STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Venetian Care & Rehabilitation Center, The	275 John T O'Leary Boulevard South Amboy, NJ 08879

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Complaint #: 186850 Based on interviews and medical record review (MR) and other pertinent facility documentation on 6/4/25, it was determined that facility failed to thoroughly investigate an allegation of abuse for 1 of 4 residents (Resident #4). This deficient practice was evidenced by the following: According to the admission Record (AR) Resident #4 was admitted with diagnoses including but not limited to: Visual Loss, Presence of Artificial Eye, Unspecified Hearing Loss, and Anxiety Disorder. A review of the Minimum Data Set (MDS), an assessment tool dated 3/30/25, revealed that Resident #4 had a Brief Interview of Mental Status (BIMS) score of 15, indicating that Resident #4 was cognitively intact, and was Supervision/Touch assistance with ADLs (Activities of Daily Living), independent with transfers and continent of bowel and bladder. During an interview with the Surveyor on 6/4/25 at 12:30 P.M., Resident #4 stated that they were not able to remember the date or the exact time but stated that sometime after supper that someone came in the room and pulled down their pants. Resident #4 stated the person cleaned him/her up, put a diaper on them, even though they don't wear diapers. Resident #4 further stated that the person then started to put a hospital gown on them, and after he/she began to cry, they then took the hospital gown off and put their clothes back on him/her. Resident #4 stated that they are unsure who the individual was, because they cannot see, and has hearing loss. Resident stated that they told their family member about the issue. During a telephone interview with Resident #4's family member on 6/4/25 at 1:06 P.M., the family member stated the incident was video recorded and occurred on 5/23/25, and started at 8:57 P.M., and lasted until 9:20 P.M. The family member stated that the Certified Nursing Aide #1 (CNA #1) went into Resident #4's room, and stated to the resident, let me change your diaper. The family member stated that CNA#1 then looked down Resident #4's pants, he then goes to get a towel and [NAME] coat. CNA #1 then wipes the resident with the towel, and the resident then yells that it's cold, the family member states that CNA#1 then throws the [NAME] coat on the resident. The family member further stated that Resident #4 began to yell what is this, I have my own pajamas, and I have to go to the bathroom,' CNA#1 then put Resident #4's clothes back on. The family member stated that another aide came into the room and told CNA#1, you're not supposed to do this for [resident], and she got the resident out of bed and took them to the bathroom. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a Reportable Event Record/Report dated 5/31/25. The summary and conclusion was included with the Reportable. The Administrator was not able to provide any statements regarding the incident. The Administrator verified that she conducted the investigation for the incident. Surveyor attempted to call CNA#1 on 6/4/25 at 2:30 P.M., there was no answer, and call was not returned. During an interview with the Licensed Practical Nurse (LPN) on 6/4/25 at 3:02 P.M., she stated that she was Resident #4's primary nurse on the night of the incident. The LPN stated that she heard Resident #4 yelling as she was passing by the room. She stated as she walked in the room, she observed CNA #1 providing care. She stated she then told CNA #1, you don't need to do anything for Resident #4, they are independent. LPN stated that to calm Resident #4 down, she allowed Resident #4 to feel her arm and hold on to her, because Resident #4 cannot see and did not have their hearing aids in their ears. She stated Resident #4 was yelling, I have to go to the bathroom. LPN denied being asked to write a statement. During an interview with the LPN/Infection Control Nurse (LPN/ICN) on 6/4/25 at 3:36 P.M., she stated that she was notified of the incident on 5/26/25, and she spoke to Resident #4's family member regarding the incident that occurred on 5/23/25. She stated the family member stated they had mentioned that she felt Resident #4 was inappropriately touched, and they wanted to provide videos of the incident. Stated that she watched the video of the care, stated that she did not see CNA #1 touch Resident #4 inappropriately, however, when CNA #1 pulled Resident #4 up in the bed, the resident did say ouch. Resident #4 allowed her to do a full skin assessment, and she did not see any bruising on Resident #4's skin. She further stated that she explained everything that was in the video to the Administrator. She denied writing a statement. During an interview with the Administrator on 6/4/25 at 4:10 P.M., she stated that during an investigation of abuse that involves a staff member, the staff member is immediately suspended pending the investigation. The investigator then speaks to the involved residents, staff, and family members to find out what happened. They would also speak to other alert and oriented residents on the alleged staff member's assignment. The Administrator stated she did not collect statements from other staff members that worked at the time of the incident, nor did she collect statements from other alert and oriented residents on the staff member's assignment. The administrator denied watching the video recording of the incident. A review of the facility's policy presented by the Administrator, titled Abuse. Neglect, Exploitation or Misappropriation-Reporting and Investigating with a revision date of September 2022, , included but was not limited to the following: under the heading for Policy Statement, it states, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Under the heading, Investigating Allegations, it states: 1. All allegations are thoroughly investigated. The administrator initiates investigations .7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence .d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; . h. interviews staff members (on all shifts) who have contact with the resident during the period of the alleged incident .j. interviews other residents to whom the accused employee provides care or services; .l. thoroughly documents the investigation completely and thoroughly. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	N.J.A.C: 8:39-4.1 (a) 5, 12