

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2024
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NAME OF PROVIDER OR SUPPLIER N J VETERANS MEM HOME PARAMUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1 VETERANS DRIVE PARAMUS, NJ 07652
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint #: NJ00164109, NJ00164820, NJ00174873</p> <p>Census: 219</p> <p>Sample Size: 4</p> <p>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.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/27/2024
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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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060228	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2024
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NAME OF PROVIDER OR SUPPLIER N J VETERANS MEM HOME PARAMUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1 VETERANS DRIVE PARAMUS, NJ 07652
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S 000	Initial Comments The facility was 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: Based on facility document review on 08/12/2024, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 3 of 14 day shifts. This deficient practice was evidenced by the following: 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 at N.J.S.A. 30:13-18 (the Act), which	S 560	1. The facility was found to not be in compliance with NJ Administrative Code Chapter 8:39, Standards for Licensure of Long Term Care Facilities. Per 30:13-18, new minimum staffing requirements for nursing homes- the facility did not met the staffing ratios for CNA coverage -1 to evrry 8 residents on 7/21/24 for CNAs. 27 CNAs for 222 residents, required at least 28 CNAs. On the day shift 7/27/24 for CNAs. 27 CNAs for 222 residents, required at least 28 CNAs. On the day shift 7/28/24 for CNAs. 25 CNAs for 220 residents, required at least 27 CNAs. On	9/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/27/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060228	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2024
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NAME OF PROVIDER OR SUPPLIER N J VETERANS MEM HOME PARAMUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1 VETERANS DRIVE PARAMUS, NJ 07652
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S 560	<p>Continued From page 1</p> <p>established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and</p> <p>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.</p> <p>The surveyor requested staffing for the weeks of 07/21/24 to 07/27/24 and 07/28/24 to 08/03/24.</p> <p>The facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:</p> <p>-07/21/24 had 27 CNAs for 222 residents on the day shift, required at least 28 CNAs. -07/27/24 had 27 CNAs for 221 residents on the day shift, required at least 28 CNAs. -07/28/24 had 25 CNAs for 220 residents on the day shift, required at least 27 CNAs.</p>	S 560	<p>the day shift</p> <p>The facility will increase staffing coverage and assure accuracy with respect to reporting on the number of staff present and residents in the building and not include those hospitalized. The DON or facility designee will verify daily staffing and census for the facility.</p> <p>2. All residents are affected by this deficient practice.</p> <p>3. The daily rosters will only include residents in bed and not in hospitals or out on pass. Each unit will be dabulated and added together for the entire facility. Staffing will include CNAs in the building scheduled for resident assignment per unit roster.</p> <p>4. Proper resident head count and staffing present will be verified by DON or designee for the day and remain with staffing coordinator for future reference.</p>	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060228	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/28/2024
NAME OF FACILITY N J VETERANS MEM HOME PARAMUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1 VETERANS DRIVE PARAMUS, NJ 07652	

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	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	08/28/2024	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/12/2024	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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