STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and policy review, the facility failed to ensure staff used respectful and appropriate identifiers during meal service on one of six resident units (Independence Unit) reviewed for dignity. This failure had the potential to contribute to a negative outcome related to the promotion and respect of resident well-being and quality of life. Findings include: Review of the facility's policy titled, Dignity, revised 02/12/25, revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Residents are treated with dignity and respect at all times.provided with a dignified dining experience.Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs . 1.During an observation on 09/02/25 at 12:23 PM, the Independence unit dining room had approximately ten to twelve residents seated and prepared for lunch service. The following observations were made:At 12:35 PM, the meal cart was placed near the dining room for staff to begin meal service.Two staff members pointed at a table near the meal cart, and Certified Nurse Aide (CNA) 2 responded saying, They're a Feeder.At 12:40 PM, CNA3 pointed at a resident and asked a colleague if they also were a Feeder?At 12:41 PM, Charge Nurse (CHN) 1 stated that residents were Feeders. 2. During an additional observation on 09/05/25 at 12:29 PM, the Independence unit dining room had approximately ten to twelve residents seated and prepared for lunch service. The following observation was made:CNA1 pointed at the recently arrived meal cart parked near the dining room, and asked a colleague if a resident was now a Feeder? Review of the assignment sheets on Freedom unit, Independence unit, Eagle unit, Liberty unit, Old [NAME] unit, and the Stars and Stripes unit were placed each shift at the nurses' stations. Review of the assignment sheets on Freedom unit, Independence unit, Eagle unit, and Stars and Stripes unit identified residents by name that would require assistance at meals as Feeders on each assignment sheet. These assignment sheets were placed each shift at the nurses' stations. During an interview on 09/05/25 at 1:04 PM, CNA1 verified that the staff used the term Feeder when a resident required meal assistance. During a concurrent interview on 09/05/25 at 2:20 PM, CNA4 and CNA2 both verified that staff used the word Feeder to identify which residents required assistance with meals. CNA4 and CNA2 both stated they were not aware if the label Feeder was a dignity issue or not. During an interview on 09/05/25 at 2:35 PM, the Charge Nurse (CHN) 1 said that she helped fill out the assignment staffing form for Independence unit. She stated that the word Feeder was used to identify which residents needed assistance with meals. CHN1 confirmed that it was a word used to identify residents and was not aware if it was a dignified way to identify residents or not. During an interview on 09/05/25 at 2:43 PM, the Director of Nursing (DON) stated that the unit clerk and the unit supervisor would complete the assignment sheets on each unit. Upon the review of the assignment sheet, and the assignment tab labeled Feeders, he said that he would change the form to read Assist with Meals. He confirmed that using the label Feeders described an action and not a resident need, and that it was not appropriate to say in the presence of residents. NJAC 8:39-4.1(a)

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on record review, and interviews, the facility failed to invite one resident (Resident (R)2) out of a total sample of 35 residents to participate in the care plan process. This failure had the potential to deny residents the opportunity to be able to make decisions about the care they receive. Findings include: During an interview on 09/02/25 at 12:50 PM, R2 stated that she has not been to a care plan meeting since being admitted to the facility. R2 also stated that she was not aware that residents were to be invited. A review of R2's electronic medical record (EMR) located under the MDS 3.0 tab revealed an annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/25; admission date of 07/09/24; Brief Interview for Mental Status (BIMS) 15 out of 15 indicating cognitively intact; diagnosis of unspecified dementia, Type2 diabetes mellitus, Parkinson's disease, spinal stenosis, cervical region; muscle weakness, cellulitis or right lower limb The facility failed to provide evidence that R2 was invited to the care meetings that were being held. During an interview on 09/04/25 at 3:35 PM, the Social Services Director (SSD) stated that the facility does a verbal invite with the residents and sends a letter to the resident representative. The SSD also stated that the facility did not chart that R2 was invited to the care plan meeting, so we cannot say that [R2] was invited. During an interview on 09/05/25 at 11:05 AM, the Deputy Chief Executive Officer (DCEO) stated that the residents should always be able to participate in care planning unless deemed not cognitively able to. During an interview on 09/05/25 at 1:46 PM, the Director of Nursing (DON) stated that all residents should be invited to participate in the care plan meeting. A review of the policy titled Care Plan - Comprehensive with a revision date of 11/17/24 stated An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Reflect the resident's expressed wishes regarding care and treatment goals. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments.' NJAC 8:39-27.1(a)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, document review, and policy review, the facility failed to update the code status in all records to Do Not Resuscitate (DNR) for two of 33 (Resident (R)16 and R171) residents reviewed for code status out of a total sample of 35 residents. This failure increased the likelihood of causing severe harm or death if CPR (Cardiopulmonary Resuscitation) was performed against a resident's wishes if found unresponsive with no pulse or no breathing.Findings include: Review of the facility's policy Practitioner Orders for Life-Sustaining Treatment (POLST) Policy with a review date of 09/03/25 indicated, .The facility will honor a valid POLST in good faith. POLST complements-[sic] but does not replace-[sic] advance directives. If directives conflict and clarification is not possible, the most recent document guides care.: For revisions, complete new POLST, mark prior as VOID, update EHR [electronic health record] and chart. Enter orders into EHR consistent with POLST. 1.Review of R16's undated Face Sheet' located under the Snapshot tab in the electronic medical record (EMR) indicated R15 was admitted to the facility on [DATE] with the diagnosis of dementia. Review of R16's Recapitulation Physician Order Sheet located in the hard chart and dated for 09/01/25 through 09/30/25, revealed an order dated 11/27/24 which indicated R16 was a Full Code. Review of R16's Physician Orders located in the hard chart indicated an order dated 09/02/25 for R16's code status to be DNR/DNI [Do Not Resuscitate/Do Not Intubate]. Review of R16's POLST located in the hard chart and dated 08/22/25 indicated R16's POA had signed for R16 to be a DNR/DNI with long term artificial nutrition. The spine of the hard chart did not indicate the code status of R16. Review of R16's Care Plan located under the Care Plan located in the EMR dated 12/02/24, indicated a Focus of I have a POLST to clearly state my wishes when my health begins to decline. The interventions indicated, I do not wish to be resuscitated if I stop breathing. I do not wish to receive chest compressions if my heart stops beating. I do not wish to receive artificial nutrition if I am no longer able to / or [sic] take food by my mouth. During an interview on 09/03/25 at 11:54 AM, Registered Nurse (RN)1 stated, We don't have a list of residents that are a DNR. We look at the POLST in the front of the resident's chart, and there is also an order in the hard chart that says what their code status is. We also put a sticker on the spine of the hard chart to reflect the current code status. During an interview on 09/03/25 at 1:10 PM, RN2 stated, Their [residents] charts have it [code status] in there. I also look at this, [name of unit] Resident Roster. Review of the Resident Roster indicated R16 was a Full Code. During an interview on 09/03/25 at 1:16 PM, RN1 was asked who is responsible for updating the Resident Roster when changes occur. RN1 stated, These are updated by the unit clerk, charge nurse, or the nurse when they receive changes in their care. During an interview on 09/03/25 at 1:23 PM, Unit Clerk (UNC)1 was asked the current code status for R16 and UC1 replied, [R16] is a full code. I know because he has been here a long time. UC1 did not refer to the POLST or the hard chart before answering. During an interview on 09/03/25 at 5:03 PM, Licensed Practical Nurse (LPN)2 looked at the Resident Roster and stated, He [R16] is a full code. Then LPN2 went to R16's hard chart and reviewed the POLST in the front of the chart. LPN2 went to RN1 and stated, This POLST doesn't match the cheat sheet we have for [R16]. RN1 began reviewing the current POLST and stated, This [cheat sheet] hasn't been updated to reflect the current POLST that we have. RN1 was asked if this should match and RN1 stated, Yes. During an interview on 09/04/25 at 7:46 AM, the Director of Nursing (DON) stated, The POLST supersedes orders on the Recapitulation Physician Order Sheet for code status. I only expect the nurses to refer to the POLST if there is any question of the code status. During a review of R16's Hemodialysis Notebook on 09/04/25 at 3:00 PM, which is taken to dialysis with each appointment time, reflected in the front of the notebook of a POLST form dated 08/09/22 and signed by R16's POA (Power of Attorney) that indicates R16 was a Full Code with a defined trial period of artificial nutrition. During an interview on (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/04/25 at 3:05 PM, RN1 stated, This is the old POLST. The current POLST should be here in this [hemodialysis] book for DNR/DNI. During an interview on 09/04/25 at 4:00 PM, the DON reviewed the POLST form in the front of the dialysis notebook and stated, This should have been replaced with the current POLST form. 2.Review of R171's Facesheet located in the EMR under the ADT tab revealed she was admitted to the facility on [DATE] and had diagnoses which included dementia. Review of R171's Interdisciplinary Progress Notes located in the EMR under the Charting tab revealed a Quarterly 2 Assessment Review note dated 06/12/25: Attempt CPR [cardiopulmonary resuscitation], no artificial nutrition [POLST - Practitioner Orders for Life-Sustaining Treatment] The note further stated that family attended a meeting on 06/12/25 and was looking into changing the POLST. Review of R171's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/14/25 and located under the Charting tab of the EMR revealed a Staff Assessment for Mental Status was completed which revealed R171's cognition was severely impaired. Review of the front of R171's paper chart revealed a POLST dated 06/15/25 and signed by a physician which indicated family's wishes to not attempt resuscitation (DNAR). Review of R171's paper chart under the Physicians Orders tab revealed two Physician's Order summaries, signed by a physician on 07/30/25 and 09/02/25. Each summary was also signed and dated by two nurses. Both documents conveyed full code (perform CPR) and were ordered as of 04/01/15. Neither documented the DNAR order from the POLST dated 06/15/25. During an interview on 09/03/25 at 2:35 PM, Registered Nurse (RN) 3 stated she looked at the POLST in the front of the paper chart to determine the orders and resident/family wishes for code status. During an interview on 09/03/25 at 2:40 PM, Unit Manager (UM) 1 reported she looked at the front of the paper chart at the POLST to identify the orders and resident/family wishes for code status. UM1 stated R171's POLST reflected she was not to receive CPR. When UM1 reviewed the Physician's Order documents dated 07/30/25 and 09/02/25, she stated they were to reflect the POLST, and since they did not, she planned to correct the Physician's Order immediately. During an interview on 09/04/25 at 7:46 AM, the Director of Nursing (DON) stated the physician order summary, labeled as Physician's Order in residents' paper charts were printed monthly by the pharmacy and reflected the orders given by the physician for the resident. The DON stated the code status order was an exception because the POLST was a separate order, which could be updated at any time and superseded any orders on the physician order summary. The DON stated he expected that the physician order summaries would have been updated by 09/02/25 for R171's POLST which was dated 06/15/25. NJAC 8:39-4.1(a)NJAC 8:39-27.1(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a written transfer notice that contained all required information was provided for three of three residents and/or their representatives (Resident (R) 4, R1, and R6) reviewed for hospital transfer out of 35 sample residents. This failure had the potential to result in the resident and their Resident Representative (RP) not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired.Findings include: 1.Review of R4's admission Record located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE]. Review of R4's General Notes, located under the Notes tab of the EMR, dated 01/01/25 through 08/27/25, revealed R4 was discharged to the hospital on [DATE] and again on 07/16/25. Review of the EMR Evaluations and Documents tab along with review of the Progress Notes tab revealed no evidence that a written notice of transfer was provided to R4 or her RP. During an interview on 09/05/25 at 4:50 PM the Social Worker (SW) stated when a resident was discharged she sent out the bed hold policy and transfer notice to the family but did not keep a copy of what was sent and she did not document in the resident medical record the date it was sent, and who it was sent to. She stated she had no documentation to show that a transfer notice was provided to the resident or responsible party. 2.Review of R1's undated Face Sheet' located under the Snapshot tab in the EMR indicated R1 had been admitted to the facility on [DATE] with the diagnosis of congestive heart failure and chronic obstructive pulmonary disease. Review of R1's annual Minimum Data Set (MDS) located under the MDS 3.0 tab in the EMR, with an Assessment Reference Date (ARD) of 06/16/25 indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was cognitively intact. Review of R1's Nursing Progress Notes located under the Charting tab in the EMR, a note dated 07/09/25 at 12:44 PM which indicated, .resident complaining of nauseous, cramps in legs and unable to ambulate. BP [blood pressure] 86/43, O2 sat [oxygen saturation] 97% on RA [Room Air]. put Trendelenburg position [sic] Re-check vitals after 5 [sic] min. BP 97/51 O2 sat 90% on RA. Oxygen administer [sic] via NC [nasal cannula] at 3LPM [liters per minute], -11:20am A call was placed to [name of doctor] to make him aware of resident change in status [sic]. MD [Medical Doctor] ordered for resident to be transfer to. ER [emergency room] for Hypoxia [low oxygen saturation]. Further review of the nursing progress notes did not indicate documentation to reflect the resident was provided in writing the reason for transfer to the hospital on [DATE]. During an interview on 09/04/25 at 1:50 PM, the Social Services Director (SSD) stated, I send a copy of this letter to the resident's RP [Resident Representative] and/or POA [Power of Attorney] that says the reason for admission to the hospital. Asked if she keeps documentation that was provided to the resident which explains the reason for transfer and the SSD stated, No, I do not. During an interview on 09/05/25 at 9:00 AM, R1 was asked if he had received a letter from the facility that stated the reason for transfer to the hospital on [DATE]. R1 stated, I don't have anything like that. During an interview on 09/05/25 at 4:15 PM, the Director of Nursing (DON) was asked what his expectation of the SSD's documentation of the written reason for transfer that is provided to the resident and/or RP and the DON stated, I will have to get back to you on this. The DON returned to the conference room at 5:30 PM and stated, I don't have anything further to add. The DON also confirmed that the facility did not have a policy on transfer notices. 3.Review of R6's Facesheet located in the electronic medical record (EMR) under the ADT tab revealed he was admitted to the facility on [DATE] and was hospitalized from [DATE] to 08/05/25. Review of R6's paper chart revealed a New Jersey Universal Transfer Form dated 07/08/25 and addressed to the hospital detailing pertinent resident information needed by the hospital to evaluate R6 and provide care to him. Review of Interdisciplinary Progress Notes located in the EMR under the Charting tab revealed R6 was sent out to the hospital for (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation on 07/08/25. A note dated 08/06/25 at 2:19 AM documented that he was readmitted to the facility after treatment in the hospital for cellulitis and congestive heart failure. Review of R6's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/11/25 and located under the Charting tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. Review of the paper chart revealed no notice of transfer form directed to R6 regarding his transfer to the hospital. During an interview on 09/05/25 at 12:35 PM, R6 reported he was hospitalized several times during his time at the facility. R6 was unable to recall receiving any written notice of his transfer to the hospital; he was not notified of the appeal process or provided the State Long Term Care Ombudsman contact information. During an interview on 09/05/25 at 12:46 PM, Licensed Practical Nurse (LPN) 1 reported when she sent a resident out to the hospital she sent a New Jersey Universal Transfer Form and other information the hospital needed to care for the resident. When asked if there was any paper that went to the residents informing them of why they were being transferred, their appeal rights, and the ombudsman's contact information, LPN1 stated there was no paperwork with that information that nursing provided to the resident. During an interview on 09/05/25 at 5:05 PM, the Social Services Director (SSD) reported she mailed the family members a notice of transfer letter but did not notify the resident. Nursing notified the residents since they were with the residents at the time of transfer. NJAC 8:39-4.1(a)31,32

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to accurately assess one resident (Resident (R)143) for nutritional needs regarding R143's weight gain out of a total sample of 35 residents This failed practice had the potential to cause unmet nutritional needs.Findings include: A review of R143's electronic medical record (EMR) located under the MDS 3.0 tab revealed the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/17/25; admission date of 06/11/25; Brief Interview of Mental Status (BIMS) unable to assess indicating severe impaired cognition; Alzheimer's disease; height of seventy inches, weight of one hundred sixty pounds, with a weight loss of 5% or more in the last month or weight loss of 10% or more in the last six months and not on a physician prescribed weight loss regimen. A review of R143's EMR Assessments tab revealed a nutritional assessment dated [DATE] that indicated R14 received a regular puree diet with nectar thick liquids; with an admission weight of 160 pounds (lbs.). A review of R143's weights revealed that on admission R143 weighed 159.8 lbs. and on 07/10/25 R143 weighed 167.2 lbs. which is a 4.63% weight gain in one month. On 09/03/25 R143 weighed 174.2 lbs. which is a 9.01% weight gain in three months. During an interview on 09/05/25 at 5:15 PM the Registered Dietitian (RD) stated that when MDS was completed there was an entry error showing an unplanned weight loss. The RD stated that the Registered Dietitian is the one that completes the nutritional status on the MDS. During an interview on 09/05/25 at 11:05 AM the Deputy Chief Executive Officer (DCEO) stated that MDS should reflect accurate information. DCEO also stated that the assessment drives the care of the residents and the level of assistance needed. During an interview on 09/05/25 at 11:45 AM the Director of Nursing (DON) stated that the MDS should always have accurate information to ensure that the information is correct when developing the comprehensive plan of care. During an interview on 09/05/25 2:27 PM, the MDS Coordinator (MDSC) verified that the MDS was not correct and a modification had to be completed to reflect the status of R143. A review of the facility policy titled Resident Assessments indicated that A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. The results of the assessments are used to develop, review and revise the resident's comprehensive care plan. NJAC 8:39-33.2(d)

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on observation, record review, and staff interview, the facility failed to ensure one of one resident (Resident (R)133) reviewed for wander guards out of a total sample of 35 residents was appropriately screened and had documentation to support the use of the wander guard. This failure had the potential to restrict R133's movement about the unit when the alarm would sound when R133 was near an exit door. Findings include: Review of R133's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including dementia, depression, and psychotic disorder. Review of R133's quarterly Minimum Data Set (MDS) assessment under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 07/20/25, revealed he scored ninety-nine out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Further review revealed no wandering behavior indicated. Review of R133's Care Plan, located under the Care Plan tab of the EMR dated 07/12/25, revealed I have Dementia, I have expressed my desire to go home, and this places me at risk of wandering and elopement. Interventions in place were to apply a code alert and complete an elopement risk assessment. Review of R133's Physician Orders, located under the Orders tab in the EMR dated 01/17/25 revealed wander guard to right ankle. Review of R133's Elopement Risk Assessment located under the Observations tab in the EMR dated 04/14/25 and 07/15/25 revealed R133 was not at risk for elopement. Review of R133's General Notes, located under the Notes tab of the EMR, dated 01/01/25 through 08/27/25, revealed no documentation of any wandering or exit seeking behaviors. During an interview on 09/05/25 at 10:07 AM, Registered Nurse (RN)4 stated R133 was total care and preferred to be out of bed. He enjoyed socializing with other residents. RN4 stated R133 was confused but he was not exit seeking. She said he had never tried to get off the unit or get out of the building. During an interview on 09/05/25 at 10:24 AM, Licensed Practical Nurse (LPN)2 said R133 was confused at times. He liked to roll around the nursing station in his wheelchair and speak with the nurses. He was not exit seeking and had never tried to leave and never spoke about it. She said he had a wander guard before, but she did not think he had one now, but she would have to check. During an observation on 09/05/25 at 10:46 AM of R133 sitting in wheelchair at a table in the TV room, CNA5 pulled back R133's right pants leg and verified the wander guard placement. During an interview on 09/05/25 at 2:32 PM Director of Nursing (DON) stated if a resident was assessed not to be an elopement risk they should not have a wander guard. NJAC 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure a resident's nasal cannula and nebulizer mask were stored properly when not in use for one of two residents reviewed for oxygen therapy (Resident (R) 94) out of a total sample of 35 residents. This failure had the potential to increase the risk of a respiratory infection for residents receiving respiratory therapies. Findings include:Review of R94's admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was readmitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). Review of R94's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/25 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of ninety-nine out of 15 which indicated the resident was severely cognitively impaired. The resident was coded as receiving oxygen therapy. Review of R94's Physician Order, dated 02/04/24 and located in the resident's EMR under the Orders revealed an order oxygen at 2 Liters per Minute (lpm) via nasal cannula continuously. Further review revealed an order dated 09/18/23 for a nebulizer treatment three times daily as needed for shortness of breath and wheezing. Observation on 09/02/25 at 4:50 PM and 09/03/25 at 2:35 PM revealed R94's oxygen nasal cannula was lying at the foot of the resident's bed, uncovered and the nebulizer mask was on the floor during the first observation and then was uncovered on the TV stand during the second observation. During an observation and interview on 09/03/25 at 2:35 PM, Licensed Practical Nurse (LPN) 2 verified that R94's nasal cannula and nebulizer masks were uncovered. LPN2 stated the reason the cannula and nebulizer mask should be covered in a bag was an infection control issue. During an interview on 09/05/25 at 2:32 PM, the Director of Nursing (DON) said all nasal cannulas and nebulizer masks should be covered in a bag when not in use. Review of the facility's policy titled Care of Respiratory Equipment revised 04/2025 revealed, all respiratory equipment will be cared for using good infection control principles to prevent the transmission of nosocomial infections to residents. All reusable equipment must be stored in plastic bags or following the manufacturer's recommendations after cleaning. 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
	315459	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to have collaboration of care involving dialysis for one of three residents (Resident (R)16) reviewed for dialysis out of a total sample of 35 residents. This failure had the potential for inaccurate or missing clinical information not being communicated to the right people.Findings include: Review of R16's undated Face Sheet located under the Snapshot tab in the electronic medical record (EMR) indicated R16 was readmitted to the facility on [DATE] with the diagnosis of end stage renal disease requiring dialysis. Review of R16's admission Minimum Data Set (MDS) located under the MDS 3.0 tab in the EMR, with an Assessment Reference Date (ARD) of 08/05/25 indicated R16 was receiving dialysis while a resident in the facility. Review of R16's Care Plan located under the Care Plan tab in the EMR indicated a Focus dated 07/31/25 for I am at risk for complications for renal failure/ESRD [end stage renal disease] [sic] requiring dialysis. The interventions were . Dialysis three times a week Monday, Wednesday, and Friday. Check left AV graft [arteriovenous fistula] every shift for bruit and thrill. Monitor access site for signs of bleeding and symptoms of infection. Another Focus dated 07/31/25 was for I have a [sic] AB graft and a subclavian Perma cath [catheter]. The interventions were I will follow left arm precautions with no BP [blood pressure], blood work or BS [blood sugar] by fingerstick in my left arm/hand. My right subclavian perma cath [sic] will have a protective dressing on at all times except when being accessed. Review of R16's Hemodialysis Communication Record located in the hard chart for dialysis indicated the following failures:07/30/25 In the section To be completed by the licensed nurse prior to dialysis treatment the Access site swelling, drainage, pain. and AV Fistula/Graft Thrill were left blank on the communication record.08/01/25 In the section To be completed by the licensed nurse prior to dialysis treatment the AV Fistula/Graft Bruit and Thrill were left blank on the communication record.08/18/25 In the section To be completed by the licensed nurse prior to dialysis treatment the Access site swelling, drainage, and pain were left blank on the communication record.08/20/25 In the section To be completed by the licensed nurse prior to dialysis treatment the Access was documented as None There were also no vital signs documented on the communication record. During an interview on 09/04/25 at 3:05 PM, Registered Nurse (RN)1 stated, The top and bottom sections of this form are to be out by the nurse here and the middle section is to be filled out by the dialysis nurse. Asked if the sections that the facility nurse is to be completed are to be left blank and RN1 stated, No, the sections are to be completely filled out by the nurse. During an interview on 09/05/25 at approximately 4:15 PM, the Director of Nursing (DON) stated, The vital signs are to be documented prior to the dialysis treatment on the form. This resident has two access sites. The dialysis is using the AV graft in the arm for now because the perma cath has just recently been placed. The nurses should have the access questions answered. Review of the facility policy Care of a Dialysis Resident dated 01/06/25 indicated, . 1. Residents who are on dialysis will be assessed [sic] including vital signs before leaving for the dialysis center. 2. Residents who are [sic] go to dialysis will use the dialysis communication form as a tool for communication between the Facility and Dialysis Center. Information to be included each visit includes the Resident's vital signs and any pertinent information. Information will be recorded on the communication form by the sending nurse. 3. The dialysis communication form will be sent with the resident. NJAC 8:39-5.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails, documented discussion related to risk versus benefits, and signed informed consent for one of four residents (Resident (R)133 reviewed for side rails out of 35 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment.Findings include: Review of R133's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including dementia, depression, and psychotic disorder. Review of R133's quarterly Minimum Data Set (MDS) assessment under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 07/20/25, revealed she scored ninety-nine out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Further review of the MDS indicated that side rails were not in use. Review of R133's Care Plan, located under the Care Plan tab of the EMR dated 10/09/24, revealed I am at risk for falls. Interventions in place were I prefer to have the upper 2 side rails up when I am in bed to assist me with mobility and transfers. Review of R133's Physician Orders, located under the Orders tab in the EMR, dated 08/25/25, revealed no order for bilateral quarter side rails. During an interview on 09/05/25 at 10:07 AM, Registered Nurse (RN)4 stated the facility did not have side rail assessments and there was no process for side rail use. She stated the facility did not use side rails because they were restraints, but they used enablers. During an interview on 09/05/25 at 10:24 AM, Licensed Practical Nurse (LPN)2 stated the facility did not have side rails, but they had enabler bars that were used for repositioning. LPN2 stated the facility was restraint free. She said that all residents had enablers but there was no process or assessment for them. Observation on 09/05/25 at 10:35 AM of R133 room with LPN2 revealed she considered the quarter inch side rails as an enabler. During an interview on 09/05/25 at 10:54 AM, Unit Manager (UM)2 said the facility used enablers but did not use side rails. UM2 stated that all residents had enablers. UM2 stated the enablers were offered two different sizes but the residents did not sign an informed consent, and there was no discussion of risk and benefits or informed consent, or alternates attempted prior to side rail use. During an interview on 09/05/25 at 2:32 PM, Director of Nursing (DON) was unsure of any process for side rail use. The DON agreed there were side rails on some beds in the facility including on R133's bed. Review of the facility's policy titled Bed Safety and Bed Rails undated revealed, Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one- quarter, or one- eighth lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. For the purpose of this policy bed rails include a. side rails; b. safety rails; and c. grab /assist bars. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:a. The assessed medical needs that will be addressed with the use of bed rails.b. The residents' risks from the use of bed rails and how these will be mitigated.c. The alterative that were attempted but failed to meet the resident's needs; andd. The alternatives that were considered but not attempted and the reasons. NJAC 8:39-27.1(a)