STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22001L	A. BUILDING: _____ B. WING _____	C 07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALT	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

(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) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ00153351, NJ00153484, NJ00153548, NJ00153914, NJ00154627, NJ00157115, NJ00157430, NJ00158194, NJ00158972, NJ00159228, NJ00160484, NJ00160600, NJ00161672, NJ00161784, NJ00161854, NJ00161878, NJ00162243, NJ00162476, NJ00163007, NJ00164481, NJ00164757. Survey Dates: 07/04/23 - 07/07/23 Survey Census: 272 Sample Size: 32 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint: NJ 157115	S 560	Element #1: Corrective action: Residents of Runnells Rehabilitation and	7/8/23

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

Electronically Signed | 08/02/23

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S 560	Continued From page 1 Based on interviews and review of facility documents, it was determined that the facility failed to ensure staffing ratios were met for 14 of 21 day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA staffing for residents on 14 of 21 day shifts as follows; 1. For the 3 weeks of Complaint staffing from 06/18/2023 to 07/08/2023, the facility was deficient in CNA staffing for residents on 14 of 21 day shifts as follows: -06/18/23 had 17 CNAs for 269 residents on the	S 560	Health care Center were not adversely impacted by the facility failing to provide staffing at required levels as listed. Element #2: Identification of at risk residents: 100% of all residents had the potential to be impacted by this deficient practice. Element #3: Systemic Changes: DON/Administrator/Designee will continue reviewing scheduled staffing daily to verify facility compliance with the state required staffing levels. All Supervisors and Staffing Coordinator were reeducated by the RN ADON to notify DON/Administrator/Designee regarding call outs which may impact our staffing requirements to enact all administrative nursing staff to report to the facility to assist with providing care to our residents when needed. DON/Administrator/Designee will continue with the facilities recruitment and retention plan including not limited to incentives, identifying open positions, posting all open positions, and increasing our agency relationships to enhance our current staffing needs. Element #4: Quality Assurance: DON/Administrator/Designee will report staffing turnover/ New Hires/Open positions monthly x 3 months to our QAPI Team for review and revision as necessary.	

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S 560	Continued From page 2 day shift, required 34 CNAs. -06/19/23 had 30 CNAs for 269 residents on the day shift, required 34 CNAs. -06/20/23 had 27 CNAs for 269 residents on the day shift, required 34 CNAs. -06/22/23 had 27 CNAs for 269 residents on the day shift, required 34 CNAs. -06/23/23 had 26 CNAs for 269 residents on the day shift, required 34 CNAs. -06/24/23 had 29 CNAs for 269 residents on the day shift, required 34 CNAs. -06/26/23 had 33 CNAs for 269 residents on the day shift, required 34 CNAs. -06/28/23 had 31 CNAs for 271 residents on the day shift, required 34 CNAs. -06/29/23 had 30 CNAs for 271 residents on the day shift, required 34 CNAs. -06/30/23 had 30 CNAs for 271 residents on the day shift, required 34 CNAs. -07/01/23 had 27 CNAs for 273 residents on the day shift, required 34 CNAs. -07/02/23 had 30 CNAs for 273 residents on the day shift, required 34 CNAs. -07/03/23 had 26 CNAs for 271 residents on the day shift, required 34 CNAs. -07/04/23 had 31 CNAs for 271 residents on the day shift, required 34 CNAs.	S 560		

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F 000	INITIAL COMMENTS A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00153351, NJ00153484, NJ00153548, NJ00153914, NJ00154627, NJ00157115, NJ00157430, NJ00158194, NJ00158972, NJ00159228, NJ00160484, NJ00160600, NJ00161672, NJ00161784, NJ00161854, NJ00161878, NJ00162243, NJ00162476, NJ00163007, NJ00164481, NJ00164757. Survey Dates: 07/04/23 - 07/07/23 Survey Census: 272 Sample Size: 32 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		7/8/23

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Electronically Signed | 08/02/2023

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review, the facility failed to protect the right of two (Resident (R) 11 and R7) of four residents reviewed for abuse to be free from [redacted] abuse by another facility resident. R11 experienced [redacted]l abuse by R24 resulting in [redacted] injury requiring hospitalization and R7 experienced physical abuse by R23 resulting in [redacted] injury requiring hospitalization and [redacted]. The failure resulted in harm to R11 and R7. Findings include: 1. A. Review of R24's "Profile" tab in the electronic medical record (EMR) revealed [redacted] was admitted to the facility's [redacted] unit on [redacted] with diagnoses, according to the "Medical Diagnoses" tab of the EMR, of [redacted] R24 was discharged from the facility on [redacted]. Review of R24's [redacted] hospital "Discharge Summary," located in the "Miscellaneous" tab of the EMR, revealed the resident was brought to the emergency room for [redacted] and [redacted]. [redacted] was diagnosed with [redacted]. R24's documented [redacted] included [redacted] though he was at [redacted].	F 600	ELEMENT ONE: CORRECTIVE ACTION: Resident # 7 was sent to the Emergency Room [redacted] on for evaluation and did not return to the facility. Resident # 23 was sent to the Emergency Room Crisis [redacted] and did not return to the facility. Resident #24 was sent to the emergency room for evaluation on [redacted] and did not return to the facility. Resident #11 was sent to the Emergency room for evaluation on [redacted] and returned with no new orders, and was subsequently discharged to [redacted] on [redacted] ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: 100% of all residents had the potential to be impacted by the deficient practice. ELEMENT THREE: SYSTEMIC CHANGES: Staff were re-educated on abuse and neglect, including recognizing, intervening and treating post abuse. Resident council meeting was held to review with residents signs and symptoms of abuse, and who to contact to report.	

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F 600	Continued From page 2 There were no [redacted] documented. Review of R24's [redacted] "Minimum Data Set (MDS)," assessment, with an assessment reference date (ARD) of [redacted] revealed he scored [redacted] on the "Brief Interview for Mental Status (BIMS)," indicating [redacted]. R24 required extensive assistance with [redacted] and [redacted] was ambulatory but [redacted] on [redacted] feet. Review of R24's [redacted] "Care Plan," located in the "Care Plan" tab of the EMR, revealed, "[R24] has [redacted] " The interventions included: "All staff to converse with [R24] while providing care . . . [R24] needs assistance/escort to activity functions . . . [R24's] preferred activities are looking [at] [redacted] around . . . Encourage ongoing family involvement. Invite [R24's] family to attend special events, activities, meals . . . [and] Introduce [R24] to residents with similar background, interests, and encourage/facilitate interaction." Review of R24's [redacted] "Notes," located in the "Notes" tab of the EMR, revealed the resident had [redacted] incident of attempting to [redacted] f during care on [redacted]. No additional [redacted] were documented. Review of R24's [redacted] 1:38 AM "Occurrence [sic] Note," located in the "Notes tab of the EMR, revealed, "Around 10 PM, resident [redacted] abuse [sic] [redacted] roommate [R11] with [redacted] and [redacted] roommate sustained [redacted]	F 600	ELEMENT FOUR QUALITY ASSURANCE: Director of Nursing/Administrator/Designee to audit 5 random staff members to ascertain knowledge of abuse including recognizing, intervening and treating, daily x7, once weekly x4 weeks and monthly x2. Director of Nursing/Administrator/Designee to audit 5 random residents to ascertain their knowledge of signs and symptoms of abuse, and who to report allegations of abuse. Daily x7 days weekly x4 and monthly x2. Needed corrections and re-education will be addressed as they are discovered. Results to be reported monthly to QAPI team for review and revision as necessary.	

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injuries to [redacted], all parties were notified. Order obtained to send [redacted] to [emergency room]. Resident was picked [up] by 911 at 10:45 PM."

B. Review of R11's "Profile" tab in the EMR revealed the resident was admitted the facility on [redacted] with diagnoses, according the "Medical Diagnoses" tab of the EMR, of [redacted] R11 was discharged from the facility on [redacted]

Review of R11's [redacted] "MDS" assessment, with an ARD of [redacted] and located in the "MDS" tab of the EMR, revealed R11 scored [redacted] on the BIMS, indicating [redacted] R11 required limited assistance with [redacted] R11 occasionally exhibited [redacted] directed towards others and [redacted].

Review of R11's "Care Plan," located in the "Care Plan" tab of the EMR and dated [redacted], revealed, "[R11] is [redacted] staff) r/t [related to] [redacted], [and] [redacted]." The interventions included: "The resident's [redacted] are [redacted]). The resident's behaviors is [sic] de-escalated by redirecting . . . Analyze times of [redacted] behavior and document . . . Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain, etc. . . . [and] When the resident becomes agitated: Intervene before [redacted]s; guide away from source of [redacted] in conversation; if response is [redacted] staff to walk calmly away, and approach later."

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The "Care Plan" also documented, "[R11] is an [redacted] risk/[redacted] r/t [redacted]." The approaches included: identify pattern of [redacted] is [redacted]? is resident looking for something? does it indicate the need for more exercise? intervene as appropriate . . . Monitor location every [redacted] Document [redacted] behavior and attempted diversional interventions in log . . . [and] Provide structured activities: toileting, walking inside and outside, r[redacted] strategies including [redacted], [redacted] and [redacted] boxes."

Review of R11's [redacted] "Occurrence [sic] Note," located in the "Notes" tab of the EMR, revealed, "Resident [redacted] abuse [sic] by [redacted] roommate with a [redacted] as a result resident sustained [redacted] and [redacted] around 10 PM [on 03/18/23]. I was trying to take the [redacted] chased me trying to [redacted] too. I called for help, all the CNA [certified nurse aides] came and helped. All parties involve [sic] were notified, order obtained to send resident to [Emergency Room]. Resident picked up by 911 at 10:30 PM."

Review of R11's [redacted] 6:18 AM "Orders - General Note from eRecord," located in the "Notes" tab of the EMR, revealed, "[R11] arriver [sic] at the facility at around 2:20 AM via emergency transportation, [redacted] was brought to the unit at 2:30 AM in a [redacted] emergency personnel . . . [redacted], will not stay still in the stretcher, [redacted] was dropped off at the [redacted] and will not [redacted] was offered to [redacted] but [redacted] would not [redacted] around the hall, had to be monitored [redacted]

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Review of R11's [redacted] "Care Plan," located in the "Care Plan" tab of the EMR, revealed, "[R11] was a receiver of [redacted] by another resident in the [redacted]. The approaches included: "Separate the [redacted] residents. Call 911, police, and transfer to ER [emergency room] for evaluation. Apply [redacted] ntil transferred out to ER. Provide [redacted] . . . . Upon readmission: monitor any injuries to [the] [redacted] and follow any treatment orders if applicable. Provide with [redacted] services to allow [redacted] ability to vent any concerns [redacted] may have related to incident. Encourage [redacted] to visit as often as possible for support. Social services to visit weekly as well to assist with adjustment period."

C. Review of the facility's [redacted] "Reportable Event Record/Report," provided on paper, revealed on [redacted] at 9:30 PM, a [redacted] abuse incident occurred, and was reported to the state agency on [redacted] at 10:00 PM. The narrative documented, "On [redacted] at approximately 9:30 PM, both residents were sitting talking with each other in the dayroom witnessed by staff as they were also roommates. Suddenly [R24] picked up a [redacted] and before staff could get to [redacted] proceeded to [redacted] [R11] with the [redacted] Causing [R11] injuries to [redacted] s as well as a [redacted]. As staff where [sic] attempting to [redacted] [R11] [redacted] [R24] started [redacted] and [redacted] at the staff as well. Supervisor spent some time calming down [R24] enough for [redacted] and relax, while the other staff were tending to the [redacted] f [R11] and calling 911. Police arrived with paramedics and transferred both residents separately to [the hospital.] [R24]

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was sent for a [redacted] evaluation and [R11] was sent to be evaluated for [redacted]. [R11] was later sent back to the facility, stable with [redacted] and didn't understand what happened. [R24] is currently [redacted] and will be placed in a facility better suited for his needs." The police, Ombudsman, both residents' physicians, and both residents' responsible parties were notified. The facility conducted an investigation which included interviews with multiple staff members. The investigation revealed R24 had no history of [redacted] and staff could not determine why [redacted] with R11.

In an interview on 07/06/23 at 3:37 PM, Licensed Practical Nurse (LPN) 4 stated on the evening of [redacted], she witnessed R11 and R24, who were roommates, sitting and talking with each other in the day room. She stated, '[redacted] [R24] [redacted] and [redacted] [R11]. I called for help . . . We separated the residents." LPN4 stated she did not witness an argument or any behavior preceding the event that would cause R24 [redacted] R11. She stated R24 admitted to her that [redacted] R11 but did not state a reason to her. LPN4 stated, R11 suffered [redacted] and a [redacted] that required emergency medical transport to the Emergency Room for evaluation. She stated, [redacted]"

In an interview on 07/06/23 at 3:52 PM, the Director of Nursing (DON) stated in the event of [redacted] abuse resulting in [redacted] the incident should be reported to the state agency and police department within two hours. She stated this incident of [redacted] l abuse resulted in [redacted] for R11.

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F 600	Continued From page 7 She stated the incident was reported on [redacted] within a half hour of the occurrence. 2. A. According to R23's "Profile" tab of the EMR, the resident was admitted to the facility on [redacted] with diagnoses, per the "Medical Diagnoses" tab of the EMR, of [redacted]. Review of R23's [redacted] "Pre-Admission Screening and Resident Review (PASRR) Level I Screen," located in the "Miscellaneous" tab of the EMR, revealed R23 was in a [redacted] and had a diagnosis of [redacted] A [redacted] n" was requested. Review of R23's [redacted] "PASRR Level II Psychiatric Evaluation," located in the "Miscellaneous" tab of the EMR, revealed [redacted]; however, R23 did not meet the conditions for a [redacted] The [redacted] t documented, "Pt [patient] became [redacted] at [redacted] residence. Pt was noted to be [redacted]. Poor ADLs [activities of daily living], [redacted] Pt kept asking if [redacted] e [redacted] [medications], this behavior has stopped." Nursing home placement was recommended and the rationale was, "Pt. needs [redacted] - when [redacted] stable . . . [he] needs assistance with [redacted]." The evaluation documented R23 did not have an active [redacted], had a [redacted] and treatment needs that could be met in a nursing	F 600		

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facility, and did not need specialized services.

Review of R23's [redacted] Care Plan," located in the "Care Plan" tab of the EMR, revealed, "[R23] has Level II PASRR determination with [redacted] related to [redacted]." On [redacted] the "Care Plan" documented, "The resident is [redacted]) for meeting [redacted]s." The approaches included: "All staff to converse with resident while providing care . . . [and] establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary . . . The resident uses [redacted] . . . Administer [redacted] medications as ordered by physician. Monitor for side effects and effectiveness [every shift]."

Review or R23's "Notes," under the "Notes" tab of the EMR, did not reveal any documented behaviors since admission until an incident on [redacted]

Review of R23's [redacted] "Occurance [sic] Note," located in the "Notes" tab of the EMR, revealed, "[R23] is observed leaving [R7's] room with [redacted]. [R23] showed no [redacted] prior and after the incident. Supervisor . . . was made aware . . . [physician] is informed and ordered [redacted]." A cut was noticed on the [redacted] around the [redacted]. Resident denies [redacted]. When asked what happened, [R23] states, "[redacted]." When asked again [redacted] later in the presence of . . . [police officer], [R23] reiterated, [redacted]

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	315009	A. BUILDING _____ B. WING _____	C 07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	**40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922**

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[redacted] Resident was immediately removed from [R7's] room and redirected inside [redacted] room . . . 911 is called. Officers . . . arrived around 4:30 PM and interviewed both [residents] separately. [R23] is asked to [redacted]s. A [redacted] was noted on the [redacted]. Resident denies [redacted] is applied after being [redacted]. Approximately after 5 PM [sic], [R23] is escorted out[redacted]r by two EMS [emergency medical service] personnel and sent to [hospital]."

B. Review of R7's "Profile" tab of the EMR revealed[redacted] was admitted to the facility on [redacted] with diagnoses, according to the "Medical Diagnoses" tab of the EMR, [redacted] R7 was discharged from the facility on[redacted]

Review of R7's admission "MDS" assessment, with an ARD of [redacted] and located in the "MDS" tab of the EMR, revealed he scored[redacted] on the BIMS, indicating severely [redacted] R7 experienced [redacted] but no additional behavioral symptoms. [redacted] required[redacted] with bed mobility, transfers, and locomotion.

Review of R7's [redacted] "Care Plan," located in the "Care Plan" tab of the EMR, revealed, "The resident uses [redacted] medications [redacted]) r/t [related to] [redacted]" The approaches included, "Monitor/record occurrence of for target behavior symptoms (SPECIFY: [redacted]) and document per facility protocol."

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Review of R7's [redacted] "Occurance [sic] Note," located under the "Notes" tab in the EMR, revealed, "At approximately 4:15 PM while giving medications to one of my patient [sic], the nursing assistant while standing in front of the patient's room, called for my attention. As I raced into [R7's] room, [R23] was seen walking away from inside the room with [redacted] [R7] was found [redacted] and a [redacted] with both [redacted] and [redacted]. When asked what happened, [R7] states [redacted] (pointing at [R23]) [redacted] At approximately 4:20 PM, 911 was immediately called. Treatment was provided. [redacted]. [R7] is advised and educated not to [redacted]. Supervisor . . . is notified. Officers . . . arrived at around 4:30 PM and interviewed both residents. [Physician] and POA [Power of Attorney] were made aware. Approximately 5:15 PM, resident is taken to [Hospital] [redacted] escorted by two EMS [emergency medical service] personnel."

Review of R7's [redacted] "No Type Specified" note, located in the "Notes" tab of the EMR, revealed, "Called [Hospital] . . . informed writer that [R7] is in [redacted], awaiting transfer to an [redacted] in [redacted] in [redacted]"

C. Review of the [redacted] "Reportable Event Record/Report" revealed an incident of [redacted] abuse occurred on [redacted] at 4:45 PM, and the incident was called in to the state agency on [redacted] at 5:44 PM. The narrative documented, "On [redacted] at

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approximately 4:45 PM, a nursing aide observed [R23] in the room of another resident, [R7]. [R23] had, what appeared to be, [redacted] and proceeded to walk out of [R7's] room, heading towards [redacted]. The nursing aide entered [R7's] room and observed [R7] sitting on the couch with [redacted] and a [redacted]. The nursing aide called for the nurse and another aide called for the nursing supervisor. [R23] was placed on [redacted] monitoring in [redacted] room and [R7] was assessed by the nurse and [redacted]. 911 was called at 4:48 PM. Two officers from the [redacted] Police Department arrived at approximately 4: 55 PM. An ambulance arrived at 5:15 PM and [R7] was transported to [the hospital] for evaluation of [redacted]. Another ambulance arrived at 5:25 PM and [R23] was transported to [the hospital] for crisis [evaluation]." The police, Ombudsman, both residents' physicians, and both residents' responsible parties were notified. The facility conducted an investigation which documented, "A nursing aide on the unit had observed [R7] lying in bed at approximately 4:00 PM. This same aide also observed [R23] ambulating on a different hall of the unit at that same time. Another nursing aide, who was assigned to [R7], saw the resident in bed at 4:30 PM and provided him with water. When she exited [R7's] room, she observed [R23] down the hall at the nursing station. At approximately 4:45 PM, this same nursing aide observed [R23] in the room of [R7] with [redacted] and [redacted] to [R7's] [redacted]. Upon questioning, [R23] repeated several times, [redacted] but could not elaborate any further. When [R7] was questioned about the incident, [redacted] answered, '[redacted]!' [redacted], also, was unable to provide any further information. No other staff

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member on the unit heard any noises indicative of a [redacted] altercation taking place . . . It appears that a [redacted] altercation occurred between [R7] and [R23], facility is unable to [redacted] abuse as there is no evidence as to what may have caused the altercation or which resident was responsible for initiating the altercation; it is unclear if the resident acted willfully or in self-defense."

In an interview on 07/05/23 at 4:10 PM with LPN3, she stated she did not witness an altercation between R7 and R23; she was called to the room by the nurse [Registered Nurse (RN) 1] and recalled seeing a [redacted] to R23's room and R23 with [redacted] and found R7 with a [redacted]. LPN3 stated when she spoke with R23 after the incident, R23 reported R7 had called [redacted]" and [redacted] had reacted by [redacted] R7.

In an interview on 07/06/23 at 12:33 PM, CNA3 stated she had just seen both residents about 15 minutes prior to the incident and had not witnessed any [redacted]. She stated she found R23 leaving R7's room with [redacted], and R7 with [redacted].

In an interview on 07/06/23 at 2:35 PM, RN1 stated he did not witness the incident between R7 and R23; he was called to R7's room by the CNA. RN1 stated R23 stated [redacted] R7, but he could not recall if [redacted] stated anything had happened to cause the [redacted].
In an interview on 07/06/23 at 3:52 PM, the DON stated in the event of [redacted] abuse resulting in [redacted] the incident would be reported to the state agency and police department within two hours. She stated this

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F 600	Continued From page 13 incident of [redacted] abuse resulted in [redacted] for R7 and was reported to the state agency within an hour of incident on [redacted] Review of the facility's "Prohibition of Resident Abuse & Neglect" policy, dated 02/28/23 and provided on paper, revealed, "Our facility practices ZERO tolerance of resident abuse, neglect, mistreatment, exploitation or misappropriation of property by anyone including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends, vendors, or any other visitors or individuals . . . Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish . . . Instances of abuse of all residents, irrespective of mental or physical condition, cause physical harm, pain, or mental anguish . . . Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." NJAC 8:39-4.1 (a) 5	F 600		