two staff members during care at all times. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the incident provided and noted that on 08/10/22 Resident #29 reported an allegation of verbal abuse to the Nursing Supervisor. The facility suspended the CNA pending investigation. 08/25/22 at 11:48 AM, the surveyor entered the room with the RNUM . Resident #29 in the presence of the RNUM agreed to an interview. The resident stated that he had been residing at the facility for 5 years and had a supportive family. Resident #29 stated that something happened and he/she reported it to the Social worker. (SW) Resident #29 stated a female CNA referring to him/her as a black bastard, when he/she inquired about what was going to be served for dinner. Resident #29 stated, I did not like it, I reported it. On 08/25/22 at 12:45 PM, an interview with the RNUM confirmed that 2 staff were to care for Resident #29 at all times. The RNUM stated that a prior allegation of abuse prompted the facility to revise the care plan and implemented that two staff would care for and answer Resident #29's call light all times. On 08/25/22 at 1:30 PM, the surveyor requested all investigative reports regarding Resident #29 for review. The following documentation were provided: 03/31/21 12:18 PM, Resident #29 stated that S staff member was verbally abusive. 04/06/21 4:08 PM, Resident #29 alleged verbal abuse from a staff member. 05/03/21 4:36 PM, reported alleged physical abuse. Resident #29 reported that an aid slapped him in the face. 05/10/21 1:48 PM, alleged verbal and physical abuse. 11/24/21 2:06 PM, Resident #29 stated that a Certified Nursing Assistant (CNA) called him a damn pig 11/24/21 The intervention implemented again for 2 CNAs to be present when entering Resident #29's room. 2 staff will be present when care was rendered. 08/10/22 at 23:08 PM Resident stated that the staff who provided care was verbally abusive. The CNA was suspended, pending an investigation. The surveyor obtained the CNA's file. The CNA received in-service education on abuse and neglect on 09/24/21. The CNA had been working at the facility since 2015. There was no disciplinary action or written warning on the file. On 08/25/22 at 12:06 PM, the surveyor interviewed the Licensed Social Worker (SW) who confirmed that Resident #29 reported the alleged abuse. The SW stated that she met with Resident #29 and completed the investigation. Resident #29 was able to describe the time and described the staff involved. The resident indicated that he/she was not afraid and felt comfortable. On 08/30/22 at 09:30 AM, the DON provided the incident report pertaining to the above allegation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was statement from one staff only. On 08/30/22 at 10:58 AM, two surveyors conducted a telephone interview with the CNA who provided care to Resident #29 on 08/10/22. The CNA stated, that she was aware of the plan of care, she could not find any staff to assist. She stated, that night the facility was short handed. One of the CNA on duty that could assist her,was not allowed to enter Resident #29's room due a prior allegation of abuse. On 08/30/22 at 12:30 PM, the surveyor conducted an interview with the DON. The surveyor reviewed the Care Plan with the DON, the DON stated that the CNA did not follow the plan of care. The surveyor reviewed the Interdisciplinary Progress Notes dated 08/10/22, with the RNUM, the RNUM stated, that she was told that only documentation of clinical relevance should be entered in the medical record. The RN stated that Resident #29 made appropriate remarks . The appropriate remark was not entered in the medical record. 37547 NJ Complaint #156759 Based on observation, interviews, and record review, it was determined that the facility failed to develop a comprehensive, person-centered care plan for a resident who had known triggers for Post-Traumatic Stress Disorder (PTSD). This deficient practice was identified for 1 of 47 residents sampled for comprehensive care plans (Resident #24). This deficient practice was based on the following: Refer to F600 J On 08/18/22 at 10:28 AM, the surveyor observed Resident #24 seated in a wheelchair at the bedside. When interviewed, the resident informed the surveyor that on 07/30/22, he/she pressed the call light to request scheduled pain and anxiety medications and the call light was answered by the Certified Nursing Assistant (CNA) who reportedly informed the resident's assigned nurse. The resident stated the nurse walked in the room and stated that she would obtain the resident's vital signs and medications simultaneously and then proceeded to walk out of the resident's room and closed the door behind her. The resident reportedly pressed the call light in an effort to call the nurse back to the room. The resident stated that the nurse walked back into the room and yelled at the resident to, Stop buzzing. The resident stated that a verbal exchange ensued between the two and when the resident pointed his/her finger into the nurse's face, she pulled down her mask and attempted to bite the resident's finger. The resident stated the nurse continued to scream and the resident got out of bed at that point and attempted to get away from her. The resident alleged that the nurse lunged the medication cart towards him/her three times and hit the resident's left foot. The resident reportedly tried to call for a nursing supervisor and the nurse pulled the wheelchair two or three times and caused the resident to do a wheelie in the wheelchair and the nurse continued along side the resident as the resident attempted to leave the nursing unit. The resident confirmed that the nurse was an agency nurse who had never provided care to him/her before and was not permitted to return to the facility. The resident further stated that the nursing supervisor responded and escorted the crazy nurse off of the unit, and the resident was assured that the nurse was not permitted to return to the facility. The resident further stated that he/she had severe PTSD and was visibly upset during the recount of the event. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's medical record reflected the following: Review of Resident #24's Resident Facesheet revealed that the resident was admitted to the facility in September of 2021, with a single diagnosis of Post-traumatic stress disorder. Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated 08/10/22, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was fully cognitively intact. Further review of the MDS indicated that the resident was independent with bed mobility, required limited assistance of one person for transfers, required set up for meals and required extensive assistance of one person for toileting and personal hygiene. Active Diagnoses that were identified in the assessment included but were not limited to: anxiety, depression, psychotic disorder (not specified) and PTSD. Review of Resident #24's Plan of Care (POC) revealed that a single diagnosis of Post-traumatic stress disorder (PTSD) was identified on every page of the 33-page document. Further review of the POC revealed that there was an entry dated 07/30/22, which confirmed the resident's account of the incident that occurred between the resident and the agency nurse. The problem identified that the resident had an altercation with a nurse, reported that the agency nurse yelled at the resident, pointed her finger at the resident, and blocked the resident with the medication cart in his/her room. Goals included that were effective on 08/11/22, included that the resident would feel safe and would be allowed to move freely around the facility. Interventions included: Staff to treat resident with dignity, respect, not raise their voices or yell at the resident, staff to allow the resident to leave his/her room as long as environment was safe, encourage resident to engage in care, staff to encourage resident to move about the facility at will, if resident asserts themselves verbally, staff to actively listen, validate, and respond to resident in an intentionally calm or low voice and lastly, staff to engage with resident and provide support. Further review POC revealed that there was no entry related to the resident's primary diagnoses of PTSD, triggers, and related goals and interventions. On 09/01/22 at 9:04 AM, the surveyor interviewed the Supervisor of Nursing/MDS Coordinator (SON/MDSC), who stated that each unit was assigned it's own MDS Nurse. She stated that she bore the responsibility to sign that the MDS was completed prior to submission. The SON/MDSC stated that the facility held Interdisciplinary Team Meetings/Care Planning MDS meetings. She remarked that it was identified in meetings that Resident #24 had a lot of pain. When the surveyor asked if she would expect to see a POC entry related to PTSD, she stated, Yes, especially with some of the resident's behaviors that I have heard about. The SON/MDS described the resident behaviors which included: yelling at staff, dressing change refusal and room mate refusal. She stated that a PTSD POC should have been there in the POC with specific triggers which may provoke the resident's behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/02/22 at 9:52 AM the surveyor interviewed the 7 AM - 3 PM Supervisor, who reportedly worked on another unit. The surveyor asked her to review Resident #24's Care Plan which was kept in a binder on the counter at the nurse's station with the surveyor. The 7 AM - 3 PM Supervisor stated that the MDS Nurse who was assigned to the unit was responsible to generate and update the resident's POC. The 7 AM - 3 PM Supervisor stated that the resident's POC should have included a PTSD entry and how to handle the resident's behaviors when they come up. The 7 AM - 3 PM Supervisor stated, Like what just happened now. The 7 AM - 3 PM Supervisor stated that the Unit Clerk phoned her unit and requested that she come over and address a concern with Resident #24. The 7 AM - 3 PM Supervisor stated that the resident complained that he/she requested a topical medication to treat foot pain that was no longer ordered and the resident hollered at the the nurse to, Do it now! The 7 AM - 3 PM Supervisor stated that she phoned the doctor and obtained an order and the doctor advised her to send the resident to the hospital if no relief. The 7 AM - 3 PM Supervisor stated, The POC was very important and that was why it was left on the desk. That is why it is here. On 09/02/22 at 10:02 AM, the surveyor interviewed Resident #24's assigned MDS nurse who stated that she was unsure if she initiated the resident's POC. She stated that the resident had behaviors, but not PTSD. She stated that the POC was generalized with behaviors, not specifically PTSD. She further stated that maybe we have not connected the behaviors and the diagnosis together. On 09/02/22 at 9:31 AM the surveyor interviewed the Social Worker (SW), who stated that Resident #24 had spoken to her about their diagnosis of PTSD and informed her that loud noises upset the resident and set off their PTSD such as with bed alarms and floor mats used by the facility. The SW stated that we suggested that we kept the resident's door closed a little bit, and the resident informed her that the resident did not want the door closed, because it was the resident's preference to keep the door open. The SW stated that the resident also referred to stuff that happened during war time. The SW further stated that, The POC should have addressed the resident's PTSD and included interventions and goals to include triggers such as loud noises and closing the door. On 09/02/22 at 12:13 PM the surveyor interview the Director of Nursing (DON), who stated that she would review Resident #24's POC because PTSD was the big problem. She stated she would have expected that the POC would have included an entry for the diagnosis of PTSD and related behaviors. The DON further stated that if staff were aware that the resident had PTSD, it should have been care planned to help alleviate the resident's behaviors. Review of the facility policy titled, Care Plans-Comprehensive (undated) revealed the following: Purpose: An individual comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident's comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Each resident's comprehensive care plan is designed to: Incorporate identified problem areas, Incorporate risk factors associated with identified problems, Build on the resident's strengths, Reflect the resident's expressed wishes regarding care and treatment goals, Reflect treatment goals, timetables and objectives in measurable outcomes, Identify the professional services that are responsible for each element of care, Aid in preventing or reducing declines in the resident's functional status and/or functional levels, .Reflect currently recognized standards of practice for problem areas and conditions . The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans: When there has been a significant change in the resident's condition, When the desired outcome is not met, When the resident has been readmitted to the facility from a hospital stay; and at least quarterly . NJAC 8:39-11.2 (e)(1)(2)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint #NJ00156516 Part A Based on interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure nursing staff appropriately removed an indwelling urinary catheter (soft plastic or rubber tube that is inserted into the bladder to drain urine) in accordance with professional standards of nursing practice which necessitated a transfer to the hospital for treatment, and a urinary tract infection. This deficient practice was identified for 1 of 3 Residents reviewed for indwelling urinary catheter care (Resident #179) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The facility's failure to have a system in place to ensure that nursing staff appropriately removed an indwelling catheter posed a serious and immediate threat to the health, and welfare of all residents who required catheter care. An adverse outcome had occurred and was likely to occur as the identified non-compliance resulted in an immediate Jeopardy (IJ) situation that began on [DATE] at 2:50 PM when the Registered Nurse (RN) improperly removed the indwelling catheter. The RN used scissors to cut through Resident #179's indwelling catheter, which then caused the remaining catheter to retract into the bladder. The Immediate Jeopardy (IJ) situation was identified during an onsite survey conducted on [DATE], and the facility was notified of the IJ, on the same day, at 3:20 PM. The facility submitted an acceptable removal plan on [DATE] at 2:55 PM. The team verified the removal plan during an onsite visit conducted on [DATE]. Findings included: (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:30 AM, the surveyor toured the 200 Unit of the facility and observed that Resident #179's door was closed. On the door, the surveyor observed signage posted which identified the required PPE (Personal Protective Equipment) to enter the room. The surveyor observed staff donning (putting on) and doffing (removing) with the required PPE before entering and exiting the room. An interview with the Registered Nurse/Unit Manager (RN/UM) revealed that Resident #179 was on isolation for Extended Spectrum Beta Lactamase (ESBL, antibiotic-resistant bacteria) and Methicillin Resistant Staphylococcus Aureus (MRSA, antibiotic-resistant bacteria) in the urine. On [DATE] at 11:29 AM, the surveyor donned the appropriate PPE, knocked at the door, waited for Resident #179 to answer, and entered the room. The surveyor observed Resident #179 in bed, awake with eyes open, and the surveyor observed a splint to the left arm. The surveyor explained the purpose of the visit, and Resident #179 agreed to be interviewed. Resident #179 was alert and stated that he could not move their left arm. Resident #179 answered all questions appropriately. The surveyor observed an indwelling urinary catheter covered with a catheter drainage bag hung on the bed frame. On [DATE] at 09:30 AM, the surveyor returned to the 200 Unit, the door was open, and Resident #179 was not inside the room. Upon inquiry, the RN/UM informed the surveyor that Resident #179 had tested + for COVID-19 in the evening during routine testing and was transferred to the 700 Unit. On [DATE] at 08:30 AM, the surveyor observed Resident #179 on the 700 Unit. The door was closed. Signage with the required PPE was posted on the door. The surveyor reviewed the medical record for Resident #179 on [DATE]. According to the Admission Face Sheet (an admission summary), Resident #179 was readmitted to the facility on [DATE] following a hospitalization for urinary retention. Resident #179 had diagnoses which included, but were not limited to, hypertension, diabetes mellitus, depression, hyperlipidemia, and End Stage Renal Disease. A review of Resident #179's Plan of Care, updated on [DATE] and [DATE], revealed that Resident #179 had decreased range of motion (ROM) and muscle strength related to co-existing chronic medical conditions. Resident #179 also was at risk for infection due to urinary retention. The care plan goal was for Resident #179 to not have a urinary tract infection and to receive the care needed to maintain their current functional status. The Annual Minimum Data Set Assessment (MDS), an assessment tool used by the facility to prioritize care, dated [DATE], revealed that Resident #179 scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. The section H of the MDS, which addressed Bladder and Bowel, Resident #179 received a score of 9 for H 0300. The score was indicative of the presence of an indwelling catheter in the bladder. The Interdisciplinary Progress Notes (IDPN) revealed that on [DATE] at 3:00 PM, a Registered Nurse documented in the IDPN, Per assigned desk nurse statement, in the process of removing resident catheter. She cut it and put a towel under it to prevent the urine from draining into the resident's pants. Before she could pull the catheter out part of the catheter retracted. It was reported to the writer. Director of Nursing (DON) and Assistant Director of Nursing (ADON) made aware. NP (Nurse Practitioner) made aware and gave order to transfer Resident #179 to the Emergency Department (ED) for retracted [indwelling urinary] catheter . Resident #179 was picked up at 2:55 PM by 911 crew. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A late IDPN entry dated [DATE], timed 3:30 PM, read, Dc' d [indwelling urinary] catheter retracted in the process of removing it. Resident transferred to ED. On [DATE] at 11:52 AM, the surveyor interviewed the RN/UM regarding the IDPN dated [DATE]. The RN/UM stated that the Registered Nurse (RN #1), who oversaw the unit on [DATE], cut the indwelling urinary catheter in the process of removing the indwelling urinary catheter. She stated that there was an order to remove the indwelling urinary catheter on [DATE]. RN #1 proceeded to execute the order to remove the urinary catheter. The RN/UM stated that RN #1 reportedly had never removed a urinary catheter before. She cut the urinary catheter with a pair of scissors instead of using a syringe to remove the water to deflate the balloon. The remaining urinary catheter then retracted into the bladder. Resident #179 was transferred to the ED for evaluation and treatment the same day. The hospital discharge summary was requested and was not available for review by the surveyor. The RN/UM stated she would inform the DON of the request for the hospital discharge summary. On [DATE] at 12:30 PM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed that she was aware of the above incident and informed the surveyor that RN #1 was currently suspended pending disciplinary action. The surveyor requested the investigation and the employee file for review. The surveyor also requested RN #1's telephone contact to conduct an interview. On [DATE] at 9:23 AM, the surveyor interviewed a random Registered Nurse (RN) assigned to the 200 unit regarding nursing resource materials available to the staff. The RN directed the surveyor to the binder outside the nursing station that contained all the policies and procedures. The surveyor located in the binder policy # 4:035 B titled, Indwelling Catheter Replacement, dated [DATE], which outlined the following: Indwelling Catheter replacement must have a physician order indicating size and schedule. Indwelling catheter replacement must be done by a registered nurse whose clinical skill has been checked by the instructor of nursing. If the physician and/or registered nurse, who has demonstrated clinical competence for this procedure is not available, send Resident to the emergency room for indwelling Catheter. The policy did not include a procedure to remove an indwelling urinary catheter. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:00 AM, the surveyor conducted a telephone interview with RN#1, who confirmed she was the nurse who received the order to remove the indwelling urinary catheter on [DATE]. RN #1 stated that she was overwhelmed that day and did not want to leave the procedure for the next shift. RN #1 stated she went to Resident #179's room with the Certified Nurse Aide (CNA), and she then used a pair of scissors from the treatment cart, cut the indwelling urinary catheter, and urine was splashing all over. She stated she then looked for the indwelling urinary catheter but could not locate it on the bed. RN #1 stated she realized that the indwelling urinary catheter retracted into the bladder. She stated she applied a towel to protect the resident's clothing, informed the RN/UM what had happened, and went to the desk and called and reported the incident to the Nurse Practitioner (NP). The NP then gave an order to transfer Resident #179 to Emergency Department for evaluation and treatment, and she reported the incident to the DON and initiated the 911 call for transfer. She stated that the DON informed her to leave the floor once she completed her statement. RN #1 stated that she had not received any in-service education on how to remove an indwelling urinary catheter at the facility. She stated she was aware that besides deflating the balloon, another simple way was to cut the indwelling urinary catheter. She stated, I made a mistake. RN #1 stated that she met with the DON in the office and explained what had happened. The DON informed her that she was suspended. The surveyor then asked RN #1 to elaborate on her work history prior to being employed by the facility. RN #1 stated that she worked as a floor nurse for a long-term care facility and a psychiatric hospital before working at the current facility. She stated she had been a Registered Nurse for [AGE] years. RN #1 stated after being hired by the facility, during orientation, she was able to demonstrate and was evaluated on the skill sets of inserting an indwelling urinary catheter. However, she was not evaluated on indwelling urinary catheter removal. A review of RN #1's orientation file provided by the Nurse Educator (NE) confirmed that she received in-service education on inserting a urinary drainage catheter on [DATE] during orientation. The surveyor requested RN #1's employee file from the DON. RN #1's employee file contained three written warnings, one for a medication error, the second for not donning the proper PPE during an outbreak, and the most recent was for an allegation of verbal abuse toward a family member. RN #1 also stated that she was informed during her hearing with the Employee Relation Officer ([NAME]) that she did not document all the required information on the hospital transfer form prior to sending Resident #179 to the ED. The surveyor then asked RN #1 if there were any resource materials on the floor that she could have used prior to removing the indwelling urinary catheter. She stated that she did not review any indwelling urinary catheter removal procedure before cutting the urinary catheter with scissors. She stated that she was provided with a form titled Wisconsin Technical College (Nursing Skills 21.13 Checklist for [indwelling urinary catheter Removal] during her hearing with [NAME] on [DATE]. On [DATE] at 10:15 AM, the surveyor reviewed the Facility assessment dated [DATE]. According to the documentation provided, the Facility Assessment had to identify and analyze the facility's resident population, which must be considered when determining staffing and resources needed to care for the residents. Understaffing training, it is revealed, Licensed nursing staff receive training and demonstrate competencies in areas of responsibility related to providing skilled nursing care to residents of the facility. Nurses receive updated and additional training as necessary to meet the changing needs of our residents. Training and competencies include, but not limited to: (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Licensed nurse training and/ or competencies. Oxygen set up Oxygen masks . Nasal cannula / Non-Rebreather /Simple face mask Wound care / Dressing Change Suctioning skill/ Trach care Glucometer Medication Pass Indwelling catheter replacement CPR The facility's Indwelling Catheter Replacement policy did not cover Foley Catheter Removal. On [DATE] at 10:37 AM, the surveyor conducted an interview with the NP responsible for Resident #179's care. The NP stated that she wrote an order to remove the indwelling urinary catheter and initiate a voiding trial. She received a call from the nurse, who stated that something had happened. The nurse stated she cut the indwelling urinary catheter to remove it, and the catheter retracted. The NP stated, I came on the unit, examined the Resident, the resident was not in pain. I gave an order to transfer Resident #179 to the ED for evaluation and treatment. The NP stated, I had never heard of such a procedure. The NP further stated that she was not informed of any follow-up or recommendations from the ED. The NP stated that she reviewed the After Visit Summary the next day and could not identify what treatment was provided. She said she called the hospital and spoke to the staff, but the hospital staff could not comment on what treatment was provided. The NP stated she asked for the Urology report and was informed that the Urologist was not called in to see Resident #179. The NP then explained to the ED, what had happened, and that the issue needed to be addressed immediately. The NP stated the Urologist was then made aware that Resident #179 had the retracted catheter in the bladder. On [DATE] at 12:03 PM, the surveyor interviewed the NE in charge of orientation and staff competencies. The surveyor inquired about specific competencies and skill sets necessary to care for resident needs. The NE provided the surveyor with the orientation package. A review of the orientation package confirmed that indwelling urinary catheter removal was not included in the competencies. RN #1 did not receive in-service training for indwelling urinary catheter removal. The NE stated that Licensed Staff had to go to general orientation classes for two days and then work with a mentor on the floor for 14 days (for full time) employees. Mandatory training was scheduled yearly, and skill sets for competencies were completed every two years. Based on the orientation package provided, the facility staff did not receive competency training for indwelling urinary catheter removal. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The NE stated that he was aware of the adverse outcome with the Foley catheter on the [DATE] incident. He was informed that Resident #179 was transferred to ED for treatment because the indwelling urinary catheter was improperly removed. The surveyor requested in-service education training provided after the incident, but none had been provided. When asked how nursing staff competency education was being tracked, the NE added the DON would inform him of any needed in-service education training. The Orientation package provided by the facility was reviewed with the NE on [DATE] and did not include Foley Catheter Removal. The current policy revealed how to insert an indwelling urinary catheter only. The facility was unable to provide the rationale for nursing staff not being trained or assessed for competency on how to remove an indwelling urinary catheter. On [DATE] at 4:40 PM, the surveyor conducted a second interview with RN #1. She stated that she had performed the skill to remove an indwelling urinary catheter before deflating the balloon. She stated that cutting the indwelling urinary catheter was a simple procedure that she had not used prior. She stated that she overheard nurses saying that you could cut the indwelling urinary catheter to remove it, and that was why she cut the indwelling urinary catheter. She stated that after the incident, she went to the internet, watched a video, and realized that she did not follow the proper technique. RN #1 stated that she cut the catheter 4 to 5 inches below the insertion site, not by the port, to evacuate the water. The surveyor then asked RN #1 to elaborate on the procedure for indwelling urinary catheter removal. She stated: 1. Verify the order, identify the patient, explain the procedure, provide privacy, use a syringe to deflate the balloon by aspirating the water, and gently pull the indwelling urinary catheter. She stated she was very concerned regarding the resident's well-being. She kept calling every day to inquire regarding Resident #179's status. RN #1 was able to elaborate on the process of properly removing an indwelling urinary catheter. She could not provide the rationale for cutting the indwelling urinary catheter, which caused Resident #179 to be transferred to the ED for treatment. On [DATE] at 09:30 AM, The DON provided the Investigation Report for review. The surveyor reviewed the final report, which revealed the following: Physical Evidence On [DATE], the charge nurse reported that in the process of removing Resident #179's indwelling urinary catheter, she cut the catheter and part of it retracted into the bladder. Resident #179 was immediately discharged to the hospital for intervention. CT urogram (used to examine the kidneys and bladder) without contrast was performed in the hospital with the impression there is significant bladder wall thickening with peri cystic inflammation suggesting cystitis (inflammation of the urinary bladder), no hydronephrosis or renal calculi identified, a note is made of small bilateral pleural effusion (abnormal fluid collection between thin layers of tissue lining the lung and the wall of the chest cavity), and urinary bladder is partially collapsed around Foley catheter. No further intervention was taken at the hospital. Recommendations: [DATE] Urology consult by ___, with recommendation for bladder ultrasound. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[DATE] Bladder ultrasound taken on with conclusion of bladder not visualized, to consider ST scan not ordered. On [DATE] resident was seen by the Cardiology group and cleared for cystoscopy. On [DATE], cystoscopy was performed for removal, and a new Foley catheter was placed. The resident was referred for follow-up with Urologist. Resident's care plan revision: Bladders scan every shift Monitor for signs and symptoms of infection Observe Resident for any abdominal pain Encourage fluids Refer to MD if no urinary output Staff Education All nurses were given competency for Foley catheters. Conclusion A Cystoscopy was performed on Resident #179; the retracted piece of the indwelling urinary catheter was removed, and a new indwelling urinary catheter was re-inserted. The resident is being monitored for any signs and symptoms of infection. A bladder scan is being performed every shift to monitor for bladder retention. Resident #179 will be seen by a urologist on [DATE] at the facility. The RN who cut the Foley catheter remains on suspension pending investigation. On [DATE] at 9:51 AM, an interview was conducted with the DON, who stated that she made her last rounds at 2:50 PM and was informed that Resident #179 had to be sent out because the nurse cut the indwelling urinary catheter. When asked if the nurse provided the rationale for cutting the indwelling urinary catheter, the DON added that the indwelling urinary catheter removal was a skill set that was taught in school, and all licensed staff should know how to remove an indwelling urinary catheter. The DON did not interview RN #1 to identify the causal factor, implement corrective action, or prevent recurrence. The DON stated that during her career, she had never heard of cutting the indwelling urinary catheter as a skill set to remove the indwelling urinary catheter. The DON stated that RN #1 was suspended pending disciplinary action, and the incident had been reported to the Department of Health. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:17 AM, a second surveyor interviewed the Physician Assistant (PA) covering for the Urologist. He stated they had been assigned to the facility for about 1 ,d+[DATE] to 2 years. Their responsibilities consisted of reviewing all urology consults and changing all indwelling urinary catheters monthly. Resident #179 was seen at the hospital for urinary retention ([DATE]- [DATE]), and an indwelling urinary catheter was inserted prior to discharge to the facility. He was made aware of the adverse outcome of the indwelling urinary catheter removal by the NP. Resident #179 had to have a scheduled cystoscopy to remove the remaining catheter in the bladder. He stated if the resident had a cardiac history, medical clearance had to be obtained to ensure that the resident was stable to sustain the procedure under anesthesia. The PA stated that based on the report obtained from the facility, Resident #179 was able to void and did not develop signs/ symptoms of infection. The PA was unaware that Resident #179's urine culture and sensitivity tested positive for E Coli, ESBL, and MRSA on [DATE] and that Resident #179 had to be placed on Macrobid (antibiotic) to treat the urinary tract infection. On [DATE] at 12:06 PM, the surveyor interviewed the CNA who assisted the RN #1 on [DATE]. The CNA stated that Resident #179 got out of bed three times weekly. It was almost 3:00 PM, and Resident #179 had been dressed and was up and sitting in a wheelchair. The nurse asked her to assist with removal of the indwelling urinary catheter. She stated, she went to the room, pulled Resident #179's pants down just enough to see the indwelling urinary catheter. The CNA stated the catheter was long, the nurse retrieved a pair of scissors from her packet and cut the yellow part that goes into the penis. The nurse then told me to pull out the long part from the pants. The CNA stated that the nurse asked her, What happened to the other part? The CNA stated, I do not know, and the RN #1 stated, It went back inside. The RN #1 then attempted to retract the penis to see if she could visualize the other part of the catheter and she could not. RN #1 then called the UM, explained what had happened, and I was told to return Resident #179 to bed. Upon further inquiry, the CNA stated, I never assisted any other staff at the facility to remove an [indwelling urinary catheter]. I worked in the ED before, and I know when you insert an [indwelling urinary catheter], you have to put water into the port to inflate the balloon and when you had to remove them, [indwelling urinary catheter] you have to take the water out. The surveyor then asked why she did not offer any guidance to RN #1. The CNA replied, She is an RN. She is supposed to know. On [DATE] at 09:43 AM, the surveyor interviewed RN #1 with another surveyor present. RN #1 stated that she attended and graduated from one of the State Colleges. During her academic years, she was taught how to remove an indwelling urinary catheter, but the skill sets were not demonstrated. She stated that in nursing school, she was not evaluated on the skill sets to remove an indwelling urinary catheter. RN #1's failure to remove the Foley catheter in accordance with professional standards of nursing practice resulted in harm, unnecessary transfer to the hospital for treatment and a urinary tract infection. Resident #179 had to have a Cystoscopy (procedure to look inside the bladder with a camera) to remove the retracted indwelling urinary catheter. RN #1 did not seek assistance from other nursing staff to remove the indwelling urinary catheter. She did not inform the Nurse Educator that she needed assistance with the indwelling urinary catheter removal. Part B (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Based on interview and document review, it was determined that the facility failed to ensure: a.) the facility policy was followed to document all pertinent information on a universal transfer form prior to a resident being transferred to the hospital, and b.) thoroughly review instructions/recommendations on the After Visit Summary (hospital discharge summary) to facilitate continuation of care. This deficient practice was identified for 1of 3 Residents reviewed for indwelling urinary catheter care (Resident #179) and was evidenced by the following: 2. On [DATE] at 11:30 AM, the DON provided a copy of the reportable event forwarded to the Department of Health. The surveyor reviewed the report and observed that the facility did not include the New Jersey Universal Transfer Form (NJUTF) that was identified as not completed. Pertinent information regarding the reason for transfer was not entered to inform the ED of the reason for transfer. On the NJUTF the following information was documented, Tube/catheter. Resident # 179 was sent back to the facility with the remaining catheter in the bladder. The Urologist was not called and informed that the nurse cut the indwelling urinary catheter and the remaining catheter was still inside Resident #179's bladder. The ED was informed of the retracted catheter remaining in the bladder on [DATE], one day after the resident was transferred to the ED, by the NP. On [DATE] at 11:34 AM, the DON provided the surveyor a copy of the undated facility's policy Resident Transfer Form. The policy revealed: Purpose: The purpose of this procedure is to ensure continuity of care in transfer from the facility to the hospital or other extended care facility. Procedure: 1. In the event a resident needs to be transferred to a hospital or other long-term care facilities, the charge nurse is responsible for filling out a Resident Transfer Form. 2. The form must be completed totally, and all information must be up-to-date and accurate. 3. The attached copy of the completed transfer form is to be placed in the resident's chart. 4. Information received in reference to resident transfers will be forwarded to the units by the nursing office. 5. The Nursing Services Clerk will transcribe the information to the Universal Transfer Form and date and sign the form. The form will be placed in a sheet protector and placed in the front of the chart. The facility failed to enter all the pertinent information on the NJUTF to facilitate continuity of care. The reason for the transfer was not documented, and the ED had not been informed that Resident #179's indwelling urinary catheter was cut. The remaining catheter remained in the resident's bladder. The Urologist was not called and informed of the incident. Resident #179 returned to the facility with the remaining catheter not being removed from the bladder. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. The surveyor reviewed the After Visit Summary dated [DATE], which revealed that during the ED visit, Resident #179 received Rocephin [a broad spectrum antibiotic] 1 gram (gm), intravenously at the hospital for preventive measure of UTI. Please give Cephalexin (Keflex; antibiotic) 500 mg (milligrams) every 12 hours for the next 7 days for treatment of Urinary Tract Infection. The physician, or the NP was not made aware of the recommended continued medication order. The surveyor reviewed the [DATE] Medication Administration Record (MAR) and the order was not transcribed. On [DATE] at 10:23 AM, in the presence of the survey team the surveyor conducted an interview with the Assistant Director of Nursing (ADON). The ADON confirmed that staff missed the instructions on the After Visit Summary for the Keflex order. The ADON stated, on [DATE] during the final investigation regarding the adverse outcome with the Foley Catheter Removal, she discovered that Resident #179 did not receive the Antibiotic ordered on [DATE]. She reported the incident to the DON, and the administrator. She stated, she consulted with the (MD) who ordered Urine analysis, urine culture and sensitivity, Keflex 500 mg twice daily for 10 days for preventive measure. The facility received the urine culture result on [DATE] and the final report revealed the following: Urine Culture Colony Count Source: Colony Count: 100, 000 + Grams-Negative Rods Gram-Positive Cocci in clusters Extended Spectrum Beta Lactamase (ESBL)- Positive ESBL is an enzyme that causes an organism to become resistant to extended-Spectrum cephalosporins, monobactams and extended-spectrum penicillins. Contact precautions indicated. Positive for MRSA. Contact precautions indicated. The NP was informed of the result on [DATE]. Resident #179 was placed on contact isolation. Keflex was discontinued and Macrobid 100 mg was ordered twice daily for 5 days. On [DATE] at 10:05 AM, the surveyor conducted an interview with the Medical Director (MD) in the presence of the team. The MD confirmed that the facility discussed with him the adverse outcome with the urinary catheter removal. He stated he was consulted by both the DON and the Assistant Director of Nursing regarding Resident #179's not receiving the Antibiotic ordered at the hospital since [DATE]. He gave a verbal order to obtain Urine Analysis, urine culture and sensitivity and ordered Keflex 500 milligrams every 12 hours for 10 days for UTI. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The surveyor observed a signed verbal order in the clinical record dated [DATE]. The MD stated, apparently this nurse had heard that cutting the [indwelling urinary catheter] was the easiest way to take the [indwelling urinary catheter] out. She opted for the easiest way. I am not sure where the education came from. I just do not know how it happened; the nurse needed to be suspended. The MD further stated, he started in July and identified that staff education, lack of oversight from the physician, infection control, mishandling of patient's care, policies and standards procedure needed to be addressed. He added the facility needed a system to track significant issues. [DATE] at 3:02 PM, the surveyor conducted a telephone interview with the Registered Nurse (RN #2) who received Resident #179's After Visit Summary on [DATE]. The RN #2 confirmed that she was assigned to Resident #179 on the third shift (11:00 PM-07:00 AM) She stated that she did not see the instructions for the Keflex order and did not inform the NP. RN #2 stated that she reviewed the After Visit Summary with the Supervisor of Nursing (SON) and they both missed the instructions to administer Keflex. The Keflex order was not documented on the After Visit Summary dated [DATE], and Resident #179 received the Keflex 15 days later ([DATE]). RN #2 stated, she was made aware of the mistake by the ADON, and DON. The RN stated, I do not know how I missed the order. I reviewed the After Visit Summary that day and did not see the order. The SON and the NP both reviewed the After Visit Summary and missed the order. Resident #179 did not receive the antibiotic for 15 days. Resident #179's UA and C&S result was positive for E.Coli, ESBL and MRSA on [DATE]. The facility was unable to provide a rationale for the nurses failing to thoroughly review the After Visit Summary and then failing to communicate the recommendations to the physician/NP. On [DATE] at 12:32 PM, during an additional interview with the NP in the presence of the survey team.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 27193 Complaint #NJ156886 Based on interview, record review, and review of other facility documents, it was determined that the facility failed to ensure a resident who sustained a fall with a possible fractured arm received a timely recommended medical follow-up by failing to: a.) thoroughly review the After Visit Summary (discharge hospital summary) and communicate the recommendations to the physician, and b.) thoroughly review an X-Ray report received on 07/13/22, and alert the physician of the recommended follow-up with more films to confirm the possible fracture detected on the X-Ray. This deficient practice occurred for 1 of 47 sampled residents reviewed (Resident #44) who sustained a fall with a hematoma (collection of blood outside of blood vessels) on the forehead on 07/12/22. There was a 12 day delay from 07/13/22 to 07/25/22. The recommended follow-up was as soon as possible for a visit in 2 days (around 07/14/22), and was evidenced by the following: Reference: New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist: On 08/16/22 at 10:52 AM, during the initial tour of the facility, the surveyor observed Resident #44, who had a yellow cast on the right forearm. The resident was sitting in a chair in the room close to the nursing station and did not respond to the surveyor's greetings. On 08/17/22 at 1:16 PM, the surveyor observed Resident #44 in the room eating lunch. Resident #44 consumed approximately twenty-five percent of the lunch tray. On 08/18/22 at 1:28 PM, the surveyor observed Resident #44 sitting quietly in the resident's room and wearing non-skid socks on both feet. The yellow cast was observed on the right forearm. On 08/19/22 at 8:51 AM, Resident #44 was observed sitting in the room eating breakfast. The yellow cast was observed on the right forearm. On 08/23/22 at 9:22 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who cared for Resident #44. The CNA stated that Resident #44 was totally dependent upon staff for care but was able to feed themself after set-up. The CNA stated that Resident #44 could be combative with care. However, she had developed a trusting relationship with the resident, and the resident was not very combative with her during care. The CNA also stated that the family was very involved. The surveyor reviewed Resident #44's medical record on 08/17/22. According to the Admission Face Sheet, Resident #44 was admitted to the facility with diagnoses which included, but were not limited to: hypertension (high blood pressure), pernicious anemia (a condition in which not enough red blood cells are produced due to deficiency of vitamin B12 in the body) and Dementia (a group of symptoms that affects memory, thinking and interfered with daily life) with behavioral disturbances. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The quarterly Minimum Data Set Assessment (MDS), an assessment tool used by the facility to prioritize care, dated 05/22/22 and 08/22/22, revealed that Resident #44 was severely cognitively impaired. Resident #44 scored 99 on the Brief Interview for mental status (Normal score 8-15). Further review of the MDS revealed that Resident #44 was unable to make their needs known. A Care Plan (CP) dated 10/29/20 revealed the following problems: Cognitive- Resident #44 was impaired in decision making ability related to Depression, Dementia, and anxiety as evidenced by difficulty making decisions in new situations, poor decision ability, and needs cues and supervision. The fall care plan dated 12/27/17, last revised 07/28/22 included the following: Keep my surroundings safe and free from clutter. Keep my bed at the lowest safe position. Apply non-skid strips on the floor. Assist me to wear non-skid socks when I am not wearing shoes . A Progress Note dated 07/12/22 revealed that Resident #44 sustained a fall with injury. Resident #44 was observed lying on the floor in the room with a hematoma (collection of blood) on the forehead measuring 3.5 centimeters (cm) x 3.5 cm. Resident #44 was transferred to the Emergency Department (ED) for evaluation and treatment. CT Scan (Computed Tomography) of the spine and head performed at the hospital was negative for fracture. The nurse documented upon return to the facility the following: Scalp hematoma still persists, no signs and symptoms of distress noted. The recommendations to follow up as soon as possible for a visit in 2 days was not depicted on the After Visit Summary dated 07/12/22. The following entries were documented in the clinical record: On 07/13/22 - 07:00 AM. Received resident in bed sleeping, hematoma still persists on right forehead slept in the night. Neuro checks (assess an individual's neurological functions, motor and sensory response, and level of consciousness) within normal limits . will continue to monitor. On 07/13/22, the surveyor reviewed the medical record which lacked evidence of a post fall nursing assessment completed for the 7:00 AM - 3:00 PM shift. On 07/13/22 at 4:00 PM, the resident (referring t Resident #44) received in bed, sleeping, and the patient spit out Tylenol offered. Upon assessment, swelling was noted on the right wrist. When assessing the right hip, the resident was guarding. MD (Medical Doctor) made aware and ordered stat X-Ray of the right side of the upper body, forearm, femur, right pelvis, right humerus, right tibia/ fibula. The resident remained in bed. Will continue to monitor. On 07/14/22, there was no evidence of a documented post fall assessment for the 7:00 AM - 3:00 PM shift. On 07/14/22, 11:00 PM - 7:00 AM shift, revealed that Resident #44 refused vital signs, all care rendered, no delayed injury noted from past fall. On 07/14/22 at 5:40 PM, the following entries were noted, Received resident in bed, X-Ray of the body was done. No fracture noted. Meals and meds well tolerated. No delayed injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The surveyor reviewed the X-Ray result, dated 07/13/22, timed 5:38:22 PM, and observed the word Alert was stamped on the X-Ray result. Under the section Forearm AP [(Antero Posterior) and lateral, Right. The following were documented: The study is significantly limited. No fracture or bone destruction are seen in the forearm. However, there is a possible subtle nondisplaced fracture in the right distal right radius. No soft tissue masses are seen. Conclusion: Limited study. There is a possible nondisplaced fracture in the distal right radius. Follow-up more complete wrist films are recommended along with clinical correlation. The above recommendations were not communicated to the physician/Nurse Practitioner in charge of Resident #44's care. On 08/29/22 at 9:20 AM, the surveyor interviewed the Registered Nurse (RN) who received the X-Ray report on 07/13/22. The RN stated that she reviewed the X-Ray result along with the Unit Manager and did not see the recommendations. The surveyor inquired about the word Alert observed on the report. The RN stated, alert means abnormal The RN further stated that she reviewed the first page only and did not see the second page with the recommendation. The RN stated it was only on 07/25/22 that she was made aware of the second page. The RN confirmed that she did not contact the nurse practitioner or physician with the recommendations documented on the X-Ray report that the resident had a right wrist fracture. The RN stated that she met with the Director of Nursing (DON), and the DON had not informed her that she had to provide a statement pertaining to this incident. The RN stated she was not provided with any education either. The RN elaborated that on 07/25/22, a change of condition was reported by the CNA who cared for Resident #44, and the nurse then assessed the resident. At that time, it was noted that Resident #44 was limping, guarding the right side, and appeared to have pain in the right arm. The physician was called and ordered an X-Ray of the right side of the body. The X-Ray report dated 07/25/22 timed 11:46:33 PM, confirmed the fracture identified on the report dated 07/13/22 and indicated the following: Comparison is dated 07/13/22. As was suspected on the previous examination (07/13/22), there is a nondisplaced distal radius fracture without significant interval healing. No additional fractures are observed. There is no destructive bony process. The surrounding soft tissues have a normal appearance. The NP gave an order to transfer Resident #44 to the hospital for evaluation and treatment. Imaging Tests[X-Ray forearm two views Right] confirmed a closed fracture of the distal end of the right radius with delayed healing. During the second ED visit dated 07/26/22, a second X-Ray confirmed the fracture detected since 07/13/22. Resident #44 returned with a splint to the right arm. On 08/10/22, during a visit to the orthopedist, Resident #44 had a cast applied to the right hand to facilitate healing of the fracture. The cast was removed on 08/23/22. The Nurse Practitioner signed the X-Ray report on 07/19/22 and missed the recommendations on the X-Ray report. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/29/22 at 10:05 AM, an interview with the Director of Nursing (DON) in the presence of another surveyor revealed that during the investigation, she noted that the nurse failed to pick up on the recommendations both on the After Visit Summary and on the X-Ray report; therefore, there was a delay in treatment. The DON stated, When a consult comes in, there should be a follow-up. The DON confirmed that the recommendations were not detected during the 24 hours chart check. The DON added, There is going to be a write-up for the nurses and the supervisors as well. An entry dated 07/26/22, timed 10:15 AM, revealed that the son was made aware of the fracture on 07/26/22. He indicated, I still want my (Resident #44) to go to the hospital in case she fell and sustained an injury or serious medical condition. The family was not informed of the fracture on 07/13/22. On 08/29/22 at 10:33 AM, an interview with the Registered Nurse/Unit Manager (RN/UM) revealed that she was unaware of the follow-up required as documented on the After Visit Summary until 07/25/22. The RN/UM confirmed that she reviewed the X-Ray report also and missed the recommendations. On 08/30/22 at 09:30 AM, the surveyor requested all investigative reports for Resident #44 from the DON. The facility provided a Reportable Incident dated 07/25/22. The report revealed the final investigation indicated that Resident #44 was observed with swelling. X-Ray done, result was positive for fracture of the right distal radius. MD (physician) notified of result and ordered for Resident #44 to be transferred to the hospital for further evaluation and treatment. Resident #44 returned from the hospital with a splint to the right arm. On 08/30/22 at 12:13 PM, conducted a second interview with the regularly assigned CNA assigned to Resident #44. The CNA stated that the bruises had been present since last week. The CNA stated that she did not report it to the nurse because the bruise had been there since the fall, and she thought the nurse knew about it. Conclusion: Resident (referring to resident #44) was noted with swelling of the right wrist region on 07/29/22. resident did have an X-Ray of the same area on 07/12/12, which the radiologist reported as inconclusive for fracture. However, based on clinical record provided by the facility and reviewed on site, Resident #44 was noted with swelling of the right wrist on 07/13/22. An X-ray was ordered and carried out on that same day, 07/13/22. The X-Ray report dated 07/13/22 came with an Alert as there was a possible nondisplaced fracture seen, and the facility was to order more films to correlate. The facility missed the recommendations. The physician or the nurse practitioner was not made aware until 07/25/22, when a change of condition was reported. On 08/31/22 at 10:09 AM, during a second interview with the DON, she indicated that the Nursing Supervisor informed her on 07/25/22 that she needed to schedule an orthopedic appointment that had been missed on 07/12/22. She did not have any prior knowledge of the incident. On 08/31/22 at 11:18 AM, the surveyor observed Resident #44 sitting in the room with the left hand holding the right wrist. On 08/31/22 at 12:30 PM, an interview with the Physical Therapy (PT) Director revealed that Resident #44 was not referred to PT immediately after the fall. He received a referral on 07/29/22. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/31/22 at 1:43 PM, an interview was conducted with the NP in charge of Resident #44's care. The NP was asked if she was aware of the fracture when she signed the report on 07/19/22. She stated that she did not know exactly what she did. When asked to elaborate on the process if a fracture was detected on the X-Ray report, she said she would usually follow up immediately and notify the family right away. The NP stated, I could not remember. I don't know. There was no documented evidence that the fracture was detected and discussed with the family on 07/13/22. The RN who reviewed the report did not inform the NP. On 09/01/22 at 8:55 AM, the surveyor conducted a second interview with the RN. The RN stated that she had been aware of the After Visit Summary recommendations. She added that she had discussed the recommendations with the NP, and the NP then informed the son, and the NP indicated that there was no need to follow up. On 09/01/22 at 11:21 AM, during a second interview with the RN/UM, she confirmed that she reviewed the X-Ray result with the Charge Nurse. The UM stated, We both saw the word Alert, and we don't know how we missed it. When asked if the radiology department was called to clarify the Alert, the RN/UM stated that she did not contact radiology to clarify the Alert. On 09/01/22 at 11:21 AM, during a third interview with the RN, who initially received the X-Ray report, she maintained that she did not review the whole report. She stated, If I was aware, I would call the MD/NP immediately., and we did not follow up with the care that needed to be provided. The RN stated, This is a delay in treatment. I learned my lesson and need to review the whole report to the end. The RN further stated that she had not received any education yet regarding the incident. The surveyor then asked the RN to elaborate on the facility's documentation post-fall. The RN stated that the staff was to perform a daily head-to-toe assessment for 5 days after a fall. When asked if body check was done or the protocol was being followed, she replied that Resident #44 was always combative with care. There was no documented evidence that assessment was carried out post fall on all three shifts for five days. On 09/01/22 at 9:07 AM, the surveyor observed Resident #44 in bed. Resident #44 was not dressed. On 09/01/22 at 2:13 PM, an interview with the Nursing Supervisor on duty that day revealed that she did not review the After Visit Summary or the X-Ray result. The nurse told her there was no fracture. She did not assess the resident as the resident returned the same day. She was not aware of the recommendations. She added that the Nursing Supervisor on the day shift was to follow on the next day. On 09/02/22 at 9:37 AM, the regular CNA assigned to Resident #44 retired. Throughout the survey until 09/01/22, the surveyor would observe Resident #44 sitting in the room eating breakfast early in the morning. On 09/02/22 at 9:37 AM, the surveyor observed Resident #44 in bed. The side rails were elevated on both sides. The breakfast tray was untouched. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 09/02/22 at 10:20 AM, an interview with the Charge Nurse revealed that the breakfast tray was served around 7:30-08:00 AM. Care was not provided to Resident #44 until the surveyor inquired about the breakfast tray at 10:30 AM. The nurse stated that the resident was left in bed due to a cardiologist visit. There was no rationale provided for the breakfast tray left at the bedside with the side rails up and the breakfast tray, not within the resident's reach. The Charge Nurse also acknowledged that since the fall, the resident had not been able to ambulate and confirmed that Resident #44 could not reach the breakfast tray. That same day the Charge Nurse had to use a transport chair to transfer Resident #44 from the room to the hallway to be weighed. No weight loss was noted. On 09/02/22 at 10:25 AM, an interview with the CNA who cared for the resident that day revealed that he worked the 3:00-11:00 PM shift and was unfamiliar with Resident #44's routine. He was aware that Resident #44 was combative with care. The CNA added that he did not provide care yet to Resident #44. Resident #44 was a high risk for falls. Resident #44 received a score of 16 on the Fall Risk Assessment. A care plan to prevent falls was in place prior to the fall. After the fall, dated 07/12/22, the care plan was revised to include non-skid strips on the fall care plan. However, the facility did not follow up with: a) recommendations on the After Visit Summary. b) recommendations on the X-Ray report, which came with an Alert. Resident #44's clinical record lacked evidence that the physician or nurse practitioner was consulted with all the recommendations dated 07/12/22 and 07/13/22 and that a head to toe assessment was done on all three shifts following the fall. The clinical record lacked evidence of any steps taken to address Resident #44's health status in a timely manner. The facility lacked evidence of a system to ensure that all recommendations and consults were thoroughly reviewed, documented, and communicated to the physician or the nurse practitioner in a timely manner. Although the nurse practitioner confirmed that she signed the X-Ray report on 07/19/22, the clinical record lacked evidence that she was aware of the possible fracture, acted upon the recommendations, and consulted with Resident #44's family before 07/26/22. An undated facility policy entitled Guidelines for Charting and Documentation included: The purpose of charting and documentation is to provide : 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, and the progress of the resident's care. 2. Guidance to the physician in prescribing appropriate medications and treatments. 3. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. The above findings were reviewed with the facility administrative staff on 09/01/22 and again during the Exit Conference. No further information was provided. NJAC 8:39-27.1 (a)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 27193 Complaint #NJ156516 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to ensure that licensed nursing staff had the specific competency and education on the removal of a resident's (Resident #179) indwelling urinary catheter. This deficient practice was identified for 1 of 1 Registered Nurse (RN) reviewed and was evidenced by the following: Refer to F658 L The clinical record of Resident #179 was reviewed on [DATE]. According to the Admission Face Sheet, Resident #179 was readmitted to the facility on [DATE] following hospitalization for urinary retention. Review of Resident #179's care plan updated on [DATE] and [DATE], revealed that Resident #179 was at risk for infection due to urinary retention. The care plan goal was for Resident #179 not to have a Urinary Tract Infection and to receive the care needed to maintain his/her current functional status. The Annual Minimum Data Set Assessment (MDS) an assessment tool used by the facility to prioritize care dated [DATE], revealed in section H which addressed Bladder and Bowel, that Resident #179 had an indwelling urinary catheter in the bladder. A review of the Interdisciplinary Progress Notes (IDPN) dated [DATE] at 3:00 PM, revealed that the Registered Nurse (RN) caring for Resident #179 had used an improper procedure in attempts to remove the indwelling urinary catheter which caused part of the catheter to retract into the resident's bladder. It was noted that the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Nurse Practitioner (NP) were made aware. Orders were given to transfer Resident #179 to the emergency room for retracted indwelling urinary catheter removal. Resident #179 was transferred via 911. On [DATE] at 11:52 AM, the surveyor interviewed the RN Unit Manager (RN/UM) regarding the IDPN dated [DATE]. The RN/UM revealed that the RN caring for Resident #179 had cut the indwelling urinary catheter. The RN/UM stated reportedly the RN had never removed an indwelling urinary catheter before, so the RN cut the catheter with a pair of scissors instead of using a syringe to remove the water to deflate the balloon. The remaining portion of the catheter retracted into the bladder. On [DATE] at 9:23 AM, the surveyor interviewed a RN assigned to the 200 unit regarding resource materials available on the floor. The RN directed the surveyor to the binder located outside the Nursing Station that contained all the facility policies and procedures. A review of the facility policy, # 4:035 B titled, Indwelling Catheter Replacement dated [DATE] revealed: Indwelling Catheter replacement must have a physician order indicating size and schedule. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Indwelling catheter replacement must be done by a registered nurse whose clinical skill has been checked by the instructor of nursing. If the physician and/or registered nurse, who has demonstrated clinical competence for this procedure is not available, send Resident to the emergency room for indwelling Catheter. The binder and the policy did not include the procedure for the removal of an indwelling urinary catheter. On [DATE] at 11:00 AM, the surveyor conducted a telephone interview with the RN. The RN stated that she had not received any in-service or education on how to remove an indwelling urinary catheter at the facility. The RN stated that after being hired by the facility and during orientation, she was able to demonstrate and be evaluated on the skill sets of inserting an indwelling urinary catheter but was not evaluated on the removal of an indwelling urinary catheter. The surveyor then asked the RN if there were any resource materials on the nursing unit that she could have referenced prior to removal of the indwelling urinary catheter. The RN stated that she did not review any procedure on indwelling urinary catheters but that she was provided with a form titled, [redacted -out of state form] Nursing Skills 21.13 Checklist for [redacted] (indwelling urinary catheter) Removal from a facility representative on [DATE]. A review of the RN's orientation file provided by the Nurse Educator (NE) confirmed that the RN received in-service education on how to insert an indwelling urinary catheter on [DATE] during orientation. On [DATE] at 11:15 AM, the surveyor reviewed the Facility assessment dated [DATE]. According to the documentation provided, the facility had to identify and analyze the resident population that must be considered when determining staffing and resources needed to care for the residents. Under staff training it is noted, Licensed nursing staff receive training and demonstrate competencies in areas of responsibility related to providing skilled nursing care to residents of the facility. Nurses receive updated and additional training as necessary to meet the changing needs of our residents. Training and competencies include, but were not limited to: Licensed nurse training and/ or competencies. Oxygen set up Oxygen masks . Nasal cannula / Non-Rebreather /Simple face mask Wound care / Dressing Change Suctioning skill/ Tracheostomy care Glucometer Medication Pass (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Indwelling catheter replacement Cardiopulmonary resuscitation (CPR) The Facility's policy for Indwelling Catheter Replacement did not cover indwelling urinary catheter removal. On [DATE] at 12:03 PM, the surveyor interviewed the NE in charge of orientation and staff competencies. The surveyor inquired about specific competencies and skill sets necessary to care for resident's needs. The NE provided the surveyor with the orientation package used by the facility. A review of the orientation package confirmed that indwelling urinary catheter removal was not included in the competency. The RN had not received any in-service training for indwelling urinary catheter removal. The NE stated that licensed staff had to go to general orientation classes for 2 days, then they had to work with a mentor on the nursing unit for 14 days. The NE stated mandatory training was scheduled yearly and skill sets for competencies every two years. Based on the orientation package provided, the facility staff did not receive competency training for indwelling urinary catheter removal. The NE stated that he was aware of the adverse outcome with the attempted indwelling urinary catheter removal on [DATE] and that Resident #179 had to endure emergency care because the indwelling urinary catheter was improperly removed. The surveyor requested in-service or education training that was provided after the incident, none was provided. A review of the facility provided policy revealed it had not been revised to include indwelling urinary catheter removal. When asked how licensed staff competency education was being tracked, the NE added he would be informed by the DON of any needed in-services or educational training. The facility could not provide the rationale for licensed staff not being trained or provided competency on how to remove an indwelling urinary catheter. NJAC 8:,d+[DATE].3(a), 27.1(a)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Reference F 600, F 658, F 880 and F 886 Based on observations, interviews, review of medical records and review of facility documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure: a) that an alert and oriented resident (Resident #24) who was being verbally abused by an Agency Nurse was not prevented from leaving the unit to seek help by a Certified Nurses Aide (CNA) on [DATE], who was permitted to work for seven shifts without any additional abuse training or investigation to rule out possible abuse until surveyor inquiry b) that a resident's (Resident #179) Foley urinary catheter was removed in accordance with professional standards of practice which resulted in transfer to an acute care hospital on [DATE] and the resident returned to the facility on [DATE] with a portion of the severed catheter which remained in the bladder and the resident was consequently ordered a prophylactic antibiotic to prevent infection to be administered at the facility that the resident did not receive, prior to a required urological surgical procedure after awaiting cardiac clearance to extract the foreign body that remained in the bladder and later resulted in the resident receiving additional antibiotic treatment for ESBL (Extended-spectrum beta lactamases, a bacterium with antibiotic resistance) and MRSA (methicillin-resistant Staphylococcus aureus, a bacterium with antibiotic resistance) in the urine c) that immediate contact tracing was completed in response to to newly identified COVID-19 staff and residents in accordance with local health department guidance provided on [DATE] d) that immediate action was taken to prevent the spread of COVID-19 during an outbreak which began on [DATE] by failing to complete contact tracing and complete immediate follow-up resident and staff testing upon identification of COVID-19 positive staff and residents to prevent the continued spread of infection. This posed a serious and immediate threat to the safety and well-being of all residents who resided at the facility, were made subject and vulnerable to abuse, had foley urinary catheters, and were placed at risk for contracting COVID-19, which is a harmful and deadly virus. The failure of the LNHA to ensure the facility operated in a manner that ensured residents were cared for in a manner and an environment that enabled residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being posed a serious and immediate threat to the health, safety, and welfare of all residents who resided at the facility in compliance with federal, state and local requirements as outlined in the Administrator Job Description, resulted in an immediate jeopardy (IJ) that was identified on [DATE] at 4:16 PM, and was sent to the facility via e-mail at 4:18 PM. A Removal Plan was received on [DATE] at 9:37 AM, and the survey team verified the implementation of the Removal Plan on [DATE] at 9:26 AM. This deficient practice was evidenced by the following: A review of the facility's Job Specification 60293, Chief Executive Officer, Care Facility ([DATE]), revealed that the duties of the CEO/LNHA included but were not limited to: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Oversees the development, implementation, and monitoring of clinical programs designed to meet the level of functioning and/or care needs of clients. Ensures the implementation of department policies and statutes applicable to the operation of the care facility. Oversees the development and management of a quality assurance system to comply with standards promulgated by accrediting and certifying agencies; .Federal Department of Health and Human Services and NJ Department of Health and Senior Services. Provides protection of clients' civil and legal rights . Findings included: Refer F600 On [DATE], the LNHA failed to ensure residents were free from abuse after a resident (Resident #24) was prevented from leaving an abusive situation by Certified Nursing Aide (CNA #1), who continued to work with other residents following no investigation. This deficient practice was identified for 1 of 5 residents reviewed for abuse (Resident #24). On [DATE] at 10:38 AM, the surveyor interviewed Resident #24, who stated on [DATE], they received Percocet and Xanax every six hours and asked an aide to find the nurse to administer the medications. An Agency Nurse (LPN #1) entered my room and informed me that they would administer my medications and take my vital signs and proceeded to leave the room and closed the door. The resident stated that they proceeded to use the call bell, and LPN #1 came back into the room to tell me to stop pushing the call bell; she pulled down her mask and attempted to bite my finger as I pointed at her. The resident continued that they got out of bed to get away from LPN #1. LPN #1 lunged her nurse's cart at me three times and hit their left foot, causing a wound to re-open. The resident stated that they were trying to get away from LPN #1 and get to the Registered Nurse Supervisor (RN Supervisor). The resident stated as they were attempting to leave the unit in the hallway, the nurse assaulted them by pulling the wheelchair (w/c) ,d+[DATE] times, which positioned the resident on only two back wheels, and the two front wheels were lifted off of the floor. The resident stated that there was a (CNA #1) there, but they could not recall the name of who tried to calm the crazy nurse down. A review of the Resident Facesheet (an admission summary) reflected that the resident was admitted to the facility in September of 2021 but did not include admitting diagnoses. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [DATE], reflected a brief interview of mental status (BIMS) score of 15 out of 15, which indicated the resident was fully cognitively intact. It further reflected the resident had verbal and behavioral symptoms directed toward others that occurred four to six days in the last seven days of assessment. Section I Active Diagnoses included the resident having hypertension (high blood pressure), anxiety, depression, psychotic disorder, and PTSD. It further included a seven-day look back period. The resident received daily antianxiety, antidepressant, and opioid medications. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the individualized comprehensive Care Plan (CP) included a problem area initiated on [DATE], for at risk for altercation in mood/behavior; history of major depressive disorder, anxiety, use of Seroquel (antipsychotic medication) for agitation, use of Xanax for anxiety, and Remeron for anxiety/depression/mood with interventions that included to observe for efficiency of medications; monitor for target behaviors or behaviors not easily redirected; refer to nurse if noted behaviors worsening, unable to redirect; keep the room well lit, open blinds for sunlight; and give medications Remeron, Xanax, Seroquel as ordered. A further review of the CP included a diagnosis of PTSD, however, did not include a problem area or interventions pertaining to the resident's diagnosis of PTSD. On [DATE] at 10:00 AM, the surveyor reviewed the facility provided investigation report for Resident #24's incident which occurred on [DATE]. A review of the staff statements included a statement provided by CNA #2, which detailed that they were taking care of a resident when they heard a noise in the hallway and came out into the hallway and saw Resident #24 trying to leave the floor. She stated that, I stopped them from leaving the floor. CNA #2 stated that both she and another CNA called the charge nurse, but I did not know what was going on. CNA #2's statement appeared to be what the surveyor witnessed CNA #1 do in the surveillance video. No statement from CNA #1 in the investigation report was provided. On [DATE] at 10:31 AM, the surveyor reviewed the surveillance video with the Assistant Licensed Nursing Home Administrator (ALNHA) #1, Employee Relations/Legal Specialist, another surveyor, and the Employee Relations/Legal Specialist confirmed CNA #1 was the aide who was blocking the door. CNA #2 was the aide observed later walking up the hallway towards LPN #1, CNA #1, and the resident during the altercation. At this time, the surveyor reviewed the investigation packet with ALNHA #1, who confirmed there should have been a statement from CNA #1 included in the investigation report. On [DATE] at 10:59 AM, the DON provided the surveyor with CNA #1's statement dated [DATE], which was the exact same statement provided by CNA #2. At this time, the surveyor asked the DON to read both CNA #1 and CNA #2's statements, and she confirmed that both statements were the same but was signed by the corresponding CNA. At this time, the surveyor requested to watch the video footage again with the DON. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:10 AM, the surveyor with the DON, Employee Relations/Legal Specialist, and another surveyor viewed the video footage. When comparing the surveillance footage with the statements, the surveyor asked the DON if the statements clearly reflected what had happened. The DON reported that she completed a three-page reportable to the New Jersey Department of Health (NJDOH) and told RN #1 to watch the video to see if anything should be added to her statement. Then the DON reported she had left for vacation. The DON stated that the ADON had watched the video with RN #1, who did not want to change her statement. The DON stated the purpose of an investigation was to determine a root cause analysis and confirmed these statements were not clear. The DON stated when she returned from vacation, the investigation was completed by the ADON, and she did not review it even though she was responsible for oversight of all aspects of nursing. The DON confirmed the resident had the right to leave the unit, and no staff, including the two CNAs, should have stopped the resident from leaving the unit. The surveyor reviewed the video with the DON. The DON acknowledged CNA #1 was standing in front of the exit door blocking Resident #24 from exiting the unit, which was an issue because this was considered a restraint. The DON stated that even if the resident was confused, which Resident #24 was not, staff could not stop the resident from leaving. The DON stated staff had to ensure the resident's safety and could follow the resident from a distance, but staff could not prevent the resident from leaving the unit. The DON stated the ADON was on vacation but confirmed the investigation was incomplete. She had to re-open the investigation to clarify the statements and determine why CNA #1 stood in front of the door. On [DATE] at 01:14 PM, the surveyor re-interviewed Resident #24, who stated CNA #1 was stopping LPN #1 from verbally abusing them, but confirmed CNA #1 was preventing them from leaving the unit and told them they were not allowed to leave the unit. The resident stated CNA #1 could have done more since she was not letting them leave, and they did not know why. On [DATE] at 10:30 AM, the surveyor reviewed the nursing schedules since [DATE], which revealed CNA #1 worked seven shifts at the facility after the incident. On [DATE] at 09:51 AM, the surveyor interviewed Resident #24, who stated they were imprisoned for twenty months and preferred the door to their room remain open because the closed door triggered their PTSD, causing anxiety. The resident stated on [DATE]; they were waiting for LPN #1 to administer their routine Percocet and Xanax medication so they could go back to sleep. LPN #1 closed their room door and started yelling at them, and the resident reported they just wanted to escape LPN #1, who grabbed their wheelchair and almost tipped the chair over. Resident #24 stated that they remembered the aide (CNA #1) saying their name and that they knew her and they could not leave, but Resident #24 stated they could not determine who the aide was at the time. Resident #24 stated they just wanted the RN Supervisor, which made them feel angry because they were being prevented from escaping from LPN #1, and CNA #1 was not helping the situation. CNA #1 could have opened the door to let me leave, but she would not let me leave, which made me mad. The resident stated they had never been prevented from leaving the unit before, so they could not understand why that was happening. The facility's failure to ensure all residents were free from abuse, including verbal, physical, restraints, and involuntary seclusion by not investigating the actions of CNA #1 after a written statement acknowledged she stopped the resident from leaving the unit as well as video footage confirming she blocked the exit door preventing the resident from leaving the unit posed a serious and immediate threat for abuse which can cause serious physical and emotional harm or impairment. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	This resulted in an Immediate Jeopardy situation. The IJ was identified on [DATE], and the LNHA, ALNHA #1, ALNHA #2, DON, and Director of Veterans Health Care Services were notified of the IJ at 02:55 PM. A written Removal Plan was accepted and verified onsite on [DATE], which included staff members will be immediately relieved from their duties; to ensure the safety of the residents, a comprehensive investigation will commence at the time of the event to ensure a thorough and complete review of all contributing factors have been conducted; all staff in-serviced on the Abuse and Neglect Policy. Refer to F658 Based on interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure nursing staff appropriately removed an indwelling urinary catheter (soft plastic or rubber tube that is inserted into the bladder to drain urine) in accordance with professional standards of nursing practice which necessitated a transfer to the hospital for treatment, and a urinary tract infection. This deficient practice was identified for 1 of 3 Residents reviewed for indwelling urinary catheter care (Resident #179) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The facility's failure to have a system in place to ensure that nursing staff appropriately removed an indwelling catheter posed a serious and immediate threat to the health and welfare of all residents who required catheter care. An adverse outcome was likely to occur as the identified non-compliance resulted in an immediate Jeopardy (IJ) situation that began on [DATE] at 2:50 PM when the Registered Nurse (RN) improperly removed the indwelling catheter. The RN used scissors to cut through Resident #179's indwelling catheter, which then caused the remaining catheter to retract into the bladder. The Immediate Jeopardy (IJ) situation was identified during an onsite survey conducted on [DATE], and the facility was notified of the IJ, on the same day, at 3:20 PM. The facility submitted an acceptable removal plan on [DATE] at 2:55 PM. The team verified the removal plan during an onsite visit conducted on [DATE]. Findings included: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:30 AM, the surveyor toured the 200 Unit of the facility and observed that Resident #179's door was closed. On the door, the surveyor observed signage posted which identified the required PPE (Personal Protective Equipment) to enter the room. The surveyor observed staff donning (putting on) and doffing (removing) with the required PPE before entering and exiting the room. An interview with the Registered Nurse/Unit Manager (RN/UM) revealed that Resident #179 was in isolation for Extended Spectrum Beta Lactamase (ESBL, antibiotic-resistant bacteria) and Methicillin Resistant Staphylococcus Aureus (MRSA, antibiotic-resistant bacteria) in the urine. On [DATE] at 11:29 AM, the surveyor donned the appropriate PPE, knocked at the door, waited for Resident #179 to answer, and entered the room. The surveyor observed Resident #179 in bed, awake with eyes open, and the surveyor observed a splint to the left arm. The surveyor explained the purpose of the visit, and Resident #179 agreed to be interviewed. Resident #179 was alert and stated that he could not move their left arm. Resident #179 answered all questions appropriately. The surveyor observed an indwelling urinary catheter covered with a catheter drainage bag hung on the bed frame. On [DATE] at 09:30 AM, the surveyor returned to the 200 Unit, the door was open, and Resident #179 was not inside the room. Upon inquiry, the RN/UM informed the surveyor that Resident #179 had tested + for COVID-19 in the evening during routine testing and was transferred to the 700 Unit. On [DATE] at 08:30 AM, the surveyor observed Resident #179 in the 700 Unit. The door was closed. Signage with the required PPE was posted on the door. The surveyor reviewed the medical record for Resident #179 on [DATE]. According to the Admission Face Sheet (an admission summary), Resident #179 was readmitted to the facility on [DATE] following hospitalization for urinary retention. Resident #179 had diagnoses that included but were not limited to, hypertension, diabetes mellitus, depression, hyperlipidemia, and End Stage Renal Disease. A review of Resident #179's Plan of Care, updated on [DATE] and [DATE], revealed that Resident #179 had decreased range of motion (ROM) and muscle strength related to co-existing chronic medical conditions. Resident #179 also was at risk for infection due to urinary retention. The care plan goal was for Resident #179 to not have a urinary tract infection and to receive the care needed to maintain their current functional status. The Annual Minimum Data Set Assessment (MDS), an assessment tool used by the facility to prioritize care, dated [DATE], revealed that Resident #179 scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. Section H of the MDS, which addressed Bladder and Bowel, Resident #179 received a score of 9 for H 0300. The score was indicative of the presence of an indwelling catheter in the bladder. The Interdisciplinary Progress Notes (IDPN) revealed that on [DATE] at 3:00 PM, a Registered Nurse documented in the IDPN, Per assigned desk nurse statement, in the process of removing the resident catheter. She cut it and put a towel under it to prevent the urine from draining into the resident's pants. Before she could pull the catheter out, part of the catheter retracted. It was reported to the writer. Director of Nursing (DON) and Assistant Director of Nursing (ADON) were made aware. NP (Nurse Practitioner) made aware and gave the order to transfer Resident #179 to the Emergency Department (ED) for retracted [indwelling urinary] catheter . Resident #179 was picked up at 2:55 PM by 911 crew. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A late IDPN entry dated [DATE], timed 3:30 PM, read, Dc' d [indwelling urinary] catheter retracted in the process of removing it. Resident transferred to ED. On [DATE] at 11:52 AM, the surveyor interviewed the RN/UM regarding the IDPN dated [DATE]. The RN/UM stated that the Registered Nurse (RN #1), who oversaw the unit on [DATE], cut the indwelling urinary catheter in the process of removing the indwelling urinary catheter. She stated that there was an order to remove the indwelling urinary catheter on [DATE]. RN #1 proceeded to execute the order to remove the urinary catheter. The RN/UM stated that RN #1 reportedly had never removed a urinary catheter before. She cut the urinary catheter with a pair of scissors instead of using a syringe to remove the water to deflate the balloon. The remaining urinary catheter then retracted into the bladder. Resident #179 was transferred to the ED for evaluation and treatment on the same day. The hospital discharge summary was requested and was not available for review by the surveyor. The RN/UM stated she would inform the DON of the request for the hospital discharge summary. On [DATE] at 12:30 PM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed that she was aware of the above incident and informed the surveyor that RN #1 was suspended pending disciplinary action. The surveyor requested the investigation and the employee file for review. The surveyor also requested RN #1's telephone contact to conduct an interview. On [DATE] at 9:23 AM, the surveyor interviewed a random Registered Nurse (RN) assigned to the 200 unit regarding nursing resource materials available to the staff. The RN directed the surveyor to the binder outside the nursing station that contained all the policies and procedures. The surveyor located in the binder policy # 4:035 B titled, Indwelling Catheter Replacement, dated [DATE], which outlined the following: Indwelling Catheter replacement must have a physician order indicating size and schedule. Indwelling catheter replacement must be done by a registered nurse whose clinical skill has been checked by the instructor of nursing. If the physician and/or registered nurse, who has demonstrated clinical competence for this procedure, is not available, send the resident to the emergency room for an indwelling Catheter. The policy did not include a procedure to remove an indwelling urinary catheter. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:00 AM, the surveyor conducted a telephone interview with RN#1, who confirmed she was the nurse who received the order to remove the indwelling urinary catheter on [DATE]. RN #1 stated that she was overwhelmed that day and did not want to leave the procedure for the next shift. RN #1 stated she went to Resident #179's room with the Certified Nurse Aide (CNA), and she then used a pair of scissors from the treatment cart, cut the indwelling urinary catheter, and urine was splashing all over. She stated she then looked for the indwelling urinary catheter but could not locate it on the bed. RN #1 stated she realized that the indwelling urinary catheter retracted into the bladder. She stated she applied a towel to protect the resident's clothing, informed the RN/UM what had happened, and went to the desk and called and reported the incident to the Nurse Practitioner (NP). The NP then gave an order to transfer Resident #179 to Emergency Department for evaluation and treatment, and she reported the incident to the DON and initiated the 911 call for transfer. She stated that the DON informed her to leave the floor once she completed her statement. RN #1 stated that she had not received any in-service education on how to remove an indwelling urinary catheter at the facility. She stated she was aware that besides deflating the balloon, another simple way was to cut the indwelling urinary catheter. She stated, I made a mistake. RN #1 stated that she met with the DON in the office and explained what had happened. The DON informed her that she was suspended. The surveyor then asked RN #1 to elaborate on her work history before being employed by the facility. RN #1 stated that she worked as a floor nurse for a long-term care facility and a psychiatric hospital before working at the current facility. She stated she had been a Registered Nurse for [AGE] years. RN #1 stated after being hired by the facility, during orientation, she was able to demonstrate and was evaluated on the skill sets of inserting an indwelling urinary catheter. However, she was not evaluated for indwelling urinary catheter removal. A review of RN #1's orientation file provided by the Nurse Educator (NE) confirmed that she received in-service education on inserting a urinary drainage catheter on [DATE] during orientation. The surveyor requested RN #1's employee file from the DON. RN #1's employee file contained three written warnings, one for a medication error, the second for not donning the proper PPE during an outbreak, and the most recent was for an allegation of verbal abuse toward a family member. RN #1 also stated that she was informed during her hearing with the Employee Relation Officer ([NAME]) that she did not document all the required information on the hospital transfer form prior to sending Resident #179 to the ED. On [DATE] at 10:15 AM, the surveyor reviewed the Facility assessment dated [DATE]. According to the documentation provided, the Facility Assessment had to identify and analyze the facility's resident population, which must be considered when determining staffing and resources needed to care for the residents. Understaffing training, it is revealed, Licensed nursing staff receive training and demonstrate competencies in areas of responsibility related to providing skilled nursing care to residents of the facility. Nurses receive updated and additional training as necessary to meet the changing needs of our residents. Training and competencies include, but are not limited to: Licensed nurse training and/ or competencies. Oxygen set up Oxygen masks . Nasal cannula / Non-Rebreather /Simple face mask (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Wound care / Dressing Change Suctioning skill/ Trach care Glucometer Medication Pass Indwelling catheter replacement CPR The facility's Indwelling Catheter Replacement policy did not cover Foley Catheter Removal. On [DATE] at 10:37 AM, the surveyor interviewed with the NP responsible for Resident #179's care. The NP stated that she wrote an order to remove the indwelling urinary catheter and initiate a voiding trial. She received a call from the nurse, who stated that something had happened. The nurse stated she cut the indwelling urinary catheter to remove it, and the catheter retracted. The NP stated, I came on the unit, examined the resident, and the resident was not in pain. I gave an order to transfer Resident #179 to the ED for evaluation and treatment. The NP stated, I had never heard of such a procedure. The NP further stated that she was not informed of any follow-up or recommendations from the ED. The NP stated that she reviewed the After Visit Summary the next day and could not identify what treatment was provided. She said she called the hospital and spoke to the staff, but the hospital staff could not comment on what treatment was provided. The NP stated she asked for the Urology report and was informed that the Urologist was not called in to see Resident #179. The NP then explained to the ED, what had happened, and that the issue needed to be addressed immediately. The NP stated the Urologist was then made aware that Resident #179 had the retracted catheter in the bladder. On [DATE] at 12:03 PM, the surveyor interviewed the NE in charge of orientation and staff competencies. The surveyor inquired about specific competencies and skill sets necessary to care for resident needs. The NE provided the surveyor with the orientation package. A review of the orientation package confirmed that indwelling urinary catheter removal was not included in the competencies. RN #1 did not receive in-service training for indwelling urinary catheter removal. The NE stated that Licensed Staff had to go to general orientation classes for two days and then work with a mentor on the floor for 14 days (for full-time) employees. Mandatory training was scheduled yearly, and skill sets for competencies were completed every two years. Based on the orientation package provided, the facility staff did not receive competency training for indwelling urinary catheter removal. The NE stated that he was aware of the adverse outcome with the Foley catheter on the [DATE] incident. He was informed that Resident #179 was transferred to ED for treatment because the indwelling urinary catheter was improperly removed. The surveyor requested in-service education training provided after the incident, but none had been provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. Building B. Wing	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When asked how nursing staff competency education was being tracked, the NE added that the DON would inform him of any needed in-service training. The Orientation package provided by the facility was reviewed with the NE on [DATE] and did not include Foley Catheter Removal. The current policy revealed how to insert an indwelling urinary catheter only. The facility was unable to provide the rationale for nursing staff not being trained or assessed for competency on how to remove an indwelling urinary catheter. On [DATE] at 4:40 PM, the surveyor conducted a second interview with RN #1. She stated that she had performed the skill to remove an indwelling urinary catheter before deflating the balloon. She stated that cutting the indwelling urinary catheter was a simple procedure that she had not used prior. She stated that she overheard nurses saying that you could cut the indwelling urinary catheter to remove it, and that was why she cut the indwelling urinary catheter. She stated that after the incident, she went to the internet, watched a video, and realized that she did not follow the proper technique. RN #1 stated that she cut the catheter 4 to 5 inches below the insertion site, not by the port, to evacuate the water. The surveyor then asked RN #1 to elaborate on the indwelling urinary catheter removal procedure. She stated: 1. Verify the order, identify the patient, explain the procedure, provide privacy, use a syringe to deflate the balloon by aspirating the water, and gently pull the indwelling urinary catheter. She stated she was very concerned regarding the resident's well-being. She kept calling every day to inquire regarding Resident #179's status. RN #1 elaborated on the process of properly removing an indwelling urinary catheter. She could not provide the rationale for cutting the indwelling urinary catheter, which caused Resident #179 to be transferred to the ED for treatment. On [DATE] at 09:30 AM, The DON provided the Investigation Report for review. The surveyor reviewed the final report, which revealed the following: Physical Evidence On [DATE], the charge nurse reported that in the process of removing Resident #179's indwelling urinary catheter, she cut the catheter and part of it retracted into the bladder. Resident #179 was immediately discharged to the hospital for intervention. CT urogram (used to examine the kidneys and bladder) without contrast was performed in the hospital with the impression there is significant bladder wall thickening with peri cystic inflammation suggesting cystitis (inflammation of the urinary bladder), no hydronephrosis or renal calculi identified, a note is made of small bilateral pleural effusion (abnormal fluid collection between thin layers of tissue lining the lung and the wall of the chest cavity), and urinary bladder is partially collapsed around Foley catheter. No further intervention was taken at the hospital. Recommendations: [DATE] Urology consult by ___, with recommendation for bladder ultrasound. [DATE] Bladder ultrasound taken on with conclusion of bladder not visualized, to consider ST scan not ordered. On [DATE] resident was seen by the Cardiology group and cleared for cystoscopy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], a cystoscopy was performed for removal, and a new Foley catheter was placed. The resident was referred for a follow-up with a Urologist. Resident's care plan revision: Bladders scan every shift Monitor for signs and symptoms of infection<[TRUNCATED]