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 09/28/2020

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 # NJ 139699 CENSUS: 104 SAMPLE SIZE: 5 Based on observations, interviews, review of medical records and review of other pertinent facility documents on 9/24/20 and 9/28/20, it was determined that the facility failed to ensure residents were protected from actual [redacted], and failed to adequately monitor and supervise a known [redacted] seeking resident (Resident [redacted] with a known history of [redacted] encounters with residents. When on [redacted], Resident [redacted] was observed by 2 Certified Nursing Assistants (CNAs) in another resident's room, with his/her [redacted] and opened and Resident [redacted] was observed in [redacted] of Resident [redacted]. The facility also failed to investigate when on [redacted], Resident [redacted] alerted a CNA that a [redacted] (Resident [redacted]) entered [redacted] room and [redacted] [redacted] The facility also failed to follow their policy titled "Abuse" and notify the police for 1 of 5 residents (Resident [redacted] sampled for abuse. This placed all residents living on the [redacted] unit in an Immediate Jeopardy situation. The IJ was identified on 9/24/2020 at 5:07 p.m., when the Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ situation, which ran from 9/20/20 until 9/24/2020 at 5:58 p.m., when the facility provided an acceptable Removal Plan to remove the immediacy.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		11/27/20

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

Electronically Signed | 10/28/2020

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.

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 09/28/2020

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 600	Continued From page 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. §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: COMPLAINT # NJ 139699 Based on observations, interviews, review of medical records and review of other pertinent facility documents on 9/24/20 and 9/28/20, it was determined that the facility failed to ensure residents were protected from actual [redacted], and failed to adequately monitor and supervise a known [redacted] seeking resident (Resident [redacted] with a known history of [redacted] encounters with residents. When on [redacted] Resident [redacted] was observed by 2 Certified Nursing Assistants (CNAs) in another resident's room, with his/her [redacted] and opened and Resident [redacted] was observed in [redacted] Resident [redacted] The facility also failed to	F 600	Resident [redacted] was placed on increased supervision with 1:1 caregiver. Resident 1 was referred to psychiatrist for follow up visit, and was seen on [redacted]. Resident [redacted]'s care plan was updated to reflect the changes to [redacted] plan of care prior to, and on, [redacted]. On [redacted] the police were called to report event. All residents in the facility have the potential for risk for sexual encounter with resident [redacted]. The facility completed an audit interviewing residents to identify if any other residents had encounters with Resident [redacted] that were inappropriate and require investigation. Audit was started 9/24/20 and completed on 9/29/2020. Following 9/24/2020, resident was on 1:1 supervision to prevent such interactions.	

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 09/28/2020

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 600	Continued From page 2 investigate when on 9/20/20, Resident [redacted] alerted a CNA that a [redacted] (Resident [redacted]) entered [redacted] room and [redacted]. The facility also failed to follow their policy titled "Abuse" and notify the police for 1 of 5 residents (Resident [redacted] sampled for abuse. This placed all residents living on the [redacted] unit in an Immediate Jeopardy situation. The IJ was identified on 9/24/2020 at 5:07 p.m., when the Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ situation, which ran from 9/20/20 until 9/24/2020 at 5:58 p.m., when the facility provided an acceptable Removal Plan to remove the immediacy. This deficient practice was further evidenced by the following: 1. According to the "Admission Record" (AR), Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident [redacted] had [redacted] impairment. The MDS also indicated Resident [redacted] required limited assistance for Activities of Daily Living (ADLs). 2. According to the AR, Resident [redacted] was admitted to the facility on [redacted] and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted]	F 600	The facility will review new incidents with the interdisciplinary care team during morning rounds to ensure the immediate response was implemented and that the resident was responsive to changes to plan of care. The facility will implement a [redacted] meeting that meets weekly. The committee will be interdisciplinary and include the [redacted] During meeting the team will review residents eligible for gradual dose reduction, new behaviors, and [redacted] abuse incidents. The team will discuss the immediate responses to plan of care and any additional changes to meet the residents' needs. First meeting scheduled for 11/27/2020. The staff were re-educated on the abuse policy and appropriate responses including reporting and notification initiated 9/23/2020 and completed 10/9/2020. The Director of Nursing and administrator/designee will review incident reports weekly to ensure appropriate responses including but not limited to reporting and notifications. This will begin on 11/25/2020. The department head team will interview the residents randomly during the month for three months to see if they have any concerns or complaints about other residents being inappropriate beginning week of 11/23.	

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 09/28/2020

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 600	Continued From page 3 Review of the MDS, an assessment tool dated [redacted], revealed that Resident [redacted] had a BIMS score of [redacted], which indicated that the resident had [redacted] impairment. The MDS also indicated Resident [redacted] required extensive assistance for ADLs. 3. According to the AR, Resident [redacted] was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the MDS, an assessment tool dated [redacted], revealed that Resident [redacted] had a BIMS score of [redacted], which indicated that the resident had [redacted] impairment. The MDS also indicated that Resident [redacted] needed limited assistance for ADLs. Review of the Care Plan (CP) dated [redacted] revealed a "Focus" that Resident [redacted] was an affectionate person and enjoyed having a close relationship with Resident [redacted] and they spend time together and at times may demonstrate [redacted]. Interventions included but were not limited to: Monitor to ensure [redacted] remains [redacted] 4. According to the AR, Resident [redacted] was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted], and [redacted]. Review of the MDS, an assessment tool dated [redacted], revealed that Resident [redacted] had a BIMS score of [redacted], which indicated that the resident had [redacted] impairment. The MDS also indicated that Resident [redacted] needed limited	F 600	Results of these audits will be reported monthly to the Quality Assurance Steering Committee. Any trends will be reviewed and discussed for root cause analysis. After the three months of reporting the Committee will decide on the frequency of audits. This has been initiated for the month of October QA review.	

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 09/28/2020

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 600	Continued From page 4	F 600		

assistance for ADLs.

According to the documentation on the Facility's Reportable Event Record/Report (FRE), reported to the New Jersey Department of Health (NJDOH) by the DON on 7/29/20, with an event date of [redacted] at 9:30 p.m., the report indicated the type of incident as "Resident to Resident abuse" between Resident [redacted] and Resident [redacted]

According to the witness statement with the FRE the Licensed Practical Nurse (LPN #1) reported that on [redacted] at approximately 9:30 p.m., when she entered the resident's room she observed Resident #1 standing at the head of Resident [redacted] bed with [redacted] and in Resident [redacted]. Resident [redacted] was startled and [redacted] to the floor on [redacted]. The LPN initiated a room change and interviewed the residents and Resident [redacted] at that time, had a BIMS score of [redacted] Resident [redacted] had a BIMS of [redacted], and did not recall the engagement, and stated "I was sitting on the floor picking pieces putting something together."

The Reportable Event Summary for [redacted] showed that both residents were interviewed by the Social Worker (SW) on [redacted], regarding the events of the preceding evening. "Both residents denied concerns or distress. Both denied recalling events reported."

In addition, the FRE dated [redacted], showed the following interventions were implemented after the incident, Resident [redacted] was moved to another room, and both residents will remain without roommates. Mood and behavior monitoring would be on going for both residents including monitoring for any signs and symptoms of social isolation. Physicians and families for both residents were notified and plans of care were

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 09/28/2020

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 600	Continued From page 5	F 600		

updated. Companionship was to be supervised in common areas and both residents were referred for psychosocial services for further recommendations.

According to the documentation on the Facility's Reportable Event Record/Report (FRE), reported to the New Jersey Department of Health (NJDOH) by the DON on 9/8/20, with an event date of [redacted] at 5:00 p.m., the report indicated the type of incident as "[redacted]s" between Resident [redacted] and Resident [redacted].

According to the witness statement with the FRE the Registered Nurse (RN #1) reported that on 9/6/20, she knocked on the resident door then entered the room and saw that Resident [redacted] was standing and [redacted]. Resident [redacted] was in the wheelchair sitting close to Resident [redacted]'s [redacted]. Resident [redacted] said "[redacted] To Resident [redacted]. The nurse then questioned the Certified Nursing Assistant (CNA #1) if the residents was supposed to be together in this room. The CNA stated "no," then she went into the room and removed Resident [redacted] from the room. Resident [redacted] was then moved to a different unit and the incident was reported to the families.

According to the witness statement with the FRE, CNA #1 reported that on [redacted], the nurse reported to the CNA that there was another resident in the room with Resident [redacted] When the CNA entered the room, she observed Resident [redacted] pulling up their pants and Resident [redacted] was next to Resident [redacted]. The CNA then removed Resident [redacted] from the room and returned the resident back to their room.

According to the "Reportable Event Summary" for the event of [redacted], the DON reviewed the

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 09/28/2020

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 600	Continued From page 6	F 600		

security camera and observed Resident [redacted] entering Resident [redacted]'s room at 5:04 p.m., RN #1 enters the same room at 5:08 p.m., then walked back out and is seen speaking with CNA #1 in the hallway. CNA [redacted] then brought Resident [redacted] out of the room at 5:09 p.m.

Review of documentation on the FRE by the Unit Manager (UM) dated [redacted] after interviewing Resident [redacted] and Resident [redacted], revealed that Resident [redacted] denied recollection of events from the prior night and the resident denied any distress and appeared in good spirits. Resident [redacted] also denied recollection of events from the previous night and denied any distress or emotional upset.

In addition, the "Reportable Event Summary" dated [redacted] the DON reported that the Interdisciplinary Team (IDT) met on 9/7/20 to discuss the events of 9/6/20, between Resident [redacted] and Resident [redacted], and the following interventions were put in place; a room change was implemented, Care Plans were updated, Power of Attorney (POA) and Medical Doctors (MD) for both residents were made aware of the incidents.

Resident [redacted]'s CP was updated with the following intervention on [redacted], staff should ensure that the resident avoids socializing with previous roommate to avoid any social interactions which require consent.

During an interview on 9/24/20 at 10:30 a.m., Resident [redacted] reported to the surveyor regarding the [redacted] incident that he/she remembered that day and stated,"...everything went very quickly." Resident [redacted] came out of using the bathroom and Resident [redacted] had [redacted] and was [redacted]

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 09/28/2020

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 600	Continued From page 7	F 600		

"I said whoa what are you doing?" Resident [redacted] said Resident [redacted] laughed then the nurse came in. "Then things moved fast." They moved my roommate out after that to a different room. When the surveyor asked if they were having a [redacted] Resident [redacted] responded [redacted]" During the interview Resident [redacted] was alert, oriented to the surroundings, and answered appropriately.

During an interview on 9/24/20 at 11:38 p.m., the Social Worker (SW) verified that in addition to the incident on [redacted], between Resident [redacted] and Resident [redacted], there was another encounter between the two residents on [redacted], when they were roommates. According to the SW a staff member walked in and found Resident [redacted] standing over Resident [redacted] with [redacted] on [redacted] As an intervention Resident [redacted] was moved to a different hall but stayed on the same unit. The SW interviewed the residents after the incident and "they both said they did not remember the incident. They both denied it."

During an interview on 9/24/20 at 1:05 p.m., the DON reported that after one of the two incidents between Resident [redacted] and Resident [redacted], she consulted with the [redacted] by phone and "we did not consider abuse because neither of the 2 were in physical or mental distress." The [redacted] did not see either of the 2 residents after the incident on [redacted] or [redacted] "because they seemed mentally fine, no distress." The DON also stated that the 2 residents were never asked if they were having a [redacted] because the BIMS score for Resident [redacted] was [redacted] therefore "we did not feel it was an option." The DON reported that after the incident on [redacted] the intervention was to move Resident [redacted] to a different unit. The DON stated, "they both were

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 09/28/2020

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 600	Continued From page 8	F 600		

upset when they were separated." There was no documentation provided that revealed the consultation with the [redacted] professional opinion.

Review of Resident [redacted] CP showed a focus of a potential for mood instability related to wanting to socialize with peers dated [redacted] Interventions included but were not limited to: Activities that are meaningful and of interest, behavioral health consults as needed, and companionship to be supervised in common areas.

Review of Resident [redacted]s Care Plan (CP) revealed a "Focus" of being an affectionate person and enjoying having a close relationship with a friend (Resident [redacted] and may demonstrate [redacted] with an initiated date of [redacted]. Interventions included but were not limited to: Monitor, document and make POA aware of any changes in behavior, assure residents are frequently monitored when spending time together, close supervision to ensure interactions remain appropriate, and monitor to ensure affection remains benign.

Review of the MR failed to show any documentation of [redacted] consults for Resident [redacted] or Resident [redacted] until 9/10/20. According to the Facility document dated [redacted] the [redacted] documented that Resident #1 was diagnosed with a [redacted]) with [redacted], moderate to severe memory problems suggest a diagnosis of [redacted]. No documentation was found to reveal the [redacted] was notified of the alleged [redacted] events. In addition, the [redacted]

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 09/28/2020

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 600	Continued From page 9	F 600		

consults did not include reference to informed consent for [redacted] encounters.

During an interview on 9/24/20 at 1:05 p.m., the DON reported that Resident [redacted] also was involved in another incident on [redacted], with Resident [redacted] on the [redacted] unit. A staff member was doing checks on the resident and observed Resident [redacted] in Resident [redacted]s room and [redacted] in Resident [redacted]s room. Review of the progress notes dated [redacted]0, failed to reveal an assessment by the Registered Nurse (RN), and there was no documentation that the police were notified, or that the resident was sent to the Emergency Room for an evaluation after the alleged [redacted] with Resident [redacted] on [redacted]. The progress notes also failed to show that Resident [redacted] was assessed by the Medical Doctor, the [redacted], and that the facility had obtained consent for [redacted] with Resident [redacted]

Reference: N.J.S.A 52:27G-7.1: Report of suspected abuse: (New Jersey refers to this paragraph as the "Mandatory Reporter"). This section requires that "Any caretaker, social worker, physician, registered or licensed practical nurse, or other professional or staff member employed at a facility, and any representative of a managed care entity who, as a result of information obtained in the course of that individual's employment, has reasonable cause to suspect or believe that an institutionalized elderly person is being or has been abused or exploited, shall report such information to the ombudsman or to the person designated by the ombudsman to receive such a report.
If an individual reporting suspected abuse or exploitation pursuant to this subsection has reasonable cause to suspect or believe that the

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 09/28/2020

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 600	Continued From page 10	F 600		

institutionalized elderly person is or has been the victim of a crime, the individual shall additionally report such information to the local law enforcement agency and to the health administrator of the facility.

During an interview on 9/24/20 at 2:19 p.m., the DON reported that Resident [redacted] was not sent to the hospital for an evaluation on [redacted] because the LPN assessed the resident and there was "no injury or signs or symptoms of distress." He/she was not in any distress and was not abused, as evidenced by the [redacted] and [redacted] assessment by the nurse. "It was not abuse, they were just expressing [redacted] s determined by no injury or distress. The patients were calm and happy." In addition, the DON stated, the families were okay with it.

During an interview on 9/24/20 at 2:50 p.m., the Social Worker (SW) reported that another incident occurred on [redacted]. Resident [redacted] entered Resident [redacted] room and exposed his/herself to Resident [redacted] Resident [redacted] reported to the SW that the incident made him/her uncomfortable but Resident [redacted] did not remember details when interviewed on [redacted], two days after the incident.

During an interview on 9/24/20 at 3:35 p.m., CNA #1 reported she had witnessed Resident [redacted] and Resident [redacted] engaged in [redacted] on [redacted], around 5:30 p.m. When CNA #1 entered the room, she observed Resident [redacted] in Resident's [redacted]. Resident [redacted] quickly removed [redacted] from Resident #[redacted] and ran into the bathroom. The CNA asked if Resident [redacted] was okay and he/she responded that he/she [redacted]." The CNA removed Resident [redacted] and returned him/her to their rooms

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 09/28/2020

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 600	Continued From page 11	F 600		

and reported the incident to the nurse. The CNA also reported that the DON did not interview her regarding the incident.

CNA #1 also reported, that on [redacted] around 8:15 p.m., she and another CNA were looking for Resident[redacted] because the resident was on frequent checks and the resident was not in his/her room. When CNA #1 walked into Resident [redacted] room, she saw Resident [redacted] and Resident [redacted] together. Resident [redacted] was sitting on the bed with [redacted], and Resident [redacted] was standing up and [redacted] Resident [redacted] responded by covering his/her[redacted] and Resident [redacted] ran into the closet. CNA #1 also reported that earlier in the day around 5:30 or 6:00 p.m., she observed Resident [redacted] and Resident [redacted] in Resident [redacted] room. [redacted]." CNA #1 stated she reported everything to the nurse.

In addition, CNA #1 reported that Resident [redacted] had reported to her on [redacted], that "[redacted]." Resident [redacted] then wanted the room door closed because he/she was upset by the incident because he/she was undressing when he entered the room. The CNA identified the man as Resident[redacted]

During an interview on 9/24/20 at 3:15 p.m., the DON stated that Resident [redacted] was put on "close supervision after [redacted]. They check on him hourly to assure [redacted]." However, the facility staff was unable to provide documentation sheets of hourly checks after the [redacted] and [redacted] incidents.

Review of the facility's document titled "hourly checks for safety" showed Resident [redacted] was started on hourly checks on [redacted] at 11:00

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 09/28/2020

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 600	Continued From page 12	F 600		

p.m., through 9/23/20.

Review of the Physician Order Sheet (POS) showed Resident [redacted] was placed on 1:1 observation on [redacted] during the survey.

Review of the facility policy titled "Abuse" dated October 27, 2017, revealed the following under Policy: It is the policy of the Facility that each resident will be free from "Abuse." Abuse can include verbal, mental, sexual, or physical abuse .... Residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties.
Abuse Policy under section "D" "Identification" included but was not limited to the following: It is the policy of this facility that all staff monitor residents and will know how to identify potential signs and symptoms of "abuse." Occurrences, patterns and trends that may constitute 'abuse' will be investigated.

Abuse Policy under section "G" Reporting and Response, included but was not limited to the following: 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.

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 09/28/2020

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 600	Continued From page 13 Under "External Reporting" Initial reporting of allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State agency. A follow up investigation will be submitted to the state agency within five (5) working days. Law Enforcement: All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. Facility staff will fully cooperate with the local law enforcement designee. Under F. Protection: It is the policy of this facility that the residents will be protected from the alleged offenders. The IJ was identified on 9/24/2020 at 5:07 p.m., when the Administrator (Admin) and the Director of Nursing (DON), were notified of the IJ situation which ran from 9/20/20 until 9/24/2020 at 5:58 p.m., when the facility provided an acceptable Removal Plan to remove the immediacy which included placing Resident [redacted] on 1:1 monitoring. A revisit occurred on 9/28/2020 to verify the Removal Plan was in place. .	F 600		
F 609 SS=D	N.J.A.C. 8:39-4.1(a)5 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	F 609		11/27/20

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 09/28/2020

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 609	Continued From page 14 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 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: COMPLAINT # NJ 139699 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 9/24/2020, it was determined that the facility staff failed to report an allegation of abuse to the New Jersey Department of Health (NJDOH) and to the Police, for 1 of 5 residents (Resident #1), reviewed for abuse. The facility also failed to follow the facility policies titled, "Abuse" and the "Reportable Events" form. This deficient practice was evidenced by the following:	F 609	On 9/22/2020 NJ DOH was notified of event that occurred on [redacted]. On 9/24/2020 the police were called to report and investigate incident. The facility completed an audit to ensure there are no past events that the police needed to be notified. Audit was initiated 9/24/2020 and completed on 9/29/2020. All residents are at potential risk for incidents not being reported as required by state law. The facility will continue to review new	

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 09/28/2020

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 609	Continued From page 15 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] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident [redacted] had [redacted]. The MDS also indicated Resident [redacted] required limited assistance for Activities of Daily Living (ADLs). Review of the Care Plan (CP) revealed a "Focus" of being an affectionate person and enjoying having close relationship with a friend and may demonstrate [redacted], with an initiated date of [redacted]. Interventions included: Monitor, document and make Power of Attorney (POA) aware of any changes in behavior, assure residents are frequently monitored when spending time together, close supervision to ensure interactions remain appropriate, and monitor to ensure affection remains benign. During an interview on 9/24/20 at 1:05 p.m., the Director of Nursing (DON) reported that Resident [redacted] was involved in a [redacted] on [redacted] at 8:00 p.m., with Resident [redacted]. Resident [redacted] was observed with Resident [redacted] in Resident [redacted]s room and both were undressed. During an interview on 9/24/20 at 1:33 p.m., the Administrator (Admin) stated that the incident on [redacted], involving Resident [redacted] was not reported to the police because he was not sure of all the	F 609	incidents with the interdisciplinary care team during morning rounds to ensure the immediate response is implemented and that the resident is responsive to changes to plan of care. This process had been in place prior to event, with updated template for daily incident reporting to administrator as of 11/13/2020. The supervisor was reeducated on 9/23/2020 by DON and then on 10/2/2020 prior to next scheduled work day by DON together with HR on the abuse policy and appropriate responses including reporting to administration and notification including police and DOH. The staff were re-educated on the abuse policy and appropriate responses including reporting and notification initiated 9/23/2020 and completed 10/9/2020. The Administrator was re-educated on the abuse policy and appropriate responses including reporting and notification including police on 9/24/2020. The Director of Nursing and administrator/designee will review incident reports weekly to ensure appropriate responses including but not limited to notification and reporting including to police. Initial weekly meeting scheduled for 11/25/2020. Results of these audits will be reported monthly to the Quality Assurance Steering Committee. Any trends will be reviewed and discussed for root cause analysis. After the three months of reporting the Committee will decide on the frequency of audits. This has been initiated for October QA review.	

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 09/28/2020

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 609	Continued From page 16	F 609		

policies since he was new to the facility.

During an interview on 9/24/20 at 2:19 p.m., the DON stated, "We did not consider any incident abuse. No one was injured, or distressed. We spoke with the families and they were fine with it .... It's not abuse they are just expressing their [redacted] expressions determined by no injury or distress. The patients were calm and happy."

During an interview on 9/24/20 at 2:50 p.m.,the Social Worker (SW) reported another incident that occurred on [redacted]. Resident [redacted] entered Resident [redacted]s room and [redacted] his/herself to Resident [redacted]. Resident [redacted] reported to the SW that the incident made him/her uncomfortable but Resident [redacted] did not remember details when interviewed on [redacted], two days after the incident.

During an interview on 9/24/20 at 4:45 p.m., the DON stated, that Resident [redacted] reported the incident to the Certified Nursing Assistant (CNA) on [redacted], and the DON did not find out about the incident until [redacted] and she was still investigating the incident. She also stated that she did not have anything yet on paper and the incident had not been reported to the police.

According to the facility's Policy titled "Abuse" 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

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 09/28/2020

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 609	Continued From page 17 reasonable suspicion of a crime against a resident in the facility. Under "External Reporting" Initial reporting of allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State agency. A follow up investigation will be submitted to the state agency within five (5) working days. N.J.A.C. 8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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: COMPLAINT # NJ 139699	F 610	Incident Report was initiated at time of survey for incident that occurred in the week of [redacted] involving Resident [redacted]. Care plans were reviewed at that time to ensure updated plan of care.	11/27/20

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 09/28/2020

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 610	Continued From page 18 Based on interviews, review of Medical Records (MR), and review of other pertinent facility documents on 9/24/2020, it was determined that the facility failed to conduct a thorough investigation of an allegation of abuse, for 1 of 5 sampled residents (Resident [redacted]). The facility also failed to follow the facility policy titled "Resident Accidents and Incidents." This deficient practice was evidenced by 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] Review of 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 Resident [redacted] had [redacted]. The MDS also indicated Resident [redacted] required limited assistance for Activities of Daily Living (ADLs). During an interview on 9/24/20 at 2:50 p.m., the Social Worker (SW) reported that Resident [redacted] voiced to a Certified Nursing Assistant (CNA), that on [redacted], that Resident [redacted] himself/herself. The SW spoke to the resident and he/she reported being uncomfortable. During an interview on 9/24/20 at 4:45 p.m., the Director of Nursing (DON), stated that Resident [redacted] reported the incident to the CNA on [redacted] and the DON did not find out about the incident until [redacted] The DON was only able to provide a statement from the CNA about the incident she was unable to provide an incident investigative	F 610	Resident was interviewed by SW on 9/22/2020 to ensure she felt safe and had no concerns. All residents are potentially at risk when facility fails to conduct a thorough investigation of an allegation of abuse. Staff and resident concerns are reviewed daily in morning meeting with DON/ designee present to ensure any allegation of abuse are investigated and reported appropriately. This was initiated on 11/13/2020. The Director of Nursing and administrator/designee will review incident reports weekly to ensure appropriate responses including but not limited to reporting and notifications. This will begin on 11/25/2020. The staff were re-educated on the abuse policy and appropriate responses including reporting and notification initiated 9/23/2020 and completed 10/9/2020. Facility implemented a new and more comprehensive policy for incident and accident reports on 11/24/2020. Education initiated with staff on that date with goal to complete education by 11/27/2020. Staff and resident concerns are reviewed daily in morning meeting with DON/ designee present to ensure any allegation of abuse are investigated and reported appropriately. Facility will track concerns that are identified as requiring investigation and reporting as an incident.	

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 09/28/2020

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 610	Continued From page 19 report and reported that nothing regarding the incident on [redacted], with Resident [redacted], had been put on paper to this date. According to the facility policy titled "Resident Accidents and Incidents," dated February 2019, revealed the following under "Policy;" Ensure all incidents involving a resident are reported, documented and investigation initiated after the incident is identified. Review of the facility policy titled "Abuse," dated October 27, 2017, revealed the following under section "E," "Investigation;" It is the policy of this facility that reports of "abuse" ...are promptly and thoroughly investigated. N.J.A.C. 8:39-4.1(a)5	F 610	This was initiated on 11/13/2020. Results of these audits will be reported monthly to the Quality Assurance Steering Committee. Any trends will be reviewed and discussed for root cause analysis. After the three months of reporting the Committee will decide on the frequency of audits. This has been initiated for October QA review.	
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 139699 Based on interviews, Medical Record (MR) review, and review of pertinent facility documentation on 9/24/20 and 9/28/20, it was determined that the facility's administration failed to ensure that the facility's policies and procedures were implemented, including the	F 835	On 9/24/2020 the police were called to report event. All residents in the facility are at potential risk for adverse effects when facility is not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident.	11/27/20

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 09/28/2020

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 835	Continued From page 20 Policy titled "Abuse," for 1 of 5 residents (Resident [redacted]) sampled for abuse. This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident [redacted] was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident [redacted] had [redacted]. The MDS also indicated Resident [redacted] required limited assistance for Activities of Daily Living (ADLs). During an interview on 9/24/20 at 1:33 p.m., the Administrator (Admin) reported that he had only been the Admin at the facility since August 2020, but he was aware of the 3 incidents involving Resident [redacted] having [redacted] with other residents. The Admin stated the police were not notified; "no not for the September incidents," and further stated "I'm new so I'm not sure of all the policies." The Admin did state he reviewed the abuse policy after the incidents in September, however, he was still not sure if the police should have been notified. In addition, the Admin stated, "The past 2 incidents with Resident [redacted] showed no evidence of touching. I did not call it in as abuse because I didn't think it was abuse since there was no touching episodes, [redacted] and [redacted], are the [redacted] I'm talking about." However the Admin agreed that no one knows what happened before the staff member went into the room and found them [redacted]	F 835	The facility completed an audit to ensure there are no past events that required police notification. Audit was started 9/24/20 and completed on 9/29/2020. The facility will continue to review new incidents with the interdisciplinary care team during morning rounds to ensure the immediate response is implemented and that the resident is responsive to changes to plan of care. This process had been in place prior to event, with updated template for daily incident reporting to administrator as of 11/13/2020. The Administrator was re-educated on the abuse policy and appropriate responses including reporting and notification including police on 9/24/2020. The Director of Nursing and administrator/designee will review incident reports weekly to ensure appropriate responses including but not limited to notification and reporting including to police. Initial weekly meeting scheduled for 11/25/2020. The Regional Director of Operations/designee will review incident reports monthly starting 11/27/2020 to ensure appropriate responses including but not limited to reporting and notifications including police. Results of these audits will be reported monthly to the Quality Assurance Steering	

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 09/28/2020

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 835	Continued From page 21 Review of the facility policy titled "Abuse" dated October 27, 2017, revealed the following under Policy: It is the policy of Facility that each resident will be free from "Abuse." Abuse can include verbal, mental, sexual, or physical abuse .... Residents will be protected from abuse, neglect, and harm while they are residing at the facility. 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. Under "External Reporting" Initial reporting of allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State agency. A follow up investigation will be submitted to the state agency within five (5) working days. Under "Internal Reporting" section "b;" The Administrator will involve key leadership personnel as necessary to assist with reporting, investigation and follow up. N.J.A.C. 8:39-4.1(a)5	F 835	Committee. Any trends will be reviewed and discussed for root cause analysis. After the three months of reporting the Committee will decide on the frequency of audits. This has been initiated for the month of October QA review.	