STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315219	A. BUILDING ______ B. WING ______	C 02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	**3001 EVESHAM ROAD VOORHEES, NJ 08043**

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F 000	INITIAL COMMENTS COMPLAINT # NJ 143044 CENSUS: 137 SAMPLE SIZE: 4 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. Based on interviews, review of Medical Records (MR), and review of other pertinent Facility documents on 2/19/21 and 2/24/21, it was determined that the Facility staff failed to ensure a resident with [redacted] was appropriately protected to prevent the resident from actual abuse by a staff member. The facility staff also failed to follow their policy titled: "Abuse Prohibition," to notify the Police and the New Jersey Department of Health (NJDOH) timely, for [redacted] residents (Resident #1) reviewed for abuse. On 2/10/21, during the 11:00 p.m. to 7:00 a.m. shift a Certified Nursing Assistant (CNA #1) used a [redacted] and [redacted] to barricade a Resident in the bed. Several staff members on the 7:00 a.m. to 3:00 p.m. shift observed the furniture in place and failed to remove the barricade or report it to the Supervisor or Administration until approximately 7 hours later when the Speech Therapist (ST) observed the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/22/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 furniture blocking the bed and alerted her Director. This placed Resident #1, as well as all residents with [redacted] in an Immediate Jeopardy (IJ) situation. The IJ was identified on 2/24/21 at 2:40 p.m., when the Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ situation and were provided the IJ template. The IJ ran from approximately 6:40 a.m. on 2/10/21, until 2/10/21 at approximately 2:30 p.m., when the Unit Manager (UM) reported the incident to the Director of Nursing (DON) and the Administrator and removed the CNAs and the Nurse from their assignment and suspended them pending the investigation. The Facility provided an acceptable Removal Plan which included in-servicing of the staff involved on Abuse, Reporting of Abuse and Prohibition Restraints Policy which removed the Immediacy. The IJ was Past Non-Compliance (PNC).	F 000		
F 600 SS=J	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. §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:	F 600		2/24/21

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F 600	Continued From page 2 COMPLAINT # NJ 143044 Based on interviews, review of Medical Records (MR), and review of other pertinent Facility documents on 2/19/21 and 2/24/21, it was determined that the Facility staff failed to ensure a resident with [redacted] was appropriately protected to prevent the resident from actual abuse by a staff member. The facility staff also failed to follow their policy titled: "Abuse Prohibition," to notify the Police and the New Jersey Department of Health (NJDOH) timely, for 1 of 3 residents (Resident #1) reviewed for abuse. On 2/10/21, during the 11:00 p.m. to 7:00 a.m. shift a Certified Nursing Assistant (CNA #1) used a [redacted] and [redacted] to barricade a Resident in the bed. Several staff members on the 7:00 a.m. to 3:00 p.m. shift observed the furniture in place and failed to remove the barricade or report it to the Supervisor or Administration until approximately 7 hours later when the Speech Therapist (ST) observed the furniture blocking the bed and alerted her Director. This placed Resident #1, as well as all residents with cognitive impairment in an Immediate Jeopardy (IJ) situation. The IJ was identified on 2/24/21 at 2:40 p.m., when the Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ situation and were provided the IJ template. The IJ ran from approximately 6:40 a.m. on 2/10/21, until 2/10/21 at approximately 2:30 p.m., when the Unit Manager (UM) reported the incident to the Director of Nursing (DON) and the Administrator and removed the CNAs and the Nurse from their assignment and suspended them pending the	F 600	Previously Submitted and Accepted with Removal Plan	

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F 600	Continued From page 3 investigation. The Facility provided an acceptable Removal Plan which included in-servicing of the staff involved on Abuse, Reporting of Abuse and Prohibition Restraints Policy which removed the Immediacy. The IJ was Past Non-Compliance (PNC). This is deficient practice is further evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was admitted on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], indicated Resident #1 was unable to ambulate and required extensive assistance for Activities of Daily Living (ADLs). Review of Resident #1's Care Plan (CP) revealed a Focus of Impaired/Decline in [redacted] function or [redacted] related to a condition other than [redacted] evidenced by a Brief Interview for Mental Status (BIMS) score of [redacted] on [redacted] According to the Progress Notes dated [redacted], the Registered Nurse (RN) documented Resident #1's mental status as alert and oriented to person with [redacted] skills for daily routine. According to the documentation on the Facility's Reportable Event Record/Report (FRE), reported to the New Jersey Department of Health	F 600		

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F 600	Continued From page 4 (NJDOH) by the Director of Nursing (DON) on [redacted], with an event date and time of [redacted] at 1:30 p.m., the DON reported the type of incident as "Staff-to-Resident Abuse." The FRE "Narrative," described the event as follows: At approximately 1:30 p.m. on [redacted], the staff went into Resident #1's room and upon entering the room the staff observed the residents left side of the bed against the wall and on the right side of the bed was a floor mat up against the side of the bed with [redacted] at the head and foot of the bed. The staff immediately removed the furniture away from the bed and removed the bed away from the wall. The resident was assessed, and no injuries were found. Staff involved and caring for the resident at the time were suspended pending the investigation and sent home. According to the "Individual Statement Form," obtained by Administration during the investigation: The 11:00 p.m. to 7:00 a.m., CNA (CNA #1) documented that when she entered Resident #1's room on [redacted] she observed the resident "hanging on the bed," she put the resident back in bed and sat there to "keep an eye on him/her." When CNA#1 looked out the door she noticed another resident coming out of their room who needed assistance. When she looked back at Resident #1, he/she was again trying to get out of bed (OOB), so she put the dresser in front of the bed before leaving the room. CNA #1 then attended to several other residents before seeing the oncoming CNA (CNA #2). CNA #1 stated that during rounds with CNA #2 she reported to her that she had put the [redacted] next to the bed because she had to attend to another resident and asked if CNA #2 would "remove it" for her.	F 600		

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F 600	Continued From page 5 According to the "Individual Statement Form," the 11:00 p.m. to 7:00 a.m., Licensed Practical Nurse (LPN) documented that she checked the vital signs and [redacted] on Resident #1 around 6:10 a.m. on 2/10/21, and had observed the bed in the lowest position, the floor mat was next to the bed, and the bed was against the wall. The furniture was not against the bed preventing the resident from getting up. According to the "Individual Statement Form," the 7:00 a.m. to 3:00 p.m., CNA (CNA #2) documented that upon arriving on her shift on [redacted], Resident #1's bed was against the wall and furniture was against the bed. "The resident gets out of bed. So, the table drawer is by his/her bed. The bed is all the way down and we checked on him/her often." When she worked on [redacted], the bed was against the wall, but no furniture was against the bed. When she worked on [redacted] upon leaving for the night the furniture was not against the bed. The bed was against the wall because he/she attempts to get out of the bed. According to the "Individual Statement Form," the 7:00 a.m. to 3:00 p.m., CNA (CNA #3) documented that she noticed the furniture was against the wall in the morning on [redacted], but prior to that date there was no furniture against the bed. The resident's bed was placed alongside of the wall to create space to use the [redacted] for [redacted] According to the "Individual Statement Form," the 7:00 a.m. to 3:00 p.m., Registered Nurse (RN) documented that when she arrived to the unit on [redacted] in the a.m., she had noticed that the bed was against the wall with furniture on the right side, and the fall mat was on the floor. The	F 600		

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F 600	Continued From page 6 furniture was not next to the bed when she worked on [redacted], however, the bed had been against the wall since last week and even with the bed against the wall the resident was still trying to get up independently. The RN also documented that Resident #1 was a [redacted] and had [redacted] a week prior after attempts of getting up unassisted. According to the "Individual Statement Form," the Occupational Therapy Assistant (OTA) documented that upon entering Resident #1's room on [redacted], she observed the resident sleeping in bed with the bed pushed against the wall and a [redacted] on its side with [redacted] blocking the side of the bed. According to the "Individual Statement Form," the Unit Manager (UM) documented that when she went onto the unit on [redacted], to get report around 8:30 a.m., the nurse did not report any issues regarding Resident #1. Around 1:30 p.m., she received a call from the Director of Rehabilitation (Rehab) with concerns about safety of a resident. She immediately went to Resident #1's room and observed the resident resting comfortably in bed. "The left side of the bed was against the wall, on the right side there was a fall mat on its side against the bed, there was 2 [redacted] next to the [redacted] After assuring the resident was safe, I reported my finding to the DON." Review of the "Investigation Summary," dated 2/10/21, under "Nature of Incident," was "Inappropriate fall intervention," the documentation included: At approximately 6:40 a.m., the CNA was sitting with Resident #1 because he/she was agitated, when another resident urgently required the attention of the	F 600		

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F 600	Continued From page 7 CNA. The CNA propped the [redacted] against the bed next to the furniture before leaving the room. At 7:00 a.m., the next shift came in and completed rounds. Resident #1 received morning ADLs and was assisted with both meals. The therapist identified that the floor mat was being used inappropriately and reported the concern. The assigned care staff were placed on administrative leave pending an investigation. Further review of the "Investigation Summary," dated [redacted], revealed documentation that interviews completed revealed that the staff member who put the [redacted] against the bed and those who cared for Resident #1 on the following shift were conflicted on how best to keep the resident safe since he/she was unaware of his/her own limitations making the resident a [redacted] risk. Each staff member was motivated by their responsibility and desire to keep the resident safe although the intervention chosen was not appropriate. The staff members will be brought back on [redacted], or their next scheduled shift thereafter with re-education on appropriate fall interventions, restraint protocols, and abuse prohibition. Each staff member will be monitored weekly for a period of one month. Review of the FRE showed documentation that the following interventions were put in place: The staff caring for Resident #1 were sent home and suspended pending the investigation. Resident #1 was assessed for injuries and none were found. The furniture and the bed were readjusted and positioned properly. During an interview on 2/19/21 at 11:45 a.m., the DON stated that the UM and the DR came to her office around 2:00 or 2:30 p.m. on [redacted] and reported that the furniture in Resident #1's room	F 600		

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F 600	Continued From page 8	F 600		

was positioned next to the bed. "They said the staff had it like that to prevent him/her from getting OOB so he/she would not fall." The DON reported the incident to the Administrator (Admin) prior to going to the unit. When the DON arrived on the unit, she asked the 2 CNAs and the LPN to go to the nursing station and wait there until she came back to interview them and get their statements. Upon entering the room she observed the right side of the bed against the wall and the [redacted] were on the side of the bed, one near the head of the bed, and the other [redacted] was near the bottom of the bed. The [redacted] was positioned between the bed and the [redacted] The staff then removed the barricade from around the bed and put the [redacted] back in place next to the bed on the floor.

The DON also stated that despite the [redacted] and [redacted] up against the bed the resident could still get OOB but was likely to have a more severe injury because he/she could get caught between the [redacted]

During an interview on 2/19/21 at 1:04 p.m., the OTA stated the Speech Therapist (ST) reported to her that the furniture was around the bed and Resident #1 was barricaded in the bed with the [redacted]. The ST said she would call the Director of Rehab, so the OTA went to the unit. The OTA observed "the bed against the wall with the [redacted] tilted on its side vertically and the [redacted] were pushed up against the [redacted] holding the [redacted] up. The mat was between the [redacted] and the bed." The resident at that time was sleeping. The OTA was not sure if she moved the floor mat or the [redacted] away from the bed prior to leaving the room.

During an interview on 2/24/21 at 9:51 a.m., the

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Speech Therapist (ST) reported that on [redacted] a CNA reported to her that Resident #1 was agitated that day, so she waited and did not see him until around 1:30 p.m. When she walked into Resident #1's room she observed the "blue mat and [redacted] next to the bed. The bed was against the wall on the left side, the mat was standing up and it was kind of holding him/her in the bed. It was a barrier to keep him/her in bed."

The ST stated that Resident #1 had good days and bad days. Some days he/she was [redacted]. The nurse told the ST they were looking into Resident #3's medications because of the behaviors and fatigue.

The ST also stated she left everything as is because "it was like a crime scene." The ST returned to the Rehab department and notified a co-worker of the barricade. The co-worker went right over there to see him/her while the ST called the Director of Rehabilitation (DR). The ST also stated, that she did not report the incident to anyone since she did not see any nurse on the unit and since the resident was calm, but she did not move any furniture away from the bed prior to leaving the room. "Because he/she was calm I did not move anything because I wanted nursing to see it. I preferred nursing to see the side of it, so I did not move it." The ST agreed that Resident #1 could have been in danger because the furniture was left in place. "Yes, if [redacted] got agitated and tried to climb over the dresser yes, [redacted] could have gotten hurt. Because [redacted] was calm, I left everything as is."

The ST returned to the Rehab department and reported her observation to her coworker, the

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F 600	Continued From page 10 Occupational Therapy Assistant (OTA) then called the DR. During an interview on 2/24/21 at 10:24 p.m., the DR stated that on [redacted], in the afternoon (not sure of the time), she received a call from the OTA who reported that Resident #1 had a [redacted] tipped on its side against the bed and [redacted] were holding the [redacted] in place against the bed. The DR immediately called UM and reported the incident to the UM. The DR informed the UM that she would notify the Administrator. During an interview on 2/24/21 at 10:53 a.m., the UM stated that on [redacted] around 1:30 p.m. she received a phone call from the DR who reported that the Rehab staff saw Resident #1 in bed with the [redacted] and [redacted] against the bed. The UM immediately went to the unit and saw CNA #1 and CNA #2 and asked them "what was going on?" Neither CNA reported anything about Resident #1 or anything about the furniture against the bed to the UM. The UM also stated, "I walked into the room and thought thank God I'm not a Department of Health Surveyor because this would get us in a (expletive) load of trouble. The left side of the bed was against the wall, the [redacted] was upright against the opposite side of the bed with [redacted] against the mat. I checked the resident to make sure he/she was okay. He/she was calm and was sleeping." The UM further stated that when she received morning report from the nurse no behaviors or falls were reported to her. She left everything in place and went to get the DON. "I felt I needed someone to see it to prove it." The UM stated that she did not ask any other staff member to watch Resident #1 for safety while she left the unit to go	F 600		

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F 600	Continued From page 11 get the DON. She returned to the unit with the DON, and at that time they put the [redacted] back on the floor next to the bed and put the [redacted] back in place. The UM stated that it is everyone's responsibility to keep the residents safe and leaving the barricade in place "still put his/her safety at error. I also made an error in judgement." During an interview on 2/24/21 at 10:55 a.m., the LPN stated, that "nothing was out of place" when she went into Resident #1's room to check the blood sugar at 6:00 or 6:10 a.m. on [redacted] The bed was in the lowest position and the resident was sleeping. No one else was in the room at that time. The LPN also stated that the staff did not report Resident #1 had any negative behaviors or attempted to climb out of the bed during the night. During an interview on 2/24/21 at 11:49 a.m., the day shift CNA #2 stated, at the start of her shift she made rounds around 7:00 a.m., and saw Resident #1 sleeping in bed with the [redacted] upright against one side of the bed with [redacted] holding the [redacted] in place and the other side of the bed was against the wall. The CNA reported that she did not remove the barricade because Resident #1 was combative and attempts to get OOB. She left the furniture in place because of his/her behaviors and did not think to report it to anyone. She also reported that the resident could have really hurt himself/herself and all the staff are responsible for the resident's safety. During an interview on 2/24/21 at 12:20 p.m., CNA #3 stated, that when she went in Resident #1's room she observed the bed against the wall and the [redacted] against the bed and thought "this is something new," however Resident #1	F 600		

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COMPLETE CARE AT VOORHEES, LLC	**3001 EVESHAM ROAD VOORHEES, NJ 08043**

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F 600	Continued From page 12 was never combative with her. The [redacted] was there when she first came in at the beginning of her shift and the small end table was at the foot of the bed. She also agreed that it is a safety issue if there is a barricade around the bed and the resident could get hurt. During an interview on 2/24/21 at 12:38 p.m., RN#1 stated, that she observed the barricade in place around Resident #1's bed when she made rounds at the beginning of her shift, around 7:00 a.m. She reported that the left side of the bed was up against the wall and the right side of the bed had the [redacted] standing upright behind 2 nightstands. At that time, she said the resident was calm and was sleeping but he/she would have periods of confusion and behaviors of being combative and would hit staff during care. The RN also agreed that it is a safety issue if there is a barricade around the bed and the resident could get hurt. Review of the "Investigation Summary," dated [redacted],"Conclusion and Plan," listed the following: Although the actions of the staff caring for Resident #1 could have been perceived as abuse, there was no intent to harm. There was only intent to keep the resident safe and uninjured by a fall. The staff as well as the employee assigned to care for Resident #1 on [redacted] were re-educated. Each staff member assigned will be monitored weekly for a period of one month. Daily room rounds will be completed to ensure appropriate fall interventions are in place. Findings will be recorded and reported during monthly Quality Assurance and Performance Improvement (QAPI). CNA #2 verified that she was in-serviced on Abuse at the Facility upon hire [redacted] months ago,	F 600		

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F 600	Continued From page 13	F 600		

and that she was aware that barricading a resident in bed is a form of restraint and restraints are a type of abuse. CNA #2 also stated that the staff are responsible for the resident's safety and Resident #1 could have really been hurt.

Several attempts were made to interview CNA #1 by phone, however, she failed to return phone calls from the Surveyor.

Review of the Facility's In-Service Training Record showed CNA #1 was in-serviced on the topic "Abuse Training" on [redacted]

Review of the Facility's In-Service Training Record showed CNA #2 was in-serviced on the topic "Abuse Prevention and Reporting" on [redacted].

Review of the Facility's In-Service Training Record showed CNA #3 was in-serviced on the topic "Abuse Training" on 9/2/20, and she reported yearly in-servicing on abuse.

Review of the Facility's Course Training Record showed the RN was educated on Abuse Prohibition on [redacted], and Dementia Care on [redacted]

According to the Facility Policy titled "Abuse Prohibition" with an effective date of 6/1/96, and a Revision date of 7/1/19, revealed under Policy, (Facility Name) prohibits abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Centers also strive to comply with the Elder Justice Act (EJA).

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F 600	Continued From page 14 Under the EJA, employees are designated as mandated reporters and are obligated to immediately report any suspicion of a crime against a resident. Reporting a suspicion of a crime only to an immediate supervisor does not meet the obligation to report. Retaliation in any form against an employee who reports a suspicion is strictly prohibited. According to the Facility Policy titled "Reporting," under "Federal Law," Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property within 24 hours if the event does not result in serious bodily injury. Resident #1, a [redacted] resident was barricaded in bed by a CNA on [redacted] with a [redacted] upright and [redacted]. Several staff members observed the barricade/restraint and failed to report the incident immediately to the Supervisor or Administration or remove the furniture until 7 hours later. This deficient practice placed Resident #1, as well as all residents with cognitive impairment in an Immediate Jeopardy (IJ) situation. The Removal Plan was verified on 2/24/21, the second day of the survey. The Immediate Jeopardy was past Non-Compliance. Interventions to remove the Immediacy were verified on 2/24/21, the second day of the survey and included, in-servicing, disciplinary action and education to employees who failed to report the	F 600		

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F 600	Continued From page 15 incident, and suspension and education of the CNAs. N.J.A.C.8:39-4.1(a)5	F 600		
F 609 SS=D	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 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 143044	F 609	1. The occurrence involving resident #1 has been reported to the Voorhees	3/31/21

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Reference: Peggy's Law

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 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.

Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 2/19/21 and 2/24/21, it was determined that the facility staff failed to report timely, an allegation of abuse to the New Jersey

F 609 (Plan of Correction)

Township Police Department. The case number is 2021-05995

2. The center acknowledges that all residents have the potential to be affected by this practice. The center will complete physical assessments on all residents,as well as, conducted interviews with residents who are able to participate. Any suspected signs and symptoms, or verbal allegations, of abuse will be immediately reported to all appropriate agencies.

3. All staff have been re-educated on the timeliness of abuse reporting as well as reporting all abuse allegations to the appropriate agencies.

4. The center's administrator or designee will review the abuse policy and procedures at the monthly QAPI committee meeting. The Director of Nursing or designee will conduct random interviews with staff to ensure all staff have a full understanding of reporting procedures in conjunction with random room checks to ensure this practice does not occur. This process will be followed weekly for 3 months. Any concerns will be addressed immediately and reviewed at the centers QAPI committee meetings.

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F 609	Continued From page 17 Department of Health (NJDOH) and to the Police, as well as failed to follow their Policies titled, "Abuse Prohibition," and their "Reporting" form for 1 of 4 residents (Resident #1) sampled. This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was admitted 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 #1 was unable to ambulate and required extensive assistance for Activities of Daily Living (ADLs). Review of Resident #1's Care Plan (CP) a revealed a Focus of [redacted] evidenced by Brief Interview for Mental Status (BIMS) score of [redacted] on [redacted] According to the Progress Notes dated [redacted] the Registered Nurse (RN) documented Resident #1's mental status as, [redacted] to [redacted] with [redacted] skills for daily routine. According to the documentation on the Facility's Reportable Event Record/Report (FRE), reported to the New Jersey Department of Health (NJDOH) by the Director of Nursing (DON) on	F 609		

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F 609		F 609		

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[REDACTED], with an event date and time of [REDACTED] at 1:30 p.m., the DON reported the type of incident as "Staff-to-Resident Abuse."

During an interview on 2/24/21 at 2:00 p.m., the Director of Nursing (DON) stated the incident was not reported to the Police but said she was aware that incidents of abuse are supposed to be reported to the Local Police.

Further review of the FRE revealed documentation that the Medical Doctor (MD) and the Ombudsman were notified of the incident on [REDACTED], however, there was no documentation to show that the police were notified of the abuse incident and the facility Administration was unable to provide documentation to verify that the Local Police were informed.

According to the Facility Policy titled "Abuse Prohibition" with an effective date of 6/1/96, and a Revision date of 7/1/19, revealed under Policy, (Facility Name) prohibits abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Under Process section 7.4 Report allegations involving neglect, exploitation, or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of resident property with 24 hours if the event does not result in serious bodily injury. Under 7.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required.

According to the Facility Policy titled "Reporting," under "Federal Law," Report allegations involving

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F 609	Continued From page 19 abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property within 24 hours if the event does not result in serious bodily injury. N.J.A.C. 8:39-9.4	F 609		