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	01/23/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews, medical record reviews, and reviews of other pertinent facility documentation on 1/23/26, it was determined that the facility failed to implement the required residents' transfer assistance as instructed in the residents' individualized care plan. This deficient practice was identified for 2 of 3 residents reviewed (Resident #1 and Resident # 2).The evident is as follows: The evidence is as follows: On 1/23/26, the surveyor reviewed the Face Sheet (FS) for Resident #1, which revealed that Resident #1 was admitted to the facility with a diagnoses that included but not limited to, Parkinson's disease, depression, heart failure, and anxiety disorder.A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 1/12/26, revealed that Resident #1 had a Brief Interview Mental Status (BIMS) score of 15 out of 15, indicating that the resident was cognitively intact. Further review of the MDS revealed the resident was dependent on staff for toileting hygiene and required maximal assistance with toilet transfer and chair-to-bed transfers. A review of Resident #1's fall care plan, with an effective date of 1/14/26, and last revised on 7/31/24, indicated the resident required one-person assistance with transfers from bed to wheelchair and two-persons assistance for transfer from wheelchair to bed. Further review revealed the resident's Kardex, (a staff reference tool summarizing care needs), with an instruction for two-person assistance for transfers from toilet to wheelchair. A review of Resident #1's statement dated 9/22/25 revealed that Certified Nursing Assistant (CNA #1) transferred the resident from the wheelchair independently by lifting the resident out of the wheelchair to a standing position without the assistance of another staff member which caused near-fall for the resident. Reviewed of facility's Final Investigation document revealed that Resident #1 reported to the Social Worker (SW#2) that CNA#1 assisted them to stand in the bathroom using a grab bar. The document revealed that when the resident finished using the bathroom, CNA #1 assisted the resident to stand while she provided personal hygiene without the assistance of a second staff member. The facility investigation concluded that the Resident #1 required two-person transfer during the evening and evening shifts.Review of the Facility Reportable Event (FRE) revealed that the resident reported pain rate 5 out of 10. A mobile x-ray result for the lumbar spine indicated a fracture at L1. The resident was transferred to Hospital for further imaging and evaluation. Hospital imaging report dated 12/16/25 indicated no definite acute fractures is identified. On 1/23/26 at 11:01AM, the surveyor conducted an interview with CNA #2 who confirmed that staff are aware the resident's mode of transfer and the number of assistance required is on the assignment sheet and on the resident's care plan. The CNA provided the assignment sheet to the surveyor which confirmed the resident's transfer requirements. On 1/23/26 at 11:28 AM, the surveyor conducted an interview with Registered Nurse (RN #1) who stated that each resident is evaluated by rehabilitation staff who normally establish residents' transfer status and sends the order to the nurse to transcribe.On 1/23/26 at 11:56AM the surveyor conducted an interview with Resident #1, who stated that he did not recall this incident but knows they that he required two- staff assistance to (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer from the wheelchair to the bed. The resident further stated that two-person assistance was not consistently provided by staff. On 1/23/26 at 1:51PM, the surveyor conducted an interview with Social Worker (SW #2) who stated that she recalled Resdient#1 and the incident was reported to her by the resident. She further revealed that Resident #1 had stated that CNA # 1 attempted to transfer the resident independently, and had difficulty, which caused near miss of fall.On 1/23/26 at 3:04 PM, the surveyor conducted an interview with the Director of Nursing (DON) who stated it is important for nursing staff to follow the resident's care plan regarding transfer status to ensure resident's safety. The DON further stated the care plan served as a guideline for the provision of safe care. 2. On 1/23/26 the surveyor reviewed the Face Sheet (FS) for Resident #2, which revealed the resident was admitted to the facility with a diagnoses that included but not limited to, primary osteoarthritis of right hip, primary osteoarthritis of right knee, pain in right knee, Diabetes, hearing loss and history of falls.A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 11/24/25 revealed that Resident #2 had a Brief Interview Mental Status (BIMS) score of 14 out of 15, indicating that the resident was cognitively intact. MDS further revealed the resident was dependent on staff for bed-to chair transfer.According to Resident #2's care plan with an effected date of 2/24/25, the resident is at risk for falls related to a history of falls. The resident's care plan interventions included the use of a Hoyer lift for all transfers with the assistance of two staff members at all times as a safety precaution.A review of Resident #2's Kardex, (a staff reference tool summarizing care needs), revealed the resident required a Hoyer lift with 2-person assistance to transfer. On 1/23/26 at 10:29AM, the surveyor conducted an interview with Resident #2 who stated that 2 staff members assisted him toward the edge of the bed, they said 1,2,3 and both assisted him to transfer into the wheelchair without the machine. The resident further stated, They did what they wanted to do.On 1/23/26 at 1:16PM, the surveyor conducted an interview with SW #1 who stated that she interviewed Resident #2 and that the resident informed her that they were was transferred out of bed without a mechanical lift (Hoyer lift).The surveyor reviewed facility's investigation which stated: the facility was able to substantiate illegitimate transfer via the agency staff by way of investigation and correlation to the resident's initial interviewOn 1/23/26 at 11:28 AM the surveyor conducted an interview with the Registered Nurse (RN) #1 who revealed each resident was evaluated by rehabilitation to determine the transfer status. An order form was sent to the nurse to transcription, and the clerk updated the transfer status on the assignment sheet to reflect the new order.On 1/23/26 at 3:04 the surveyor interviewed the DON who stated that the expectation was for the staff to provide safe services by following the care plan.On 1/23/26 the facility's Activities of Daily Living (ADL) policy revised on 10/25, under policy statement it revealed that ADL assistance shall be provided in accordance with each resident's assessed needs, care plan, preferences, and applicable federal, state, and local regulation. NJAC 8:39-33.1(d)