STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	**132 EVERGREEN RD EDISON, NJ 08818**

(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 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00158515, NJ00159983, NJ00164423, NJ00163314, NJ00160359, and NJ00159785 Survey Dates: 09/05/23 through 09/07/23 Survey Census: 162 Sample Size: 11 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		

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

Electronically Signed | 09/26/2023

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
	051225	A. BUILDING: _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	132 EVERGREEN RD EDISON, NJ 08818

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S 000	Initial Comments Complaint #: NJ00158515, NJ00159983, NJ00164423, NJ00163314, NJ00160359, and NJ00159785 Survey Dates: 09/05/23 through 09/07/23 Survey Census: 162 Sample Size: 11 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00158515, NJ00159983, NJ00164423, NJ00163314, NJ00160359, and NJ00159785 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to	S 560	Corrective Actions related to deficiency Identified deficient shifts cannot be corrected. No residents were adversely affected by this practice Identification of At-risk Residents Current residents have the potential to be affected by this practice	9/27/23

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

Electronically Signed — 09/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	051225	A. BUILDING: _____ B. WING _____	C 09/07/2023

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S 560	Continued From page 1 maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 1 of 7 day shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for 1 week of staffing from 11/27/2022 to 12/03/2022, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: 1. For the week of Complaint staffing from 11/27/2022 to 12/03/2022, the facility was deficient in CNA staffing for residents on 1 of 7	S 560	Systemic Changes The Staffing Coordinator will staff the facility at or above the minimum staffing requirements Staffing coordinator and Supervisors of Nursing were in-serviced on minimum staffing requirements and strategies to cover open shifts to ensure minimum staffing requirement is met. The schedule will be reviewed by the staffing coordinator 8 weeks in advance to identify open shifts. Open shifts will be posted 8 weeks in advance for internal staff to sign up for additional/overtime shifts Per Diem staff will be called to obtain schedules one month in advance The 4 Contracted Staffing Agencies (Intily, Century 22, Acute Care and EShift) will be provided with the available open shifts 6 weeks in advance with agency rate boosted as needed ADON or designee will review staffing one month in advance to identify any potential staffing challenges and put a plan in place to ensure staffing minimum requirement is met Staffing coordinator will schedule extra staff on all shifts daily whenever possible to cover any possible call outs or schedule changes Active recruitment efforts by Marketing, Online and Print Media to post open positions Staff incentive for referring applicants to open positions in place, ending 9/30/2023 QAPI ADON or designee will review schedule daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	051225	A. BUILDING: _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	132 EVERGREEN RD EDISON, NJ 08818

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S 560	Continued From page 2 day shifts as follows: -11/27/22 had 17 CNAs for 192 residents on the day shift, required at least 24 CNAs.	S 560	ADON or designee will discuss staffing during daily Operations meeting to identify any staffing challenges and efforts in place to ensure minimum staffing requirement is met. Minutes will be kept of this meeting. Staffing Coordinator will complete daily Staffing Audit Form which will be reviewed by the ADON or designee Results of the staffing audits will be reported by the ADON or designee to the monthly QAPI Committee x 3 months then quarterly x 2 for reviews or recommendations	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
051225		9/27/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL HOME MENLO	132 EVERGREEN RD EDISON, NJ 08818

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/27/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
9/7/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO