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June 3, 2025

By ECF
Honorable Julien Xavier Neals
United States District Judge
District of New Jersey
MLK, Jr. Federal Bldg. & U.S. Courthouse
Newark, New Jersey 07101

Re: ***United States of America v. State of New Jersey***
No. 2:24-cv-09577-JXN-JSA

Dear Judge Neals:

Pursuant to the consent decree in the above-referenced matter, attached to this letter is the first report of The Hibiscus Group, the appointed monitor for the New Jersey Veterans Memorial Homes at Menlo Park and Paramus. *See* ECF No. 5, ¶¶ 102, 118.

We thank the Court for its attention to this matter.

Respectfully submitted,

ALINA HABBA
United States Attorney

By: *s/ Susan Millenky*
SUSAN MILLENKY
Assistant United States Attorney

cc: Counsel of Record (By ECF and email)

CERTIFICATE OF SERVICE

I, Susan Millenky, Assistant United States Attorney for the District of New Jersey, hereby certify that on June 3, 2025, the foregoing was served on counsel for defendants by ECF and email.

Dated: Newark, New Jersey
June 3, 2025

s/ Susan Millenky
SUSAN MILLENKY
Assistant United States Attorney

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
Civil Action No. 24-cv-09577 (JXN) (JSA)

The Hibiscus Group, LLC
Court Appointed Monitor

Baseline Report

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June 2, 2025

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Executive Summary

This Monitoring Report is issued in accordance with the requirements of the Consent Decree between the United States and the State of New Jersey ordered October 3rd, 2024. This was pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C.§ 1997 which resulted in an investigation of the State of New Jersey Veterans Homes (Veterans Homes) to determine whether residents were at risk of harm because of failing to provide adequate medical care or to implement adequate infection control protocols and practices. The Parties agreed that The Hibiscus Group would serve as the quality monitor to assess and report whether the Homes are in compliance with the Substantive Remedial Measures identified in the Consent Decree.

During the initial six months The Hibiscus Group monitoring team assessed both Veterans Homes during six onsite visits to the New Jersey Veterans Home at Paramus and three onsite visits to the New Jersey Veterans Home at Menlo Park. In addition to the onsite visits, monitors have had significant communication with the leadership teams at both facilities and with the Compliance Officer, Director of Healthcare Services, and Quality Assurance Coordinator at the central office of the Department of Military and Veterans Affairs by way of virtual calls, emails, and document exchanges.

The following report summarizes the results of The Hibiscus Group's baseline assessment of each Veterans Home. The report contains a separate evaluation of each of the Veterans Homes, including an assessment of the degree of compliance with each Substantive Remedial Measure. The monitoring team believes that both Veterans Homes have made important improvements since the initial investigative report in 2023. The monitoring team will continue to perform a more in-depth assessment of each Veterans Home's degree of compliance in the following months.

Implementation

Per the requirements of the Consent Decree, DMAVA Leadership appointed an Agreement Coordinator to serve as a point of contact for the United States and the State of New Jersey (Parties) and the Monitor. DMAVA Leadership created an annual Implementation Plan that describes the actions it will take to fulfill its obligations under the Consent Decree. The Implementation Plan was created within 90 days of the effective date of the Consent Decree and was circulated for discussion to the Parties. The Implementation Plan identified the issues to be addressed during the first year; and, for each issue, stated planned actions and identified the following: persons responsible, resources needed, the target completion date, a completion status measure, how the QAPI process will account for the issue in the future and the expected outcome. DMAVA

Leadership also submitted a general forecast of issues to be addressed in successive years. All Parties reviewed and provided comments on the Implementation Plan before it was finalized.

The New Jersey Veterans Home at Paramus

Introduction

During the six month period following the execution of the Consent Decree, the monitoring team conducted 6 onsite visits at Paramus. Four of the six onsite visits were considered full monitoring evaluations during which the monitoring team made observations of care, conducted formal and informal resident and staff interviews, attended regular weekly and/or quarterly meetings with both leadership and clinical staff, and reviewed medical records. Two additional visits were conducted for the purpose of reviewing resident and staff records. The Monitor has had monthly contact with DMAVA Leadership and the NJ Veterans Home at Paramus (Paramus), and has also communicated virtually and in-person with additional staff members.

At each onsite visit, the monitoring team attended several clinical meetings including, but not limited to, the morning meeting, the afternoon wrap up, weekly, monthly and quarterly Quality Assurance and Performance Improvement (QAPI) meetings and individual resident assessment meetings. In addition, the monitoring team reviewed several medical records, resident care plans and readmission paperwork in order to assess the ability of the staff at Paramus to identify a change in resident condition. The findings from these activities are described below.

General Medical & Nursing Care

Paramus has conducted Facility Assessments annually and with any changes to services provided. Upon completion of the Facility Assessment, Department of Military and Veterans Affairs (DMAVA) leadership, along with the Medical Director, Agreement Coordinator and Department Heads, review the document page by page looking at the census, the acuity levels of each resident and the clinical skills required to care for each resident. The CEO at each facility is responsible for communicating this information to the education coordinators to ensure staff training is conducted based on resident care needs that are identified in the Facility Assessment.

The State and DMAVA/facility leadership have succeeded in reviewing existing policies to ensure that they conform to the requirements in the Consent Decree. The policies are reviewed and updated as needed, with pertinent staff members providing input. New or

modified policies are shared with staff via the facility's intranet. Any new or modified changes are emailed to the Paramus CEO to initiate education and inservice.

The admission packet contains valuable information on each resident that includes demographic information, medical history, reason for admission, medications the resident currently takes, functional ability, mental health and behavioral issues, and information that helps staff know who the resident is (e.g. favorite food, favorite music, things upsetting to the resident, etc.). The admissions committee meets weekly and the provided information provides a solid basis on which to make admission decisions.

Paramus has succeeded in providing the residents appropriate specialized medical, nursing and other clinical services. Formal interviews with specialized clinical staff including, but not limited to, infection prevention and control, wound care and therapy revealed appropriate credentials, qualifications and competency for their respective positions; however, concerns were identified related to how the facility verifies nursing and nursing assistant competency as indicated below.

DMAVA and Paramus have succeeded in establishing appropriate clinical care policies and procedures; however, in some areas, they have not consistently implemented these policies and procedures as designed. As such, the facility is not able to ensure the consistent provision of appropriate nursing and medical care. The following paragraphs provide supporting evidence.

Competency Evaluation

The competency forms that Paramus uses to evaluate staff competency include sections to indicate the Method of Instruction (education session, video, demonstration, and/or policy and procedure review), the Method for Observation (observation, return demonstration, written test, and/or verbal review) and Evaluation Summary (pass, fail, remediation). The completed forms that were reviewed have only check marks and do not indicate which methods were used to determine competency. Future onsite visits will allow the monitoring team to investigate staff comments, and ensure nurse competency education is thorough and not just checking the box.

It is notable that education was provided when a physician ordered an intravenously administered medication that was atypical for the facility. The pharmacy delivered the medication and all nursing staff, not just the nurses on the resident’s particular unit, received an inservice. Although the training was provided, documentation was not evident that staff was competency tested in administering the medication.

The monitors believe that the education program to evaluate nurse competency is not being implemented as designed. The monitors have concerns about the process of evaluating the nurses on approximately 50 competencies in one day. Therefore, nurse competency cannot be determined. The monitors' recommendations are as follows:

- Align competency testing with care and services identified as needed in the Facility Assessment, emphasizing skills that are high-risk, high-volume and problem-prone;
- If Paramus chooses to use their current competency testing forms, they should appropriately use the codes available and indicate the method of instruction, observation and evaluation;
- Determine what should be included in an appropriate list of competencies based on skills that are high-risk, high-volume and problem-prone.

Nursing assistant competency testing is done using different forms. The majority of the forms are competency check lists that use terminology indicative of an observable activity (e.g. washed hands, verbalized) for the steps in the procedure.

Documentation - Bowel Elimination

The monitors observed several instances that question whether Paramus is able to document assessments, diagnoses, treatments, monitoring and reassessments in a way that is able to withstand clinical scrutiny and furthermore provide a basis for quality assurance and performance improvement.

The monitoring team reviewed the bowel elimination log for a resident who had a recent order change related to bowel elimination. This log is not part of the Electronic Medical Record (EMR), rather it is in paper format and completed by the certified nursing assistants assigned to care for the resident. The monitor reviewed the bowel elimination log during the late afternoon on 02/14/25. No entry was present for 01/11/25 and the entries for 01/09/25, 01/10/25, 01/12/25 and 01/13/25 were negative for a bowel movement (BM). The monitors met with the Supervisor of Nursing Services (SNS) for that unit during the early morning on 02/15/25 to share the concerns. The monitors reviewed the same bowel elimination log and noted that an entry was made for the 01/11/25 date that had been empty the day before. The entry indicated a large, formed bowel movement. No explanation was given for the late entry, and the entry was not made in accordance with standard of practice. For example, it was not clearly identified as a late entry, it did not indicate the date and time of the late entry, and there was no signature of the individual making the entry. The monitors made it clear that the entry was not present on the previous day and that the way in which the late entry was documented was unacceptable. The SNS had no explanation but remarked it was

difficult to monitor documentation because of the various places documentation needed to be entered (e.g. various logs kept on clipboards, EMR, and paper forms). The SNS stated she would follow up to ascertain who had completed the documentation. The monitors discussed this event with the Director of Nursing (DON) who stated she would follow up on this issue. Because of the failure of nursing staff to note the missing entry, an assessment of bowel elimination was not done and it is unknown whether treatment was provided as ordered. The veracity of documentation entered several days after the fact is questionable.

The monitoring team discussed this with the DON during a subsequent visit. The DON shared she had followed up on the incident; however, none of the staff she interviewed had an explanation. Despite the lack of closure on the event, staff received an inservice on the standard of practice for making a late entry into the record.

Other Documentation

Additional examples of documentation issues include the following:

- Changing a physician order without evidence that the physician was informed and approved the change;
- Documentation that is inconsistent between the EMR and the handwritten record (e.g., Braden assessments for predicting pressure injury risk and weekly skin checks);
- Initialing medication administration hours after the medication was administered;
- Failure to have the results of physician consultations in the record in a timely fashion;
- Write-overs (especially as they pertain to numbers and dates);
- Failure to use indicated codes on documents such as the MAR and the use of E-Effective or N-Nurse Notes for PRN (as needed) medication effectiveness; and
- Documentation of ten treatments on a resident who had expired two days prior

The above examples do not withstand clinical scrutiny and raise concerns about the facility's ability to consistently deliver physician-ordered care, adhere to standards of care, and meet regulatory requirements. Such documentation issues could negatively affect a resident's overall well-being, including their physical, mental, and psychosocial health.

Assessment

Paramus has nurses in the Minimum Data Set (MDS) department who complete resident assessments as required. Members of the Paramus leadership team have stated that nurses are improving in their ability to clinically and critically think through

changes; however, in review of physician orders and nurses' documentation, monitors are concerned that physicians, rather than nursing staff, are identifying changes. For example, monitors have observed that several medical records contain an order to administer an additional 240 ccs (cubic centimeters) of fluid per shift. This indicates that the physician has hydration concerns, but nothing in the nurses notes indicates that they have noted signs or symptoms of dehydration such as dry mouth, dry and cracked lips, etc. Another example is the problem that the QAPI project related to antibiotic stewardship is hampered by the lack of documentation for signs and symptoms of a urinary tract infection for which labs or an antibiotic has been ordered. On future monitoring visits the monitors will continue to look for evidence that floor nurses are performing resident assessments to detect or respond to changes in condition.

Medication and Treatment Administration Records

The monitors discovered several issues with documentation in the medication administration records (MAR) and treatment administration records (TAR) that demonstrate failure to implement their policies and procedures. These concerns are discussed in more detail in the medication administration section.

Electronic Medical Record (EMR)

According to facility leadership, the monthly recapitulation of orders involves a triple check by nursing, making sure all orders are correctly transcribed from one month to the next. The night shift begins the process, the day shift reviews for accuracy, and the evening shift does a final review before sending it to the pharmacy who then enters it into the software that prints the comprehensive order sheet for the subsequent month, the MAR, and the TAR. Because the EMR (which was selected by the facility approximately ten years ago) does not comprehensively integrate all systems, paper records must be included with EMRs to make each resident record is complete. The result is cumbersome and includes duplication of effort (e.g. the use of written logs that are then entered into the EMR) and/or "antiquated" systems (e.g. the monthly recapitulation of orders that contain greater opportunity for error than a fully integrated system).

DMAVA leadership recognizes that for third parties who have access to the records (The Hibiscus Group, survey agencies, etc.) the system is difficult to navigate. While staff and providers are frustrated with the EMR, they are accustomed to the current system. DMAVA Leadership has gone through the process of procuring a new system; however, the process has been frustrated by New Jersey laws, particularly equal employment opportunity regulations. DMAVA leadership stated that the more common long term care electronic medical records vendors (e.g. Matrixcare) do not want to complete paperwork (specifically the EEO form) that is required by NJ Statutory Law. The procurement

process would need to be changed legislatively in order for the DMAVA team to be able to successfully address this issue. The monitors recognize that there is no short-term resolution to the EMR situation but will continue to monitor for errors that may occur as a result of a dual record keeping process.

Changes in Condition

Paramus clinical staff routinely assesses residents for symptoms of pain, both in response to changes in resident condition when one would reasonably expect pain to result, and when other relevant staff, residents or visitors communicate suspected pain in the event the resident is not able to verbalize pain. The monitoring team confirmed that upon learning a resident is experiencing pain, the clinical staff is responsive, provides treatment in a timely manner, communicates with the physician as needed and continues treatments and assessments to ensure the pain is effectively managed.

The monitoring team confirmed that nursing staff at Paramus are routinely assessing residents at heightened risk of infection, including but not limited to COVID (corona virus disease), for material changes in presenting symptoms or changing conditions indicative of possible or worsening infection. It was determined through medical record review that when respiratory infections were suspected at Paramus, the clinical staff appropriately noted and reported to infection control and other necessary staff any symptom related to the suspected infection, regardless of how minor, even if a test for that infection was negative or inconclusive.

Paramus leadership has identified problems with respect to completing/reviewing the SBAR process, a documentation method that captures and reports resident changes in conditions to the physician. The monitoring team is aware that the Paramus management team is working to improve completion of these forms as part of their efforts to improve outcomes in the area of antibiotic stewardship. Monitors have concerns regarding antibiotic stewardship in that nursing staff are not documenting in the resident's medical record symptoms of infections such as Urinary Tract Infections (UTIs). Future onsite visits will allow the monitors to further evaluate whether nursing staff are sufficiently identifying changes in condition, performing an assessment, and documenting appropriate signs and symptoms of all infections.

At both the morning meeting and the afternoon wrap up the Paramus staff members provide a report of events and changes in condition over the previous several hours. The 24-hour report is used to generate much of the information shared in these meetings. The monitors believe that the nurses' involvement in both planning and implementing resident care helps to effectively identify changes in resident condition. However, the monitors believe, and have suggested at several onsite summary

meetings, that a more robust interdisciplinary discussion of the residents at the morning meeting (with a follow up discussion at the afternoon wrap up), would be beneficial, especially as it relates to evaluating the effectiveness of nursing care. Future onsite visits will provide an opportunity for the monitoring team to conduct thorough record review and attend meetings in order to determine compliance with respect to the ability of the nursing staff to retain records and evaluate the effectiveness of nursing care.

The monitors observed CNA walking rounds between the day and afternoon shifts. The purpose of walking rounds is for the outgoing shift to report to the oncoming shift things such as change in resident condition. The oncoming CNA stated she did the rounds just to make sure the day shift did what he/she was supposed to do. The oncoming CNA did not want to get blamed for things that the day shift CNA had not done. The two CNAs did not talk to one another. The monitors will continue to assess for evidence that this lack of communication does not impact resident care.

Resident Care Plans

The Paramus staff members create an individual care plan for each resident. Nursing staff use the EMR to develop the care plans by selecting from pre-programmed plans. Assigned staff complete the Centers for Medicare and Medicaid Services Minimum Data Set (MDS) upon resident admission and at least quarterly thereafter. These assessments are part of the EMR. The MDS identifies actual or potential Care Area Assessments (CAAs) of concern with Admission, Annual, Significant Change in Condition, or Significant Correction of a Prior Comprehensive Assessment. Paramus clinical staff determine whether the identified concern requires the development of a care plan. The Paramus software has prepopulated care plans and nurses select the appropriate care plans for the resident and appropriate prepopulated interventions. Paramus has one MDS Coordinator and a team of four nurses who complete MDSs at the required times. Care plans are modified as necessary based on MDS assessments. These plans are then shared with the Resident family, and/or guardian at Care Conferences which are documented in the electronic medical record.

When a resident has a material change in health status or an incident presenting or indicating a significant health risk, staff members are to communicate that change by documenting it on the 24-hour report. Staff are to update care plans and Kardexes (the documentation system used by DMAVA to track key resident information) within two business days in response to the root cause of the change. The nursing assistant assignment sheet also must be updated as necessary. In reviewing care plans, the monitoring team found that some resident care plans did not address concerns such as constipation, recurrent urinary tract infections, or hydration. During an interview, the

MDS coordinator stated that nurses on the units have the ability to add/modify careplans; however, in most cases, the nurse calls the MDS nurse who then changes the care plan. If the nurse from the Resident's unit does not notify the MDS nurse when there is a new concern, the nurse must take responsibility for the care plan. In one case, the MDS nurse was informed of a resident fall but not of a resident's problem with constipation. The MDS nurse modified the care plan for falls but no one developed a care plan for constipation. In another example, a nurse entered a care plan for the administration of intravenous fluids for hydration, but did not address the underlying concern for lack of hydration.

Some care plans have clear interventions. For example, one care plan that was reviewed indicated staff members are to do a straight catheterization if a bladder scan shows residual of more than 400ccs (cubic centimeters) and monitor for signs/symptoms of UTI with the signs and symptoms listed. Other care plans have interventions that are ambiguous such as 'encourage fluids' without an indication for how much, or 'refer to cardiologist as needed' without an indication for what signs, symptoms or vital sign parameters indicate the referral is needed. Care plan interventions also lack personalized approaches. In some cases, including the resident's name in the intervention is the only personalization. The monitors feel that the actual intervention could be personalized to the resident. For example, a resident with a UTI had an intervention to "encourage PO (oral) fluids as tolerated." The care plan did not include personalized information such as what the resident preferred to drink or dietary input including the amount of fluid the resident should be consuming based on his/her weight and any contributing diagnoses. There was no baseline information as to how much the resident typically drank in a day or any information indicating why the resident was not consuming fluids. Adding this type of information personalizes the interventions.

The same resident had a care plan for increasing the resident's participation in activities of her choosing. The interventions were that the resident would be provided the activities calendar and that staff would encourage her to participate in activities at least 3-4 times per week. The care plan does not include identification of activities the resident prefers or whether the resident prefers to do activities in her room, or whether the resident likes to participate in offsite activities.

The admission paperwork for residents of Paramus includes an informative document called "Getting to Know You" that includes information that provides insights into the residents likes and dislikes such as favorite music, favorite foods, things that calm the resident, hobbies, etc. This type of information could improve the personalization of the care plans.

The monitoring team also found that some Kardexes and Nursing Assistant Assignment Sheets did not contain necessary information such as positioning devices like a hip abductor or a Roho cushion. In March 2025, nursing assistants were trained in and started using the EMR. Upon signing into the computer, the first thing the nursing assistant will see is the assigned cares for the resident, and any alert (entered by the nurse) indicating a change in assignment. Monitors encourage Paramus management to evaluate the purpose for the Kardex, the nursing assistant assignment sheet, and the care assignment in the EMR to determine the most efficacious manner of getting updated information to the nursing assistants.

The current system of documentation includes both paper and electronic records. While disciplines such as licensed nursing and social services use the EMR, other disciplines are in the process of being added to the system. Nursing assistants were trained and began using the system in March 2025. Recreational therapy is scheduled to be the next discipline. Therapies, including restorative therapy, are provided by a third party.
At the time of this report, monitors have not determined whether therapy treatment plans are communicated to staff in such a way that other disciplines, such as nursing, are able to provide care and treatment that is in alignment with the therapy treatment plan.

Vascular Wounds and Pressure Injuries

Paramus has engaged a wound care company to assist in the care of residents with wounds. The nurses employed by the wound care team are certified wound, ostomy, and continence nurses (WOCN). Paramus also has a WOCN on staff. Weekly rounds are conducted by the wound care physician, his nurses, and at least one member of the Paramus staff who is responsible for this care delivery system. Wounds are regularly discussed at QAPI meetings and a review of how the facility is performing on the pressure ulcer Quality Measure (QM) is done monthly.

According to training materials all RNs are checked annually for wound care competency, and every shift, including the night shift, contains one or more RN. During review of educational records, monitors found that documentation of competency for any of the skills on the competency check list is inadequate. On future monitoring visits, wound care competency of facility RNs will be further assessed.

The wound care company staff performs weekly rounds on residents who are on the wound care list. During rounds, the physician assesses each of the wounds and dictates a progress note that includes wound characteristics, an evaluation of healing status,

and any changes in physician's orders for treatment. These dictated notes are then transcribed and placed in the resident's record. A wound care log is also maintained that lists all of the residents with wounds and the description and status of each wound. Any new or worsening wounds that are discovered between weekly rounds are communicated to the wound care company, and a member of that team comes to assess the wound the next business day following discovery or within 72 hours, whichever is earlier.

The monitors observed three dressing changes on separate visits. The first was performed by a Paramus staff member and was well done with good technique and attention to infection prevention standards. The monitor observed a second dressing change which was done during wound rounds. The monitor observed both verbal and non-verbal expressions of pain. The resident had not received pain medication prior to the dressing change. This was reported during the summary meeting, and observation at a subsequent visit showed that the same resident did receive pain medication prior to the dressing change but it was unclear whether it was given early enough to be effective. Upon interviewing additional residents about pain management at the time of dressing changes, the monitors did not hear any complaints. During a third dressing change, the monitor observed that a staff member failed to appropriately change gloves and perform hand hygiene when moving from one wound to the next on the resident. Staff also did not change gloves and perform hand hygiene after touching the resident's urinary catheter tubing and the urinary drainage bag.

The Paramus Medical Director attends various monthly and quarterly QAPI meetings. This is one way the Medical Director provides oversight of the wound program. The monitors reviewed QAPI minutes and noted numerous audits pertaining to residents at risk of skin injury, as well as those residents with a break in skin integrity. Such audits include determining if ordered positioning devices are in place, if alternating air pressure mattresses are set up appropriately for the resident and functioning well, and if residents are turned and repositioned as necessary. The results of the audits are generally at 100% compliance. The Paramus QAPI staff presents wound information at Quarterly QAPI meetings, including the number of wounds being treated each month. This information is further broken down into how many pressure ulcers and vascular wounds are being treated, and whether wounds are facility acquired or community acquired.

Despite the positive results of audits, the facility continues to have facility acquired pressure ulcers. It was noted in Paramus QAPI minutes that one facility acquired pressure ulcer was discovered at a Stage 3 and management questioned why the ulcer wasn't discovered sooner. The monitors reviewed documentation of weekly skin checks

and/or skin assessments and found that these were not consistently documented as having been done. A family member informed the monitor that the resident was sometimes not gotten out of bed during the day and sometimes, when gotten out of bed and into the wheelchair, was left up too long. The monitor observed some positioning devices that were inappropriately placed. For example, a wedge cushion was placed under the resident's hip; however, the angle was inadequate to relieve pressure from the resident's sacral area where the resident had a wound. In addition, the Kardex and/or nursing care plan did not always identify positioning devices.

The MDS 3.0 Facility-Level Quality Measure Report for Report Period 07/01/2024 - 12/31/2024 shows the facility adjusted percent for pressure ulcer at 5.7% which is lower than the state and national comparison group percentages of 7.3% and 6.6% respectively. The percentile ranking was 48. The Report Period 08/01/2024 - 01/31/25 showed the facility adjusted percentage at 6.7% which is, again, lower than the state and national national comparison group percentages of 7.4% and 6.6% respectively. The percentile ranking was 58. Per the National Institute of Health, a percentile ranking greater than 75 is cause for concern. The facility has a system and multiple QAPI audits in place to address the issue of skin integrity and the monitors encourage continued work toward prevention of pressure injuries.

Medication Administration

Paramus has established and continues to maintain a Medication Variance Committee responsible for reviewing averted and actual medication variances. The Committee consists of the Paramus CEO, Assistant CEO, Pharmacy Consultant, DON, Assistant DON, Instructor of Nursing, QAPI coordinator and the floor nurse. The Instructor of Nursing schedules meetings monthly and the committee issues monthly reports. The medication and treatment errors are listed by unit and by shift, and include a statement of whether the resident experienced any adverse effect. In addition, all medication errors for the quarter are reviewed in the quarterly Pharmacy and Therapeutics meeting with the Medical Director. According to education records all committee members have received training in quality assurance and performance improvement.

Paramus has a pharmacy consultant who reviews and monitors all medications for efficacy, side effects and continued appropriateness. The pharmacist also makes recommendations for the physician’s consideration if warranted. In addition, the pharmacy consultant communicates regularly with physicians and nursing staff, writing notes in the resident records and discussing the suitability of medications. The pharmacy consultant is also involved in the antibiotic stewardship program in an attempt to improve the prescribing and use of antibiotics and ensure that residents receive the right antibiotic, at the correct dose, for the correct duration, and only when necessary.

During the first onsite visit to Paramus, the monitoring team observed that during the morning medication pass medications were not being administered within the allotted two-hour window. This could result in medication not being administered at the prescribed time. This occurred on each morning of the visit. Several staff members on different units stated that this was quite common for the morning medication pass . The monitoring team shared this information with facility leadership who worked with nursing staff to shorten the duration of the medication pass. The monitoring team saw improvement in this area and during the March 2025 visit, observed the medication passes on several units ended within the two hour window.

While speaking with several licensed nurses, the monitoring team heard several statements about why the nurses thought the medication pass took so long. These statements included such things as having too many medications to administer within the timeframe, interruptions, and having some older and poorly functioning vital sign machines. Using the older machines contributed to the medication pass taking longer. Nursing staff has requested new vital signs machines but were told that obtaining new machines was not in the budget.

The monitoring team has some concerns about the ability of Paramus to stock and/or have access to the medications that the residents require. A nurse reported that medication errors occur because ordered medications are not available to administer. The nurse stated that the medications aren't available because sometimes the nurse has not requested the medication be refilled in a timely manner, the medication is on backorder, or the medication must come from a different pharmacy completely. In reviewing MARs the monitor confirmed nurses documented that when medications were not administered it was because they were either waiting for prescription delivery or medications were not on hand.

The monitoring team inquired about an issue with a prescription for Rivastigmine Tartrate. The pharmacist suggested, and a physician ordered, a lower dose capsule to start, increasing the dose every two weeks. During the first two weeks of receiving the prescription, nurses documented on the MAR the medication was administered on two days and not administered/not available on four days. The monitoring discussed this with the pharmacist who, after looking at the dispensing records stated that the newer, lower dose medication was, in fact, unavailable during the first week of the prescription. The conclusion was that the nurse signed but did not actually administer the lower dose capsule, or that the nurse dispensed the higher dose that the resident had been previously taking and that was likely still in the medication cart. There was no evidence the physician had been informed of the missing doses of medication. In a record review, the monitors also noted a similar situation when Glucotrol XL was ordered for the Resident. One dose out of eight doses was initialled as having been given. The other

doses were not administered and nurses documented it was because the medication was not available. The monitors asked whether the facility had an emergency pharmacy from which to procure medications that were not available from either the onsite or offsite pharmacy serving the facility. The monitors also asked if there was an acceptable timeframe identified for missing medications. The Paraumus management team did not provide an answer.

The monitoring team made several observations related to accurate, effective and timely documentation, reporting, and investigation of averted and actual medication variances. During two onsite visits the monitors observed a nurse flipping through MARs at the end of the shift. When the monitor questioned the activity, the nurse, who identified as an agency nurse, said he/she was verifying there were no omissions. The monitor did not see the nurse make any additional entries on any of the MARs. During this same onsite visit, the monitoring team observed a different nurse on a different unit performing the same review of the MARs; however, the monitoring team observed the nurse making entries on four different pages. The monitors shared this observation with facility leadership staff during the summary meeting, with the expressed concern that staff members may not be following the standard of practice for medication administration that includes documentation immediately after the resident receives the medication.

During an onsite visit in March 2025, the monitoring team asked to review one of the MAR binders several minutes after the med pass had concluded. The nurse went to get the binder, opened it and began to initial on several pages of the MAR. The monitoring team questioned the nurse and requested that the nurse stop making entries. After several requests, the nurse reluctantly handed the binder to the monitor. The monitor noted that numerous omissions were still present, and one medication that was scheduled to be administered in the evening had been initialled as administered that morning. In discussing the situation the nurse stated that all medications had been administered, but not initialled as given at the time of administration. The monitoring team noted that the front of the MAR binder included medication administration instructions that included highlighted reminders for nurses to sign the MAR at the time medications are administered.

The monitoring team reviewed a second MAR binder on the same unit and noted one omission. Upon questioning the omission, the nurse administering medications stated she had missed the medication and immediately notified the physician.

The monitoring team informed facility leadership of these observations, stating that this practice put all residents at risk for harm, and asked for a plan of correction by the end of the day. The plan of correction included one on one education, facility wide education

on medication administration protocol, clear instructions for blister pack and bingo cards, the development of audit tools to monitor timeliness of MAR signatures/initials and implementing audits by the Instructor of Nursing, pharmacy consultant and unit supervisor. Perhaps most importantly, it also puts forth a plan of action to reinstate the standard of practice for medication/treatment administration documentation and a system for monitoring going forward. The monitoring team determined that this plan of correction was acceptable, noting that any resident for whom a medication was missed should be observed for possible change in condition that might be a result of missing a medication (e.g. those diabetic or cardiac issues).

The next day, the monitoring team observed a nurse on a different unit reviewing the TAR and making several entries. The monitor questioned this activity and the nurse stated she was initialing all the treatments she had done during the shift.

The monitoring team has determined that some nurses, both agency and those employed at Paramus, have become comfortable with the practice of initialing for treatments and medication administration later or at the end of the shift, rather than as they are providing treatments or administering medications. Simply initialing to prevent omissions puts residents at risk, results in inaccurate data and makes it difficult for the medication variance committee to address averted and actual medication variances.

In summary, medication administration should be done in accordance with the physician's orders and include documenting the name of the medication, the dose, the route of administration, and the frequency of administration. The issues of late administration, late documentation of medication administration, documentation that unavailable medications were administered, and the unavailability of medications, are unsafe. This can lead to untoward effects on the residents.

The monitoring team will continue to observe medication/treatment administration, evaluate the plan of correction and determine whether Paramus is taking the necessary steps to 1) ensure the safe dispensation of medications; 2) establish/implement a system to accurately track variances in the administration of medications; and 3) ensure that residents receive their medications and treatments as prescribed.

Falls

Paramus has created, implemented, and maintained a system to prevent resident falls. The monitoring team confirmed that Paramus staff members complete resident risk assessments upon admission, quarterly, and as needed, using a standardized fall risk assessment tool. Unit managers conduct walking rounds three times a week to ensure appropriate assistive devices are available for the residents to whom they are assigned in order to help prevent accidents and falls. Nursing assistants are required to round

every 30-minutes in an effort to prevent falls. These rounds are documented on a checklist that is initialed by staff. CNA assignment sheets include blocks of time during which they supervise residents in common areas. During these times, the CNA does not leave the area. The maintenance department conducts routine environmental rounds to ensure that resident rooms and common areas remain as free of accident hazards as possible.

Monitors have observed fall prevention safety devices utilized by residents who are at risk for falling that help prevent falls or that minimize injury if a fall occurs. These include the use of wheelchair and bed alarms (silent), hi/lo beds, and fall mats on the floor next to the bed.

Monitors reviewed documentation related to numerous falls. Positive observations included completion of fall investigations, post fall huddle worksheets, collection of resident/staff statements and performance of neurological checks for those falls that were unwitnessed. Fall investigations included pharmaceutical reviews to determine any medication associated risks for falls.

In addition, the Paramus nurse investigator subsequently conducts a post-fall investigation using a form-based report (Risk Watch). This form asks about the location of the fall, what the resident was doing at the time of the fall, whether the fall was witnessed, the assigned caregiver, who reported the fall and at what time, the physician who was notified and at what time, the family or power of attorney who was notified and what time, whether the ambulance was called, and whether the resident was sent to the hospital. Assessment information includes vital signs, pulse oximetry, blood sugar level, cognitive status prior to and after the fall, whether an injury occurred and what, if any, action was taken (e.g. initiation of neurological checks, presence of pain, and therapy referral). The nurse's note entered into the medical record is included, as well as the resident's statement of what happened, and the statement of any witnesses. There is also documentation stating the last time the resident was observed before the fall occurred, what care (e.g. toileting, administration of pain or anxiolytic medications) was provided prior to the fall, information about environmental conditions, type of footwear worn, preventive measures in place at the time of the fall and whether a bedrail was in use. Lastly, the nurse investigator writes a conclusion about how the fall occurred, the root cause of the fall, whether the incident was recorded, reported and investigated and whether the care plan was updated.

The monitor reviewed a number of the form-based reports and noted that interventions were identified based on the root cause analysis of the fall. These interventions included therapy referrals, offering residents assistance with toileting if the staff member noted

the resident was awake during the night, ensuring a resident who smokes had smoking materials so that he/she was not leaning forward in the wheelchair to retrieve cigarettes, and reinforcing staff education to provide constant supervision of residents who are out of bed and have poor safety awareness.

Weekly falls meetings are held to discuss individual resident falls. During an interview with the monitoring team a management-level staff member reported that at times information documented on fall investigative reports is missing or inaccurate. This makes it difficult to address the root cause of the fall and minimize future occurrences. In addition, at least one additional management-level staff member informed the monitoring team that not all falls are reported per regulation. Future onsite visits will allow the monitoring team to investigate and ensure the accuracy of reported data.

Paramus implemented a formal Performance Improvement Project (PIP) for reduction/prevention of falls and falls with major injury on 02/12/25. The background leading up to the need for the project read, “Falls have been increasing since Q4 of 2024. Falls with major injuries have also become a recurring issue. Incident reports have reportedly been noted with inaccurate information or have been lacking in proper root cause analysis.” Note that performance improvement strategies to reduce falls have been ongoing since at least 2023. Most recently, yellow tags were placed on equipment used by residents at high risk for falls; additional Life Enrichment staff were hired for the evening shift; the Assistant Director of Nursing (ADON) and members of the interdisciplinary team began post incident rounding; and, troubleshooting was conducted related to wireless alarm issues. It is not clear why previously implemented interventions were ineffective but corrective actions were adjusted in an effort to further reduce falls.

The goal for the PIP initiated on 2/12/25 is to “reduce/prevent all falls and falls with major injury; limit monthly fall average to 16 or less quarterly and sustain zero falls with major injury; and achieve facility wide understanding of fall prevention for nursing staff….” During the initial phase of the project the DON/ADON will finalize plans for restructuring the investigative process and inservice nursing supervisors and floor staff. In phase 2, there are plans to use data collected from the revised process and improved root cause analysis to identify targeted interventions to reduce/prevent the greatest number of falls. This initiative will need to be tracked over time to determine if it is effective in meeting project goals.

The monitors believe Paramus staff members do a thorough job of collecting data on a systemic level such as date and time of falls and location; however, that information is not always fully utilized to formulate systemic fall prevention interventions. For example,

data indicated that a higher number of falls occurred at change of shift but the intervention for staff to be more vigilant during this time period was discontinued without explanation. In another example, it was noted that falls occurred in the designated smoking area; however, corrective actions were individualized for specific residents and did not include a systemic approach such as increased surveillance of the smoking area which was not visible from inside the facility. Data collected through the PIP should be utilized to develop systemic interventions in addition to those identified for individual residents.

The monitors noted that on the MDS 3.0 Facility-Level Quality Measure Report for reporting period 07/01/24 - 1/31/24, the Facility Adjusted Percent for Falls was 49.1% which is higher than the Comparison Group State Average of 37.8% and the Comparison Group National Average of 44.2%. The percentile ranking which is obtained from the National comparison is at the 61st percentile. The QM Report for the reporting period 08/01/2024 to 01/31/2024 is 47.1%, 38.0%, and 44.2% respectively with a percentile ranking of 55. Per the National Institute of Health, a percentile ranking greater than 75 is cause for concern. Monitors encourage the QAPI team to continue to collect and analyze system-wide data in their effort to continuously reduce resident falls.

Oversight and Management of Medical Care

During the March 2025 onsite visit, the monitor requested to see credentialing packets of five physicians with privileges at the facility. Each folder contained a Credentialing Review Packet that included the following: copies of the physician's license; Specialty Board Certification, as applicable; controlled Drub Substance Registration, Federal CDS Registration (DEA); the physician's national provider number; a copy of liability insurance; a curriculum vitae; and a letter verifying hospital privileges or a primary source from a physician or nurse practitioner. The physician must verify he/she received a copy of the facility by-laws and interpretive guidelines. The packet also contains a self-attestation about the moral, ethical and professional qualifications and competence of the physician; as well as a signed release form allowing the facility to make inquiries and consult with anyone about the same. Finally, the packet contains a document entitled Standards and Procedures for Physicians who provide care to residents. Each of the packets reviewed were complete, including evidence of licensure and insurance renewals as appropriate.

Previously, Paramus had in-house physicians which leadership staff said resulted in the nurses relying too heavily on the physicians rather than using their own assessment skills. The facility now has a well-qualified, licensed, and credentialed Medical Director and contracted physicians who are not onsite but visit the facility on a daily basis.

DMAVA leadership believes that the nurses' assessment skills have now strengthened and they aren't afraid to use those skills now.

The monitoring team attended a quarterly QAPI meeting and was impressed with the Medical Director's engagement with the QAPI program as a whole. His active participation in the meeting led to interdisciplinary discussion and root cause analysis. He was not afraid to challenge the staff to produce more definitive data when necessary (e.g. the repeated failure to complete SBARs). He suggested a deeper root cause analysis, including an analysis to determine whether this problem was occurring on certain units and/or certain shifts. He also said that instead of continuing to re-educate, management needed to start holding people accountable for their performance. Again, this further accentuates the need for determining whether interventions implemented have had the desired effect and the need to modify interventions if ineffective.

The Medical Director was also involved in the antibiotic stewardship program. The QAPI team identified a particular physician who orders antibiotics for infections that don't meet McGeers criteria. The Medical Director met with this physician and it was reported to the monitoring team that this meeting went well and the physician was receptive to changing this practice.

The monitoring team believes that the Medical Director has been successful in maintaining a consistent level of appropriate medical care throughout the Paramus facility. He dedicates sufficient time to the facility, including time onsite, to provide adequate oversight and management of medical care at Paramus. On future visits the monitoring team will inquire about the Medical Director's system of oversight to ensure he is 1) performing chart and quality assurance reviews; 2) taking an oversight role in staff education regarding key clinical areas identified in the consent decree; 3) identifying and communicating appropriate performance expectations for other physicians, and monitoring their performance; and 4) performing peer review of other medical providers and is subject to external peer review himself when providing direct care.

Infection Prevention Detection & Control

Paramus has created, implemented, and maintained appropriate infection prevention, detection, and control practices including the maintenance of written infection control policies that are consistent with applicable federal and state guidelines. The Annual Facility Assessment contains a section devoted to the Infection Prevention and Control Program. This program contains an assessment tool for potential infection risk factors in seven different categories including, but not limited to, community and populations served, treatment and care practices, emergency management, and cleaning,

disinfection, and handling of devices. Management staff involved in the process score events/conditions according to their potential impact on residents and staff, probability the event/condition will occur and the facility's preparedness to deal with the event/condition. Each risk event/condition is then listed with interventions and goals for how the Paramus facility will approach them. The list includes such things as immunizations, staff training, preventing and controlling infections and communicable diseases, handwashing, antibiotic stewardship, tracking infections, reporting infections, etc. This assessment tool is consistent with tools recommended for use by CMS and the CDC.

Paramus has an infection control department that, at the beginning of the Consent Decree, had a department head and 2 additional nurses. At the time of this report the department has increased from 2 to 3 additional nurses. It should be noted that the additional staff member was added because management has delegated oversight of the wound care program to infection prevention and control. The head of the department is a registered nurse who has a certification from the Association for Professionals in Infection Control and Epidemiology. The other licensed nurses have a certification from the Center for Disease Control. The head of the department is a full time employee and works Monday through Friday. The other nurses are also full time employees and provide coverage on weekends.

During orientation and annually thereafter, the education department provides education on infection control. The Infection Control RN presents the information that includes the topics of infection control, antibiotic stewardship, blood borne pathogens, tuberculosis, enhanced barrier precautions, donning/doffing of personal protective equipment and handwashing. During orientation and annually thereafter, the education department and infection control departments do a fit-test on all staff to ensure they have a properly fitting N-95 mask.

Paramus has created, and is implementing and maintaining, good infectious disease testing protocols. During the onsite visits, monitors have noted during the morning clinical meeting, the afternoon wrap up meeting, and change of shift reports that staff administer rapid tests for the detection of flu and Covid and a respiratory panel when residents present with any type of respiratory concern. Members of the infection control team do surveillance for infections by attending the clinical and wrap-up meetings, making infection control rounds, and monitoring documentation including SBAR and Stop and Watch forms, both of which are used to report changes in resident condition.

Paramus has had two Covid and/or flu outbreaks in the past 6 months and monitors commended the Paramus team for their efforts in containing the outbreaks. The

Paramus team defines an outbreak as more than one individual having the disease. Frequent communication occurs between the infection prevention team and the NJ Department of Health to ensure that protocols are up to date and to obtain confirmation that infection prevention and control interventions utilized meet the current standard of practice. The Paramus team also ensures that proper preventive strategies are used based on the prevalence of communicable diseases occurring in the community. A representative from the NJ Department of Health Communicable Disease Service consults on-site twice a year and more if the facility requests it. This individual is also available for consultation as needed.

Anyone entering Paramus must participate in an electronic screening process that is focused on ascertaining whether the individual has signs/symptoms of Covid, Covid immunization status, and exposure to anyone who potentially has or has had Covid. The individual's temperature is also taken via the device. Appropriate actions are taken as necessary such as, recommendations for mask wearing or preventing an individual from entering the facility.

The management team at Paramus has designated a specific unit that is used for isolating residents who test positive for a communicable disease. This unit is empty and readily available when necessary. If a resident tests positive for a communicable disease, the resident is isolated on this unit until he/she meets the requirements for discontinuing isolation. Dedicated staff members care for residents on this unit, that is, they do not care for other residents who are not in isolation. When residents are symptomatic and/or suspected of having been in close contact with someone known to be infected by an infectious disease but do not test positive, the resident is isolated on his unit or in his/her room.

Monitors observed and informally interviewed members of the housekeeping team to determine whether staff were knowledgeable of cleaning protocols that were to be followed. Housekeeping staff were able to discuss different cleaning solutions and the length of time the solution had to remain on a surface in order to be effective. One housekeeper demonstrated the mixer he/she used when preparing large volumes of cleaner to ensure the dilution was correct. In April 2024, facility management started using Glo Germ, a product that is used to assess whether high touch surfaces have been properly cleaned. The Housekeeping Supervisors perform audits to ensure proper cleaning and report results at QAPI meetings.

Monitors have observed the Paramus staff members' response to two separate Covid/flu outbreaks and commend the Paramus team for their diligence in containing the outbreaks. According to leadership at DMAVA, a specific Outbreak Response Plan

is available on the DMAVA website. The monitoring team has not accessed that plan and will review this in the near future.

The Infection Prevention and Control Department and Education Department do monthly audits of all staff including agency staff, security, volunteers, salon staff, physicians and third party contractors, to assess whether staff members, etc. are properly using, handling and implementing appropriate personal protective equipment and performing appropriate and effective hand hygiene. A review of January 2025 and February 2025 infection control meeting minutes records hand hygiene compliance ratings at 95% and 82% respectively; and gowning/gloving compliance at 100% for both months. Monitors noted that over the previous six months there has been an improvement in how staff members are wearing facemasks. On the initial onsite visit in October monitors observed that, of those staff members who were wearing facemasks, many of them improperly pulled on the front of the face mask to readjust it or wore it below the nose. In January, monitors did not observe improper wearing of the masks and also saw staff properly adjust their masks by using the earloops.

Clinical Care Policies, Procedures & Training:

DMAVA Leadership and the Paramus facility have an established system to maintain and communicate new policies and procedures via their Intranet. The three New Jersey Veterans Homes have made significant strides in working together and this started with developing and updating all policies and procedures. The monitoring team interviewed staff members in management positions who said they provided input in the policy and procedure updates and were happy with the process. New or modified policies are shared with staff via the facility's intranet. Any new or modified changes are emailed to the CEOs to initiate education and inservice.

In the previous Medication Administration section, the monitoring team discusses several concerns related to incomplete MARs, incorrectly documenting a late entry and falsification of a record. In addition, the monitoring team had conversations with several staff members who were concerned about competency testing at Paramus. As discussed in the General Medical and Nursing Care section, the monitoring team has concerns about how competency is documented, and therefore overall staff competency cannot be determined.

Given the above noted concerns with medication administration and competency, the monitoring team has not yet determined whether DMAVA has implemented an appropriate system of oversight and accountability at Paramus. On future onsite visits,

the monitoring team will assess whether staff are following policy and procedure as designed.

Quality Assurance and Performance Improvement

The Paramus facility, under the direction of the State of New Jersey has established a robust QAPI Program. The DMAVA QAPI Coordinator oversees the QAPI Program and works with Paramus leadership and the *facility* QAPI Coordinator to monitor the implementation and effectiveness of the program.

On a monthly basis, the Director of Veterans Healthcare Services receives a monthly QAPI Report for which data is reported in the following clinical areas: Wounds (number of new facility and community acquired), Hospitalizations (Reason), Weight Loss of 5% or more (Reason), Emergency Room Visits (Admitted, Returned to the Facility), Rehospitalization within 30 Days or Less (Reason), Falls (Number of residents on psychiatric medications, residents with more than one fall, major injuries, and number of silent alarms in use), Skin Tears (location on the body), Residents on Oxygen (continuous, as needed), Intravenous Administrations (medication, fluids/electrolytes, Other), Residents on the Restorative Program (Reason) Infection Control (Urinary Tract Infections (Number of residents with a foley catheter, number of infections with/without a foley catheter), Enhanced Barrier Precaution (Reason), Pharmacy (number of medication errors and why, psychoactive medication use (Number of residents, number on 2+ psychoactive medications, dose reduction efforts, care plan inventions) Antibiotic Starts (Type of infection, Meets McGeers Criteria) and Abuse/Neglect Allegations (Date, Brief Description, Staff Suspension/Removal, Substantiation, Police involvement).

The scope of the QAPI program (and the monthly collection of data) provides management the opportunity to timely and effectively detect problems with the provision of protections, services, and support. It also assists in identifying trends in the various areas being monitored by the QAPI team. The DMAVA QAPI Coordinator reported that she reviews the CMS Quality Measures (QMs) for patterns and trends, stating that she looks into any negative trends and any QMs where the facility is above the 50th percentile or where the facility percentage is above the state average.

Monitors have attended a variety of QAPI weekly, monthly and quarterly meetings. Meetings are attended by members of the management team and various department managers as appropriate for the topic, including but not limited to, therapy, recreational therapy, social services, dietary, housekeeping, and infection control. Attendees provide input at these meetings but there is a lack of evidence that the team gathers input from direct care staff. Suggestion boxes are placed in several areas in the facility but

monitors have not seen evidence that this provides any input from direct care staff or residents as related to QAPI activities.

The QAPI team has demonstrated success in some of the projects they have initiated. For example, the monitor attended a weekly QAPI meeting that was focused on weight loss. The QAPI Coordinator at Paramus stated that the goal they had established, based on a comparison to state and national QMs, had been met for three months in a row. The assembled QAPI team acknowledged this success and were eager to identify other interventions that could assist in actually exceeding the established goal.

The medical director is very engaged in the QAPI process and asks questions about different QAPI projects. During a quarterly meeting, the medical director expressed some frustration that he kept hearing about nursing staff failing to complete SBAR (Situation, Background, Assessment, and Review/Report) communication tools in regard to UTIs. He stated that more definitive data was needed to determine if failure to complete the SBARs was occurring on certain units and/or certain shifts. He also said that instead of continuing to re-educate staff, leadership needed to start holding people accountable for their performance. This further accentuates the need for determining whether implemented interventions, such as re-education, have been effective and whether certain interventions need to be modified or changed.

In reviewing numerous QAPI plans, monitors did not see a clear definition of the problem that includes determining contributing causes or measurable and objective outcomes (triggers). It does not appear that there is a thorough evaluation of whether interventions have resolved or have had an impact on the issue being addressed. In addition, some interventions lacked a definitive method for ensuring that the intervention was implemented. Monitors encourage the QAPI team to ensure that process improvement plans identify the root causes of systemic issues and address resident care, as well as determine the effectiveness of interventions.

Monitors question whether QAPI plans need further development to ensure that interventions have the desired effect and to determine whether monitoring activities are adequately capturing the right data. For example, in continuing efforts to prevent falls, nursing assistants (CNAs) conduct rounds every half hour. CNAs document by initialling the time on a grid each time they complete the rounds; however, the process of initialling that rounds are completed does not contribute to proving or disproving that this intervention is effective in preventing falls. In addition, the data indicating the time each resident fell showed a pattern of falls occurring during change of shift. Although the QAPI team initiated a plan addressing that time period, the intervention was

discontinued with no explanation. There was no evidence that the problem identifying that falls were occurring at change of shift had been resolved.

Monitors found some examples of documentation of clinical care that did not withstand scrutiny. Monitors shared these concerns with the Paramus management team, including problematic documentation on MARs and TARs and concerns with respect to the accuracy and completeness of the falls data. These documentation problems result in inaccurate or missing documentation that impacts the QAPI program.

Monitors noted that the Education Department provides a session on Quality Improvement to staff during orientation and annually thereafter; however monitors did not review the content of the training. Monitors also do not know the content of the QAPI training provided for the management team.

The monitors acknowledge that DMAVA and the Paramus team have expended considerable time and effort on the QAPI program. Going forward, the monitoring team will continue to assess the QAPI program, including any components of the Consent Decree that have not been addressed in this report.

Emergency Operations & Preparedness

Paramus has created, maintained, and updated as necessary a comprehensive Emergency Preparedness Program that is designed to shift operations in the event of an emergency, such as disasters and public health emergencies, to meet the health, safety, and security needs of residents and staff, to communicate effectively to staff, residents, and family members, and to appropriately ensure the continuity of Veterans Homes operations in accordance with applicable regulations. Various emergency scenarios are outlined and policies have been developed to ensure continuity of operations and provide essential services during disasters, public health emergencies, and other emergencies. The Annual Assessment also contains materials based on a Facility and Community-Based Risk Assessment. This document includes information including with whom the Paramus facility has agreements in case residents need to be evacuated (e.g. facilities, transportation), services to meet food and water requirement in case of a need to shelter in place, generator testing operations, and facility system risk assessments (e.g. Emergency Lighting, Heating, Refrigeration). Paramus also worked with the NJ Department of Health in determining the probability of various hazardous events (e.g. snow storm, earthquake, chemical spill, etc). Both the Emergency Preparedness Program and the Facility Assessment include revision dates that indicate the plans have been reviewed at least annually and more often in accordance with applicable federal and state laws and guidelines.

Paramus has a Communication Policy that contains procedures for communicating with residents, staff members, and resident family members in a manner assuring that a family member with legal authority over a resident's care has sufficient information to act in the residents best interest. The facility uses a RAVE communicator system (a platform that provides critical communication and collaboration tools). It is used for sending mass notifications, targeted messages, and facilitating communication during emergencies or planned events.) as well as land-line telephones, e-mail blasts to powers of attorney, and text messages.

Paramus has an Emergency Staffing Plan policy and an Essential Designation Plan that are used to ensure that the facility has sufficient clinical staff to ensure Resident safety during an emergency. The Essential Designation plan includes a process for shifting staff duties within the facility when necessary.The Paramus Staffing Coordinator is responsible for contacting nurse staffing agencies (identified in the plan) if additional staffing is needed.

DMAVA has ensured that management at Paramus are familiar with the requirements and provisions of the Emergency Preparedness Program and that staff are trained on the program in a manner suitable to their position at least annually and that regular practice exercises are conducted. The monitor confirmed that the education department includes emergency preparedness training in staff orientation and annually.

The monitor reviewed the Program, the minutes of several inservices held with management to review management's responsibilities during upcoming drills, and after action reports from numerous drills held over the past months. The drills reviewed included a mock evacuation disaster drill and monthly fire drills that were conducted by a third party. Minutes of the meetings include an organizational chart that depicts major roles during a disaster and who is responsible. These roles include, but are not limited to, an Incident Commander, Safety Officer, Liaison Leader, Public Information Officer, Logistic/Planning, Documentation Assistant, Communication Unit, Labor Pool Manager and Supply Procurement Unit Leader. The responsibilities of these various personnel are clearly defined in inservice materials. Drills also include Observers who document an assessment of how well the drill was performed.

In January 2025, the Incident Commander initiated emergency response when an earthquake occurred in the Paramus area. The after action report included a positive response, with nursing and social services ensuring that residents and staff were safe and not suffering any psychological effects from the earthquake, the facility and grounds were inspected immediately for any damage and that power, gas, and water lines were

intact, and the Secretarial Assistant notified families that all residents were safe and that the facility was undamaged.

The monitoring team reviewed numerous reports by the Fire Safety Corporation that conducts fire drills monthly and includes different days of the week, different units, and different shifts. The Fire Safety observer documents his/her evaluation of the drill and the monitor found that staff response to all of the drills successfully met criteria. The monitoring team also observed a fire drill during an on-site visit. Staff appropriately closed fire doors, closed the doors to resident rooms explaining why to the residents, retrieved fire extinguishers, and accounted for residents.

Management staff responsible for observing and critiquing the mock evacuation and mock elopement drill identified areas for improvement including communication (overhead announcements were not clearly heard on all units), encouragement of staff to participate in the drills, and better organization by those in charge of specific areas involved in the drills. Paramus intends to conduct emergency preparedness practice drills on a regular basis.

During the onsite visit in March 2025, the CEO said he would be unavailable for part of the day as he was attending a community leadership meeting related to Emergency Preparedness.

Staffing

Paramus assigns sufficient clinical staff (providing direct care) so that resident acuity needs are met. The clinical staff addresses resident acuity by using a daily acuity worksheet and also by completing/reviewing the Facility Assessment at least annually. Paramus has Registered Nurses (RNs) as unit managers and also as supervisors of nursing services (SNS). Each unit has one designated SNS during the 7-3 shift. During the 3-11 and the 11-7 shifts two SNS share coverage of all the units. The SNSs are RNs and can assist with care delivery on the units if necessary. Paramus has assigned clinical staff in a way that satisfies regulatory staffing requirements and ensures resident safety.

Paramus has a 5 Star staffing rating on CMS Nursing Home Compare. The total number of nurse staff hours per resident per day is 4 hours and 58 minutes compared to a national average of 3 hours and 51 minutes; nurse staffing on the weekends is 4 hours and 22 minutes. The facility provides 1 hour and 20 minutes of RN hours per resident per day compared to a national average of 40 minutes and 2 hours and 20 minutes of nursing assistant hours per resident per day compared to a national average of 2 hours

and 19 minutes. Regarding staff turnover, Paramus has 19.4% total nursing staff turnover compared to a national average of 48.4%. RN turnover is 18.8% compared to a national average of 45.1%.

Paramus has adequately allocated staff responsibilities and workloads to assure that staff assigned to specialized duties, such as restorative care, are not regularly reassigned to provide direct clinical care instead. The monitoring team confirmed that therapy and restorative care is provided by a contracted company and several staff members reiterated that the restorative care nurses are not asked to provide direct clinical care.

Although the facility has staff in sufficient numbers, a review of Resident Council Minutes dated 9/13/24, 10/4/24, and 11/1/24 indicated that residents voiced concerns related to call lights not being answered timely and a lack of staff at nursing stations especially on weekends. At the 11/1/24 meeting, a staff member reported that five new Unit Clerks were being hired to cover evenings and weekends. Paramus is taking initiative to respond to resident needs as these Unit Clerks will not only be available if residents approach the nurses station with a request, they will also be able to respond to call lights by asking the resident over an intercom what the resident needs.

Paramus has maintained an emergency staffing plan that permits them to maintain resident safety during emergencies. The monitoring team has conducted interviews and reviewed plans and documents related to emergency preparedness. Additional information is discussed in the Emergency Preparedness section earlier in this document.

Paramus has assigned supervisory staff and facility leadership in sufficient numbers to ensure resident safety and well-being. These staff members are also assigned in a way that complies with the mandates of the Consent Decree, the provision of appropriate care and, to the monitor’s knowledge, DMAVA’s policies and procedures. As discussed in previous sections, the monitoring team questions the extent to which some of the clinical staff members are demonstrably competent and appropriately trained. Future onsite visits will allow for observation of competency testing (including return demonstrations), further observation of direct care, interviews and reviewing the following records: resident medical records and education and training records, including evidence of competency.

The monitoring team had several opportunities during the onsite visits to interview and observe the individuals serving in the roles responsible for supervision and management of clinical services. The Director of Nursing (DON) has been working at

Paramus for one year and has an extensive and well-rounded clinical background. Immediately she took an active role in addressing the use of psychoactive drugs, wounds and weight loss and she sees these issues improving. The DON is actively involved in the daily, weekly, monthly and quarterly clinical meetings and the facility assessment, as well as the review of policies and procedures.

The DON has taken initiative to develop relationships with her clinical team, including nurses and nursing assistants. She spent time discussing with the monitoring team the role that cultural backgrounds played in developing strong working relationships with her staff and initiated a diversity training inservice, hosted by the DMAVA Central Office Diversity, Equity, Inclusion and Belonging group. The inservice was offered at 9:30am, 11:15am and 2:00pm on each of the following three days: 1/21/2025, 1/23/2025 and 2/3/25. Through all of these efforts she has earned the respect of the nursing and nursing assistant staff.

The monitoring team is impressed with the DON's ability to lead clinical meetings, encourage communication, listen to shift change reports and educate her staff if she feels they don't understand what is being communicated. She welcomes communication from the monitoring team, is receptive to the findings that are discussed and is responsive to the recommendations that are suggested. The monitoring team often noticed the DON nodding in agreement with the findings and is confident in the ability of the DON to identify issues and investigate the extent to which the problem is/is not widespread rather than reacting to fix one issue.

The monitors share the Medical Director's concern that Paramus leadership does not hold staff accountable for their performance. As discussed in the MAR section, some nurses have become comfortable with the practice of initialing for treatments and medication administration later or at the end of the shift, rather than as they are providing treatments or administering medications. The monitors feel that this problem could have been avoided with proper oversight of clinical care. Furthermore, during a summary meeting one leadership staff member asked the monitors to disclose the particular resident record that was referred to, rather than taking initiative to identify issues and investigate the extent to which the problem is/is not widespread. The monitors have concerns about the ability of Paramus leadership staff to accurately determine and assess the competency of clinical staff (discussed in the General Medical & Nursing section above and also Clinical Care Policies, Procedures & Training below). As such, the monitoring team has not yet determined whether DMAVA has implemented an appropriate system of oversight and accountability at Paramus.

Paramus relies heavily on agency staffing. During one of the first months following the execution of the consent decree, the monitoring team noted that the facility used agency staff anywhere from 6-24 times per day. This included both nurses and CNAs. The monitors interviewed one agency staff member who said she worked at Paramus 4-5 days a week and she didn't see that changing anytime soon. Another agency nurse said she was consistently staffed at Paramus and was generally assigned to the same area. This is great for consistency with residents and other staff.

Leadership staff at Paramus has worked to address the reliance on agency staffing by increasing wages and pay for certified nursing assistants. The leadership staff feels this has been successful as it shows respect for the CNAs and that the Paramus facility as a whole values their work. The monitoring team has seen improvement in the need for agency staffing as the numbers have decreased over the last several months.

According to the Facility Assessment document, DMAVA and the Paramus facility have implemented numerous activities designed to attract and retain staff. The management team monitors the salaries of clinical positions in the geographical area to remain competitive with other healthcare entities. The facility also received a grant to allow for additional compensation (bonuses) for clinical staff who did not have call outs or who had defined overtime hours. In the past year the DMAVA Central office hired a recruiter to assist with the recruitment of frontline staff. The Human Resources staff visits job fairs and local schools and also uses a variety of methods to post positions, including posting on websites such as Indeed. The monitoring team will continue to assess for continued success in attracting and retaining facility staff.

Organizational Accountability

DMAVA met the requirement for designating an Agreement Coordinator (AC) as well as a succession plan should the identified AC no longer be able to fill the role. The AC was involved in the development of the required Implementation Plans to ensure compliance with each provision of the Consent Decree and Veterans Homes policies. The AC has also succeeded in accurately collecting data on clinical care outcomes. He routinely reviews QM, QAPI reports and CASPERS and will work with other DMAVA leadership staff members to dig into trends that might be concerning.

The AC is responsible for regularly engaging with the stakeholders (identified as residents, staff, family members and the VA Central Office). DMAVA has succeeded in establishing mechanisms for regularly sharing with and receiving information from stakeholders. The facility CEOs conduct bi-weekly virtual town halls with powers of attorney who choose to attend. The AC informed the monitors that he met with each

shift change at both Paramus and Menlo Park prior to the consent decree. He plans to continue to do this annually, or as needed. The AC also meets routinely with various veterans groups at both Paramus and Menlo Park - during the month of February he was at each facility twice. He regularly attends the Resident Council meetings and invites any Resident Council member to reach out to him directly. According to a review of Resident Council meeting minutes, the same concern with respect to a timely response to call lights continues to be reported. The monitors will follow up on this issue to determine why this continues to come up at the monthly meetings.

DMAVA has identified three compliance officers as required by the Consent Decree (the CEOs of each facility as well as the DMAVA Quality Assurance Coordinator) who are responsible for the implementation and enforcement of an effective compliance program at each individual Veterans Home as well as DMAVA. The AC meets with these three individuals biweekly.

The monitors observed several gray boxes in which staff and residents can anonymously report concerns. The monitors are unsure how often, if ever, they are used. Paramus has an Employee Relations Officer (ERO) who, together with various union representatives, has established a mechanism by which staff can report any concerns. This includes a booklet that defines how any type of complaint is resolved. While Paramus has a policy in place, the monitors have concerns about the willingness of staff to report any concerns as evidenced by the following:

- Monitors were told by several staff members that they do not file written statements because they are afraid of retaliation and/or getting terminated
- Monitors were told that facility leadership instructed clinical staff not to speak with us
- Three members of the management team expressed concerns that they would be fired after speaking with us
- Several CNAs said they were “afraid to talk to us” as they were worried about retaliation
- Several staff members requested to speak with us outside of working hours so that management and/or leadership would not see them speaking with us

Paragraph 107 of the Consent Decree discusses requirements related to instructing facility staff to cooperate fully with the monitor. Given the above statements, in our professional opinion the monitoring team believes that Paramus leadership should do more to effectively instruct staff to cooperate with monitors without fear of retaliation.

Paragraph 106 of the Consent Decree discusses access that the monitor will have relating to persons, employees, facilities, buildings, programs, services, documents, data, records, materials and things that are necessary to assess the Veterans Homes' progress and implementation efforts with the Consent Decree. Despite this paragraph, the monitoring team experienced difficulty accessing and reviewing a pertinent personnel file. In addition, Paramus leadership was not willing to answer questions during an interview related to the termination of an employee.

The NJ Veterans Home at Menlo Park

Introduction

During the six month period following the execution of the Consent Decree, the monitoring team conducted 3 onsite visits at the NJ Veterans Home at Menlo Park (Menlo Park). The 3 onsite visits were considered monitoring evaluations during which the monitors made observations of care, conducted formal and informal resident and staff interviews, attended regular meetings with both leadership and clinical staff, and reviewed medical records. The Monitor has had monthly contact with DMAVA Leadership and the NJ Veterans Home at Menlo Park (Menlo Park), and has also communicated virtually and in-person with additional staff members.

At each onsite visit, the monitoring team attended several clinical meetings including, but not limited to, the morning meeting, the afternoon wrap up and Quality Assurance and Performance Improvement (QAPI) meetings. In addition, the monitoring team reviewed several medical records, including resident care plans and admission paperwork in order to assess the ability of the staff at Menlo Park to identify a change in resident condition. The findings from these activities are described below.

General Medical & Nursing Care

Menlo Park has conducted Facility Assessments annually and with any changes to services provided. Upon completion of the Facility Assessment, Department of Military and Veterans Affairs (DMAVA) leadership, along with the Medical Director, Agreement Coordinator and Department Heads, review the document page by page looking at details such as the census, the acuity levels of each resident and the clinical skills required to care for each resident. DMAVA Director of Health Services and DMAVA Quality Assurance Coordinator are responsible for communicating this information to the education coordinators to ensure staff training is conducted based on resident care needs.

The monitors interviewed the Instructor of Nursing who stated that he has one day a month that is devoted to competency testing which includes observations of return demonstrations in the classroom and/or observations of staff providing care at the bedside. In addition, staff members who have not been competency tested in a particular subject can be tested by their nursing supervisor prior to providing care. The nursing supervisor documents the testing and informs the Instructor so it can be recorded in the staff members file. The Instructor of Nursing showed the monitors the spreadsheet that tracks which staff members are due for training/competency and when.

The monitor reviewed a staff member education file, a Mandatory Education packet, and several spreadsheets that identified staff members by name and the completion of various competency testings. Licensed nurses (RN and LPN), are competency tested in 17 skills including but not limited to medication administration, dressing changes, gastrostomy tube reinsertion, foley catheter insertion and removal, bladder scanner, and tracheostomy care. While trained on other topics, these are the ones selected for competency checks. In speaking with the Director of Healthcare Services, these 17 skills were selected based on a review of the Facility Assessment and the determination that they tend to be skills that are more problematic. Checklists used for competency testing included language that a step in the procedure was actually demonstrated. The monitor also reviewed a number of post tests used to demonstrate that staff understood what was taught. Certified Nursing Assistants receive training and competency testing in areas such as obtaining and recording weights, cares related to elimination, nutritional assistance, hygiene and grooming, wound prevention infection control, and safety practices.

If a new treatment or procedure is to be performed by staff, vendors are called in to do the training for the staff (e.g. certain IV treatments). In the past year the medical director has provided an inservice on detection of changes in resident condition and the wound consultant has provided an inservice on wound care. The CEO also shared that the facility has an Education Week that involves managers in providing educational activities in a “fun way.” In the past, this has included skits to instruct on resident abuse, a room that is set up with numerous safety risks for staff to identify, and team building exercises.

Menlo Park has succeeded in providing the residents appropriate specialized medical, nursing and other clinical services. Formal interviews with specialized clinical staff including, but not limited to, infection prevention and control, wound care and therapy revealed appropriate credentials, qualifications and competency for their respective positions.

The State and DMAVA/facility leadership have succeeded in reviewing existing policies to ensure that they conform to the requirements in the Consent Decree. The policies are reviewed and updated as needed, with pertinent staff members providing input. New or modified policies are shared with staff via the facility's intranet. Any new or modified changes are emailed to the Menlo Park CEO to initiate education and inservice.

DMAVA and Menlo Park have succeeded in establishing appropriate clinical care policies and procedures. A few areas have shown inconsistent implementation of policies and procedures, such as wound care where weekly skin checks and Braden skin risk assessments are not always completed. This is discussed further in the Vascular Wounds and Pressure Injuries section. The monitors will be following up on this during future onsite visits.

Electronic Medical Record (EMR)

According to facility leadership, licensed nurses do the monthly recapitulation (recap) of orders by hand and then review it for accuracy. Nursing sends the recap to the in-house pharmacist who then manually enters it into a software program from which the medication and treatment administration records can be printed for distribution to the units. Because the EMR (which was selected by the facility approximately ten years ago) does not comprehensively integrate all systems, paper records must be included with EMRs to make each resident record complete. The system is cumbersome and includes duplication of effort (e.g. the use of written logs that are then entered into the EMR) and/or “antiquated” systems (e.g. the monthly recapitulation of orders that contain greater opportunity for error than a fully integrated system). According to QAPI minutes, nine medication errors were identified for one month. The majority of these errors were the result of transcription errors.

DMAVA leadership recognizes that for third parties who have access to the records (The Hibiscus Group, survey agencies, etc.) the system is difficult to navigate. While staff members and providers are frustrated with the EMR, they are accustomed to the current system. DMAVA Leadership has gone through the process of procuring a new system; however, the process has been frustrated by New Jersey laws, particularly equal employment opportunity regulations. Some of the more common long term care electronic medical records vendors (e.g. Matrixcare) are not interested in serving the New Jersey VA nursing homes because of the requirements. The procurement process would need to be changed legislatively in order for the DMAVA team to be able to successfully address this issue. The monitors recognize that there is no resolution to the EMR situation but will continue to monitor for errors that may occur as a result of a dual record keeping process.

Changes in Condition

While monitors were onsite, they attended morning clinical meetings and afternoon wrap up meetings. At these meetings, supervisory nurses from each unit reported on changes of condition such as hand swelling, presence of respiratory and/or urinary symptoms, and skin tears. In addition to reporting, members of the clinical leadership team asked questions and suggested interventions to remedy identified changes in condition. The Assistant Chief Executive Officer (ACEO) - Clinical reviewed and critiqued SBAR forms that accompanied any change of condition that was communicated to the physician. The facility is working to improve the quality of the information staff records on the form. The Director of Nursing (DON) and other members of the team routinely brought their laptops to the morning meeting and monitors observed them accessing the EMR and also checking for lab and x-ray results available through other web portals.

These meetings are an excellent demonstration of team work and “in the moment” teaching experiences by members of the leadership team including, but not limited to, the Medical Director, DON, CEO, ACEO, and Infection Preventionist. The CEO and ACEO stated that they continue to guide members of the team to think critically and make sound clinical decisions.

Nursing supervisors on each unit lead change of shift reporting between shifts and ensure that changes of condition are recorded on the 24-hour log book that is maintained at the nurses station. Any member of the interdisciplinary team can enter information in these log books which are then used by the nurse supervisors for reporting at the clinical meetings. Various members of the management and clinical team, including licensed nursing and nursing assistants, periodically perform rounds. During these rounds they observe for any changes in resident condition as well as for any safety concerns. Menlo Park utilizes a document, called SENTRIES, to alert weekend staff of residents who are experiencing a significant change in condition.

If a change in a resident’s condition is noted, clinical staff conduct a resident assessment, including an MDS significant change assessment if required (i.e. a major decline or improvement that is not expected to return to baseline within two weeks). If the resident’s physician is not onsite, the nurse is to complete an appropriate assessment and document it on the SBAR tool. This tool assists the nurses in ensuring he/she has the necessary information to convey to the physician, enabling the physician to modify medications or treatments. It is noted that management is working to improve the quality of the SBAR documents.

Menlo Park clinical staff routinely assesses residents for symptoms of pain, both in response to changes in client condition when one would reasonably expect pain to result, and when other relevant staff, residents or visitors communicate suspected pain in the event the resident is not able to verbalize pain. The monitoring team confirmed that upon learning a resident is experiencing pain, the clinical staff is responsive, provides treatment in a timely manner, communicates with the physician as needed and continues treatments and assessments to ensure the pain is effectively managed.

Monitors interviewed numerous residents about care and services provided by the facility. These interviews included whether staff routinely assessed the resident for pain. All of the interviewed residents reported that staff asks them if they have pain and offer pain medications when needed. Monitors did not observe any residents who appeared to be in pain, nor did residents verbalize pain symptoms. Monitors will continue to assess this area during future onsite visits.

The Menlo Park facility has a robust infection prevention, detection, and control surveillance program that guides and reminds clinical staff to report any changes in condition that are indicative of possible or worsening infections. The infection control team not only attends all clinical meetings to hear about infections, they also perform a daily review of resident records to detect any signs or symptoms of infection, and orders for labs and x-rays. During a recent flu outbreak, nurses were instructed to perform a respiratory assessment on all residents on all shifts for ten days in order to detect changes in condition, no matter how minor, as early as possible. The IP maintains a list of residents on quarantine in the shared drive that is updated daily and is accessible to all staff.

Resident Care Plans

The Menlo Park facility staff creates and maintains functional, person-centered and individualized care plans for each resident. Nursing staff use the electronic medical record to develop the care plans by selecting from pre-programmed plans. MDS staff complete the Centers for Medicare and Medicaid Services Minimum Data Set (MDS) upon resident admission and at least quarterly thereafter. These assessments are part of the electronic medical record. The MDS identifies actual or potential care area assessments (CAAs) of concern with Admission, Annual, Significant Change in Condition, or Significant Correction of a Prior Comprehensive Assessment. Menlo Park clinical staff determine whether the identified concern requires the development of a care plan. The software has prepopulated care plans and nurses select the appropriate care plans for the resident and appropriate prepopulated interventions. Staff modifies the care plan as necessary based on MDS assessments as well as any changes in condition such as falls or new medical needs. These plans are then shared with the

resident's family, and/or guardian at Care Conferences which are documented in the electronic medical record. The facility has two full time and one part time MDS nurses.

Monitors reviewed several care plans of residents who were readmitted from the hospital. One of these care plans was for one resident who had been hospitalized when a fall resulted in a hip fracture. The resident had a fall care plan that was initiated in 2022. The care plan had various revisions, as evidenced by dates, and while many interventions are generic, there are several that are specific to this resident. For example, interventions to remind the resident not to pick up items from the floor, is a fall intervention that would not necessarily be on the fall care plan of another resident. Another care plan for wounds was specific for three surgical procedures and not just for "surgical wounds."

When a resident has a material change in health status or an incident presenting or indicating a significant health risk, staff members are to communicate that change by documenting it on the 24-hour report. Staff are to update care plans and Kardexes within two business days in response to the root cause of the change. The nursing assistant assignment sheet must also be updated as necessary. This sheet details the resident's Activities of Daily Living (ADLs), dietary needs, cognitive status, bowel status, activity level, and any assistive devices they use. It also notes any special interventions required, such as staying within arm's reach of a resident, and outlines the CNA's responsibilities for resident supervision and unit rounds. However, monitors observed discrepancies between the Kardex and the CNA assignment sheets and/or omissions, indicating a need for improved communication and documentation. For example heel booties and an alarm floor mat were not included on the CNA assignment sheet. In another example, the care plan listed that the resident needed to transfer by way of a Hoyer lift and the assistance of two people; however, the CNA assignment sheet listed that the resident was ambulatory with a walker.

The current system of documentation includes both paper and electronic records. While disciplines such as licensed nursing and social services use the EMR, other disciplines are in the process of being added to the system. Nursing assistants were trained and began using the system in March 2025. Recreational therapy is scheduled to be the next discipline. Therapies, including restorative therapy, are provided by a third party. At the time of this report, monitors have not determined whether therapy treatment plans are communicated to staff in such a way that other disciplines, such as nursing, are able to provide care and treatment that is in alignment with the therapy treatment plan.

Vascular Wounds and Pressure Injuries

The Menlo Park facility has a skin care delivery system that enables the provision of appropriate medical and nursing care of vascular wounds and pressure injuries. The facility has engaged a wound care company to assist in the care of residents with wounds. The nurses employed by the wound care team are certified wound, ostomy, and continence nurses (WOCN). Weekly rounds are conducted by the wound care physician, his nurses, and at least one member of the Menlo Park staff who is responsible for this care delivery system. Members of the management team, as well as the medical director, discuss skin and wound care, including QM performance, at QAPI meetings.

Monitors noted on the Facility Assessment that wound care and dressing changes are topics included in orientation and training, including competencies that are required for licensed nurses on an annual basis. The certified nursing assistant annual training includes the topic of repositioning. A minimum of two clinical staff members on each shift are able to perform wound assessments addressing all relevant characteristics of vascular wounds or pressure injuries.

The wound care company staff performs weekly rounds on residents who are on the facility's wound care list. Any new or worsening wounds that are discovered between weekly rounds are communicated to the wound care company, and a member of that team comes to assess the wound the next business day following discovery or within 72 hours, whichever is earlier. Menlo Park staff told the monitors that a member of the wound care consultant team is typically in the building 4 days per week. Monitors will verify that this is occurring on future onsite visits. During the November 2024 onsite visit, monitors noted that the wound care company was scheduled to do a staff inservice later in the month.

The Menlo Park ADON is responsible for the wound care program. A wound care log is maintained that lists residents with wounds and the description and status of each wound. During the February onsite visit, the monitor attended a meeting that included members of the facility management team and the DMAVA QA Coordinator to discuss pressure ulcers because the facility flagged for pressure ulcers on the QM report in January. Documentation presented at the meetings stated that the facility had also flagged for pressure ulcers in December. The facility performance measure in January was 8.4%, compared to the National average of 6.6%, and ranked at the 86th percentile. The number of residents included in the QM report was 13, which was down from 16 in December. Members at the meeting discussed which wounds had already been resolved and whether the wounds were facility or community acquired. The

purpose for the meeting was to clarify information, the intent was not for QAPI purposes.

During the February 2025 onsite visit, the monitor and the ADON in charge of the wound care program reviewed three residents with wounds. Review included observation of the residents for presence and use of positioning and pressure relieving devices, interview of the resident if possible, review of the medical record to verify that skin checks, Braden scale assessments, care plans, and Kardex and nursing assistant assignment sheets are accurate, and check for nutritional assessments. The review is summarized as follows:

- The first resident was observed resting in bed. He is currently on hospice care. The resident had a specialty mattress, wedge cushions, and heel booties. The current pressure ulcer is evaluated as a Stage III wound to the left buttock. The wound care consultant sees the resident weekly and the last progress note states that the wound is improving in size. A 2/18/25 order change was to cleanse the wound with acetic acid solution rather than normal saline. The resident receives protein and calorie supplements (Prostat, Boost+) and milkshakes. The resident had heel booties in place, his left forearm and wrist were elevated on pillows because of swelling, and the resident had wedge pillow and a neck pillow all of which were appropriately positioned. The resident responded he was comfortable and that his wound only hurt during dressing changes and staff provide pain medication when he requests it.
  The treatment record was reviewed and staff made a check mark indicating that dressing changes were completed, and skin checks and Braden scale assessments were completed. This was not always verified in the electronic medical record. The resident was readmitted from the hospital on 1/8/25. The ADON stated all residents have a Braden scale assessment done upon admission/readmission and then weekly times four. The resident had a Braden assessment documented in the EMR on 01/08, 01/22 and 01/29 and has a check mark (the assessment should have a numeric value) on the treatment administration record on 1/08, 02/15, 01/22, and 02/05. A review of weekly skin checks was documented in the EMR on 02/01, 02/05, and 02/12. The TAR had check marks indicating a skin check had been completed on 02/01, 02/05, 02/12, and 02/19. Neither the heel booties nor the wedge cushions were listed on the Kardex or CNA assignment sheet.
- The second resident was observed in bed with a low air loss mattress in place. The resident has a stage IV pressure ulcer on his sacrum. His shoulders were slightly turned to his left with the placement of a pillow at his back. A wedge cushion was available at the bedside but not in use. Given the location of the

resident's wound, the turning of the shoulders was insufficient to keep pressure off-loaded from the sacral area. Although the resident was wearing bilateral heel booties, the booties were inappropriately positioned too close to the knees which resulted in the heels being in contact with the mattress. A Roho cushion is ordered for the resident's wheelchair; however, the resident had a pressure relieving cushion in his chair, not a Roho cushion. The ADON stated the resident refuses to get up but said she would order the Roho cushion as ordered. The wound care consultant sees the resident's wound on a weekly basis and the consultant notes record the wound is decreasing in size. The resident does not take nutrition orally and is on an enteral feeding that includes Jevity, folic acid, vitamin B12, Vitamin D, and Zinc for wound healing. The resident was readmitted to the facility on 01/24 and a Braden scale assessment was documented on 01/24, 01/31, 02/13, and was due the day of the observation. Weekly skin checks were recorded as complete on the treatment administration record but were not recorded in the EMR.

- The third resident was observed to be properly positioned in bed; however, due to time constraints, the rest of the review was truncated.
- In looking at the Kardex for the residents and the nursing assistant assignment sheets, positioning devices were not always included on these documents or there was inconsistency between the two documents.

The monitor provided a summary of the above review at the end of the visit. The leadership team expressed appreciation for the information and stated it gave them an opportunity to improve performance.

Over the course of the onsite visits, monitors interviewed numerous residents asking whether staff were attentive to their complaints of pain (including during dressing changes if appropriate for the resident). None of the residents interviewed had complaints related to pain management.

During future on-site visits monitors will assess staff for competency and for other components not addressed in this report.

Medication Administration

The Menlo Park facility provides training and competency evaluations during licensed nurses orientation. Topics include pharmacology/nursing mathematics, medication pass, and antibiotic stewardship. The facility also contracts with a consultant pharmacy who reviews resident records to assure that medications ordered by the physician are appropriate for the resident. The pharmacy also conducts medication pass observations of the nurses to evaluate whether they are following the standard of practice for

medication administration, medication cart preparation, infection prevention measures, timeliness of administration. Reports from these observations are submitted to the QAPI committee. These activities demonstrate that Menlo Park management is ensuring that medications are safely dispensed and administered.

The Menlo Park facility has established and continues to maintain a Medication Variance Committee responsible for reviewing averted and actual medication variances. This Committee reports to the QAPI committee on a monthly basis. Monitors noted in QAPI meeting minutes several activities related to medications, including use of antipsychotic medications and whether nursing documentation supports the use of the medications, antibiotic stewardship, medication errors and the possible cause of errors, such as transcription errors during the recapitulation of orders. Minutes include discussion of interventions to correct any reported errors.

During the first onsite visit to the Menlo Park Facility (November 2024) the monitoring team noted that the morning medication pass took longer than the allotted two-hour window. Based on the half life of the medication, medications administered outside of this window could result in a medication error that should be reported to the resident's physician. This occurred on each morning of the visit. Several staff members stated that this was not an isolated event, but that it was quite common for the morning medication pass to exceed the medication window (per the Menlo Park facility policy of one hour before to one hour after the ordered time). When the monitor asked nurses their opinion for why the medication pass was routinely late, nursing staff stated they are sometimes interrupted by CNAs who cannot get a resident out of bed until the nurse applies a cream or ointment, or they are sometimes called to the nurses station when the desk nurse is not available. The monitoring team shared this information with facility leadership who discussed various strategies for improvement, including working with the Medical Director and pharmacy to assess how medication administration times might be changed to decrease the number of medications administered in the morning, evaluating whether some medications were no longer necessary, and using extended release medications if appropriate. According to the DMAVA Director of Health Services, the facility will implement the Passport medication administration system early 2025. This is a fully automated system that prepackages resident medications in an envelope labeled with the resident's name, room number, and medications. Menlo Park leadership staff anticipate this will address the current problem of late medication administration.

During the February 2025 visit, the monitor and the DON visited three units between 10:00 am and 10:13 am to determine if medication passes had been completed in a timely manner. The medication pass on the first unit visited was completed. At approximately 10:08 am, the nurse on a second unit stated she had one resident to

whom she still needed to administer medication. At approximately 10:13 am, the nurse on a third stated she had just finished her medication pass. This is a significant improvement from the previous visit where medications were still being administered at 10:43 am. The Passport equipment is on site; however, the management team is awaiting final approval from the Pharmacy Board before the units can be used.

On future visits the monitors will continue to evaluate the effectiveness of the Medication Variance Committee as well as other components of the Medication Administration provision.

Falls

The Menlo Park Facility has created, implemented, and maintained a system to prevent resident falls. The monitoring team confirmed that Menlo Park Facility staff members complete resident assessments upon admission, quarterly, and as needed, using a standardized fall risk assessment tool. Nursing assistants are required to round every 30-minutes in an effort to prevent falls. These rounds are documented on a check list that is initialed by staff. CNA assignment sheets include blocks of time during which they supervise residents in common areas. During these times, the CNA does not leave the area. The maintenance department conducts routine environmental rounds to ensure that resident rooms and common areas remain as free of accident hazards as possible. During an onsite visit the monitors identified a fall risk but were not aware of any resident falls that were the result of this concern. After discussion with Menlo Park leadership, the issue was resolved and the fall risk is no longer a concern.

Monitors observed fall prevention safety devices for residents who are at risk for falling that help prevent falls or that minimize injury if a fall occurs. These include the use of wheelchair and bed alarms (silent), hi/lo beds, and fall mats on the floor next to the resident's bed.

The Menlo Park facility nurse investigator subsequently conducts a post-fall assessment using a form-based report (Risk Watch). This form asks about the location of the fall, what the resident was doing at the time of the fall, whether the fall was witnessed, the assigned caregiver, who reported the fall and at what time, the physician who was notified and at what time, the family or power of attorney who was notified and what time, whether the ambulance was called, and whether the resident was sent to the hospital. Assessment information includes vital signs, pulse ox, blood sugar, cognitive status prior to and after the fall, whether an injury occurred and what, if any, action was taken (e.g. initiation of neuro checks, presence of pain, and therapy referral). The nurse's note entered into the medical record is included, as well as the resident's

statement of what happened, and the statement of any witnesses. There is also documentation stating the last time the resident was observed before the fall occurred, what cares (e.g. toileting, administration of pain or anxiolytic medications} were provided prior to the fall, information about environmental conditions, type of footwear worn, preventive measures in place at the time of the fall and whether a bedrail was in use is also recorded. Lastly, the nurse investigator writes a conclusion about how the fall occurred, the root cause of the fall, whether the incident was recorded, reported and investigated and whether the care plan was updated.

The monitor reviewed a number of the form-based reports and noted that appropriate immediate interventions were implemented at the time of the fall. Most post-fall interventions added to the care plan were identified based on a root cause analysis of the fall. These interventions included therapy referrals, offering residents assistance with toileting if the staff member noted the resident was awake during the night, wearing of proper footwear, etc.

Weekly falls meetings are held to discuss individual resident falls as this is a regularly reviewed care delivery system identified on the Facility's QAPI program. On future visits the monitoring team will assess the fall prevention provision to determine compliance with how the facility assesses falls on a systemic basis.

Oversight and Management of Medical Care

The Menlo Park facility has a very involved Medical Director who is also the attending physician for many of the residents. He is on site Mondays, Wednesdays, and Fridays. Four other physicians provide care in the building which results in a physician being on site daily. The Medical Director also provides on-call services to the facility so a physician is always available to residents and staff.

The monitoring team has observed positive interactions between the medical director and the clinical management team during meetings such as the morning clinical meeting, wrap up, and various QAPI meetings. Monitors are impressed by the free-flowing conversations that include questions asked and answered and teaching moments.

During the February 2025 onsite visit, the monitor requested to see credentialing packets of five physicians with privileges at the facility. Each folder contained a Credentialing Review Packet that included the following: copies of the physician's license; Specialty Board Certification, as applicable; controlled Drub Substance Registration, Federal CDS Registration (DEA); the physician's national provider number;

a copy of liability insurance; a curriculum vitae; and a letter verifying hospital privileges or a primary source from a physician or nurse practitioner. The physician must verify he/she received a copy of the facility by-laws and interpretive guidelines. The packet also contains a self-attestation about the moral, ethical and professional qualifications and competence of the physician; as well as a signed release form allowing the facility to make inquiries and consult with anyone about the same. Finally, the packet contains a document entitled Standards and Procedures for Physicians who provide care to residents. Each of the packets reviewed were complete, including evidence of licensure and insurance renewals as appropriate.

The monitor met with the medical director to discuss his role, particularly as it relates to the responsibilities defined in the consent decree and in the Implementation Plan submitted by the facility. Examples of meeting those requirements are as follows:

- The medical director stated he tracks his hours as the medical director on a time sheet. The time spent in the care of his own residents is not included on the time sheet even though he is available to the facility during these times as well.
- During onsite visits the monitors observed the medical director actively participating in clinical and QAPI meetings. He uses time at these meetings to discuss resident care, suggest additional interventions, and to educate on care topics in real time.
- According to the CEO, the medical director has provided at least one inservice, which was devoted to identification of change in resident condition.

The physician orders and consultative and/or required progress notes are not part of the electronic medical record. The unit secretaries assist in making sure any designated timelines for physician assessments and documentation are met. These notes are in the paper portion of the residents' records.

The medical director was unable to discuss how he was meeting consent decree requirements, or those areas assigned to him in the Implementation Plan, in the following areas:

- Quarterly chart audits for determined areas of concern that are to be discussed at the quarterly QAPi meeting
- Identification and communication of appropriate performance expectations for other physicians and health care practitioners, and monitoring their performance
- Performs and documents peer review over other medical providers and is subject to external peer review when providing direct care

The monitor and the medical director brain-stormed some ways and tools that might assist in meeting these requirements, such as the following:

- Use of the Standards and Procedures for Physicians that is contained in the physician's credentialing packet
- Performance in meeting antibiotic stewardship goals
- Reviewing SBARs and hospitalization data
- Having his own peer review done by the medical director at the VA Paramus facility

On future visits, the monitoring team will assess this area more fully to determine the level of compliance for this provision.

Infection Prevention Detection & Control (IP)

The Menlo Park Facility has created, implemented, and maintained appropriate infection prevention, detection, and control practices including the maintenance of written infection control policies that are consistent with applicable federal and state guidelines. The Annual Facility Assessment, the QAPI Mission Statement, QAPI minutes, and staff education documents all include evidence that infection, detection, and control efforts are a priority. The Infection Prevention Detection & Control (IP) QAPI committee meets on a monthly basis and reports data including but not limited to: numbers of residents on the various types of infection control precautions (e.g. barrier, transmission based, etc.), results of environmental audits, infections by site (urinary tract, upper respiratory, pneumonia, bone, skin, eye, and other), antibiotic utilization, and, in the event of a Covid/Flu outbreak, a Daily Quarantine Report. This report identifies requirements for personal protective equipment, a resident listing (including room number of the residents in quarantine), and dates for Covid testing (days one, three, five, and seven) for all new admissions and readmissions. The monitors noted robust and in-depth IP discussions by the Medical Director, Infection Preventionist, DON (who has an advanced long term care specific infection prevention certification from the Association for Professionals in Infection Control and Epidemiology) and other members of the clinical management team at the morning and afternoon clinical meetings. Immediate actions are initiated with any suspected infection. For example, the Infection Preventionist reminded housekeeping to use “the blue top wipes” and that all staff use soap and water as opposed to hand sanitizer with a suspected but not confirmed case of C. Diff. Staff administer a rapid test for Covid and flu and a respiratory panel is done for residents who exhibit any sign, no matter how minor, of a respiratory infection. The resident’s immunization status is also reviewed.

Menlo Park has an infection control department composed of a full time Infection Preventionist, certified by the CDC, and two additional licensed nurses (monitors do not know the certification status of these two individuals). The IP team actively performs infection related surveillance such as reviewing new admissions for immunization status, antibiotic usage, completed SBARs, new infection related orders such as labs and x-rays and ensuing results if available, and nurses notes for any potential infection control issues that have not been reported by nursing staff. The IP nurses are full time employees and provide coverage seven days a week.

During orientation and annually thereafter, the education department provides education on infection control. This includes the types of precautions used to prevent the spread of infections, use of personal protective equipment, and handwashing.

Frequent communication occurs between the infection prevention team and the NJ Department of Health to ensure that protocols are up to date and to obtain confirmation that infection prevention and control interventions utilized meet the current standard of practice. A representative from the NJ Department of Health Communicable Disease Service consults onsite quarterly. This individual is also available for consultation as needed. In February 2025, the facility had a flu outbreak with two units in quarantine. The facility did not admit any new residents to these units and residents sheltered in place on the unit. These units were used for those residents with symptoms but who had a negative test for flu. Any resident who tested positive was isolated on the designated unit, which is an empty unit used specifically for isolation purposes. Residents who tested positive for flu received a treatment dose of an antiviral, and all residents received a prophylactic dose unless they refused it. In addition, residents who received the prophylactic dose had a respiratory assessment completed every shift for ten days. The facility did due diligence in regard to identifying dates when infection prevention strategies could safely be discontinued. During the outbreak period, all staff wore face masks as required. Designated staff provided cares to residents on the isolation units.

The housekeeping department performs regular audits to assure the facility is properly cleaned and disinfected. The department checks that high touch surfaces are properly cleaned by using GloGerm. Similarly, the education and/or infection prevention department uses Caught Red Handed to evaluate, and remediate if necessary, that staff are thoroughly performing hand washing.

The facility makes use of rapid testing and respiratory panels to detect respiratory diseases. Anyone entering the facility must participate in an electronic screening process that is focused on ascertaining whether the individual has signs/symptoms of

Covid, the Covid immunization status, and exposure to anyone who potentially has or had Covid. The individual's temperature is also taken via the device.

Monitors will continue to monitor this provision, including addressing any components not fully addressed in this baseline report.

Clinical Care Policies, Procedures & Training:

DMAVA Leadership and the Menlo Park Facility have an established system to maintain and communicate new policies and procedures via their Intranet. The three New Jersey Veterans Homes have made significant strides in working together and this started with developing and updating all policies and procedures. The monitoring team interviewed staff members in management positions who said they provided input in the policy and procedure updates and were happy with the process. Any new or modified changes are emailed to the CEOs to initiate education and inservice.

The Menlo Park clinical staff have demonstrated the necessary competence and expertise in clinical areas according to education records and discussion with the Instructor of Nursing. In addition, DMAVA has assembled a leadership team that has implemented an appropriate system of oversight and accountability mechanisms sufficient to ensure that policies and practices are reliably implemented. While monitors believe that Menlo Park staff are properly trained and have the competency to complete assigned responsibilities, they are not always consistent. For example, during record review monitors noted that two out of five Braden scale assessments were not completed. In addition, the EMR indicated that three weekly skin checks were completed, whereas the TAR indicated that four weekly skin checks were completed. During future onsite visits, the monitors will follow up on these documentation concerns to ensure that policies and procedures are fully implemented.

Finally, monitors did not yet investigate and/or assess whether contractors and volunteers have received competency based training in infection prevention, detection and control. Future onsite visits will allow the monitors to review this and evaluate compliance with the requirements of the Consent Decree.

Quality Assurance and Performance Improvement

The Menlo Park Facility, under the direction of the State of New Jersey has established a robust QAPI Program. The DMAVA Quality Assurance Coordinator oversees the QAPI Program and works with Menlo Park Leadership and *facility* QAPI Coordinator to monitor the implementation and effectiveness of the program.

On a monthly basis, the Director of Veterans Healthcare Services receives a Monthly QAPI Report for which data reported in the following areas: Wounds, (Number of new facility and community acquired), Hospitalizations (Reason), Weight Loss of 5% or more (Reason), Emergency Room Visits (Admitted, Returned to the Facility), Rehospitalization within 30 Days or Less (Reason), Falls (Number of residents on psychiatric medications, residents with more than one fall, major injuries, and number of silent alarms in use), Skin Tears (location on the body), Residents on Oxygen (continuous, as needed), Intravenous Administrations (medication, fluids/electrolytes, Other), Residents on the Restorative Program (Reason) Infection Control (Urinary Tract Infections (Number of residents with a foley catheter, number of infections with/without a foley catheter), Enhanced Barrier Precaution (Reason), Pharmacy (number of medication errors and why, psychoactive medication use (Number of residents, number on 2+ psychoactive medications, dose reduction efforts, care plan inventions) Antibiotic Starts (Type of infection, Meets McGeers Criteria) and Abuse/Neglect Allegations (Date, Brief Description, Staff Suspension/Removal, Substantiation, Police involvement).

The scope of the QAPI program and the monthly collection of data provides the opportunity to timely and effectively detect problems with the provision of protections, services, and support and identify trends in the various areas being monitored by the QAPI team. The DMAVA QAPI Coordinator reported that she reviews the CMS Quality Measures (QMs) for patterns and trends, stating that she looks into any negative trends and any QMs where the facility is above the 50th percentile or where the facility percentage is above the state average.

The Menlo Park leadership team provided the monitors with a copy of the New Jersey Veterans Memorial Homes Department of Quality Improvement Mission Statement. This document identifies the core beliefs and philosophy of the program including but not limited to commitment, use of data, inclusion of all staff, all departments, and all services provided to residents, the focus on systems and processes rather than on individuals, and the use of identified goals to measure progress. The QA Leadership Committee includes the QA Coordinator, CEO, DON, Medical Director, Infection Preventionist and at least three other staff members - ACEOs and representatives from other services provided at the facility.

The Mission Statement identifies the following twelve clinical areas that the New Jersey Veterans Homes will monitor: pressure ulcers and skin breakdown, psychoactive drug use, hospitalizations and rehospitalizations, catheter rates and care, weight loss, infections, antibiotic use, restraint use, falls/fall resulting in injury, incidents of potential abuse, neglect or misappropriation, and other identified care areas. The QA Leadership Team reviews the following benchmarks to evaluate the care and services provided to

residents: NJ State measure standards, federal measure standards (ex. Casper report, Nursing Home Compare), past facility measures (baseline) additional long term care/industry standards, Department of Health survey reports, and VA survey reports. The DMAVA Coordinator has identified that her goal for the program includes that the NJ Veterans Homes Quality Measures will be less than half of what the state and national averages are. The Mission Statement includes other valuable information such as the types of audits being conducted, reports that are to be reviewed, meetings to be conducted, etc.

Monitors have attended a variety of QAPI meetings and reviewed meeting minutes from several other QAPI meetings. The facility QAPI team meets weekly to address any Quality Measures that are above the 50th percentile ranking or that are trending in the wrong direction. Once a month the appropriate members of the QAPI team meet to discuss ongoing quality projects. Members of the management team and various department managers whose departments would be providing care or services related to the topic attend these meetings. These members include but are not limited to, therapy, recreational therapy, social services, dietary, housekeeping, education, and infection control attend these meetings. Lastly there are quarterly QAPI meetings that are attended by the entire QAPI team, including the Medical Director and members of the Menlo Park leadership team. Monitors have observed that attendees, including the medical director provide input at these meetings. The Mission Statement identifies that observations and interviews of residents, family and staff are included in data that is collected. The monitoring team confirmed that information from grievance logs, routine meetings with families and resident council minutes inform the QAPI program. The monitoring team recommends increased involvement of front line staff in the QAPI program.

The Mission Statement identifies the following steps in developing a performance improvement project: identifying the problem or event, identifying contributing factors, determining root causes, and developing a clear problem statement. This should be followed by implementing the plan, studying the plan, and analyzing whether the project goals have been met. The monitors reviewed documents for various QAPI projects and noted weaknesses in completing the necessary steps to develop a successful performance improvement project. The monitoring team will continue to work with Menlo Park leadership to identify areas to improve.

Monitors noted that the QAPI Mission Statement provides a section that identifies that QAPI training is provided to all staff and volunteers. Training is to include the purpose of the QA program, definitions used in QAPI, a description of the program, the importance of striving for continuous improvement, the importance of reporting any quality concerns

brought to staff by residents/visitors, and the methods of reporting concerns. On future visits, the monitors will observe for evidence the training is occurring.

The monitors acknowledge that DMAVA and the Menlo Park QA Committee have expended considerable time and effort to the QAPI program. Going forward, the monitoring team will continue to assess the QAPI program's strengths and weaknesses.

Emergency Operations & Preparedness

The monitoring team has not fully reviewed this area to determine whether the Menlo Park facility has created, maintained, and updated as necessary, a comprehensive Emergency Preparedness Program.

The monitoring team reviewed several after action reports for real and potential emergency situations (an actual earthquake, an elopement, and a potential interruption in procurement of supplies based on a threatened longshoreman strike.) In these after action reports, the management team determined what went well and where opportunities for improvement existed. It is evident that staff responded appropriately to the events. For example, staff not only attended to the safety needs of residents, they also addressed emotional and psychological concerns of both residents and staff during the earthquake event. The monitoring team commended the Menlo Park team for proactively ordering an additional 6-8 week's worth of supplies in the event that the longshoremen strike occurred.

On future visits, the monitoring team will more fully assess the facility's compliance with this provision.

Staffing

Menlo Park assigns sufficient clinical staff (providing direct care) so that resident acuity needs are met. The clinical staffing is in accordance with the NJ State Guidelines for nursing assistants but often exceeds those ratios based on acuity needs of the residents.

The Menlo Park Facility has a 5 Star staffing rating on CMS Nursing Home Compare. The total number of nurse staff hours per resident per day is 5 hours and 59 minutes, compared to a national average of 3 hours and 51 minutes; nurse staffing on the weekends is 5 hours and 26 minutes. The facility provides 55 minutes of RN hours per resident per day, compared to a national average of 40 minutes; and 3 hours and 34 minutes of nursing assistant hours per resident per day compared to a national average of 2 hours and 19 minutes. Regarding staff turnover, Menlo Park has 23.7% total

nursing staff turnover, compared to a national average of 48.4%. RN turnover is 23.7% whereas the national average is 45.1%.

The monitors have not observed or heard of inadequate allocation of staff responsibilities and workloads that would indicate that staff assigned to specialized duties, such as restorative care, are regularly reassigned to provide direct clinical care instead. During numerous resident interviews, residents overwhelmingly stated they were happy with care and services provided. The monitors also observed interactions, including management to management, management to staff, staff to staff, and staff to resident, that were very positive and open.

At the time of this writing, monitors had not reviewed minutes from Resident Council meetings to determine if there are any persistent concerns that the facility has not resolved. Monitors will review these minutes at future onsite visits.

The monitoring team has conducted interviews and reviewed after-action reports related to emergency preparedness. The monitors did not detect staffing concerns in those interviews and reports. Additional information is discussed in the Emergency Preparedness section in this document. Monitors will evaluate the facility's Emergency Preparedness Plan in the future.

Menlo Park has assigned supervisory staff and facility leadership in sufficient numbers to ensure resident safety and well-being. Per the Facility Assessment, Administrative Staffing includes a Director of Nursing, an Assistant Director of Nurses, and Nursing Supervisors (five on the 7-3 shift, two on the 3-11 shift, and two on the 11-7 shift). Monitors reviewed the credentials and resumes of members of the Leadership team and are impressed with the education and experience of these individuals.

Staff members are assigned in a way that complies with the mandates of the Consent Decree, the provision of appropriate care and, to the monitor's knowledge, DMAVA's policies and procedures. Future onsite visits will allow for observation of staff competency testing (including return demonstrations), further observation of direct care, interviews and reviewing the following records: medical records of residents, and education and training records, including evidence of competency.

The use of agency staff continues to decrease. During a pay period in October of 2024, 55 shifts were filled by agency staff, 44 of which were on the 11-7 shift. In a February 2025 complete pay period, 22 shifts were filled with an agency nurse. All of these shifts occurred over weekends. Nine of the 22 shifts were filled by the same two nurses which contributes to more consistency in the ability to know and provide services to residents.

The CEO shared a memorandum that went out to full time nursing staff on January 27th, 2025. In the memorandum, the CEO advised staff that a VA federal grant had been secured that funds incentive bonuses to registered nurses, licensed practical nurses, and certified nurses' aids who meet the qualifications. Staff are eligible to receive one bonus per month for each of two incentives. One of the incentives is a $175 bonus for perfect attendance during pay periods starting March 8th through September 19th. The facility can award up to 343 bonuses for that incentive during that period. The other incentive is an overtime bonus for staff working overtime on the weekend starting in February and running through September. The facility can award up to 457 bonuses for that incentive. Criteria for meeting the bonus is further defined in the memo.

According to the Facility Assessment document, DMAVA and the Menlo Park facility have implemented numerous activities designed to attract and retain staff. The management team monitors the salaries of clinical positions in the geographical area to remain competitive with other healthcare entities. In the past year the DMAVA Central Office hired a Recruiter to assist with the recruitment of frontline staff. The Human Resources staff visits job fairs and local schools and also uses a variety of methods to post positions, including posting on websites such as Indeed. The monitoring team will continue to assess for continued success in attracting and retaining facility staff. As reported above, turnover rates for the facility nursing staff is approximately half of the national average.

Organizational Accountability

DMAVA identified an Agreement Coordinator (AC) as well as a succession plan should the identified AC no longer be able to fill the role. The AC was involved in the development of the required Implementation Plans to ensure compliance with each provision of the Consent Decree and Veterans Homes policies. The AC has also succeeded in accurately collecting data on clinical care outcomes. He routinely reviews QM, QAPI reports and CASPERS and will work with other DMAVA leadership staff members to dig into trends that might be concerning.

The AC is responsible for regularly engaging with the stakeholders (identified as residents, staff, family members and the VA Central Office). DMAVA has succeeded in establishing mechanisms for regularly sharing with and receiving information from stakeholders. The facility CEOs conduct bi-weekly virtual town halls with powers of attorney who choose to attend. The AC informed the monitors that he met with each shift change at both Paramus and Menlo Park prior to the consent decree. He plans to continue to do this annually, or as needed. The AC also meets routinely with various veterans groups at both Paramus and Menlo Park - during the month of February he

was at each facility twice. He regularly attends the Resident Council meetings and invites any Resident Council member to reach out to him directly.

DMAVA has identified three compliance officers as required by the Consent Decree (the CEOs of each facility as well as the DMAVA Quality Assurance Coordinator) who are responsible for the implementation and enforcement of an effective compliance program at each individual Veterans Home as well as DMAVA. The AC meets with these three individuals biweekly.