STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315309	A. BUILDING _____ B. WING _____	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	**23 SCHOOLHOUSE ROAD WHITING, NJ 08759**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ145641 CENSUS: 121 SAMPLE SIZE: 4	F 000		
F 608 SS=G	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced	F 608		7/12/21

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

Electronically Signed | 06/21/2021

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F 608	Continued From page 1 by: C#: NJ145641 Based on interviews, review of the medical records, and review of other pertinent facility documentation on 5/27/2021, it was determined that the facility failed to initiate an investigation and report an allegation of sexual misconduct to the Administration, which resulted in psychological harm to the resident (Resident [redacted]). The facility also failed to report the allegation to the New Jersey Department of Health (NJDOH) and Law Enforcement for a moderately cognitively impaired resident (Resident [redacted]) with a diagnosis of [redacted]. On 5/25/2021, Resident #4 was assigned a male Certified Nursing Assistant; on the following day (5/26/2021), Resident #4 reported to the Unit Manager that a male came into the resident's room and had inappropriately touched him/ her. However, the Unit Manager did not report the allegation to the facility's Administrator or Director of Nursing; and failed to initiate an investigation, resulting in the same male Certified Nursing Assistant providing care for Resident [redacted] for a second time on 5/26/2021. The facility also failed to follow its policy titled "Abuse." This deficient practice was evident for 1 of 4 sampled residents (Resident [redacted]) reviewed for allegations of sexual misconduct. During a tour of the [redacted] floor on 5/27/2021, the Surveyor interviewed Resident [redacted] at 9:51 a.m., who reported that a male entered the	F 608	Resident [redacted] was given social work support, [redacted] was consulted and supportive visits continue, [redacted] was consulted. Plan of care was reviewed, updated and appropriate for resident, facility to continue with resident intervention for prefers female aides. Supportive Care plan in place for Resident [redacted] on 5/27/2021. Facility completed investigation in allegation, which included but not limited to camera review to determined facility staff entering and exiting resident [redacted]'s room. Facility investigation found un-substantiated on 5/28/2021. All residents were potentially at risk but were not affected by this concern, since investigation unsubstantiated resident's claim. UM on resident [redacted]'s unit provided with specific education and in-servicing on Abuse and Reporting. The facility Administration and Department Heads were in-serviced and educated on proper reporting to the NJDOH. Administration and Departments Heads educated on Abuse policy. Weekly review of all incidents in the facility to ensure compliance with care planning, as well as identifying and reporting abuse will be monitored and documented. results of this audit (facility compliance) will be reported to Quality Steering committee monthly for three months, and then reevaluated by committee. Facility compliance with mandatory education for all staff on abuse and	

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F 608	Continued From page 2 resident's room sometime in the last week and was touching him/her. Resident [redacted] stated, [redacted]." Resident [redacted] pointed to his/her chest and abdomen, indicating where the male was touching him/her. Resident [redacted] explained that he/she reported it to the nurse. Resident [redacted] stated, "[redacted]" Resident [redacted] also stated it could not have been an Aide (Certified Nursing Assistant- CNA) because "I wash myself. No Aide washes me." Resident [redacted] was unable to recall the exact day the incident occurred. Review of the Electronic Medical Records (EMR) revealed the following: 1. According to the "Admission Record," Resident [redacted] was admitted to the facility on [redacted], with diagnoses which included but were not limited to [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident had [redacted] impairment. The MDS also indicated the resident required limited assistance for Activities of Daily Living (ADLs). Review of Resident [redacted]'s Care Plan (CP) dated [redacted] revealed the following: Under: Focus: Resident [redacted] is at risk /wanderer r/t Disoriented to place, "Resident wanders	F 608	reporting will be reported in QAPI meeting monthly to ensure all staff remain in compliance at all times.	

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F 608	Continued From page 3	F 608		

aimlessly, and [redacted] impairments." Under: Goal showed "The resident's safety will be maintained through the review date." Under: "Interventions" included: Resident [redacted] prefers female caregiver," initiated [redacted].

A review of the CNA assignment sheet dated 5/25/2021 and 5/26/2021 for the 11:00 p.m. to 7:00 a.m. shift, showed that a male CNA cared for Resident #4.

During an interview on 5/27/2021 at 10:37 a.m., the Unit Manager (UM) verified Resident [redacted] had informed her of the incident with a male. The UM stated Resident [redacted] had reported to her on [redacted] that a man came into the resident's room and was undressing him/her. The UM agreed that Resident [redacted] was able to dress himself/herself without staff assistance. However, the UM indicated, she did not question the resident further or speak to the male CNA assigned to Resident [redacted] on [redacted]. The UM also stated that she never investigated the incident any further and had not reported the incident to the Administration. The UM explained she did not speak to the male CNA because she "was going out the door" when Resident [redacted] reported the incident. The UM agreed indicated she did not do a thorough investigation and stated "in the hindsight absolutely" it should have been done.

During an interview on 5/27/2021 at 2:20 p.m., the Director of Nursing (DON) agreed the UM did not informed her Resident [redacted] complained of being touched or undressed by a male on [redacted].

During a second interview on 5/27/2021 at 1:10 p.m., the UM stated she did not care planned

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F 608	Continued From page 4 Resident [redacted] for female caregivers until [redacted]; she put the wrong date of 5/17/2021 onto the CP. The UM also stated on 5/26/2021, on the 11:00 p.m. to 7:00 a.m. shift, Resident #4 did have a male CNA again. According to the facility's Policy titled "Abuse" dated November 28, 2016 under "C Prevention," It is the policy of this facility to prevent abuse by providing residents, families and staff information and education on how and to whom to report concerns, incidents and grievances without the fear of reprisal or retribution. Under "Investigation" Procedure, the investigation is the process used to try to determine what happened. The designed facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration.	F 608		
F 609 SS=D	N.J.A.C. 8:39-4.1(a)11 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		7/1/21

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F 609	Continued From page 5 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C#: NJ145641 Based on interviews, review of the Medical Records (MR), and review of other pertinent facility documentation on 5/27/2021, it was determined that the facility failed to report an allegation of inappropriate [redacted] behavior to the New Jersey Department of Health (NJDOH) and the Police Department for 2 of 4 residents (Resident [redacted]1 and Resident [redacted] reviewed for inappropriate sexual behavior. The facility also failed to follow the facility's policy titled "Abuse." This deficient practice was evidenced by the following: During a tour of the [redacted] floor on 5/27/2021 at 10:37 a.m., the surveyor interviewed the Unit Manager (UM), who reported that she was called at home on [redacted] by a Licensed Practical Nurse (LPN #1) who was on duty and she reported that a [redacted] resident (Resident [redacted]) observed a [redacted] resident (Resident [redacted] in a male resident's (Resident [redacted] room and there may have been touching involved. The UM also	F 609	Residents [redacted] were separated. Resident [redacted] was put on close supervision. facility IDCT will review and update as needed for residents needs. Plans of care were reviewed and updated. this event was reported to the DOH on 7/6/2021. All residents had the potential to be affected by this event but were not affected. UM on resident [redacted] and [redacted] unit provided with specific education and in-servicing on Abuse and Reporting. All facility Administration and Department Heads were in-serviced and educated on proper reporting to the NJDOH on 6/23/2021. Administration and Departments Heads educated on Abuse policy on 6/23/2021 Continuous education regarding proper reporting and abuse policy with Administration and Department heads will be conducted monthly for three months and then reevaluated for continued need. These educations and in-services results	

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F 609	Continued From page 6 stated that LPN #1 stated that LPN #2 reported that she saw Resident [redacted] touching Resident [redacted] s private area. Review of the Electronic Medical Records (EMR) revealed the following: 1. According to the Face Sheet, Resident [redacted] was admitted to the facility on [redacted], with diagnoses which included but were not limited to [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted] impairment. The MDS also indicated the resident required extensive assistance for Activities of Daily Living (ADLs). A review of the Care Plan (CP) revealed a focus of [redacted] and [redacted]. Interventions included: Encouragement to participate in activities. 2. According to the Face Sheet, Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted] The MDS also indicated the resident required limited assistance for ADLs. A review of the CP revealed a focus of [redacted] " Interventions in	F 609	will be reported to the quality steering committee meeting monthly for three months. Following the three months, the committee will determine the frequency and need of the educations and/or in-servicing.	

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place included but were not limited to: Ask yes/no questions to determine the resident's needs. Review of Resident [redacted]s and Resident [redacted]s Progress Notes failed to show any documentation of an encounter between the two residents on [redacted].

3. According to the Face Sheet, Resident [redacted] was admitted to the facility originally [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to [redacted].

According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. The MDS also indicated the resident required limited assistance for Activities of Daily Living (ADLs).

A review of a typed document completed by the Director of Nursing (DON) dated [redacted] at 2:17 p.m., revealed that on [redacted] the nurse (LPN #1) reached out to the Unit Manager (UM) regarding a complaint by Resident [redacted] of a "possible inappropriate resident interaction between (Resident [redacted] and Resident [redacted]). The document also showed that the residents were "immediately separated by staff and (Resident [redacted]) was placed on close supervision pending (an) investigation." Further review of the document revealed that LPN #2 "did not observe any physical contact. When (LPN #2) entered the room, (Resident [redacted]) appeared to [redacted] while in a laying position, however (the LPN) could not see any [redacted] and was unable to determine if (Resident [redacted]) had any [redacted] underneath or if [redacted] was fastened."

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A review of a signed "Individual Statement" by LPN #2 revealed Resident [redacted] told the LPN Resident [redacted] was sitting on Resident [redacted]. The statement also revealed as LPN #2 appears in the doorway of Resident [redacted] room she observed Resident [redacted] was lying in bed on his/her back and Resident [redacted] was observed stooped over Resident [redacted] Further review of the statement showed LPN #2 stated "excuse me, (Resident [redacted]) stood up and (Resident [redacted] his/her [redacted]

During an interview on 5/27/2021 at 12:48 p.m., Resident #3 stated that when passing the resident's room, he/she observed a [redacted] resident sitting on a [redacted] and they were on the bed. Resident [redacted] stated he/she immediately reported the incident to the nurse.

During an interview on 5/27/2021 at 2:34 p.m., the DON verified that the incident was not reported to the NJDOH "because, during the investigation, we found that nothing happened." The DON also stated, "we have to report within 24 hours," but during their investigation, that they determined the incident was not a reportable event. The DON explained that they were "no incident from what we found." The DON continued to explain that "no one saw anything that was[redacted]" and Resident [redacted] and Resident [redacted] "were in the room for only a brief amount of time." In addition, the DON stated that Resident [redacted] was helping Resident [redacted]." The DON also stated, "I spoke to the nurse; we see this as a wandering behavior. There was no exposure."

During an interview on 5/27/2021 at 3:30 p.m., the Administrator stated that the incident was not reported to NJDOH because "we unsubstantiated

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F 609	Continued From page 9 it within the 24 hours." According to the facility's policy titled "Abuse" dated "November 28, 2016" under section "G;" Reporting and Response: It is the policy of this facility that "abuse" allegations ... are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect ..., are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours... In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. N.J.A.C. 8:39-9.4(f)	F 609		