STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. BUILDING _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

(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 (NJDOH). Complaint #: NJ00158248, NJ0059988, NJ00160177, NJ00160829, NJ00161593 Survey Dates: 03/18/23 - 03/21/23 Survey Census: 261 Sample Size: 21 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.	F 000		
F 600 SS=G	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: Based on interview, record review, and facility policy review, the facility failed to ensure two of	F 600	F600 Element One	5/12/23

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

Electronically Signed | 04/18/2023

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.

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F 600	Continued From page 1 two residents (Residents (R) 4 and R17) reviewed were free from resident-to-resident physical abuse. This resulted in harm when R4 was hit with a metal object and sustained [NJ Exec. Order 26] [redacted] Additionally, R17 was hit with a metal bar and sustained [NJ Exec. Order 26:4.b.1] [redacted] Findings include: Review of the New Jersey Department of Health (NJ DOH) "Reportable Event Record/Report," provided by the NJ DOH, dated [NJ Exec. Order 26:] [redacted] 2 and completed by the Director of Nursing (DON), revealed R4 and R17 had a physical altercation with a metal object. Further review of the "Reportable Event Record/Report" revealed the metal object was described as "round with 6 holes in it, some sort of bracket," not a metal bar, that both residents stated was in a drawer in their room. Per the "Reportable Event Record/Report" the object did not match any facility equipment or hardware and was immediately removed. Review of R4's "Admission Record" printed from the facility's electronic medical record (EMR) showed a facility admission date of [NJ Exec. Order 26:4.b] [redacted] with medical diagnoses that included [NJ Exec. Order 26:4.b.1] [redacted] During an interview on 03/18/23 at 4:25 PM, R4 related there had been an incident between him and his former roommate and he received [NJ Exec. Order] [redacted] from a "metal bar" he was hit with over the television volume. Review of R4's EMR "Minimum Data Set (MDS)"	F 600	R4 and R17 were separated and both sent to the hospital emergency room. Upon return resident R4 had his room moved away from R17 on a separate floor in the facility. Element Two All residents have the potential to be affected. Element Three Facility-wide in-service re-education on abuse will be administered to all departments. Annual Re-education will be administered and as needed to all staff regarding Resident Abuse. New Hires will continue to be educated upon hire. All residents with a Level 2 PSARR (Preadmission Screening and Resident Review) due to a primary diagnosis of dementia and a secondary diagnosis mental illness or intellectual disability will be reviewed for any potential negative behaviors and interviewed by Social Services. residents identified with the potential to have negative behavior will be followed by psychiatry. In addition, these residents will be discussed at quarterly interdisciplinary care meetings. Element Four Human Resources will audit employee in-services on a weekly basis for 12 weeks and monthly thereafter to ensure staff are educated. Director of Nursing or designee will audit behavior findings associated with screenings conducted by Social Workers weekly, followed by monthly on an on-going basis to ensure continued compliance with the facilities policy.	

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F 600	Continued From page 2 with an Assessment Reference Date (ARD) of NJ Exec. Order 26:4.b revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Exe out of 15 indicating R4 had NJ Exec. Order 26:4.b.1 . Review of R4's EMR "Care Plan" tab revealed no care plan for NJ Exec. Order 26:4.b.1 prior to the altercation on NJ Exec. Order 26:4.b.1 Review of R4's EMR "Progress Notes" tab showed a nurse's note written by Licensed Practical Nurse (LPN) 5 on NJ Exec. Order 26:4.b.1 at 12:49 AM, that stated, "Resident came to the nurses [sic] station at about 10:58 PM with NJ Exec. Order 26:4.b.1 and shirt. He stated that his roommate [R17] hit him several times with an iron bar which he presented to the nurse. I went to the room to take the statement from the roommate [R17]. Roommate [R17] stated that it was that [R4] hit him first with the bar on NJ Exec. Order 26:4.b.1 . Both were cleaned, NJ Exec. Order 26 treatment applied, MD's [physicians] and families made aware." Review of R17's "Admission Record" printed from the facility's EMR showed a facility admission date of NJ Exec. Order 26:4.b , readmission date of NJ Exec. Order 26:4.b , with medical diagnoses that included NJ Exec. Order 26:4.b.1 . Review of R17's EMR "MDS" with an ARD of NJ Exec. Order 26:4.b revealed a "BIMS" of NJ Exe out of 15 indicating R17 had NJ Exec. Order 26:4.b.1 . Review of the EMR "Care Plan" tab revealed no NJ Exec. Order 26:4.b.1 plan prior to the altercation. Review of R17's EMR "Progress Notes" showed a note written by LPN5 on NJ Exec. Order 26:4.b at 1:30 AM	F 600	All findings and compliance will be reported to the QAPI committee quarterly.	

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F 600	Continued From page 3	F 600		

that stated, "Note Text: Resident in room [room number, NJ Exec. Order] came to the nurse's station at about 10.58 PM [sic] with NJ Exec. Order 26:4.b.1 and shirt. He stated that his room mate [sic] hit him several times with an iron bar which he presented to the nurse. I went to the room to take the statement from the resident [R17's name]. [R17's name] stated that it was his room mate [sic] that hit him first with the bar on NJ Exec. Order 26:4.b.1. He had an [sic] NJ Exec. Order 26:4.b.1 to each of NJ Exec. Order 26:4.b.1 ."

R17 had since NJ Exec. Order 26:4, unrelated to the altercation, and was not available for an interview.

Further review of R4 and R17's EMR "Progress Notes" did not show documentation of any confrontations between the roommates or any other resident in the months preceding the incident.

Both residents were sent to the hospital emergency room and R4 returned from the hospital with NJ Exec. Order 26:4.b.1 R17 returned from the emergency room with a diagnosis of NJ Exec. Order 26:4.b.1 R17 was prescribed a NJ Exec. Order 26:4.b.1 days.
Review of the facility incident report showed the residents were separated with R4 moving to a different unit on a different floor. There was no determination on where the metal object came from since both residents were able to sign

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F 600	Continued From page 4 themselves out into the community and may have obtained the metal object while on a leave of absence. Interview with the Director of Nursing (DON) on 03/21/23 at 2:08 PM stated the residents had no history of [redacted NJ Exec. Order 26:4.b.1]. After the incident the residents were separated and sent to the hospital. "We followed our procedure for resident to resident [altercations]." When asked to review the resident to resident altercation procedure, the DON stated they did not have a written procedure to provide regarding resident to resident abuse procedure. Due to conflicting statements from R4 and R17, the facility was not able to determine who the aggressor was, who had the metal object, or where the metal object came from. Review of the facility policy titled "Abuse Reporting and Response," reviewed 10/10/06, revealed, "Procedure 1. Our facility will not condone resident abuse by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals." This citation is related to Intake NJ 00160829.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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,	F 609		5/12/23

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F 609	Continued From page 5 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: Based on interviews, record review, review of facility documentation, the facility failed to immediately report to the New Jersey Department of Health (NJDOH) 2 incidents of resident-to-resident physical altercations. A physical altercation between two residents (Residents (R) 4 and R17) which resulted in [redacted] was not reported within two hours to the SA; and 2. A physical altercation between R20 and R21 resulting in NJ Exec. Order 26:4.b.1 reported. Also, the facility failed to update their Abuse reporting and response policy to indicate that allegations of abuse, neglect, exploitation or mistreatment, the facility must: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation or resident	F 609	F609 Element One Administrator and director of nursing were educated on timely reporting of alleged violations by the facility corporate compliance officer. Element Two All residents have the potential to be affected by this practice. Element Three In-service will be re-administered by the facility corporate compliance officer to Director of Nursing and Administrator on the facilities policy regarding reporting of suspected abuse. Facility will adhere to procedure of reporting alleged violations to ensure all	

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F 609	Continued From page 6 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. Findings include: 1. Review of both R4 and R17's electronic medical records (EMR) "Progress Note" tab revealed "Progress Notes" dated [NJ Exec. Order 26:4.b], that documented an incident between R4 and R17 that happened prior to 10:58 PM on [NJ Exec. Order 26:4.b]. According to the "Progress Note" created on [NJ Exec. Order 26:4.b] at 12:49 AM, revealed "Resident [R4] came to the nurses [sic] station at about 10.58 PM with [NJ Exec. Order 26:4.b.1] and shirt. He stated that his roommate [R17] hit him several times with an iron bar which he presented to the nurse. I went to the room to take the statement from the roommate [R17]. Roommate [R17] stated that it was that [R4] hit him first with the bar [NJ Exec. Order 26:4.b.1] Both were cleaned, [NJ Exec. Order 26] treatment applied, MD's [physicians] and families made aware." Review of the facility "Reportable Event Record/Report," provided by the facility and dated [NJ Exec. Order 26:4.b], revealed the incident happened on [NJ Exec. Order 26:4.b] at 10:50 PM, and the SA was notified "called in" on [NJ Exec. Order 26:4.b] at 2:00 PM, 15.5 hours after the incident occurred. 2. Review of the facility's "Reportable Event Record/Report," provided by the facility, showed an incident occurred on [NJ Exec. Order 26:4.b] at 9:50 PM between R20 and R21. The form showed the SA	F 609	alleged violations are reported no later than two hours. Element Four Monthly audits will be conducted by corporate compliance officer on all reportable events to ensure timely submission. All findings will be reported to the QAPI committee quarterly.	

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F 609	Continued From page 7	F 609		

was notified on [NJ Exec. Order 26:4.b] at 3:26 PM, 17.75 hours after the incident occurred.

Further review of the facility "Reportable Event Record/Report" regarding R20 and R21, showed the investigation was faxed to the SA on [NJ Exec. Order 26:4.b] at 7:11 AM, which was 15 days after the incident occurred.

In an interview on 03/21/23 at 12:50 PM, the Assistant Director of Nursing (ADON) reviewed notes regarding the incident between R20 and R21 and stated she called the SA on [NJ Exec. Order 26:4.b] at 3:26 PM. When asked what the reporting timeline should be, the ADON responded, "I know you have to have the initial investigation within 48 hours."

During an interview on 03/21/23 at 2:05 PM regarding the reporting times, the Director of Nursing (DON) stated, "There is no timeline for turning in the investigation, you have to call within 48 hours."

Review of the facility's policy titled "Abuse Reporting and Response Policy," revised 10/10/06, showed, "Policy Statement- It is the policy of New Vista Nursing & Rehabilitation Center that all personnel must promptly report any incident or suspected incident of resident abuse, including injuries of an unknown source and misappropriation of resident property. Procedure . . . 4. When an egregious allegation of abuse/neglect and substantiated abuse cases, which result in significant injuries is reported, the Director of Nursing or designee or the facility Administrator, or his/her designee, will notify the following persons or agencies of such incident:
a. New Jersey Department of Health and Senior

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F 609	Continued From page 8 Services (Notification should be done within 48 hours) . . . " New Jersey Administrative Code § 8:39-5.1(a) This citation is related to Intake NJ 00160829.	F 609		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315458 Y1	A. Building B. Wing Y2	5/17/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0600	Correction	ID Prefix F0609	Correction	ID Prefix	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	Completed
LSC	05/12/2023	LSC	05/12/2023	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/21/2023	☐ YES ☐ NO