STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Brook Nursing and Convalescent Home	78 Sliker Road Califon, NJ 07830

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 - 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. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ00185571 Based on observation, interviews, and review of pertinent facility documents on 07/01/2025 and 07/02/2025, it was determined that the facility failed to implement a physician-ordered intervention to supervise and provide safety to residents from physical abuse by another resident (Resident #7,) who has a known history of aggressive behaviors towards other residents. The abuse occurred when facility staff failed to supervise, and to provide one-to-one (1:1) monitoring of Resident #7. This allowed the resident the opportunity to strike Resident #5 on the head with a metal object, causing laceration (cut) that required transfer to the hospital for treatment. This deficient practice was identified for Resident #7, 1 of 1 residents reviewed and was evidenced by the following: The surveyor reviewed the Facility Reported Event [FRE] dated 04/14/2025, which revealed that Resident #7 was observed striking Resident #5 with a grabber (a metal device used to assist residents grab items that are out of reach,) causing laceration that required transfer to the hospital for treatment. According to the FRE, the Certified Nursing Assistant (C.N.A.) who was assigned to provide one-to-one monitoring, left Resident #7 alone in the room to provide care for another resident. The FRE revealed that a Registered Nurse (R.N.) monitored Resident #7 from the hallway instead of within an arm's length as ordered. The facility's investigation into this incident showed that the R.N. monitored Resident#7 from 6 feet of the resident's room. According to the FRE, the C.N.A. heard commotion coming from resident's room and went to check the situation. Upon arrival to the room, the C.N.A observed Resident #7 striking his/her roommate (Resident #5) on the head with a grabber. At that time, the R.N. ran from the nurse's station to the resident's room and removed the grabber from Resident #7's hand and assessed both Resident #5 and #7. The R.N. then provided first aide treatment to Resident #5's cut and called the Emergency Services to take Resident #5 to the hospital for more treatment. The R.N. also called the local police department who came and took Resident #7 into custody. Resident#7 no longer resides at this facility.Review of the care plan in place at the time for Resident #7 revealed that the resident was to be on one-to-one (1:1) monitoring within an arm's reach.The staff's failure to provide one-to-one (1:1) monitoring placed Resident #5 and all other residents at harm for abuse and in an immediate jeopardy [IJ] situation. The IJ began on 04/14/2025 and was identified on 07/02/2025 at 3:50 P.M. and was reported to the Licensed Nursing Home Administrator [L.N.H.A.]. The L.N.H.A. was presented with the IJ template at the that time. An acceptable removal plan was mailed electronically on 07/08/2025, indicating the facility's actions to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice. The Director of Nursing (D.O.N.) provided education to all direct care staff, float staff and supervisors regarding the one-to -one (1:1) protocol, documentation and Abuse. The L.N.H.A. implemented an audit daily process for the supervisors to review for any 1:1 assignment and documentation. The L.N.H.A. also instituted a QAPI team weekly review to assess incident trends and compliance. The surveyor verified the removal plan on site on 07/10/2025After the IJ removal plan, the non-compliance continued 07/10/2025, at a scope and severity for no actual harm with the potential for more harm that was not an IJ. This deficient practice was identified for 1 of 1 residents [Residents #5] and was evidenced by the following:On 07/01/2025 at 9:30 A.M. the surveyor conducted a tour of the facility. The surveyor noted that the nurse's station is further than 6 feet from Resident #5 and #7's bedroom which would not have allowed the R.N. to be able to visually monitor into the room from the nurse's station and was not within an arm's length of the resident.The surveyor reviewed Resident #7's Progress note (PN) dated 04/14/2025 which confirmed that Resident #7 was to be on 1:1 monitoring while in his/her room. The PN further revealed that the assigned C.N.A left Resident #7 alone in the room with Residents #5, while the R.N. monitored from the nurse's station.A review of the closed medical admission Record [AR] for Resident #7 indicated that the resident was admitted to the facility with diagnoses which included but were not limited to Personality disorder, unspecified mood disorder, and unspecified psychosis.According to the Quarterly Minimum Data Set [MDS], an assessment dated [DATE], Resident #7 had a Brief Interview for Mental Status [BIMS] of 9 indicating the Resident #7 was moderately, cognitively impaired. Review of Resident #7's Care Plan [CP] initiated on 03/29/2025, with revisions on 04/06/2025 and 04/10/2025 revealed that Resident #7 was to have 1:1 monitoring by a staff member 24 hours/day until further notice. The CP reflected an updated intervention dated 04/06/2025 for side-by-side monitoring within arm's reach. The CP was revised again on 04/10/2025, to keep Resident #7 at arm's length to be able to get to him/her if him/her acts out aggressively to others. On