STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Complaint#: NJ#162903, NJ#173303, NJ#175318, NJ#177086 Based on interviews, Medical Records (MRs) review, and review of other pertinent facility documents on 09/30/24, 10/01/24, 10/02/24, 10/3/24, and 10/04/24, it was determined that the facility failed to protect two residents (Resident #16 and Resident #7) from physical abuse from Resident #14, who was non-compliant with his/her Psychotropic medication, required close supervision and has a known history of aggressive behavior and diagnoses of Dementia with Anxiety Disorder, Schizophrenia and Other Specified Mental Disorders due to known psychological conditions. According to the MRs, on 04/24/24, Resident #14 physically attacked Resident #16 by punching Resident #16 in the face with a closed fist and became verbally aggressive. The residents were separated, the Physician was notified and ordered Resident #14 to be sent to the local hospital for evaluation and treatment. Further review of the MRs revealed on 07/01/24, Resident #14 was observed hitting Resident #7 with a closed fist and pulling the Resident's hair, causing him/ her to fall to the ground screaming. The residents were separated by facility staff, and Resident #14 went into his/her room and slammed the door. Resident #7 sustained a laceration to the forehead and was sent to the emergency room (ER) for evaluation. He/She returned from the ER with a diagnosis of left orbital laceration with hematoma. The police were called, and Resident #14 was taken to the Psychiatric Emergency Screening Services (PESS) unit for evaluation. The facility's failure to protect Resident #7 and Resident #16 from physical abuse and failure to ensure Resident #14 plan of care was revised to address the Resident's needs, implement the recommendation for Supervision placed Resident #7, Resident #16 and all other residents in an Immediate Jeopardy situation. The Immediate Jeopardy began on 04/24/24 through 07/03/24, when Resident #14 was discharged from the facility. The facility also failed to protect Resident #13 and Resident #19 from staff to resident physical and verbal abuse. According to a facility's incident report, which included a witness statement by Certified Nursing Assistant (CNA #12), on 09/16/24 at approximately 8:25 p.m., she saw Resident #19 walk behind the nurse's station and tap the Licensed Practical Nurse (LPN#10) on the shoulder. LPN #10 then pushed Resident #19 and yelled, Get away from here; you are not supposed to be back here. CNA #12 stated she reported the incident to her supervisor. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A second incident report, which included a witness statement written by LPN #11 dated 9/17/24, revealed on the following day, Resident #13 grabbed a binder from the nurse's station counter, and LPN #10 tried to pull the binder from Resident #13. LPN #10 yelled at Resident #13, Leave the s--- [expletive] alone, she then swiped the binder away from Resident #13, hitting the Resident's hand, then yelled, Get the f--- [expletive] out of here! LPN #11 tried to separate LPN #10 and Resident #13 and then reported the incident to the Unit Manager (LPN #12). The facility's failure to ensure Resident #19 and Resident #13 was protected from physical and verbal abuse from LPN #10, placed Resident #13, Resident #19 and all other residents at risk for physical and verbal abuse and in an IJ situation. The IJ was determined to exist as of 09/16/24 through 9/17/24. for Freedom from Abuse, Neglect, and Exploitation at a Scope and Severity (S/S) of a J. The Immediate Jeopardies (IJs) was identified and reported to the facility's Director of Nursing (DON) on 10/02/24 at 9:12 p.m. The DON was presented with the IJ templates, which included information about the issues. On 10/11/24, the Surveyor did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating the DON and Assistant Director of Nursing (ADON) on investigating allegations of abuse, reviewing and revising policies, and staff education on abuse. After the removal of the IJ, the noncompliance remained at a scope and severity level of G (Actual harm that is not immediate jeopardy). This deficient practice was identified for 4 of 29 residents, Resident #7, Resident #13, Resident #16, and Resident #19, and was evidenced by the following: 1. According to the Electronic Medical Record (EMR), Resident #14 was admitted with a diagnosis of Schizophrenia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/20/24, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the Resident was cognitively intact. The assessment indicated the Resident had no hallucinations or delusions and was not a threat to self or others. According to Resident # 14's care plan (CP) dated 1/12/2024, included under Focus,: I (Resident #14) have a long Hx (history) of Mental Illness with behaviors. My behaviors can include: periods of increased agitation, periods of increased anxiety, can be physically/ verbally aggressive, assaultive, throws furniture, bangs/ slams doors, yells/ screams out, responds to internal stimuli, Delusional thinking, refuses Meds (medication) / TX (treatment), conflicts with peers/ roommate, and Low tolerance for cognitive impaired peers. Under Goal, indicated: My mood/ behaviors will remain stable with my baseline . Under Interventions included: alert to impending violence aggressive behaviors, maintain safety for all, remove all objects that can harm (him/ her) or others, keep 4 arm's length apart, decrease his/her stimuli, attempt to verbally de-escalate . Further review of the CP revealed Under Interventions, Resident #14 had an altercation with a peer on 04/24/25. According to the interventions, the Resident assaulted his/her peer and had verbal aggression. The CP interventions indicated that safety maintained for all, the police were called, and the primary care physician (PCP) orders were obtained to send the Resident to the local hospital; the Resident refused to go, pending PESS evaluation, to follow-up with the psychiatric team, and to attempt to identify antecedents to behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #14's Progress Note (PN) revealed the following: On 3/12/24, the Psychiatry Progress Note (PPN), written by psychiatric Nurse Practitioner (NP) #1, revealed Resident #14 had fair awareness of events, fair impulse control, and poor judgment. The NP also indicated the Resident had a diagnosis of Schizophrenia with anxiety and was not cooperative during the interview. Medication compliance should be encouraged at this time, and staff should send Resident #14 out to PESS if the Resident becomes a danger to self or others. On 04/24/24 at 10:18 p.m., revealed Resident #14 slapped Resident #16's face with a closed fist and became verbally aggressive. The police were notified. The Physician was notified and ordered Resident #14 to be sent to the local hospital for evaluation and treatment. On 04/25/24 at 7:35 a.m., indicated on 04/24/24 at 11:30 p.m., the emergency medical technicians (EMTS) and the police arrived at the facility to transfer Resident #14 to the hospital, but the Resident refused. The Resident screamed at EMTS, telling them to get out, and slammed the door. The police were unable to take him/ her to the hospital because of his/her refusal unless PESS determined the Resident required hospitalization . At the time of PESS, they determined that the Resident was calm and did not need to go to the hospital. The note indicated the Resident remained calm for the rest of the shift. At 12:59 p.m., the Resident was .being aggressive and combative with behaviors, attempting to hit staff, throwing items unable to redirect .Unable to redirect, 1:1 was placed outside the room for safety. On 04/26/24 at 10:47 a.m., the PPN, written by NP #3, revealed she met with the Resident to assess him/her. The Resident continued to refuse his/her medications and had intermittent outbursts of aggressive behaviors. The NP noted the Resident was evaluated by S-cope on 04/25/24, and due to severe paranoid delusion, it was recommended the Resident be evaluated for a behavioral health nursing home. The Resident is currently on one-to-one. On 4/26/24 at 1:04 p.m., written by the Nurse Manager, the PN revealed, .At times would yell out for no specific reason, throwing food and drinks on the floor. Staff supervised at a distance . On 04/30/24 at 3:46 p.m., the Social Services PN (SSPN) indicated the facility heard back from the Resident's case manager and was informed the Resident did not meet the criteria for behavioral health placement. On 5/2/24 at 1:52 p.m., written by LPN #1, Resident #14 was accosting Resident #7; the police were called, and the police advised that they could do nothing at this time. On 5/09/24 at 7:26 a.m., Resident had an episode of combative, aggressive behavior w/[with] hostile verbal outburst, throwing objects at this writer . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/13/24, the PPN written by NP #2 revealed Resident # 14 was seen for follow-up medication management due to refusal of all medications and schizophrenia paranoid type. The note indicated the Resident was agitated, unpredictable, impulsive, and suspicious and slammed the door in front of NP #2. The note continued that the Resident had a history of hitting staff, throwing items, and making multiple calls to the police and PESS. The note revealed the Resident was not taken to the hospital after a PESS evaluation since the Resident refused to go. NP #2 indicated the Resident had poor insight, judgment, and impulse control and directed the facility to call PESS if the Resident became a danger to self or others. On 5/16/24 at 12:44 a.m., Resident #14 got into a verbal altercation with Resident #7. On 5/25/24 at 2:47 p.m., the Resident continued to yell at self-picks up objects and slam them down. On 05/29/24 at 9:50 a.m., the PPN, written by NP #3, revealed the Resident refused his/her physical exam and directed the clinical staff to continue with the Resident's current care plan and encourage medication compliance. 05/29/24 at 2:26 p.m., the PN indicated a housekeeper entered the Resident's room to empty a trashcan. The Resident jumped out of his/her bed, chased the housekeeper, and attempted to throw the trashcan at the staff. The housekeeper twisted her ankle after this encounter. On 06/10/24 at 9:32 a.m., the PPN written by NP #4 revealed the NP attempted to meet with Resident #14. The Resident had his/her head covered with a blanket and refused to answer her questions about the status of his/her health. NP #4 directed the clinical staff to continue medication compliance. On 06/19/24 at 1:36 p.m., Resident #14 was yelling and slamming items in his/her room. After the noise subsided, a nurse entered the Resident's room and found two holes in the wall. Further review of the PN on 06/19/24 revealed that the Resident threw a knife in the hallway and continued to threaten staff and residents verbally and physically. On 06/20/24 at 12:06 p.m., the PNs revealed Resident #14 kicked a garbage can at a CNA, took off his/her belt, swung it at the CNA, and stated he/she was going to beat her with it. According to the note, residents and housekeeping witnessed this incident. PESS was again notified, the Resident was assessed, and the Resident was transported to the hospital. The Resident returned to the facility the same day and showed no behaviors. On 06/29/24 at 10:03 p.m., written by the LPN revealed Resident #14 came out of his/her room and threatened to kill staff if they ever entered his/her room and touched his/her belongings. Further review of the PN showed no evidence that this behavior was addressed. On 07/01/24 at 11:12 p.m., the PNs revealed Resident #14 was seen in the hallway hitting Resident #7 in the face with a closed fist and pulling Resident #7's hair, which caused him/her to fall to the floor. Resident #14 then slammed the door to his/her room. The police were called, and the Resident was taken to the PESS unit for evaluation. Both the Resident's medical provider and responsible parties were notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/03/24 at 8:00 a.m., the PNs written by LPN #2 indicated Resident #14 was discharged to a behavioral health center. A review of a document provided by the facility titled Statewide Clinical Outreach Program for the Elderly (S-cope), dated 04/25/24, indicated the outreach program screened Resident #14 due to the Resident's continuation of refusals of his/her medications, agitation, and delusional thinking. S-cope made the following recommendations: to continue one-to-one to ensure safety; to follow up with the facility's psychiatrist/physician about lifting the one-on-ones; to utilize ABC tracking (tracking of activity, antecedent, behavior, and consequences related to behaviors) to identify trends and triggers in Resident #14's behaviors; to utilize this method for five days, and then fax the completed forms to S-cope. Review of a second S-cope document dated 06/21/24 indicated the clinician made the following recommendations for the Resident's mental health needs: continue to provide one-on-one to the Resident; utilize the ABC to track and trend the Resident's behaviors, utilize and fax the completed ABC form to S-cope; and to have the facility's psychiatrist follow-up with the Resident and refusals of medications. Review of the EMR revealed no documented evidence that the Physician was notified, and an order was obtained to stop the one-on-one Supervision. In addition, the facility was unable to provide evidence that behavior tracking was forwarded to S-cope as recommended. Review of Resident #14's Medication Administration Record (MAR) dated 3/1/2024 - 3/31/2024 indicated the Resident refused his/her medications as follows: Aricept (used for dementia) Oral Tablet 5 (milligram) mg 1 tablet by mouth at bedtime 9:00 p.m. Refused on 3/2-3/6, 3/9, 3/10, 3/12 - 3/18, 3/20 and 3/22- 3/31/2024. Risperidone (used to treat symptoms of Schizophrenia) Oral Solution 1 mg/ml. Give 1 milliliter (ml) by mouth two times a day at 9:00 a.m. and 9:00 p.m. Refused 9:00 a.m. dose from 3/1- 3/31/2024. Refused 9:00 p.m. dose on 3/2 -3/7, 3/9, 3/10, 3/12-3/18, 3/20 and 3/22-3/31/2024. Review of Resident #14's MAR dated 4/1-4/30/2024 indicated the resident refused the following medications: Aricept Oral Tablet 5 (milligram) mg 1 tablet by mouth at bedtime 9:00 p.m., on 4/1-4/6, 4/8-4/14, 4/16-4/19 and 4/21-4/30/2024. Risperidone Oral Solution 1 mg/ml. Give 1 ml by mouth two times a day at 9:00 a.m. and 9:00 p.m., 9:00 a. m. dose on 4/1-4/5, 4/7, 4/8, 4/10-4/20, 4/22-4/26 and 4/28-4/30/2024, and 9:00 p.m. dose on 4/1-4/6, 4/8-4/14, 4/16-4/19, 4/21-4/25 and 4/27-4/30/2024. Review of Resident #14's MAR dated 5/1-5/31/2024 indicated the resident refused the medications as follows: Aricept Oral Tablet 5 mg 1 tablet by mouth at bedtime 9:00 p.m., on 5/1-5/12, 5/14-5/17, 5/19-5/22, 5/24-5/27 and 5/29 -5/31/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Risperidone Oral Solution 1 mg/ml. Give 1 ml by mouth two times a day at 9:00 a.m. and 9:00 p.m. Refused 9:00 a.m. dose from 5/1-5/31/2024, 9:00 p.m. dose on 5/1-5/12, 5/14-5/17, 5/19-5/22, 5/24, 5/25, 5/27, 5/29 and 5/31/2024. Review of Resident #14's MAR dated 6/1-6/30/2024 revealed the resident refused the following medications: Aricept Oral Tablet 5 mg 1 tablet by mouth at bedtime 9:00 p.m., from 6/1-6/30/2024. Risperidone Oral Solution 1 mg/ml. Give 1 ml by mouth two times a day at 9:00 a.m. and 9:00 p.m., at 9:00 a. m. 6/1-6/3, 6/5-6/12, 6/14-6/25 and 6/27-6/30/2024, and 9:00 p.m. dose on 6/1-6/19 and 6/21-6/30/2024. Review of Resident #14's MAR dated 7/1-7/31/2024 indicated the Resident refused the medications as follows: Aricept Oral Tablet 5 mg 1 tablet by mouth at bedtime 9:00 p.m. Risperidone Oral Solution 1 mg/ml. Give 1 ml by mouth two times a day at 9:00 a.m. and 9:00 p.m. on 7/1/2024. There was no evidence that the resident's plan of care was revised or the Physician was notified for all of the aforementioned refusals. 2. Review of the EMR, revealed Resident #16's was admitted with a diagnosis chronic kidney disease, high blood pressure and anxiety disorder. The MDS dated [DATE] showed the Resident had a BIMS score of 15 out of 15, which indicated the Resident was cognitively intact. A review of the CP dated 04/22/24 revealed that Resident #16 was identified as at risk for falls or injury related to decreased mobility, deconditioning and poor safety and at risk for bruising or bleeding and had the potential for alteration in his/her mood due to a diagnosis of anxiety disorder. A review of the PN dated 04/24/24 at 10:27 p.m., revealed that Resident #16 was walking into nourishment room when Resident #14 started yelling at Resident #16 and hit her/his face with a closed fist. The residents were separated and Resident #16 stated [She/he] wanted to press charges. Call to police Ice applied to red area on Resident #16's face. 3. Review of the EMR revealed Resident #7 was admitted with a diagnosis of chronic obstructive pulmonary disease (COPD). The quarterly MDS, with an ARD of 04/19/24, indicated the Resident had a BIMS score of 15 out of 15, which revealed the Resident was cognitively intact. A review of the PNs dated 07/01/24 at 11:00 p.m. revealed that Resident #7 was screaming in the hallway. Facility staff responded and separated Resident #7 and Resident #14. The police were notified, and Resident #14 was removed from the facility. In addition, the RN revealed that Resident #7 sustained a laceration on his/her forehead and was sent to the ER for evaluation and treatment of head injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the PN dated 07/02/24, at 4:56 a.m., revealed Resident #7 returned from the hospital with a left orbital laceration with a hematoma. During an interview on 09/30/24 at 6:02 p.m., the ADON stated he expected PESS to be contacted when there was aggressive behavior by a resident to decide if the Resident was a threat. However, there was no evidence provided that PESS was notified every time Resident #14 had changes in his/her behavior. During an interview on 09/30/24 at 6:42 p.m., Resident #7 stated he/she remembered Resident #14. Resident #7 explained that the Resident left his/her room to get a soda, and Resident #14 jumped him/her from behind. Resident #7 explained he/she fell to the floor, was sent to the emergency room , and the staff glued a large gash on his/her forehead. During an interview on 10/01/24 at 10:22 a.m., CNA #3 stated he worked with Resident #14 and stated the Resident would throw things at him and was very violent with both staff and residents. CNA #3 stated that anything would set the Resident off, and he/she would just flip. According to the CNA, Resident #14 would punch holes in the walls of the Resident's room. During an interview on 10/01/24 at 11:10 a.m., Resident #16 confirmed Resident #14 punched him/her in the face. Resident #16 stated it was painful, and the punch took him by surprise. During an interview on 10/01/24 at 11:19 a.m., NP #1 confirmed he remembered Resident #14. According to NP #1, Resident #14 would refuse medications and punch people in the face. NP #1 stated that there were staff who were too scared to enter the Resident's room. He did not make any medication recommendations since it did not matter if he did since Resident #14 did not take his/her psychotropic medications to treat his/her behaviors. During an interview on 10/01/24 at 12:34 p.m., CNA #4 stated she witnessed the assault from Resident #14 to Resident #7. According to the CNA, Resident #14 punched Resident #7, the Resident then fell to the ground, and Resident #14 proceeded to kick the Resident. CNA #4 further stated Resident #7 sustained a cut close to the eye, and the area was bleeding and swollen. The CNA stated the facility was not providing one-on-ones for Resident #14 prior to this incident. During an interview on 10/01/24 at 2:13 p.m., in the presence of the DON and ADON, the Administrator stated that the facility receives recommendations from S-cope for residents and does not keep a resident on one-on-one forever. At the time of the interview, a request was made for evidence of the one-on-one Supervision, why Resident #14 was taken off one-on-one Supervision, and about ABC tracking. The Administrator stated he would have to ask the nursing staff. The Surveyor also requested any psychiatric assessment after the 04/24/24 incident and before the psychiatric NP visit with Resident #14 on 05/13/24 and to provide any information related to safety measures taken with Resident #14 after 04/24/24 when he/she hit Resident #16. However, the facility was unable to provide the requested information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a second interview on 10/01/24 at 3:34 p.m., the Administrator brought in copies of Resident #14's nursing PNs and stated the Resident had no behaviors after 04/24/24, and the one-on-ones were stopped. He also presented a document from S-cope dated 04/25/24 and stated he believed S-cope came out again prior to 05/13/24. According to the Administrator, Resident #14 refused all of his/her medications. The ABC tracking was used to document all of the resident behaviors. The Administrator stated that S-cope was coming out all the time and providing direction to the facility staff on a regular basis. During an interview on 10/02/24 at 9:59 a.m., the Mental Health Clinician (MHC) with S-cope stated that she assessed Resident #14 on 04/25/24 and again on 06/21/24. The MHC stated she met with the Resident four times between 04/25/24 and 07/01/24 and made the same recommendations on 06/21/24 as on 04/25/24. MHC stated the Resident was determined not to be a danger to others when she met with Resident #14. During an interview on 10/02/24 at 10:14 a.m., Licensed Practical Nurse (LPN) #1 stated he worked the night shift and was not aware Resident #14 was on Supervision. During an interview on 10/02/24 at 10:48 a.m., the Medical Director (MD) stated he was familiar with Resident #14 and was his Primary Care Physician (PCP). According to the MD, he was surprised to hear that the Resident could refuse to go with the EMTs and police, which he had never seen before. The MD stated he remembered getting on the phone with the EMTs, and the EMTs informed him that if Resident #14 refused to be taken to the hospital, they could not force the Resident to do so. The MD stated the only way for the Resident to receive treatment was for the Resident to totally decompensate in his/her condition. Regarding the issue with Resident #14 refusing his/her psychotropic medications, he stated the facility could only monitor his/her condition. During an interview on 10/2/24 at 4:20 p.m., the DON stated that if a resident required one-on-one Supervision, they were not appropriately placed in the facility and needed a higher level of care. She stated the Resident would not be safe, and their needs were too high of an acuity for the facility. According to the DON, If someone needs that one-on-one monitoring, this is not the place for them. Review of the facility's reported incident investigation, provided by the Administrator revealed that two staff to Resident witnessed abuse occurred with Resident #19 and Resident #13 involving the same nurse (LPN #10). According to a witness statement from CNA #12 dated 09/16/24 at approximately 8:25 p.m., Resident #19 walked behind the nurse's station and tapped LPN #10 on the shoulder. LPN #10 then pushed Resident #19 and yelled, Get away from here, you are not supposed to be back here. Review of the second facility's incident investigation dated 09/17/24 revealed a witness statement from LPN #11, which showed on 09/17/24 at 7:00 a.m., she was standing at the medication cart, saw Resident #13 grab a binder from the nurse's station counter, and LPN #10 tried to pull the binder from Resident #13. According to the statement, LPN #10 yelled Leave the s--- [expletive] alone, swiped the binder away from Resident #13, hitting his/her hand, then yelled, Get the f--- [expletive] out of here! LPN #11 also indicated she tried to break them up and then reported the incident to the Unit Manager. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of Resident #19's EMR showed the Resident was admitted to the facility with diagnoses that included Alzheimer's disease with late onset, anxiety disorder, and major depression. According to the MDS, Resident #19 had a BIMS score of 2 out of 15, which indicated the Resident was severely cognitively impaired. A review of Resident #19's nursing PN dated 09/17/24 at 4:51 p.m. revealed, . Investigating staff reported aggressive behavior from staff to Resident. Witnessed incident with no injuries noted. The assigned nurse was noted to act in a confrontational manner towards [Resident #19]. Other staff members quickly de-escalated the incident. R#19 is unable to verbalize any details r/t [related to] incident but can answer simple yes or no questions. The RN assessed Resident #19, and no injury was noted. NP notified and assessed . Review of R #19's CP dated 09/17/24 revealed a long history of behaviors related to dementia problem area with an intervention of, . victim of incident 09/16/24 follow-up with psych services as needed and provide emotional support to [the] resident . Review of Resident #19's CP date initiated 12/28/23, revealed a long history of behaviors related to dementia. Interventions to include Caregivers to provide opportunity for positive interaction, explain all procedures to the Resident before starting and allow the Resident to adjust to changes. 5. Review of the EMR revealed Resident #13 was admitted with diagnoses that included dementia without behavioral disturbance, anxiety disorder, and depression. The annual MDS, with an ARD of 08/22/24 showed a BIMS score of one out of 15, which indicated Resident #13 was cognitively intact. A review of Resident #13's Physicians Progress Note, dated 09/17/24 at 10:17 a.m., revealed that the . [Resident] was seen ambulating on the unit. Says he/she is feeling well. No c/o [complaints of] pain or discomfort. It was reported to me by the DON [Director of Nursing] that [the] patient [Resident] was pushed by a staff member. The Resident does not remember the incident. No injuries noted . Plan: . Continue current medications .fall precautions. Monitor for bleeding . Review of Resident #13's nursing PNs dated 09/19/24 revealed, .Seen by [Psychiatric Provider]. Xanax [an antianxiety medication] 0.25 mg [milligrams] daily PRN [as needed] anxiety and increase in Buspar [an antianxiety medication] 15 mg BID [twice a day]. Behavior charting for anxiety X [times] 14 days . Review of Resident #13's CP dated 09/17/24 revealed a care area focus of history of behaviors related to dementia with an intervention of, . a victim of incident 9/17/24 follow-up with psych services as needed provide ongoing emotional support to [the] resident, administer medications as ordered, and monitor/document side effects and effectiveness . Review of Resident # 13's CP with a revision date on 11/28/23 revealed, Focus: history of behaviors related to dementia with behaviors that can include periods of increased restlessness, periods of increased anxiety and enters peer's personal spaces. Interventions: Attempt to identify antecedents to my behavior and monitor for wandering into other personal spaces, redirect him/her to his/her own personal space or common area. It was recorded the police were contacted on 09/19/24, and all staff were trained on abuse and neglect on 09/17/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Both incident investigations revealed the staff to Resident abuse for Resident #19 and Resident #13 was substantiated. LPN #10 was suspended on 09/17/24 while the investigation was in progress. LPN #10 did not work after this date and was terminated on 09/23/24. The documentation further revealed that the DON/ADON was aware of the incidents on 09/17/24. During a combined interview on 09/30/24 at 2:10 p.m., the Administrator and DON revealed that she [DON] was notified of the abuse allegation when she arrived at the facility on 9/17/24 at 8:00 a.m., and the ADON was notified when he arrived at 7:30 a.m. The DON notified the Administrator as soon as it was reported to her. The DON stated LPN #10 was already gone for the day; he was suspended during the investigation and asked to come to the facility to write a statement, and then was terminated on 09/23/24. According to the Administrator, he watched the camera and saw LPN #10 and Resident #13 close to each other at the nurse's station but could not see what occurred. The DON stated the ADON interviewed the residents in the memory care unit, and there was no reported abuse by LPN #10. During an interview on 10/04/24 at 11:30 a.m., CNA #12 stated on 09/16/24 at approximately 8:25 p.m., she saw Resident #19 walk behind the nurse's station, tap LPN #10 on the shoulder, then LPN #10 pushed Resident #19 and yelled, Get away from here, you are not supposed to be back here. CNA #12 stated she did report the allegation to her supervisor. However, LPN #10 continued to provide care for other residents. During a combined interview on 09/30/24 at 2:10 p.m., the DON revealed they were made aware of the abuse allegation when the ADON found a note under his door from Registered Nurse (RN) #3 with a witness statement attached prior to his arrival on 09/17/24. The Administrator confirmed he received LPN #10's statement on 09/17/24. The DON stated she reported the incident to the State Survey Agency (SSA) on 09/17/24. The DON stated she instructed CNA #12 to report allegations of abuse immediately. The DON stated she provided training to all staff members regarding reporting allegations of abuse immediately. A review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with a review date of 05/2023, revealed the following: Under Policy Statement included Residents have the right to be free from abuse, neglect .This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse . Under Policy Interpretation and Implementation included The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect exploitation and mistreatment of property by anyone including but not necessarily limited to: a. facility staff; b. other residents .e. staff from other agencies .j. any other individual .2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents . N.J.A.C.: 8:39-4.1 (a) 5 28604

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). 12679 Complaints #: NJ162903, NJ166982, NJ168479 NJ172819, NJ172820, NJ173142 NJ173303, NJ175318, NJ175692 NJ177086 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 9/30/24, 10/01/24, 10/02/24, 10/03/24, and 10/04/24, it was determined that the facility failed to ensure that Resident #10 was free from involuntary seclusion. On 4/19/24, a Certified Nursing Aide (CNA #1) placed Resident #10 in the dayroom of the [NAME] Unit. CNA #1 shut and blocked the door, sat outside the dayroom to prevent Resident #10 from exiting. According to Resident #10, she/he begged and was terrified when the CNA would not let her/him leave the day room. In addition, the facility failed to follow its policies titled PHYSICAL RESTRAINTS and Abuse, Neglect, Exploitation, and Misappropriation Prevention Program for 1 of 29 residents (Resident #10) reviewed for incident and accident. This deficient practice was evidenced by the following: A review of the REPORTABLE EVENT RECORD (RER), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents, dated 4/19/2024, completed by the former DON (FDON), revealed that on 4/19/24 at around 7:30 am, Resident #10 reported that CNA #1, who was assigned to the Resident on 4/19/24 for shift of 11:00 am to 7:00 am, had placed him/her in the day room and would not let the Resident out. The RER further indicated that the CNA was suspended. A review of the [Long Term Care] Reportable Event Survey (LTCRES), also known as RER, dated 4/19/24, completed by the FDON, provided by the facility, revealed Resident #10 reported on 4/19/24 at around 3:00 a.m., CNA #1 put the Resident in the room and blocked the door so he/she could not leave. Further review of the LTCRES included an Investigative Summary (IS), dated 4/19/24, completed by the FDON, indicated that Resident #10 reported to the nurse that he/she was placed in the day room with the door closed, preventing the resident from exiting the dayroom. The IS further indicated during an interview conducted by the FDON and Social Services (SS), Resident #10 reported he/she was in the hallway around 3:00 a.m. and was looking to leave the nursing area. According to the IS, Resident #10 said the aide took the resident and placed him/her in the day room. The Resident explained that he/she did not want CNA #1 to be outside the door blocking the resident's ability to exit. The IS further indicated that Resident #10 stated, After a period of time, the nurse on duty brought the Resident back to [his/her] room. The conclusion indicated, Upon completing this investigation, reading statements that have been provided by staff and Social Service follow-up, it is in my opinion that [Resident #10] was kept in the room against [her/his] wishes . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Actual harm Residents Affected - Few	According to the ADMISSION RECORD (AR), Resident #10 was admitted with diagnosis which included but not limited to Huntington's disease and Asthma. The Minimum Data Set (MDS), an assessment tool dated 4/4/24, revealed that Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating Resident #1's cognition was intact. A review of Resident #10's Care Plan (CP) initiated on 4/28/24 revealed under Focus: Resident #10 was left in the dayroom against the Resident's wishes. Under Goal, indicated: [The Resident] will remain free from emotional distress. My safety will be maintained within the facility. Under Interventions, it included: Allow Resident time to answer and verbalize [their] feeling and perception as needed. Analyze key times, places, circumstances, and triggers, de-escalate behavior, and document. Arrange for psychotherapy follow-up as indicated .Monitor and document resident's feelings relative to the event . A review of the Disciplinary Action Form, dated 4/19/24, included: Under Nature of Offense, noted Patient Rights and Resident Abuse or Neglect was checked off as the issues. Under: Detailed description of offense . included Resident [#10] stated [CNA #1] put her in the dayroom and would not let her out. Under Action Taken, the Suspension start date of 4/19/24. Review of CNA #1's statement, dated 4/19/24, the CNA wrote I worked on 4/18/24 on the Dementia floor of the [NAME] Wing. The patient [Resident #10] tried to go to the [NAME] wing at [3:00 a.m.], which was not [her/his first] attempt. The nurse advised me to retrieve [her/him] from South wing [and] direct [her/him] into the dayroom where the other [patients] with behaviors were being monitored [and] so i [I] did. Before [Resident #10] was in the room the nurse instructed us to keep the door closed because they are fall risks to ensure their safety. When the said [Resident #10] asked to leave the room the nurse [escorted her/him to her/his] room. No force was used there was no body to body contact. The resident did say [she/he] was gonna tell the unit manager I hurt her hand so I could get fired. When the door was closed, I was on the other side of [the] door sitting to ensure the safety of the Residents and keep an eye on them as well. A review of Resident #10's Progress Notes revealed the following: On 4/18/24 at 11:50 a.m., the Social Worker wrote, Met with Resident following up on [the] incident that occurred last night. Resident not in any distress. On 4/19/24 at 1:08 p.m., written by the Licensed Practical Nurse (LPN), LPN #14 revealed a Head to toe assessment [was] done, [and there was] no signs of physical harm observed. No further concerns [were] voiced by resident. NP and MD made aware. During an interview on 09/30/24 at 5:25 p.m., Resident #10 stated he/she was not permitted to leave the dayroom. Resident #10 further stated that when he/she asked to leave the area, the CNA told him/her to remain in the day room area. During a second interview on 10/01/24 at 11:52 a.m., Resident #10 stated he/she was terrified when [CNA #1] sat in front of the door while he/she begged CNA #1 to let him/her out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/01/24 at 5:30 p.m., the LNHA stated that he viewed the surveillance camera. According to the LNHA, he saw that Resident #10 was locked in the dayroom. CNA #1 was sitting outside the door, and Resident #10 attempted to open the door. Review of an undated policy provided by the facility titled PHYSICAL RESTRAINTS undated, indicated, . Devices are considered restraints when they impede the residents' ability to maintain independence and/or mobility . A review of a policy provided by the facility titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 05/2023, indicated, .Residents have the right to be free from Abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal management, involuntary seclusion, verbal, mental, sexual, or physical abuse .The Resident Abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: 1. Protect residents from Abuse, neglect .by anyone including, but not necessarily limited to: a. facility staff .5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems . NJAC 8:39-4.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Complaints #: NJ162903, NJ166982, NJ168479 NJ172819, NJ172820, NJ173142 NJ173303, NJ175318, NJ175692 NJ177086 Based on interviews and record review, as well as a review of pertinent facility documents on 9/30/24, 10/01/24, 10/02/24, 10/03/24, and 10/04/24, it was determined that the facility failed to report an allegation of abuse in a timely manner to the New Jersey Department of Health (NJDOH). The facility also failed to implement its policy and procedure titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program. This deficient practice was identified for 3 of 29 residents(Residents #1, #2, and #14) reviewed for incident and accident and was evidenced by the following: A review of a policy provided by the facility titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, dated 05/2023, indicated, .9. Investigate and report any allegations within timeframes required by federal requirements . A review of the REPORTABLE EVENT RECORD/REPORT (RERR), completed by the facility's Administrator on 3/27/23, revealed that the incident occurred on 3/26/23 at 8:30 p.m. and it was called in to NJDOH on 3/27/23 at around 12:30 p.m. The RERR further revealed that the event was a Resident-to-Resident Abuse at Around 8:30 p.m. Saturday [night Resident #2] was observed touching [Resident #1] inappropriately. Attached to the RERR was the facility's Investigation Summary and Conclusion (ISC), dated 3/26/23. The ISC indicated that the Administrator concluded that after a staff member investigation observed Resident #2 touched Resident #1 inappropriately while both residents were fully clothed. Both residents were assessed and separated. 1. According to the ADMISSION RECORD (AR), Resident #1' was admitted with a diagnosis which included but was not limited to Dementia. The Minimum Data Set (MDS), an assessment tool dated 9/6/24, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 1/15, indicating the Resident's cognition was severely impaired and they were dependent on Activities of Daily Living (ADLs). A review of Resident #1's care plan (CP), initiated on 11/7/19 and revised on 3/27/23, showed, I was touched by [female/male] peer. 2. According to the AR, Resident #2 was admitted with a diagnosis which included but was not limited to Dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS, dated [DATE], revealed that Resident #2 had memory problem. A review of the CP initiated and revised on 12/11/23 indicated that Resident #2 had a long history of behaviors related to Dementia, mood disorder, and a history of sexually inappropriate behaviors. Review of the form INCIDENT/ACCIDENT STAFF/RESIDENT/WITNESS STATEMENT, dated 3/26/23 at 8:30 p.m., completed by CNA #17. The CNA indicated that she witnessed Resident #2's hands rubbing Resident #1's chest and groin. The CNA removed Resident #2 from the dayroom and reported to the nurse. The facility reported the aforementioned event to NJDOH on 3/27/23 at 12:30 p.m., which was more than 2 hours from the incident time, which was not according to the facility policy as as required by federal requirements. 3. According to the AR, Resident #14 was admitted with diagnosis which included but was not limited to Schizophrenia and Anxiety Disorder. Review of Resident # 14's progress notes (PN), dated 6/19/24 at 2:27 p.m., documented by LPN #5. The LPN documented, It was reported to this nurse [that the] Resident was observed throwing a knife into the hallway. He continues to display verbal and physical threats towards staff and other residents. The facility could not provide documented evidence that the verbal threats towards staff and other residents were reported to NJDOH, which was not according to their policy. During an interview on 9/30/24 at 1:53 p.m., the Director of Nursing (DON) confirmed abuse allegations had to be reported to NJDOH within two hours, and the final report had to be completed within five days after the initial report. During a follow-up interview with the DON on 10/02/24 at 12:05 p.m., The DON stated that all resident-to-residents allegations of abuse, such as yelling or making threatening remarks, are to be reported to the DON immediately and reported to NJDOH within two hours. The DON further stated that when there is an allegation of abuse from Resident to Resident, she calls in the allegation to NJDOH as soon as she finds out. During an interview on 9/30/24 at 5:44 p.m., in the presence of the DON and Assistant DON (ADON), the Administrator indicated that the 3/27/23 incident was not reportable since the Resident did not touch anyone else. NJAC 8:39-9.4 (f) NJAC 8:39-27.1(a) 28604

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 12679 Complaints #: NJ162903, NJ166982, NJ168479 NJ172819, NJ172820, NJ173142 NJ173303, NJ175318, NJ175692 NJ177086 610 S/S H Based on interviews, review of medical records (MR), and other facility documentation on 9/30/24, 9/30/24, 10/01/24, 10/02/24, 10/03/24, and 10/04/24, it was determined that the facility failed to ensure residents' safety by not initiating a thorough and complete investigation was completed for employee-to-resident and resident-to-resident abuse allegation. Specifically, the facility failed to conduct a thorough investigation when Resident #10 was placed in involuntary seclusion, and Resident #14 threw a knife into the hallway and continued to display verbal and physical threats toward staff and other residents. The facility also failed to implement its policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program. This deficient practice was identified for 2 of 29 residents (Resident #10 and Resident #14) and was evidenced by the following 1. According to the ADMISSION RECORD (AR), Resident #10 was admitted with diagnoses which included but not limited to Huntington's disease, Muscle Weakness, Gait instability, and Anxiety Disorder. The Minimum Data Set (MDS), an assessment tool dated 4/4/24, revealed that Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating Resident #1's cognition was intact. The Care Plan (CP), dated 4/22/24, indicated that Resident #10 was left in the dayroom against her/his wishes. Review of the REPORTABLE EVENT RECORD (RER), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents dated 4/19/2024, revealed that Resident #10 reported around [7:30 a.m. Resident #10] reported that the [CNA #1] assigned last night placed [her/him] in the day room and would not let [her/him] out. A review of the [Long Term Care] Reportable Event Survey (LTCRES), also known as RER, dated 4/19/24, completed by the former Director of Nursing, provided by the facility, revealed Resident #10 reported that around 3:00 a.m., [the] [CNA] c.n.a. on duty put the Resident in the room and blocked the door so [he/she] could not leave. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Some	Further review of the LTCRES included an Investigative Summary (IS). According to the IS, on 4/19/24, Resident #10 reported to the nurse that he/she was placed in the day room with the door closed, preventing the Resident from exiting the dayroom. In addition, the IS indicated that during an interview conducted by the former Director of Nursing (DON) and Social Services (SS), Resident #10 reported he/she was in the hallway around 3:00 a.m. and was looking to leave the nursing According to the IS, Resident #10 said the aide took the Resident and placed him/her in the day room. The Resident explained that he/she did not want to be outside the door blocking the Resident's ability to exit. The IS further indicated that Resident #10 stated, After a period of time, the nurse on duty brought the Resident back to [his/her] room. The conclusion indicated, Upon completing this investigation, reading statements that have been provided by staff and Social Service follow-up, it is in my opinion that [Resident #10] was kept in the room against [her/his] wishes . Review of CNA #1's statement, dated 4/19/24, the CNA wrote I .worked on 4/18/24 on the dementia floor of the [NAME] Wing. The patient [Resident #10] tried to go to the west wing at [3:00 a.m.] which was not [her/his first] attempt. The nurse advised me to retrieve [her/him] from south wing [and] direct [her/him] into the dayroom where the other [patients] with behaviors were being monitored [and] so i [I] did. Before [Resident #10] was in the room the nurse instructed us to keep the door closed because they are fall risks to ensure their safety. According to the statement, when [Resident #10] asked to leave the room, the nurse [escorted her/him to her/his] room. No force was used. There was no body-to-body contact. The Resident did say [she/he] was gonna [going to] tell the unit manager I hurt her hand so I could get fired. The CNA further explained that when the door was closed, she was sitting on the other side to ensure the residents' safety and to keep an eye on them. A review of the Disciplinary Action Form, dated 4/19/24, included: Under Nature of Offense, noted Patient Rights and Resident Abuse or Neglect was checked off as the issues. Under: Detailed description of offense . included Resident [#10] stated [CNA #1] put her in the dayroom and would not let her out. Under Action Taken, showed a Suspension start date of 4/19/24. During an interview on 09/30/24 at 5:25 p.m., Resident #10 stated he/she was not permitted to leave the visitation area. Resident #10 further stated that when he/she asked to leave the area, the CNA told her/him to remain in the dayroom area. During a second interview on 10/01/24 at 11:52 a.m., Resident #10 stated that he/she was terrified when [CNA #1] sat in front of the door while she 'begged' the CNA to let him/her out. During an interview on 10/01/24 at 5:30 p.m., the Administrator stated that he reviewed the surveillance camera and saw Resident #10 was locked in the room. The CNA was sitting outside the door, and Resident #10 attempted to open the door. The Administrator further stated that other residents were also in the day room, and a staff member was inside the dayroom with the residents. At the time of the survey, the facility could not provide documented evidence that a complete and thorough investigation was completed for the 4/19/24 incident involving Resident #10 and other residents locked in the day room at 3:00 a.m. and that the facility assessed and ensured the safety of the residents. The facility also could not provide evidence that the nurse and staff in the day room were identified, interviewed, and educated. 2. According to Resident #14's AR indicated the Resident was admitted with diagnoses which included but not limited to Schizophrenia and Anxiety disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #14's progress notes (PN), dated 6/19/24 at 2:27 p.m., documented by LPN #5 [Resident #14] was observed throwing a knife into the hallway. [Resident #14] continues to display verbal and physical threats towards staff and other residents records that the Resident threw a knife in the hallway and made verbal and physical threats to staff and to residents. The facility was unable to provide documented evidence that when Resident #14 made verbal and physical threats to staff and to residents was thoroughly investigated to ensure other residents safety. During an interview on 10/01/24 at 5:30 p.m., the Administrator stated that the process for investigating resident/staff allegations is to pull the staff off of the unit and interview the staff and the other residents. The Administrator further stated he would ask staff for written statements and to interview other residents. However, the facility failed to provide documented evidence that the aforementioned incident was thoroughly investigated for safety. During an interview on 10/02/24 at 12:05 p.m., the DON stated she had no control over what happened prior to her hire but stated she would have begun an investigation, which would have included both staff and Resident interviews. A review of a policy provided by the facility titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 05/2023, indicated, .Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal management, involuntary seclusion, verbal, mental, sexual or physical abuse .The resident abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect .by anyone including, but not necessarily limited to: a. facility staff b. other residents .c staff from other agencies .j. any other individual .5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems . NJAC: 8:39-27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Complaints #: NJ173888 Based on interviews, record reviews, and review of other pertinent facility documents on ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], it was determined that the facility failed to assess and monitor for delayed complications after a resident fell from a geriatric chair in the day room and sustained a hematoma. The facility also failed to follow its policy titled Assessing Falls and their Causes. This deficient practice was identified for 1 of 3 residents (Resident #11) reviewed for falls and was evidenced by the following: A review of the facility's undated policy titled Assessing Falls and their Causes revealed, . Steps in the Procedure After a fall . 6. Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall and will document findings in the medical record. 7. Document any observed signs of symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings . A review of Resident #11's electronic medical record (EMR) revealed the Resident was admitted with diagnoses that included traumatic brain injury (TBI) and unspecified dementia with other behavior disturbances. Resident #11 expired on [DATE]. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of ,d+[DATE], which indicated the Resident could not be interviewed and was assessed to be severely impaired in decision making. This MDS revealed Resident #11 had physical, verbal, and behavioral symptoms directed towards others and was dependent on staff for eating, oral hygiene, toileting, bathing, and dressing. Review of the Nursing Progress Note (NPN), dated [DATE], revealed, This nurse was made aware by the CNA [Certified Nurse Aide] on duty that [the] patient [Resident #11] fell out of [the] Geri [geriatric] chair in [the] day room. The NPN further showed the Resident was found lying on the left side in the day room. A second CNA reported she did not see when the Resident fell out of the chair but heard it. Resident #11 sustained a hematoma to the forehead. A review of Resident #11's Fall Investigation, dated [DATE] and provided by the facility, revealed no evidence that a neurological assessment was completed after the fall. A review of Resident #11's NPN revealed no documentation status after the fall on [DATE]. Further review of the NPN dated [DATE] revealed Resident #11 was admitted to hospice. Review of Resident #11's Physicians Progress Note, dated [DATE], revealed, . As per nursing staff, patient continues to be aggressive, easily agitated, confused, combative, unable to redirect. fell last night. Has some scattered bruising to [the] forehead. Will make medication adjustments . Past medical history: dementia with behavioral disturbances, aggression, TBI, MVA [motor vehicle accident] . Plan: discontinued Seroquel [an antipsychotic medication used for major depression], start Zyprexa [an antipsychotic medication] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #11's NPN, dated [DATE], revealed, . Resident expired . Review of Resident #11's EMR showed no documented evidence that a neurological assessment was completed or the facility's policy was implemented after the fall on [DATE]. During an interview on [DATE] at 4:14 p.m., Family Member (F) #2 stated Resident #11 could not swallow . food was drooling from his/her mouth, lost weight, had bruises on the forehead, and was not alert when she visited after the fall on [DATE]. During an interview on [DATE] at 12:37 p.m., the Medical Director stated Resident #11 had suffered three falls within a week and could have suffered a subdural hematoma (bleeding in the brain), but the family refused to send him/her to determine that. The Medical Director stated Resident #11 declined after the last fall, and staff should have assessed and monitored for a brain bleed after the fall. During an interview on [DATE] at 1:34 p.m., Registered Nurse (RN) #1 stated she was the Nurse who assessed Resident #11 after his/her fall on [DATE] and that she completed a neurological assessment on the Resident after the fall. She further stated she should have documented the completed assessment in the progress notes, and the assessment should have been added to the fall investigation packet and given to the unit manager. During an interview on [DATE] at 10:12 a.m., F #1 stated she placed Resident #11 on hospice after the last fall on [DATE] because she thought they would be at the facility daily to feed Resident #11. F #1 stated Resident #11 could speak some words when he/she was admitted to the facility, but after the last fall, he/she lay in bed or in the geriatric chair and was not alert. During an interview on [DATE] at 10:15 a.m., CNA #6 stated that Resident #11 chewed and swallowed food and was more alert prior to the last fall on [DATE]. CNA #6 also stated Resident #11 had bruises on his/her forehead, slept more, and could not chew his/her food or swallow it after the last fall on [DATE]. During an interview on [DATE] at 11:06 a.m., CNA #9 stated Resident #11 was on hospice when the CNA was assigned to care for him/her. According to CNA #9, Resident #11 could not swallow his food, was drooling, and was not alert. During an interview on [DATE] at 5:27 p.m., the Director of Nursing (DON) stated she expected the Nurses to complete a neurological assessment after a fall on the paper neurological flow sheet. The DON stated she expected staff to monitor and document the neurological status, vital signs, and any other complications in the NPN so that care interventions could be rendered after Resident #11 experienced falls. NJAC 8:,d+[DATE].1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 C#: NJ173888 Based on interviews, record review, and review of other pertinent facility documents on [DATE], [DATE], [DATE], ,d+[DATE], and [DATE], it was determined that the facility failed to provide adequate supervision to prevent falls, determine the root cause of the falls, and implement effective interventions to prevent further falls. The facility also failed to follow its policy titled Falls and Fall Risk, Managing. This deficient practice was identified for 1 of 3 residents (Resident #11) reviewed for falls and was evidenced by the following: Review of the facility's policy titled, Falls and Fall Risk, Managing, dated [DATE] provided by the facility, revealed, . Based on previous evaluations and current data, the staff will identify interventions related to the Resident's specific risks and causes to try to prevent the Resident from falling and to try to minimize complications from falling . Policy Interpretation and Implementation Prioritizing Approaches to Managing falls and Fall Risk . 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . Monitoring Subsequent Falls and Fall Risk. The staff will monitor and document each Resident's response to interventions intended to reduce falling or the risks of falling . 3. If the Resident continues to fall, staff will re-evaluate the situation and determine whether it is appropriate to continue or change current interventions . A review of the electronic medical record (EMR) revealed Resident #11 was admitted with diagnoses that included traumatic brain injury (TBI) and unspecified dementia with other behavior disturbances. Resident# 11 expired on [DATE]. Review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE], which indicated Resident #11 could not be interviewed and was assessed to be severely impaired in decision making. This MDS revealed Resident #11 had physical, verbal, and behavioral symptoms directed towards others and was dependent on staff for eating, oral hygiene, toileting, bathing, and dressing. Review of the facility's Fall Investigation (FI), for Resident #11 revealed the following: On [DATE], CNA #11 witnessed Resident #11 stand up from the wheelchair, fall on his/her back, and then bleed from the side of his/her head. On [DATE], Licensed Practical Nurse #7 witnessed Resident #11 get out of the geriatric chair and hit his/her head on the wall. It was recorded that Resident #11 did not suffer any injuries. The root cause of the fall was not documented on the fall investigation. On [DATE], interviews were conducted with six Nurse Aides on the 3:00 p.m. to 11:00 p.m. shift, but they did not witness Resident #11's fall in the day room. The fall investigation stated CNA #10 found Resident #11 on the floor in the day room when she entered at 5:30 p.m. The root cause of the fall was not documented on the fall investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #11's progress note (PN) revealed the following: On [DATE] at 12:00 p.m., the Certified Nurse Aide (CNA) #11 alerted Licensed Practical Nurse (LPN) #9 that Resident #11 fell and hit his/her head when he/she got up from the wheelchair in the dayroom. Resident #11 was transported to the emergency room for treatment and returned with one staple to the right side of the head. On [DATE] at 12:30 p.m., Resident #11 had a witnessed fall in the dayroom out of his/her geriatric chair and hit his/her head on the wall. On [DATE] at 5:30 p.m., Resident #11 fell out of the geriatric chair in the day room and sustained a hematoma to his forehead. Review of Resident #11's care plan (CP) dated [DATE], revealed the Resident was care planned for risk for falls with interventions of activities, physical therapy (PT), safe environment, call light within reach, wear proper footwear, and bed in low position. Further review of the CP dated [DATE] revealed no new interventions were added after the fall on [DATE]. Further review of the CP dated [DATE] revealed the fall risk CP was updated with an intervention to monitor frequently for safety in relation to the fall that occurred on [DATE]. At the time of the survey, the facility could not provide evidence that the resident's CP was being implemented for frequent monitoring on [DATE]. During an interview on [DATE] at 12:37 p.m., the Medical Director confirmed falls were discussed in the quality assurance meetings, and interventions were discussed to prevent further falls. The Medical Director stated that if Resident# 11 kept falling out of the geriatric chair, either the Resident needed adequate supervision or the intervention needed to be changed because it was not effective. During an interview on [DATE] at 9:58 a.m., LPN #7 stated she witnessed Resident #11 get out of the geriatric chair and hit his/her head on the wall when she entered the room to administer medications to a resident on [DATE]. LPN #7 stated a nurse aide was in the room, but she was not sitting next to the Resident during the day. LPN #7 stated the nurse aide was responsible for feeding and watching all the residents. LPN #7 indicated there were approximately ten high-fall-risk residents in the day room at the time of Resident #11's fall, and it was difficult to keep the residents safe during mealtimes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 4:20 p.m., LPN #6, former Unit Manager on the [NAME] Unit, stated Resident #11 fell out of a geriatric chair twice, was very combative, and was always trying to get out of the bed and wheelchair, and geriatric chair because he wanted to talk. LPN #6 indicated Resident #11 should have been supervised while in the wheelchair and geriatric chair in the dayroom. LPN #6 stated after Resident #11's second fall in the day room, another CNA was added to the day room to provide one-to-one observations of Resident #11 and another resident so that the other CNA could watch the other residents in the day room. According to the LPN, the CNAs were responsible for feeding and watching the residents during meal times. LPN #6 confirmed the former Director of Nursing (DON) completed the fall investigations. Falls were discussed at the morning meetings, but the Interdisciplinary Team (IDT) did not meet on every fall to discuss interventions to prevent falls or re-evaluate interventions to prevent further falls. LPN #6 verified that the interventions were not effective in preventing falls for Resident #11. During a combined interview on [DATE] at 2:10 p.m., the Assistant Director of Nursing (ADON) and DON, both employed for three months, stated the staff held fall huddles after a resident's fall to determine the cause and implement interventions to prevent further falls. The DON stated the IDT meets to discuss the falls, re-evaluate fall interventions and change the interventions if they were not effective in preventing further falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 28604 Based on interviews, review of facility staffing records, and pertinent facility documents on 09/30/2024, 10/01/2024, 10/02/2024, 10/03/2024 and 10/4/2024, it was determined that the facility failed to ensure the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week on 08/29/23. This deficient practice had the potential to affect all 157 residents residing in the facility. This deficient practice was evidenced by the following: Review of a document provided by the facility titled Facility Assessment, dated 01/25/24, indicated, .We provide adequate staffing to meet its resident's daily needs, preferences, and routines. This includes services of a registered nurse for at least eight (8) consecutive hours a day, 7 days a week . A review of a facility document titled Nurse Staffing Report, dated 08/29/23, indicated no RN coverage for at least eight consecutive hours. During an interview on 10/04/24 at 9:33 a.m., Unit Secretary/Staffing Coordinator (US/SC) stated she typically schedules RN coverage for eight hours per day, seven days a week. US/SC stated she did not remember why there was no RN coverage on 8/29/23. During an interview on 10/04/24 at 3:31 p.m., the Director of Nursing stated the expectation was for the facility to be compliant federally. NJAC 8:39-25.2(h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 28604 Based on interview and review of facility's documents on 9/30/24, 10/1/24, 10/2/24, 10/3/24, and 10/4/24, it was determined that the facility failed to evaluate the performance of all Certified Nursing Assistant (CNAs) on an annual basis. This deficient practice was identified for 5 of 5 CNAs (CNAs #3, #13, #14, #15, and #16) reviewed for personnel records. This deficient practice was evidenced by the following: The Surveyor reviewed the employee file (Efile) presented by the facility. 1. According to CNA #3's Efile, revealed date of hire (DOH) was 10/19/19 and the Performance Evaluation for Non-Exempt Employees (PENEE) was signed and dated 2/13/23 to indicated that the CNA #3's PENEE was completed. The facility was unable to provide documented evidence that the PENEE was completed for CNA #3 for the year of 2/2024. 2. According to CNA #13's Efile revealed, DOH was 10/19/19 and the PENEE was signed and dated 3/14/22 to indicated that the CNA #13's PENEE was completed. The facility was unable to provide documented evidence that the PENEE was completed for CNA #13 for the year of 3/2023 and 3/2024. During an interview on 10/04/24 at 3:24 p.m., CNA #13 stated her annual review was completed last year and had not had one this year. 3. According to CNA #14, CNA #15, and CNA #16's Efile, revealed DOHs were 10/1/19 and the PENEE were signed and dated 2/28/22 to indicated that the CNAs PENEEs were completed. During an interview on 10/04/24 at 3:14 p.m., CNA #14 stated she did not recall if a performance review was completed last year, and one had not been completed this year. The facility was unable to provide documented evidence that the PENEEs were completed for CNA #14, CNA #15, and CNA #16's for the year of 2/2023 and 2/2024. During an interview on 10/04/24 at 11:41 a.m., Registered Nurse (RN #2), Unit Manager, stated she had not completed the CNAs PENEEs reviews in a couple of years and did not know who was responsible for completing them. During an interview on 10/04/24 at 2:00 p.m., the Director of Nursing (DON) stated the direct managers would complete the yearly PENEE reviews for the CNAs which were coordinated through Human Resources (HR). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/04/24 at 2:08 p.m., the Assistant Director of Nursing (ADON) confirmed he could not find the 2023 annual performance reviews and the HR Director could not find them. The ADON also stated he could not locate a performance review policy. During an interview on 10/04/24 at 2:10 p.m., the HR Director stated either the former DON or Unit Manager on the units were responsible for completing the annual PENEE for the CNAs. The HR Director also stated that she looked for the files but was unable to find them, and the ones that were provided to her were placed in the CNAs personnel file. N.J.A.C.: 8:39-43.17 (b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Complaint #: NJ#162903, NJ#166982, NJ#168479, NJ#172819, NJ#172820, NJ#173142, NJ#173303, NJ#175318, NJ#175692, NJ#177086 Based on interviews, record review, and review of other pertinent facility documentation, it was determined that the Licensed Nursing Home Administrator (LNHA) failed to ensure 1) residents' safety and well-being were maintained for physical and verbal abuse. The LNHA also failed to ensure the facility's policies titled Physical Restraints, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, and the Administrator job description were followed. This deficient practice was identified for 5 of 29 residents (Resident #7, Resident #10, Resident #13, Resident 16, and Resident #19) and was evidenced by the following: A review of Resident #14's Progress Note (PN) revealed the following: 1. According to the Electronic Medical Records (EMR), Resident #14 was admitted with a diagnosis of Schizophrenia. The Minimum Data Set (MDS), an assessment tool with an Assessment Reference Date (ARD) of 01/20/24, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the Resident was cognitively intact. The assessment indicated the Resident had no hallucinations or delusions and was not a threat to self or others. According to Resident # 14's care plan (CP) dated 1/12/2024, included under Focus,: I (Resident #14) have a long Hx (history) of Mental Illness with behaviors. My behaviors can include: periods of increased agitation, periods of increased anxiety, Can be physically/ verbally aggressive, assaultive, throws furniture, bangs/ slams doors, yells/ screams out, responds to internal stimuli, Delusional thinking, refuses Meds (medication) / Tx (treatment), conflicts with peers/ roommate, and Low tolerance for cognitive impaired peers. Under Goal, indicated: My mood/ behaviors will remain stable with my baseline . Under Interventions included: alert to impending violence aggressive behaviors, maintain safety for all, remove all objects that can harm (him/ her) or others, keep 4 arm's length apart, decrease his/her stimuli, attempt to verbally de-escalate . Further review of the CP revealed Under Interventions, Resident #14 had an altercation with a peer on 04/24/25. According to the interventions, the Resident assaulted his/her peer and had verbal aggression. The CP interventions indicated that safety maintained for all, the police were called, and the primary care physician (PCP) orders were obtained to send the Resident to the local hospital; the Resident refused to go, pending PESS evaluation, to follow-up with the psychiatric team, and to attempt to identify antecedents to behavior. On 3/12/24, the Psychiatry Progress Note (PPN), written by psychiatric Nurse Practitioner (NP) #1, revealed Resident #14 had fair awareness of events, fair impulse control, and poor judgment. The NP also indicated the Resident had a diagnosis of Schizophrenia with anxiety and was not cooperative during the interview. Medication compliance should be encouraged at this time, and staff should send Resident #14 out to PESS if the Resident becomes a danger to self or others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	On 04/24/24 at 10:18 p.m., revealed Resident #14 slapped Resident #16's face with a closed fist and became verbally aggressive. The police were notified. The Physician was notified and ordered Resident #14 to be sent to the local hospital for evaluation and treatment. On 04/25/24 at 7:35 a.m., indicated on 04/24/24 at 11:30 p.m., the emergency medical technicians (EMTS) and the police arrived at the facility to transfer Resident #14 to the hospital, but the Resident refused. The Resident screamed at EMTS, telling them to get out, and slammed the door. The police were unable to take him/ her to the hospital because of his/her refusal unless PESS determined the Resident required hospitalization . At the time of PESS, they determined that the Resident was calm and did not need to go to the hospital. The note indicated the Resident remained calm for the rest of the shift. At 12:59 p.m., the Resident was .being aggressive and combative with behaviors, attempting to hit staff, throwing items unable to redirect .Unable to redirect, 1:1 was placed outside the room for safety. On 04/26/24 at 10:47 a.m., the PPN, written by NP #3, revealed she met with the Resident to assess him/her. The Resident continued to refuse his/her medications and had intermittent outbursts of aggressive behaviors. The NP noted the Resident was evaluated by S-cope on 04/25/24, and due to severe paranoid delusion, it was recommended the Resident be evaluated for a behavioral health nursing home. The Resident is currently on one-to-one. On 4/26/24 at 1:04 p.m., written by the Nurse Manager, the PN revealed, .At times would yell out for no specific reason, throwing food and drinks on the floor. Staff supervised at a distance . On 04/30/24 at 3:46 p.m., the Social Services PN (SSPN) indicated the facility heard back from the Resident's case manager and was informed the Resident did not meet the criteria for behavioral health placement. On 5/2/24 at 1:52 p.m., written by LPN #1, Resident #14 was accosting Resident #7; the police were called, and the police advised that they could do nothing at this time. On 5/09/24 at 7:26 a.m., Resident had an episode of combative, aggressive behavior w/[with] hostile verbal outburst, throwing objects at this writer . On 05/13/24, the PPN written by NP #2 revealed Resident # 14 was seen for follow-up medication management due to refusal of all medications and schizophrenia paranoid type. The note indicated the Resident was agitated, unpredictable, impulsive, and suspicious and slammed the door in front of NP #2. The note continued that the Resident had a history of hitting staff, throwing items, and making multiple calls to the police and PESS. The note revealed the Resident was not taken to the hospital after a PESS evaluation since the Resident refused to go. NP #2 indicated the Resident had poor insight, judgment, and impulse control and directed the facility to call PESS if the Resident became a danger to self or others. On 5/16/24 at 12:44 a.m., Resident #14 got into a verbal altercation with Resident #7. On 5/25/24 at 2:47 p.m., the Resident continued to yell at self-picks up objects and slam them down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	On 05/29/24 at 9:50 a.m., the PPN, written by NP #3, revealed the Resident refused his/her physical exam and directed the clinical staff to continue with the Resident's current care plan and encourage medication compliance. 05/29/24 at 2:26 p.m., the PN indicated a housekeeper entered the Resident's room to empty a trashcan. The Resident jumped out of his/her bed, chased the housekeeper, and attempted to throw the trashcan at the staff. The housekeeper twisted her ankle after this encounter. On 06/10/24 at 9:32 a.m., the PPN written by NP #4 revealed the NP attempted to meet with Resident #14. The Resident had his/her head covered with a blanket and refused to answer her questions about the status of his/her health. NP #4 directed the clinical staff to continue medication compliance. On 06/19/24 at 1:36 p.m., Resident #14 was yelling and slamming items in his/her room. After the noise subsided, a nurse entered the Resident's room and found two holes in the wall. Further review of the PN on 06/19/24 revealed that the Resident threw a knife in the hallway and continued to threaten staff and residents verbally and physically. On 06/20/24 at 12:06 p.m., the PNs revealed Resident #14 kicked a garbage can at a CNA, took off his/her belt, swung it at the CNA, and stated he/she was going to beat her with it. According to the note, residents and housekeeping witnessed this incident. PESS was again notified, the Resident was assessed, and the Resident was transported to the hospital. The Resident returned to the facility the same day and showed no behaviors. On 06/29/24 at 10:03 p.m., written by the LPN revealed Resident #14 came out of his/her room and threatened to kill staff if they ever entered his/her room and touched his/her belongings. Further review of the PN showed no evidence that this behavior was addressed. On 07/01/24 at 11:12 p.m., the PNs revealed Resident #14 was seen in the hallway hitting Resident #7 in the face with a closed fist and pulling Resident #7's hair, which caused him/her to fall to the floor. Resident #14 then slammed the door to his/her room. The police were called, and the Resident was taken to the PESS unit for evaluation. Both the Resident's medical provider and responsible parties were notified. On 07/03/24 at 8:00 a.m., the PNs written by LPN #2 indicated Resident #14 was discharged to a behavioral health center. A review of Resident #14's Progress Note (PN) revealed the following: On 3/12/24, the Psychiatry Progress Note (PPN), written by psychiatric Nurse Practitioner (NP) #1, revealed Resident #14 had fair awareness of events, fair impulse control, and poor judgment. The NP also indicated the Resident had a diagnosis of Schizophrenia with anxiety and was not cooperative during the interview. Medication compliance should be encouraged at this time, and staff should send Resident #14 out to PESS if the Resident becomes a danger to self or others. On 04/24/24 at 10:18 p.m., revealed Resident #14 slapped Resident #16's face with a closed fist and became verbally aggressive. The police were notified. The Physician was notified and ordered Resident #14 to be sent to the local hospital for evaluation and treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	On 04/25/24 at 7:35 a.m., indicated on 04/24/24 at 11:30 p.m., the emergency medical technicians (EMTS) and the police arrived at the facility to transfer Resident #14 to the hospital, but the Resident refused. The Resident screamed at EMTS, telling them to get out, and slammed the door. The police were unable to take him/ her to the hospital because of his/her refusal unless PESS determined the Resident required hospitalization . At the time of PESS, they determined that the Resident was calm and did not need to go to the hospital. The note indicated the Resident remained calm for the rest of the shift. At 12:59 p.m., the Resident was .being aggressive and combative with behaviors, attempting to hit staff, throwing items unable to redirect .Unable to redirect, 1:1 was placed outside the room for safety. On 04/26/24 at 10:47 a.m., the PPN, written by NP #3, revealed she met with the Resident to assess him/her. The Resident continued to refuse his/her medications and had intermittent outbursts of aggressive behaviors. The NP noted the Resident was evaluated by S-cope on 04/25/24, and due to severe paranoid delusion, it was recommended the Resident be evaluated for a behavioral health nursing home. The Resident is currently on one-to-one. On 4/26/24 at 1:04 p.m., written by the Nurse Manager, the PN revealed, .At times would yell out for no specific reason, throwing food and drinks on the floor. Staff supervised at a distance . On 04/30/24 at 3:46 p.m., the Social Services PN (SSPN) indicated the facility heard back from the Resident's case manager and was informed the Resident did not meet the criteria for behavioral health placement. On 5/2/24 at 1:52 p.m., written by LPN #1, Resident #14 was accosting Resident #7; the police were called, and the police advised that they could do nothing at this time. On 5/09/24 at 7:26 a.m., Resident had an episode of combative, aggressive behavior w/[with] hostile verbal outburst, throwing objects at this writer . On 05/13/24, the PPN written by NP #2 revealed Resident # 14 was seen for follow-up medication management due to refusal of all medications and schizophrenia paranoid type. The note indicated the Resident was agitated, unpredictable, impulsive, and suspicious and slammed the door in front of NP #2. The note continued that the Resident had a history of hitting staff, throwing items, and making multiple calls to the police and PESS. The note revealed the Resident was not taken to the hospital after a PESS evaluation since the Resident refused to go. NP #2 indicated the Resident had poor insight, judgment, and impulse control and directed the facility to call PESS if the Resident became a danger to self or others. On 5/16/24 at 12:44 a.m., Resident #14 got into a verbal altercation with Resident #7. On 5/25/24 at 2:47 p.m., the Resident continued to yell at self-picks up objects and slam them down. On 05/29/24 at 9:50 a.m., the PPN, written by NP #3, revealed the Resident refused his/her physical exam and directed the clinical staff to continue with the Resident's current care plan and encourage medication compliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	05/29/24 at 2:26 p.m., the PN indicated a housekeeper entered the Resident's room to empty a trashcan. The Resident jumped out of his/her bed, chased the housekeeper, and attempted to throw the trashcan at the staff. The housekeeper twisted her ankle after this encounter. On 06/10/24 at 9:32 a.m., the PPN written by NP #4 revealed the NP attempted to meet with Resident #14. The Resident had his/her head covered with a blanket and refused to answer her questions about the status of his/her health. NP #4 directed the clinical staff to continue medication compliance. On 06/19/24 at 1:36 p.m., Resident #14 was yelling and slamming items in his/her room. After the noise subsided, a nurse entered the Resident's room and found two holes in the wall. Further review of the PN on 06/19/24 revealed that the Resident threw a knife in the hallway and continued to threaten staff and residents verbally and physically. On 06/20/24 at 12:06 p.m., the PNs revealed Resident #14 kicked a garbage can at a CNA, took off his/her belt, swung it at the CNA, and stated he/she was going to beat her with it. According to the note, residents and housekeeping witnessed this incident. PESS was again notified, the Resident was assessed, and the Resident was transported to the hospital. The Resident returned to the facility the same day and showed no behaviors. On 06/29/24 at 10:03 p.m., written by the LPN revealed Resident #14 came out of his/her room and threatened to kill staff if they ever entered his/her room and touched his/her belongings. Further review of the PN showed no evidence that this behavior was addressed. On 07/01/24 at 11:12 p.m., the PNs revealed Resident #14 was seen in the hallway hitting Resident #7 in the face with a closed fist and pulling Resident #7's hair, which caused him/her to fall to the floor. Resident #14 then slammed the door to his/her room. The police were called, and the Resident was taken to the PESS unit for evaluation. Both the Resident's medical provider and responsible parties were notified. On 07/03/24 at 8:00 a.m., the PNs written by LPN #2 indicated Resident #14 was discharged to a behavioral health center. A review of a document provided by the facility titled Statewide Clinical Outreach Program for the Elderly (S-cope), dated 04/25/24, indicated the outreach program screened Resident #14 due to the Resident's continuation of refusals of his/her medications, agitation, and delusional thinking. S-cope made the following recommendations: to continue one-to-one to ensure safety; to follow up with the facility's psychiatrist/physician about lifting the one-on-ones; to utilize ABC tracking (tracking of activity, antecedent, behavior, and consequences related to behaviors) to identify trends and triggers in Resident #14's behaviors; to utilize this method for five days, and then fax the completed forms to S-cope. Review of a second S-cope document dated 06/21/24 indicated the clinician made the following recommendations for the Resident's mental health needs: continue to provide one-on-one to the Resident; utilize the ABC to track and trend the Resident's behaviors, utilize and fax the completed ABC form to S-cope; and to have the facility's psychiatrist follow-up with the Resident and refusals of medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	Review of the EMR revealed no documented evidence that the Physician was notified, and an order was obtained to stop the one-on-one Supervision. In addition, the facility was unable to provide evidence that behavior tracking was forwarded to S-cope as recommended. Review of Resident #14's Medication Administration Record (MAR) dated 3/1/2024 - 3/31/2024 indicated the Resident refused his/her medications as follows: Aricept (used for dementia) Oral Tablet 5 (milligram) mg 1 tablet by mouth at bedtime 9:00 p.m. Refused on 3/2-3/6, 3/9, 3/10, 3/12 - 3/18, 3/20 and 3/22- 3/31/2024. Risperidone (used to treat symptoms of Schizophrenia) Oral Solution 1 mg/ml. Give 1 milliliter (ml) by mouth two times a day at 9:00 a.m. and 9:00 p.m. Refused 9:00 a.m. dose from 3/1- 3/31/2024. Refused 9:00 p.m. dose on 3/2 -3/7, 3/9, 3/10, 3/12-3/18, 3/20 and 3/22-3/31/2024. Review of Resident #14's MAR dated 4/1-4/30/2024 indicated the resident refused the following medications: Aricept Oral Tablet 5 (milligram) mg 1 tablet by mouth at bedtime 9:00 p.m., on 4/1-4/6, 4/8-4/14, 4/16-4/19 and 4/21-4/30/2024. Risperidone Oral Solution 1 mg/ml. Give 1 milliliter (ml) by mouth two times a day at 9:00 a.m. and 9:00 p.m., 9:00 a.m. dose on 4/1-4/5, 4/7, 4/8, 4/10-4/20, 4/22-4/26 and 4/28-4/30/2024, and 9:00 p.m. dose on 4/1-4/6, 4/8-4/14, 4/16-4/19, 4/21-4/25 and 4/27-4/30/2024. Review of Resident #14's MAR dated 5/1-5/31/2024 indicated the resident refused the medications as follows: Aricept Oral Tablet 5 (milligram) mg 1 tablet by mouth at bedtime 9:00 p.m., on 5/1-5/12, 5/14-5/17, 5/19-5/22, 5/24-5/27 and 5/29 -5/31/2024. Risperidone Oral Solution 1 mg/ml. Give 1 milliliter (ml) by mouth two times a day at 9:00 a.m. and 9:00 p.m. Refused 9:00 a.m. dose from 5/1-5/31/2024, 9:00 p.m. dose on 5/1-5/12, 5/14-5/17, 5/19-5/22, 5/24, 5/25, 5/27, 5/29 and 5/31/2024. Review of Resident #14's MAR dated 6/1-6/30/2024 revealed the resident refused the following medications: Aricept Oral Tablet 5 (milligram) mg 1 tablet by mouth at bedtime 9:00 p.m., from 6/1-6/30/2024. Risperidone Oral Solution 1 mg/ml. Give 1 milliliter (ml) by mouth two times a day at 9:00 a.m. and 9:00 p.m., at 9:00 a.m. 6/1-6/3, 6/5-6/12, 6/14-6/25 and 6/27-6/30/2024, and 9:00 p.m. dose on 6/1-6/19 and 6/21-6/30/2024. Review of Resident #14's MAR dated 7/1-7/31/2024 indicated the Resident refused the medications as follows: Aricept Oral Tablet 5 (milligram) mg 1 tablet by mouth at bedtime 9:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	Risperidone Oral Solution 1 mg/ml. Give 1 milliliter (ml) by mouth two times a day at 9:00 a.m. and 9:00 p.m. on 7/1/2024. There was no evidence that the resident's Physician was notified oo the aforementioned medications refusals refusals. 2. Review of the EMR, revealed Resident #16's was admitted with a diagnosis chronic kidney disease, high blood pressure and anxiety disorder. The MDS dated [DATE] showed the Resident had a BIMS score of 15 out of 15, which indicated the Resident was cognitively intact. A review of the CP dated 04/22/24 revealed Resident #16 was identified as at risk for falls or injury related to decreased mobility, deconditioning and poor safety and at risk for bruising or bleeding and had the potential for alteration in his/her mood due to a diagnosis of anxiety disorder. A review of the PN dated 04/24/24 at 10:27 p.m. revealed Resident #16 entered the nourishment room and walked by Resident #14, who then punched Resident #16 in the face. Both residents were separated. Resident #16 sustained no injuries. 3. Review of the EMR revealed Resident #7 was admitted with a diagnosis of chronic obstructive pulmonary disease (COPD). The quarterly MDS, with an ARD of 04/19/24, indicated the Resident had a BIMS score of 15 out of 15, which revealed the Resident was cognitively intact. A review of the PNs dated 07/01/24 at 11:00 p.m. revealed that Resident #7 was screaming in the hallway. Facility staff responded and separated Resident #7 and Resident #14. The police were notified, and Resident #14 was removed from the facility. In addition, the RN revealed that Resident #7 sustained a laceration on his/her forehead and was sent to the ER for evaluation and treatment of head injury. Further review of the PN dated 07/02/24, at 4:56 a.m., revealed Resident #7 returned from the hospital with a left orbital laceration with a hematoma. During an interview on 09/30/24 at 6:02 p.m., the Assistant Director of Nursing (ADON) stated he expected PESS to be contacted when there was aggressive behavior by a resident to decide if the Resident was a threat. However, there was no evidence provided that PESS was notified every time Resident #14 had changes in his/her behavior. During an interview on 09/30/24 at 6:42 p.m., Resident #7 stated he/she remembered Resident #14. Resident #7 explained that the Resident left his/her room to get a soda, and Resident #14 jumped him/her from behind. Resident #7 explained he/she fell to the floor, was sent to the emergency room , and the staff glued a large gash on his/her forehead. During an interview on 10/01/24 at 10:22 a.m., CNA #3 stated he worked with Resident #14 and stated the Resident would throw things at him and was very violent with both staff and residents. CNA #3 stated that anything would set the Resident off, and he/she would just flip. According to the CNA, Resident #14 would punch holes in the walls of the Resident's room. During an interview on 10/01/24 at 11:10 a.m., Resident #16 confirmed Resident #14 punched him/her in the face. Resident #16 stated it was painful, and the punch took him by surprise. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/01/24 at 11:19 a.m., NP #1 confirmed he remembered Resident #14. According to NP #1, Resident #14 would refuse medications and punch people in the face. NP #1 stated that there were staff who were too scared to enter the Resident's room. He did not make any medication recommendations since it did not matter if he did since Resident #14 did not take his/her psychotropic medications to treat his/her behaviors. During an interview on 10/01/24 at 12:34 p.m., CNA #4 stated she witnessed the assault from Resident #14 to Resident #7. According to the CNA, Resident #14 punched Resident #7, the Resident then fell to the ground, and Resident #14 proceeded to kick the Resident. She further stated Resident #7 sustained a cut close to the eye, and the area was bleeding and swollen. The CNA stated the facility was not providing one-on-ones for Resident #14 prior to this incident. During an interview on 10/01/24 at 2:13 p.m., in the presence of the Director of Nursing (DON) and ADON, the LNHA stated that the facility receives recommendations from S-cope for residents and does not keep a resident on one-on-one forever. At the time of the interview, a request was made for evidence of the one-on-one Supervision, why Resident #14 was taken off one-on-one Supervision, and about ABC tracking. The LNHA stated he would have to ask the nursing staff. The Surveyor also requested any psychiatric assessment after the 04/24/24 incident and before the psychiatric NP visit with Resident #14 on 05/13/24 and to provide any information related to safety measures taken with Resident #14 after 04/24/24 when he/she slapped Resident #16. However, the facility was unable to provide the requested information. During a second interview on 10/01/24 at 3:34 p.m., the LNHA brought in copies of Resident #14's nursing PNs and stated the Resident had no behaviors after 04/24/24, and the one-on-ones were stopped. He also presented a document from S-cope dated 04/25/24 and stated he believed S-cope came out again prior to 05/13/24. According to the LNHA, Resident #14 refused all of his/her medications. The ABC tracking was used to document all of the resident behaviors. The LNHA stated that S-cope was coming out all the time and providing direction to the facility staff on a regular basis. During an interview on 10/02/24 at 9:59 a.m., the Mental Health Clinician (MHC) with S-cope stated that she assessed Resident #14 on 04/25/24 and again on 06/21/24. The MHC stated she met with the Resident four times between 04/25/24 and 07/01/24 and made the same recommendations on 06/21/24 as on 04/25/24. MHC stated the Resident was determined not to be a danger to others when she met with him. During an interview on 10/02/24 at 10:14 a.m., LPN #1 stated he worked the night shift and was not aware Resident #14 was on one-on-one Supervision. During an interview on 10/02/24 at 10:48 a.m., the Medical Director (MD) stated he was familiar with Resident #14 and was his Primary Care Physician (PCP). According to the MD, he was surprised to hear that the Resident could refuse to go with the EMTs and police, which he had never seen before. The MD stated he remembered getting on the phone with the EMTs, and the EMTs informed him that if Resident #14 refused to be taken to the hospital, they could not force the Resident to do so. The MD stated the only way for the Resident to receive treatment was for the Resident to totally decompensate in his/her condition. Regarding the issue with Resident #14 refusing his/her psychotropic medications, he stated the facility could only monitor his/her condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/2/24 at 4:20 p.m., the DON stated that if a resident required one-on-one Supervision, they were not appropriately placed in the facility and needed a higher level of care. She stated the Resident would not be safe, and their needs were too high of an acuity for the facility. According to the DON, If someone needs that one-on-one monitoring, this is not the place for them. Review of the facility's reported incident investigation, provided by the LNHA revealed that two staff witnessed abuse that occurred with Resident #19 and 13 involving the same nurse (LPN #10). According to a witness statement from CNA #12 dated 09/16/24 at approximately 8:25 p.m., Resident #19 walked behind the nurse's station and tapped LPN #10 on the shoulder. LPN #10 then pushed Resident #19 and yelled, Get away from here, you are not supposed to be back here. Review of the second facility's incident investigation dated 09/17/24 revealed a witness statement from LPN #11, which showed on 09/17/24 at 7:00 a.m., she was standing at the medication cart, saw Resident #13 grab a binder from the nurse's station counter, and LPN #10 tried to pull the binder from Resident #13. According to the statement, LPN #10 yelled Leave the shit alone, swiped the binder away from Resident #13, hitting his/her hand, then yelled, Get the fuck out of here! LPN #11 also indicated she tried to break them up and then reported the incident to the UM. 4. Review of Resident #19's EMR showed the Resident was admitted to the facility with diagnoses that included Alzheimer's disease with late onset, anxiety disorder, and major depression. According to the MDS, Resident #19 had a BIMS score of 2 out of 15, which indicated the Resident was severely cognitively impaired. A review of Resident #19's nursing PN dated 09/17/24 at 4:51 p.m. revealed, .Investigating staff reported aggressive behavior from staff to Resident. Witnessed incident with no injuries noted. The assigned nurse was noted to act in a confrontational manner towards [Resident #19]. Other staff members quickly de-escalated the incident. Resident #19 is unable to verbalize any details r/t [related to] incident but can answer simple yes or no questions. The RN assessed Resident #19, and no injury was noted. NP notified and assessed . Review of Resident #19's CP dated 09/17/24 revealed a long history of behaviors related to dementia problem area with an intervention of, .victim of incident 09/16/24 follow-up with psych services as needed and provide emotional support to [the] resident . Review of Resident #19's CP date initiated 12/28/23, revealed a long history of behaviors related to dementia. Interventions to include Caregivers to provide opportunity for positive interaction, explain all procedures to the Resident before starting and allow the Resident to adjust to changes. 5. Review of the EMR revealed Resident #13 was admitted with diagnoses that included dementia without behavioral disturbance, anxiety disorder, and depression. The annual MDS, with an ARD of 08/22/24 showed a BIMS score of one out of 15, which indicated Resident #13 was cognitively intact. A review of Resident #13's Physicians Progress Note, dated 09/17/24 at 10:17 a.m., revealed that the . [Resident] was seen ambulating on the unit. Says he/she is feeling well. No c/o [complaints of] pain or discomfort. It was reported to me by the DON [Director of Nursing] that [the] patient [Resident] was pushed by a staff member. The Resident does not remember the incident. No injuries noted .Plan .Continue current medications .fall precautions. Monitor for bleeding . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #13's nursing PNs dated 09/19/24 revealed, .Seen by [Psychiatric Provider]. Xanax [an antianxiety medication] 0.25 mg [milligrams] daily PRN [as needed] anxiety and increase in Buspar [an antianxiety medication] 15 mg BID [twice a day]. Behavior charting for anxiety X [times] 14 days . Review of Resident #13's CP dated 09/17/24 revealed a care area focus of history of behaviors related to dementia with an intervention of, .a victim of incident 9/17/24 follow-up with psych services as needed provide ongoing emotional support to [the] resident, administer medications as ordered, and monitor/document side effects and effectiveness . Review of Resident # 13's CP with a revision date on 11/28/23 revealed, Focus: history of behaviors related to dementia with behaviors that can include periods of increased restlessness, periods of increased anxiety and enters peers' personal spaces. Interventions: Attempt to identify antecedents to my behavior and monitor for wandering into other personal spaces, redirect him/her to his/her own personal space or common area. It was recorded the police were contacted on 09/19/24, and all staff were trained on abuse and neglect on 09/17/24. Both incident investigations revealed the staff to Resident abuse for Resident #19 and Resident #13 was substantiated. LPN #10 was suspended on 09/17/24 while the investigation was in progress. LPN #10 did not work after this date and was terminated on 09/23/24. The documentation further revealed that the DON/ADON was aware of the incidents on 09/17/24. During a combined interview on 09/30/24 at 2:10 p.m., the LNHA and DON revealed that she [DON] was notified of the abuse allegation when she arrived at the facility on 9/17/24 at 8:00 a.m., and the ADON was notified when he arrived at 7:30 a.m. The DON notified the LNHA as soon as it was reported to her. The DON stated LPN #10 was already gone for the day; he was suspended during the investigation and asked to come to the facility to write a statement, and then was terminated on 09/23/24. According to the LNHA, he watched the camera and saw LPN #10 and Resident #13 close to each other at the nurse's station but could not see what occurred. The DON stated the ADON interviewed the residents in the memory care unit, and there was no reported abuse by LPN #10. During an interview on 10/04/24 at 11:30 a.m., CNA #12 stated on 09/16/24 at approximately 8:25 p.m., she saw Resident #19 walk behind the nurse's station, tap LPN #10 on the shoulder, then LPN #10 pushed Resident #19 and yelled, Get away from here, you are not supposed to be back here. CNA #12 stated she did report the allegation to her supervisor. However, LPN #10 continued to provide care for other residents. During a combined interview on 09/30/24 at 2:10 p.m., the DON revealed they were made aware of the abuse allegation when the ADON found a note under his door from Registered Nurse (RN) #3 with a witness statement attached prior to his arrival on 09/17/24. The LNHA confirmed he received LPN #10's statement on 09/17/24. The DON stated she reported the incident to the State Survey[TRUNCATED]