STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315346	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home at Paramus	1 Veterans Drive Paramus, NJ 07652

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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record reviews, and review of other pertinent facility documentation on 12/3/25, it was determined that the facility failed to report within two hours to the New Jersey Department of Health (NJDOH) an allegation involving an injury of unknown origin for a resident. This deficient practice was identified for 1 of 4 residents reviewed for abuse (Resident #2), and was evidenced by the following: A review of the Facility Reportable Event (FRE) submitted to the NJDOH was dated 10/29/25, alleging an injury of unknown injury for Resident #2 occurred on 10/28/25.On 10/27/25, the Social Worker (SW#1), interviewed Resident #2 regarding an abrasion on their left knee that was discovered on 10/24/25. When SW#1, originally interviewed Resident #2 on 10/24/25, Resident #2 stated that they had hit their own knee causing the abrasion. On 10/26/25, Resident #2 told their Medical Power of Attorney (MPOA) that they had been dropped which prompted SW#1 to reinterview the resident regarding the injury of unknown origin.According to the Resident Face Sheet (RFS), Resident #2 was admitted to the facility with diagnoses which included but were not limited to sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death) , hyperlipidemia (an abnormally high concentration of fats or lipids in the blood) , cortical age-related cataract (an age-related clouding of the eye's natural lens that starts in the outer layers (cortex) and spreads inward), and metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance, such as from organ failure, severe infections, or drug toxicity, that leads to altered mental function).A review of the Minimum Data Set (MDS), an assessment tool dated 9/10/25, Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13/15, which indicated Resident #2's cognition was intact.A review of Resident #2's Care Plan (CP) revealed that the CP had been updated on 10/26/25 under Problems/Strengths, Resident #2 claimed that on 10/23/25, while being transfer back to bed, that he/she was dropped by 2 caregivers.A review of the Occurrence Journal from the facility numbered 696471 revealed that the facility was made aware of Resident #2's allegation of being dropped on 10/26/25 which led to an investigation by the facility.A review of the Electronic Mail (Email) between SW#1 and the Director of Nursing (DON), dated 10/27/25 at 11:53 AM., revealed that Resident #2 was alleging that their knee abrasion was caused by being dropped while being assisted into bed. On 12/3/25 at 9:39 AM., the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that if a resident were to fall that would be a reportable event and she would notify her supervisor. She further stated that if a resident had reported to a family member that they had been dropped because this was the resident's story the facility would treat it the same way as an actual fall.On 12/3/25 at 11:24 AM., the surveyor interviewed SW #1 who stated that she had been notified by the DON that there had been an unexplained injury regarding Resident #2 and that she had been instructed to interview Resident #2 regarding their unexplained injury. Resident #2On 12/3/25 at 12:25 PM., the surveyor interviewed the DON with the Licensed Nursing Home Administrator (LNHA) present, and she stated that the facility began looking into Resident #2's allegation on 10/27/25. At this time the surveyor requested both the DON and LNHA to look at the FRE and both the DON and LNHA confirmed the FRE was reported 10/29/25 to the DOH.On 12/3/25 at 12:34 PM., during the interview with the DON and LNHA, the DON stated the FRE date of 10/29/25 could have been a typo. The surveyor presented the email correspondence between the DON and SW#1 confirming that the DON was notified on 10/27/25 of Resident #2's allegation that they were dropped which caused their injury.The surveyor also presented Resident #2's CP to the DON and LNHA, which indicated that the CP had been updated 10/26/25 to include Resident #2's allegation of being dropped by caregivers. When asked who could have updated the CP on 10/26/25 both DON and LNHA could not answer the surveyor. When further questioned if there was a way to check who had changed the CP, both parties stated they could not.A review of the facility's policy titled Incident Reporting and Completion dated August 2023, included the following information under State Notification:Facility shall notify the New Jersey Department of Health and Senior Services immediately by the phone, Hot line [PHONE NUMBER], [PHONE NUMBER] (609-392-2020 after hours) the Office of the Ombudsman [PHONE NUMBER] and Veterans Administration [NAME].[NAME]-Lima@va.gov [PHONE NUMBER] ext.214647 for any of the following:1. Abuse-witnessed or suspected2. Neglect-willful deprivation of services or inadequate care resulting in injury3. Exploitation- using another's resources for personal gain4. Unexplained injuryNJAC 8:39-4.1(a)5