STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D35005	A. BUILDING: _____ B. WING _____	C 12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLENNIUM MEMORY CARE AT MATAWAN	447 MATAWAN AVENUE CLIFFWOOD, NJ 07721

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R 000	8:37-2.1(i) Initial Comments When determining whether an applicant is capable of operating a dementia care home, the Department shall consider any evidence of licensure violations representing serious risk of harm to residents, any evidence of an applicant's violation of any State licensing or Federal standards in connection with an inappropriate discharge or denial of admission of a resident or patient, and an applicant's record of criminal convictions involving fraud, patient or resident abuse or neglect, a crime of violence, a crime of moral turpitude, or any other crime that presents a risk of harm to the safety or welfare of residents. TYPE OF SURVEY: Complaint Complaint #: NJ00141455, NJ00141447 Cenus: 13 Sample: 3 THE FACILITY IS NOT IN COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE N.J.A.C 8:37 STANDARDS FOR LICENSURE OF DEMENTIA CARE HOMES.	R 000		
R 365	8:37-3.1(a)(12) Resident Rights Every resident of a dementia care home shall have the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident. This STANDARD is not met as evidenced by: Complaint #: NJ00141455, NJ00141447	R 365		

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R 365	Continued From page 1 Based on interview, record review and review of recorded surveillance tape it was determined that the facility failed to provide a safe environment and considerate, respectful care that recognizes the dignity and individuality of 1 of 3 residents reviewed for physical abuse, Resident #2. This deficient practice was evidenced by the following: On 12/1/2020 the Department of Health received a Facility Reportable Event (FRE) via fax which alleged staff to resident abuse [Resident #2]. The FRE indicated that on 11/24/20 it was reported to the House Manager (HM) by the 11:00 p.m. - 7:00 a.m. staff that upon a.m. care Resident #2 was noted to have a [redacted]. The FRE further revealed that after review of the facility's video surveillance tape, it was discovered that Resident #2 was assaulted by a Certified Medication Aide (CMA) who worked the 3 p.m. to 11 p.m. shift on [redacted] The FRE also indicated that Resident #2 was sent to the emergency room on [redacted] for evaluation and that the facility informed local law enforcement. On 12/2/2020 at 10:40 a.m., the surveyor met with the HM who stated that she [HM] received a call from an 11:00 p.m. - 7:00 a.m. staff member who reported that upon providing care to Resident #2 on [redacted] in the morning, she noticed that Resident #2 had a [redacted] on the [redacted] of his/her[redacted] The HM stated that she immediately informed the Registered Nurse (RN)/also the Administrator, the Doctor and Resident #2's family that he/she had a [redacted] The HM stated that the RN instructed her to send	R 365		

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R 365	Continued From page 2 Resident #2 to the hospital for an evaluation. The HM further stated that on [redacted] she reviewed the video surveillance tape dated [redacted], and that she witnessed that the CMA had struck Resident #2 on his/her [redacted] and [redacted] of his/her [redacted] The HM stated that on [redacted] after the RN reviewed the video surveillance tape, she [RN] informed the local Police Department and terminated the CMA. On 12/2/2020 at 11:30 a.m. along with the HM, the surveyor viewed the facility's video surveillance tape dated [redacted] and observed a staff member identified by the HM, as a CMA, attempted to perform a [redacted] check on Resident #2. The surveyor observed the CMA tussled with Resident #2 striking him/her on the [redacted] of the [redacted] with her hand. The surveyor also observed that Resident #2 had a knitted blanket on his/her lap and during the tussle the blanket wrapped around Resident #2 [redacted] for an extended period of time. The surveyor also observed the CMA strike Resident #2 on the [redacted] of his/her [redacted] several times. The video surveillance tape did not have audio. The HM showed the surveyor additional footage from the video surveillance tape dated [redacted] which revealed that the CMA escorted Resident #2 while he/she was in a wheelchair to what the HM identified was the bathroom, the surveyor observed the CMA strike Resident #2 on his/her [redacted] of the [redacted]. The surveyor did not observe any other staff members in the vicinity of the incidents during review of the video surveillance tape date	R 365		

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R 365	Continued From page 3 [redacted]. On 12/2/20 the surveyor reviewed the Medical Records (MR's) of Resident #2 who moved into the facility on [redacted] with diagnosis that included [redacted] Review of the hospital record on [redacted] confirmed that Resident #2 had [redacted] on the [redacted] with diagnosis of [redacted] of the [redacted]. [redacted] was conducted at the hospital with no acute abnormalities seen. On 12/2/2020 at 11:45 a.m. the surveyor observed that Resident #2 had [redacted]. The surveyor was unable to interview Resident #2 due to his/her cognition. On 12/2/2020 at 12:30 p.m., the surveyor interviewed the RN/Administrator via telephone who stated that she was informed by the HM of staff to resident abuse. The RN/Administrator stated that upon review of the video surveillance tape, she observed that CMA #1 assaulted Resident #2. The RN/Administrator further stated that she informed the HM to send Resident #2 to the hospital for an evaluation. The RN/Administrator then stated that she called the Police to report the assault on Resident #2 and terminated CMA#1. Review of the initial police report confirmed that law enforcement authority was notified. The surveyor reviewed CMA #1's employee file and observed that she was hired on [redacted] and that an employee background check was not done and completed until [redacted].	R 365		

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R 365	Continued From page 4 Review of available documentation and post survey information requested and obtained on 1/22/21, 1/25/21, and 1/26/21, revealed the following: Documentation of in-services with sign-in sheets revealed that the facility provided the following in-services: - 2/4/19: "Patient Right." This in-service was prior to CMA #1's hire on [redacted] and no documented evidence presented to indicate that CMA #1 received this in-service upon or after she was hired. - 3/8/19: "Care of Patient with Alzheimer's." This was also provided prior to hiring CMA #1 therefore, she did not receive this in-service training. - 9/14/20: "How to Respond to Combative Behavior in Dementia." The sign-in sheet revealed that CMA #1 attended this in-service. - 12/10/20: "If anyone suspects Abuse, Neglect etc. the Manager needs to be notified immediately." This in-service was provided to all staff after the abuse incident on [redacted] and after CMA #1 was terminated. - 12/22/20 (written over with a marker): "Elderly Abuse - how to identify and respond appropriately." This was also provided after CMA #1 was terminated. During a post survey telephone interview with the RN/Administrator on 1/25/21, she stated that she was made aware of the incident and immediately instructed the HM to send the resident to the hospital for evaluation. The RN/Administrator stated that the resident had previously sustained [redacted] on the [redacted] due to resident hitting his/her head on the bed rails. She stated that they reviewed the surveillance tape to be sure that the [redacted] around resident's [redacted] on [redacted] was not due to resident hitting his/her	R 365		

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head again on the bed rails or the night table during that night on [redacted] to [redacted] The RN/Administrator offered and stated that she would have the staff call the Department for interview regarding the incident on [redacted]

During a telephone interview with the HM on 1/25/21, she confirmed that she was notified by the night shift 11:00 p.m.- 7:00 p.m. staff that while providing morning care to Resident #2 on [redacted] morning, the night shift staff noted that the resident's [redacted] had a [redacted] mark. Surveyor questioned if the mark around the resident's [redacted] was initially noted by the night shift upon start of their duty on [redacted], she stated, "no." She stated that during her investigation interviews with the night shift staff members, they indicated that residents were already asleep when they came on duty, including Resident #2, and that lights in the rooms were off.

The HM also stated that on [redacted] at around 9:00 p.m., CMA #1 notified her that Resident #2 was [redacted] and [redacted] and that Resident #2 bit her [CMA #1] hand while she attempted to perform a [redacted] on Resident #2. She also stated that a night shift staff member reported that morning that when the night shift staff member was about to give morning care to Resident #2, she noted the resident had a'[redacted] on the [redacted] side. She stated that she remembered that a report from the evening shift staff (CMA #1) on [redacted] that Resident #2 bit her hands. She stated that she then went to check and review the surveillance tape. She stated that upon reviewing the surveillance tape, she noted on the tape that CMA #1 hit Resident #2 on the [redacted] as CMA #1 was trying to do a [redacted] on Resident #2. The surveyor asked if Resident #2 had history of [redacted] and [redacted] behavior, she stated, "yes." She

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stated that staff were in-serviced on how to respond to a resident with combative behavior in 09/2020. The surveyor requested to have Resident #2's care plan sent to the Department via email.

A post survey telephone interview with the Regional nurse, a licensed practical nurse (LPN) was also conducted on 1/25/21. The Regional nurse/LPN stated that she was made aware by the HM of the abuse incident that occurred on [redacted]. She stated that Resident #2 has diagnosis and history of [redacted] behavior and often [redacted] with staff. She stated that Resident #2 had [redacted] on his/her [redacted] prior to [redacted], due to resident bumping his/her [redacted] on the bed rails. The Regional Nurse/LPN stated that she will send a copy of the incident report to the Department. The surveyor also mentioned to her that a request was made to the HM to send a copy of Resident #2's care plan.

Review of the Incident Report dated [redacted] received from the facility through an electronic mail (email) on 1/26/21, revealed a report that on [redacted] at 5:00 a.m., Resident #2 bit the hand of one of the night shift staff as the staff was trying to provide morning care. Further review of this Incident Report also included a documentation that while getting Resident #2 to his/her wheelchair, the resident hit his/her [redacted] on the bed rail. This occurred in the resident's room. On the Incident Report the Regional nurse/LPN documented, "Reviewed recent in-service with HM for Combative Behaviors for staff to utilize with patient." There was no documented evidence, however, of who attended and which staff members received and reviewed the in-service again on or after 1/18/20.

Review of the Incident Report dated [redacted],

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R 365	Continued From page 7 revealed an incident that occurred on [redacted] at around 8:47 p.m., when Resident #2, again, bit another staff member's hand [CMA #1's] while '[redacted] on Resident #2." This Incident Report also included a documentation stating, "In-services scheduled for care of Dementia Pts with Combative Behavior." On 11/24/20 morning, however, it was discovered that CMA #1 assaulted Resident #1 as the resident was refusing to have the [redacted] done on him/her. The staff {CMA #1) insisted, forced, and hit the resident to the [redacted]. Review of this in-service titled, "How to Respond to Combative Behavior[redacted]" revealed discussion of the causes of combative behavior in Dementia which includes provision of care and catastrophic reaction as triggers for combativeness. The in-service also included ways to help reduce resident's combative behavior including the following: "Don't rush, talk before trying, use a visual clue, take a time out, switch caregivers ... don't argue ...and remain calm." Although the in-service included ways to prevent and trigger these behaviors, and for staff and caregivers to understand why residents with dementia might resist care and be combative, the facility had no system in place to ensure that staff followed and implemented as in-serviced. Review of facility's Abuse and Neglect Policy documented the following, but not limited to: " ...Use appropriate interventions to deal with aggressive and/or catastrophic reactions of residents ... Recognize burnout, frustration and stress in yourself and coworkers. Know your residents. Be aware of which resident typical behavior may put them at risk ...." The facility, including the Administrator did not ensure that staff were observed, monitored, and evaluated for compliance and implementation of interventions	R 365		

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R 365	Continued From page 8 to dealing with residents with aggressive behavior. The facility did not have a system to address, recognize, and prevent staff burn out, frustration, and stress as per their Abuse and Neglect Policy to protect residents, including those with aggression component of their dementia. Review of Resident #2's care plan dated [redacted] documented that the resident is confused and could be [redacted] at times. Care plan listed the following interventions: Care with caution as the resident is [redacted] at times, allow quiet time and "administer PRNs" (as needed medications). An updated resident's care plan dated [redacted] included [redacted] behavior" as an identified concern. The interventions listed included the following: "use quiet time, approach with a low voice, speak directly to the patient, use quiet are if needed ...." Resident's care plan was not updated in a timely manner after the [redacted] incident when the resident bit a night shift staff member which occurred while the staff attempted to provide morning care to the resident at 5:00 a.m. Resident #2 bit another staff member (CMA #1) while attempting to obtain and do a [redacted] which the resident refused, resisted, and was struggling to pull his/her hand away. The facility staff were aware that the resident has dementia with behavioral [redacted] problem, however, Resident #2 was not provided a safe environment that is free from harm. The facility failed to ensure care was given with respect, dignity and consideration to Resident #2's individuality.	R 365		