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 04/02/2025

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** Complaint #: NJ00184635 Based on observations, interviews, review of medical records, and pertinent facility documentation on 03/26/25, the facility failed to: a.) ensure the safety of a moderately cognitively impaired resident with aggressive behaviors from a staff member who pepper sprayed the Resident in the face and b.) follow their, Abuse, Neglect, and Exploitation of Residents and Unmanageable Residents policies. The deficient practice resulted in Resident #6 being treated for chemical conjunctivitis and pain to the left eye. This deficient practice was identified for 1 out 2 residents (Resident #6) who were reviewed for abuse and was evidenced by the following: A review of the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by facilities to report incidents, revealed that on 3/19/25, Resident #6 was standing at the nurse's station grabbing at electronics/equipment, smashing it, and attempting to hit staff. The FRE further revealed that the Licensed Practical Nurse (LPN) #1 proceeded to get a bottle of pepper spray from her personal bag and sprayed Resident #6 to diffuse the situation. Additionally, the FRE revealed that the local police department was notified, and the Resident was transferred to the emergency room (ER) for treatment. On 03/26/25, at 11:33 A.M., during a tour of the dementia/locked unit, the surveyor observed Resident #6 sitting in a chair near the nurse's station. The surveyor asked Resident #6 questions and observed delayed responses for answers during this interview. The Resident was able to answer a few questions after much thought. Resident #6 reported that he/she felt ok. When asked if the Resident felt safe at the facility, the Resident responded, yes. According to the admission Record (AR), Resident #6 was admitted to the facility with diagnoses that included but were not limited to Dementia with severe mood disturbances and Major Depressive Disorder. According to the admission Minimum Data Set (MDS), an assessment tool dated 03/09/25, Resident #6 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that the Resident was moderately cognitively impaired. The MDS further indicated that Resident #6 was experiencing delusions and had physical and verbal behaviors towards others. (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

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(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 #6's Care Plan (CP) revealed a focus, initiated on 03/03/25, that indicated that the Resident could be verbally abusive towards others, combative towards the staff, had poor impulse control by throwing or destroying furniture, and lying down on the ground when upset. An intervention initiated on 03/03/25 included, If I become agitated, aggressive, or combative [,] maintain safety for all [,] keep at least 4 arm's length apart from me, decrease my stimuli and allow me to calm. During an interview on 03/26/25 at 12:01 P.M., the Certified Nursing Assistant (CNA) #1 stated that on 03/19/25, she worked a double shift [7 A.M. - 11 P.M.], and the Resident displayed no behaviors. She stated that although Resident #6 was not assigned to her, she was familiar with the Resident's behaviors. CNA #1 stated it was never appropriate to use pepper spray on a resident and that if she encountered an aggressive resident, she would step away and let them calm down. She further stated that she was educated on abuse and the prohibited use of pepper spray immediately post-incident. During an interview on 3/26/25, at 12:40 P.M., LPN #2 stated that she was assigned to Resident #6 on 03/19/25 for the day shift [7 A.M.- 3 P.M.] and that no behaviors were displayed during that time. She stated that using pepper spray on a resident was just wrong. During an interview with the surveyor on 03/26/25 at 1:23 P.M. with the DON and the Assistant Director of Nursing (ADON), they both stated that the camera footage was reviewed the next day, on 03/20/25, with the local police. They further stated that the police confiscated the footage, so it was not available for the surveyor to review. The DON and the ADON proceeded to describe the camera footage on 3/19/25. -Around 7:44 P.M., Resident #6 was seen at the nurse's station grabbing things and throwing them, and LPN #1 was behind the nurse's station. -Resident # 6 was then seen ripping the mouse from the computer and observed walking away from the nurse's station toward his/her room while twirling the mouse in the air. -LPN #1 was observed walking out of camera range and heading towards what they described as the med room [medication room]. -LPN #1 reappeared on camera at 8:04 P.M., running towards Resident #6 from behind. LPN #1 then ran in front of the Resident and sprayed the Resident with pepper spray three times. -Resident #6 was seen collapsing to the floor, holding his/her eyes, and appeared to be coughing. The facility provided Resident #6's hospital discharge paperwork for review, dated 03/19/25, that revealed that the Resident was treated for chemical conjunctivitis and pain to the left eye. The ADON stated that LPN #1 was suspended pending the outcome of the investigation. Upon the investigation, LPN #1 was terminated on 3/26/25, and a complaint form with the Board of Nursing was completed on the same date. Both the DON and the ADON stated that it was not acceptable for staff to use pepper spray on residents nor bring it into the facility. They further stated there was no policy reflecting this. (continued on next page)

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(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 Police Report from the responding police department included a Supplement which documented their review of the surveillance footage of the event. The video spanned from 7:53 P.M. to 8:56 P.M. and captured key moments as follows: At approximately 8:07 P.M., the footage shows the victim, [Resident name], standing in the hallway of the west wing. Certified Nursing Assistant (CNA) [CNA name] is [was] seen engaging in conversation with [Resident name]. At this point, [Resident name] does not appear to pose any threat. As [Resident name] is standing, Licensed Practical Nurse (LPN) [LPN name] approaches [him/her] and proceeds to spray [him/her] directly in the face, mere inches from [his/her] eyes with her own personal Oleoresin Capsicum spray (OC spray) [Pepper Spray]. In response, [,] [Resident name] attempts to defend [him/herself] by swinging a computer mouse with [his/her] right hand to create distance from [LPN name]. Despite [Resident name] attempts to cover [his/her] face and posing no threat, [LPN name] continues spraying [him/her] multiple times. [Resident name] then collapses to the floor, visibly in pain and discomfort, covering [his/her] eyes. Both [CNA name] and [LPN name] walk away from [Resident name], [,] leaving him on the floor without any medical assistance. [He/she] remains there, in obvious distress as other employees pass by without offering help. At 8:14 [P.M.,] the video shows [Resident name] attempting to crawl to an adjacent room [Resident name] appearing disoriented, tries to enter [Room number], which is adjacent to his own. At this point, [CNA name] sees [him/her,] grabs [him/her,] and brings [him/her] to the ground The footage shows [CNA name] and [LPN name] dragging [Resident name] across the floor by [his/her] sweatshirt and sweatpants, with [CNA name] holding [his/her] right side and [LPN name] holding [his/her] left arm. They pull [him/her] back to [his/her] room at 8:15 P.M. and immediately leave, closing the door behind them. No care is provided to [Resident name] during the brief moment they are in the room. It appears no one else enters [Resident's name] room until [Police Department] and Emergency Medical Services arrive at 8:53 P.M. Review of the facility policy titled, Abuse, Neglect, and Exploitation of Residents, revised 04/03/21, revealed under the Policy Statement that, It is the policy of the facility that acts of physical, verbal, mental and financial abuse including neglect and exploitation directed against residents is absolutely prohibited. Additionally, under the Definitions section it revealed that, Physical abuse is the inappropriate physical contact with a resident which harms or is likely to harm the resident. A review of the undated Unmanageable Residents policy, revealed under section 2 of Policy Interpretations and Implementation, that, Should the resident pose an immediate danger, or become violent or beyond control of the facility, local law enforcement agencies may be called for assistance. The facility was notified of the Immediate Jeopardy (IJ) on 3/26/25 at 4:03 P.M. The Director of Nursing (DON) was presented with the IJ template. The Administrator was not able to attend. An acceptable removal plan was electronically mailed to the surveyor on 03/31/25 at 1:48 P.M. The facility implemented a corrective action plan to remediate the deficient practice. The surveyor verified the removal plan on-site and determined the IJ for F600 was removed as of 04/02/25. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Removal Plan was as follows: 1. The facility implemented a new policy, Weapons Prohibition Policy and Procedure, that included weapons are not permitted on the premises nor to be used against a resident. 2. The facility initiated in-services with the staff on Weapons Prohibition Policy and Procedure and placed signage at the staff entrance and the time clock regarding the prohibition of weapons. 3. The facility-initiated in-servicing for all staff departments on Managing Aggressive Behaviors and Responding to Challenging Behaviors. 4. The facility initiated audits on care plans and incident investigations. N.J.A.C. 8:39-4.1 (a)(5)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint #NJ00183371 Based on observations, interviews, review of the medical record and other pertinent facility records on 3/6/25 and 3/7/25, it was determined on 3/7/25 that the facility failed to provide adequate supervision of a severely cognitively impaired resident with a known history of exit seeking which resulted in the resident eloping from the facility on 2/10/25 for 1 of 4 residents (Resident #1). The resident was located at an off-site location by an unidentified caller and returned to the facility on 2/10/25 at approximately 5:58 P.M. by the local police department. The facility's failure to provide adequate supervision to a cognitively impaired resident who was at risk for elopement posed a likelihood of serious harm, injury, impairment or death. This deficient practice placed Resident #1 and all other residents who were at risk or who had a known history of wandering or elopement in an Immediate Jeopardy (IJ) situation. The deficient practice was evidenced by the following: A Facility Reportable Event (FRE) sent to the New Jersey Department of Health dated 2/10/25, indicated that the nursing supervisor reported that the resident had been found outside of the facility after dinner at approximately 5:30 P.M. The nursing staff brought the resident back into the facility. The resident had no apparent physical injuries. The FRE did not indicate how the resident exited the facility. On 3/06/25 at 4:30 P.M. the surveyor observed Resident #1 awake, alert and fully dressed wearing a jacket. A wander guard was observed on resident's left wrist. The Resident was ambulating without the use of assistive devices. Resident #1 was socializing with another resident. The surveyor interviewed the resident who was able to state that he/she liked it at the facility. When the surveyor asked another question, the resident answered with a rambling response. It was determined he/she would not be able to continue the interview. On 3/7/25 at 9:50 A.M., during a tour of the Dementia/locked unit, the surveyor observed Resident #1 sitting in the dayroom watching television. The surveyor observed a wander guard on the resident's left wrist. According to the admission Record face sheet (an admission summary) Resident #1 was admitted with diagnoses that included but were not limited to, unspecified dementia (a group of symptoms that affect memory, thinking and social abilities), Schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges) and Schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). A review of the admission Minimum Data Set (MDS), an assessment tool, dated 1/23/25, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated that the resident was severely cognitively impaired. Further review of the MDS record indicated that the resident was independent with ambulation without any assistive devices. A review of the Care Plans for Resident #1 indicated that an elopement care plan was initiated on 1/15/25. Interventions listed for the resident were: Wander guard to the left wrist; check for placement per order; Frequently monitor resident's whereabouts; Document wandering behavior and attempted diversional interventions in behavior log. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	A Progress Note dated 2/10/25, at 6:17 P.M., written by a Licensed Practical Nurse (LPN) caring for Resident # 1 indicated the resident was observed missing at 4:45 PM. All staff were told to look for the resident. The staff received a call that Resident #1 was observed at an offsite location. Two nurses from the facility drove to the offsite location to retreive the resident. According to this note, On arrival patient [sic] was in an Ambulance accompanied by 2 EMTs (Emergency Medical Technicians) and 2 Police Officers. Patient was received awake and alert, pleasantly confused. patient [sic] assisted into police car, patient was met at facility. During an interview with the Administrator on 3/7/25, at 1:40 P.M., he provided a map of the facility. He indicated on the map the exit door locations and stated that there are cameras both inside and outside of the facility, however, the resident was not captured exiting on any of the cameras. The Administrator did not indicate that there were any adjustments made to the cameras post incident. During an interview with the Director of Maintenance (DOM) on 3/7/25, at 2:02 P.M., he revealed that the wander guard system was on the front door, the west wing door and two other doors on the west unit. He indicated that he tested the system on Fridays. He stated that if a resident wearing a wander guard was close to the door, it still should not open. He further revealed that he was made aware of the elopement the following day, 2/11/25, during morning meeting. He stated that he did not check and wasn't asked by the administrative staff to check the wander guard system and/or the doors immediately after the incident. He did continue with his weekly check on Friday, 2/14/25. During the interview, the DOM provided a log documenting the doors being tested weekly. The DOM then explained the process of how he would check the operations of the door's magnetic locks, delayed egress doors, pin pad key locks, testing of the door's hardware for proper function and condition. He would then complete the log. A review of the documentation provided by the DOM revealed testing of the function of the doors were performed prior to the incident on 2/07/2025 and after the incident on 2/14/2025. When the surveyor asked the DOM why the doors were not tested at that time, he stated he was not asked to do so. The Director of Nursing (DON) during an interview on 3/7/25, at 2:38 P.M., revealed that she was made aware of the incident around 6:00 P.M. after the situation had been resolved. The Incident Report, which contradicts the FRE, provided by the facility dated 2/10/25 revealed that .initially the supervisor reported that no staff noticed that the resident was not on the floor until a phone call from an unidentified caller received that the resident was found. No alarms reported as sounding. All egress doors functional . The DON stated that she tried to get a timeline from the Nursing Supervisor but was unable. The DON further stated that other than the statements provided she did not interview any other staff on the unit. The DON revealed that the videos were viewed while trying to figure the root-cause analysis, but they were unable to see how the resident exited the facility. She stated that they did not test the doors or the wander guard system but rather relied on natural occurrence, which she explained as watching the staff to see how quickly they responded to door alarms. However, the DON stated that the root-cause analysis later revealed that Resident #1 left via an egress door, but the doors were not tested after the elopement. During an interview with the Administrator on 3/7/25, at 4:59 P.M., he stated that he was contacted via the phone by the DON after the incident occurred. He further stated that the Interdisciplinary Team met on 2/11/25 to collaborate but could not determine how Resident #1 exited the facility from the camera footage and the staff statements. He revealed that they still did not know how the resident got out of the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA #2 on 3/7/25, at 5:43 P.M., she stated that she was familiar with the resident who wandered a lot and goes into other resident's rooms, and to the exit doors. She stated she did not see the resident when she entered the unit for the 3:00 P.M. to 11:00 P.M. shift on 2/10/25. I went to search for the resident and could not find him. I asked the other girls to help me look for the resident. When we were unable to locate the resident, I told the Nurse and the Nursing Supervisor who called the code. CNA #1 stated that other residents have tried to leave via the exit doors but that the alarm sounded, and they were stopped. She stated that she did not hear the alarm during the shift and is unsure of how Resident #1 exited the facility. During an interview with Unit Manager (UM) on 3/07/25 at 2:54 p.m., she stated that the UM's are responsible for care planning and that the DON and the Assistant Director of Nursing (ADON) oversee them. She stated that the CNAs were made aware of new interventions because she adds that information to the daily assignments. In the presence of the surveyor, the UM reviewed Resident #1's care plan intervention that read frequent monitoring of whereabouts and stated that it should be documented in the chart. She stated that the CNAs would not document anywhere it would be the nurse's responsibility. Review of the resident's electronic medical record did not reveal this documentation. According to CNA #3 during an interview with the surveyor on 3/7/25, at 6:16 P.M., he was working the evening of the incident. He did not recall seeing the resident nor hearing any alarm sounding during the shift. The Director of Social Services (DSS) during an interview with the surveyor on 3/8/2024 at 11:17 A.M., stated that she participated in elopement drills. She stated that her participation would be to contact the family regarding the incident if the staff were not able to. She revealed that she was made aware of the incident the next day 2/11/25, in morning meeting. The team discussed how the resident may have gotten out, however, she was unaware if it was identified. She revealed that she was not asked to meet with the resident for any follow up. She stated that if there was any follow up it would have been documented in the progress notes. A review of facility's undated document titled Elopement Drill Process revealed under #6 that when .the resident is located, the Social Service designee assesses the resident for emotional distress . In the presence of the surveyor, she reviewed the process and stated that she did not meet with or assess the resident, nor did she designate her co-worker to do so as indicated in step #6 of the protocol. Review of the progress notes did not indicate that a social service assessment was completed. During a follow-up interview with the DON and the ADON on 3/8/25, at 1:32 P.M., the ADON described the procedure for monitoring the wander guards. They both confirmed that the wander guard system was functioning during the weekly checks performed on 2/7/25 and 2/14/25. There was no documentation of the wander guard being tested after the incident. When asked why no post incident testing was performed the DON stated that there .was no failure with the doors. The ADON additionally stated that education for all staff was initiated after the incident. The surveyor reviewed facility in-service documents signed by facility staff dated 2/11, 2/12, 2/17, 2/19/25 titled Elopement Drill Practices. The surveyor reviewed sign-in sheets for the in-services completed and noted there were no 11-7 signatures. When surveyor questioned the ADON if the 11:00 P.M. to 7:00 A.M. shift was in-serviced his response was I was going to do it next month. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA #4 on 3/8/25, at 2:42 P.M., she stated we try to have the residents go to the dayroom where they can be watched but we can't force them. She further explained that staff are familiar with the resident. When asked what does frequent observation mean, the CNA stated staff sees the resident during rounds every 2 hours or if staff interact with them. She further stated that CNAs did not document this information anywhere. The CNA could not recall the last time was she saw Resident #1 on the day if the incident. During an interview on 3/8/25, at 2:46 P.M., with LPN #3 she stated she was familiar with the resident. She stated that the unit manager was responsible for initiating and updating care plans. She stated that frequent observation would be for residents at an increased risk for falls, behaviors or elopement. She stated frequent observation had no formal documentation or set time for how often to monitor. During a follow-up interview with the DON and ADON on 3/8/25, at 3:29 P.M., both stated that UMs were responsible for initiating the care plans and updating them. When asked what frequently monitor meant the ADON responded that it was subjective and then stated, I don't know. The DON stated that frequently was an alert word used to keep an eye out for the residents. It is a high alert word. The surveyor questioned the DON to clarify what the behavior log was and where information was documented. The DON responded, the behavior log is a progress note and the responsibility of the cart nurse. No documentation was noted in the progress notes nor was a behavior log provided. The surveyor attempted to reach the nursing supervisor and left a voice message; however, it was not returned. A review of the facility policy, titled Wander guard Policy dated 1/25, revealed under the policy statement that .it is the objective of the facility to ensure the safety and protection of wandering residents by preventing their exit from the building. Under the policy interpretation and implementation #5 a personalized care plan addressing the issue shall be developed for the identified resident. A review of the facility policy titled Care Plans Comprehensive, revised 2/01/18, revealed under the purpose of the care plan to incorporate identified problem areas and incorporate risk factors with identified problems. It revealed under the care plan intervention section that care plan interventions are designed after careful consideration of the relationship between the problem areas and their causes. When possible, interventions address then underlying source(s) of the problem area(s) rather than addressing only the symptoms or triggers. A review of Resident #1's care plan did not indicate any specific interventions to monitor the resident's whereabouts. The care plan did not indicate any specific interventions to distract Resident #1 from wandering or exit seeking behaviors. A review of the facility's undated C.N.A. job description stated under job expectations that the C.N.A. care rounds each shift every 2 hours. The facility was notified of the Immediate Jeopardy (IJ) on 3/7/25 at 5:43 P.M. The DON was presented with the IJ template. The Administrator was not able to attend. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An acceptable removal plan was electronically mailed to the surveyor on 3/10/25 at 9:31 A.M. indicating that the action the facility would take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. The surveyor verified the removal plan on-site on 3/14/25 and determined the IJ was removed as of 3/14/25. The Removal Plan is as follows: 1. The ADON educated the CNA, Nurse, Supervisor, and DOM on the Elopement Drill Process. The facility provided an email which reflected the request for the agency nurse assigned to the resident not to return to the facility. 2. The facility implemented revised a protocol to include: Post an elopement maintenance or a designee will check all egress doors, window audit and wander guard function which will be documented in the facility's electronic record. 3. The facility initiated in-servicing for all staff on the facility's Elopement Drill Process. 4. The facility initiated in-servicing with all Nurses and Administrative staff the review of Incident Protocol and Care Plan Policy. 5. Facility initiated audits on wander guards, care plans, egress doors, elopement investigations. N.J.A.C. 8:39-27.1(a)