STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315402	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARMENIAN NURSING AND REHABILITATION CENTER	70 MAIN STREET EMERSON, NJ 07630

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: [ST] 1, [ST] 3 Based on observation, interviews, review of the Medical Records (MRs), and other facility documentation on 3/11/2020 and [DATE], it was determined that the facility failed to ensure the safety of its residents and implement immediate interventions after observed sexual abuse for 1 of 4 sampled residents (Resident #2), who was cognitively impaired. In addition, the facility staff failed to follow their own policy and procedure titled, Prevention of Abuse & Neglect, to prevent further potential abuse. The facility failed to remove the alleged perpetrator off the unit immediately upon learning of the sexual abuse, allowing the staff member to continue to remain on the unit and to have access to other residents on the unit until end of shift approximately 3.5 hours. On [DATE] at approximately 11:30 a.m., Certified Nurse Aide (CNA) #1 entered Resident #2's room and observed Resident #2 lying in bed with CNA #2 at her bedside. CNA #2 was fondling Resident #2's breasts with both hands and kissing her face close to her mouth. CNA #1 then left the room and continued with her routine resident care duties and did not interrupt the incident or report the incident to a Nursing Supervisor until approximately 1:00 p.m., 1.5 hours (hr.) later. CNA #1 informed Licensed Practical Nurse (LPN) #1 who then reported the incident to the Director of Nursing (DON), however, CNA #2 was not removed from the resident unit until 3:00 p.m., approximately 2 hours later, when his shift ended. This deficient practice placed Resident #2 and all other residents on the unit in an Immediate Jeopardy (IJ) situation. The IJ was identified and reported to the DON and Administrator on [DATE] at 4:55 p.m. The IJ past noncompliance, began on [DATE] when CNA #1 was observed fondling Resident #2 at 11:30 a.m. and was removed on [DATE] when the facility initiated staff in-service education and implemented acceptable interventions for a Plan Of Correction (POC). This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated [DATE], Resident #2 had severe cognitive impairment and required total staff assistance for all Activities of Daily Living (ADLs). A review of Resident #2's care plan (CP), initiated 9/23/2016 and revised on 7/22/2019, included but was not limited to; the resident had impaired cognitive function and was at risk for further decline. A Goal included that the resident will make eye contact during verbal conversation/stimulation daily. Interventions included to Monitor level of consciousness, mental status. Engage the resident in simple, structured activities that avoid overly demanding tasks. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Cue orient and supervise as needed. On [DATE], the [ST] Department of Health ([ST]DOH) received a Reportable Event Record/Report (AAS-45) from the facility. The AAS-45 revealed the facility identified a staff to resident abuse which occurred on [DATE]. A female CNA (#1) reported observing a male CNA (#2) touching the resident's breasts and kissing her while the resident was in bed in supine position and breasts were exposed. CNA #2 was kissing the resident's face close to the mouth. There were no other residents in the room. Resident #2 was not able to verbalize any incident when questioned. The resident was assessed with [REDACTED].#2 was hired via an agency and was sent home. The agency was informed that CNA #2 was not welcome at the facility again. Additionally, the facility included an Addendum to the report prepared on [DATE] . submitted by the DON, which noted that the local police were notified on [DATE] at 2:45 p.m., (one day after the incident) and the Social Worker (SW) began facility wide inservice education on Resident Rights, Abuse . The facility also provided with the AAS-45, an undated Summary of the incident ., submitted by the DON, which included but was not limited to; On [DATE] CNA #1 reported to LPN #1 that she observed CNA #2 molesting and kissing (a) female resident (#2) in her bed. LPN #1 reported it to the DON who immediately removed (CNA #2) from the floor, canceled his afternoon shift sent him home and called the (staffing) Agency to tell them.not to send him anymore. The resident was assessed with [REDACTED].#2 cannot verbalize her needs . On [DATE] (the day after the incident), the DON notified the responsible party (RP), the physician, the police and the [ST] DOH. On [DATE], residents assigned to CNA #2 were interviewed with no negative outcomes noted. The police obtained statements from the DON, LPN #1, and CNA #1. During a care tour on 3/11/2020 at 9:58 a.m. by the surveyor, accompanied by the Licensed Practical Nurse (LPN) #1, Resident #2's skin was observed to be intact with no bruises. Resident #2 was lying in bed, awake and was nonverbal. The surveyor was not able to interview Resident #2 secondary to Resident's impaired cognitive status. Review of Resident #2's MR revealed there was no Nursing progress notes regarding the incident on [DATE]. Review of a facility Accident/Incident Statement, dated [DATE], signed by CNA #1 revealed; I (CNA #1) saw an aid, who is called (CNA #2) about 11:35 a.m., grabbing (Resident #2's) breast with his both hands and he also was kissing (Resident #2) next to her lips. An hour later (CNA #2) said to me sorry about 12:40 while I (CNA #1) was feeding a resident and I asked to him sorry for what, and he said to me that everything was his fault. During an interview with the surveyor on 3/11/2020 at 11:00 a.m., CNA #1 added that on [DATE] at 11:30 a.m. - 11:40 a.m. she went to help CNA #2 with resident care. She knocked on Resident #2's door and walked in. The privacy curtain was open and Resident #2's shirt was all the way up. She observed CNA #2 with his hands on Resident #2's breast and kissing the resident's face next to the resident's lips. CNA #1 stated she did not say anything and stepped out of Resident #2's room, because I was in shock. CNA #1 stated she then saw CNA #2 at 11:45 a.m., in the staff dining room, and at 12:00 p.m., she saw him in the resident dining room. CNA #1 indicated that CNA #2 came and looked at her while she was feeding another resident in the lunchroom and she asked him if he wanted to feed a resident, to which he responded sorry. He stated to CNA #1 that everything was his fault. CNA #1 stated that she then decided to report the incident to LPN #1. CNA #1 stated that she later saw CNA #2 in the resident television room at 1:00 p.m. and in the staff break room at 1:30 p.m. Review of facility Accident/Incident Statements, dated [DATE] and [DATE], signed by LPN #1 revealed that at 1:00 p.m., on [DATE] CNA #1 approached her and stated she needed to tell her something privately. CNA #1 stated to LPN #1 that she was checking on residents prior to lunch, approximately 11:40 am, knocked on Resident #2's room door and observed CNA #2 kissing and fondling residents breasts. LPN #1 documented that she then checked the resident with no issues and immediately reported the incident to the DON. LPN #1 further documented; (Resident #2) unable to answer my questions due to cognitive status. Additionally, LPN #1 asked CNA #1 why she waited approximately 50 minutes to report the incident to her and CNA #1 stated she did not want to get anyone in trouble but realized this action was wrong . During an interview with the surveyor on 3/11/2020 at 10:12 a.m., LPN #1 confirmed her statement and added that CNA #1 approached her before the lunch meal and asked to speak to her in private. At approximately 12:30 to 1:00 p.m., CNA #1 reported to her that earlier that morning CNA #1 observed Resident #2 being sexually abused by CNA #2. She reported that upon entering Resident #2's room, CNA #1 observed a male CNA (#2) touching Resident #2's breast while kissing the resident's face. LPN #1 enquired why CNA #1 did not come to report the allegation right away after witnessing the abuse. CNA #1 stated she was nervous and did not want to get anyone into trouble. LPN #1 stated she then went to check the resident, and then LPN #1 and CNA #1 reported the incident to the Director of Nursing (DON). During an

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) interview with the surveyor on 3/11/2020 at 12:12 p.m., the DON stated that on [DATE] at 2:00 p.m., LPN #1 and CNA #1 reported to her an allegation of sexual abuse of Resident #2 by CNA #2. The DON stated that CNA #1 did not report the incident of sexual abuse to anyone at first because, she was doubting herself and was not sure if she saw what she thought she saw, but when he (CNA #2) came to the dining room and said 'I'm sorry', that confirmed to her that she did see it. The DON stated that she did not speak with CNA #2 regarding the allegation. He was an Agency employee, so we just sent him home. The DON stated that CNA #2 stayed at the facility and finished his documentation in the breakroom and was informed that his evening shift was canceled. The DON stated that she reviewed the facility video camera for [DATE] and saw CNA #2 enter Resident #2's room and then observed CNA #1 enter the room and a few seconds later CNA #1 exited the room. The DON further stated the video revealed that about 5 to 10 minutes after CNA #1 exited Resident #2's room, CNA #2 exited the room. The DON stated she was not able to see where CNA #2 went after exiting Resident #2's room, because it was not visible on the camera. She further stated that LPN #1 and CNA #1 came to report the incident to her at approximately 1:40 p.m. to 2:00 p.m., and that CNA #2 apologized to CNA #1 at approximately 1:30 p.m. The DON stated that she did do a body check and did not observe any signs and symptoms of trauma. The resident was not sent to the hospital because as per DON, there was no reason for that. The Medical Doctor (MD), the family and the police were not called until the next day. We were in shock and it was the end of the day, so we said ok we will do it the next day. She also stated that she initially forgot to call the police on [DATE], until she was questioned by the [ST] DOH staff member on [DATE]. I said no, I forgot about Peggy's Law, but called (the police) right away after speaking with her. AS per DON, no incident report (IR) was done. The DON denied any other abuse incidents at the facility. During an interview with the surveyor on 3/11/2020 at 1:43 p.m., the Administrator stated that the DON informed him of the allegation of sexual abuse of Resident #2 on [DATE] at 2:15 p.m. The surveyor asked if he was aware that the CNA had not been removed from resident care immediately and the Administrator stated, I am pretty sure (the DON) sent him home. During an interview with the surveyor on 3/11/2020 at 2:10 p.m., the staffing coordinator, CNA #3, stated that on [DATE] sometime after 2:00 p.m., the DON instructed her to cancel CNA #2 for the [DATE] evening shift. She also told her that CNA #2 could not work at the facility anymore. However, she confirmed she was not instructed to have CNA #2 removed from the resident care unit for the 7-3 shift. She further stated that on [DATE], CNA #2 stayed on the unit and finished his documentation. During an interview with the surveyor on 3/11/2020 at 2:47 p.m., the Social Work Services Director (SW) stated that she was informed on [DATE] between 2:30 p.m., and 3:00 p.m., of the allegation of sexual abuse of Resident #2 by CNA #2. She stated that she interviewed other residents on CNA #2's assignment regarding any inappropriate touching including Resident #2. Resident #2 was not able to answer any of her questions. The SW further stated that she only questioned the residents on CNA #2's assignment, since that was the focus, but did not question any other residents on that unit. During an interview with the surveyor on [DATE] at 10:02 a.m., LPN #1 stated that she immediately reported the allegation to the DON upon being informed by CNA #1. LPN #1 stated that as an LPN she is to report to her supervisor who then would immediately suspend CNA #2. As an LPN, when she (CNA #1) came to me, I did what I was supposed to do because as an LPN I am under the supervision of an RN. In hindsight, I could have told (CNA #2) to come with me to (DON's) office . The surveyor asked the DON why CNA #2 was not removed from the resident unit immediately. During an interview with the surveyor on [DATE] at 11:07 a.m., the DON stated that on [DATE], CNA #2 was scheduled to work 7-3 and 3-11 shifts. The DON instructed CNA #3/Schedule Coordinator, to tell CNA #2 to go home and that his 3-11 shift was canceled. However, CNA #2 did not leave the resident unit until 3:00 p.m. after he finished his documentation. The DON stated that the facility policy states to send the alleged perpetrator home immediately. The DON stated that CNA #2's Agency was informed that CNA #2 was not appropriate with one of the residents, so he was not welcome in her facility. During an interview with the surveyor on [DATE] at 11:45 a.m., 7-3 shift LPN #2 confirmed that he did cosign CNA #2's documentation on [DATE] at 3 p.m., while CNA #2 was still on the unit. LPN #2 stated he was not informed on [DATE] of the allegation of abuse of Resident #2 by CNA #2. During the exit meeting on [DATE] at 5:05 p.m., the DON stated, she did not notify the Police, Doctor, Family or DOH, on [DATE]. Policy states if there was an injury to call within 2 hours, but there was no injury, so I decided to (call) the next day. Everybody was rushing to go home, and I also wanted to see the video. In hindsight, disregard anybody's reputation. I should have called the police, notify everybody and then if not true say sorry. A review of the camera video on [DATE], by the surveyor in the presence of the Administrator and DON indicated the following timeline: 11:13:37 CNA #2 observed holding a coffee cup in the hallway next door to Resident #2's room. 11:13:48 CNA #2 entered Resident #2's room. 11:32:20 CNA #1 entered Resident #2's room and exited 11:32:24. 11:32:48 CNA #2 wearing a face mask and holding a coffee cup exited Resident #2's room. Observation indicated CNA #2 was not wearing a face mask when he entered Resident #2's room. As per the DON, CNA #2 had no reason to wear a mask. He had a flu shot; only staff that did not receive a flu shot were instructed to wear a mask. 11:54 CNA #1 entered the room next door to Resident #2's room. 11:59:52 LPN #1 entered Resident #2's room and exited 12:02:57. 12:37:20 Activity person entered Resident #2's room and exited at 12:26:48. 12:53 CNA #1 observed with lunch trays in the hallway. 13:03:59 DON and LPN #1 entered Resident #2's room and both exited the room at 13:15:30 13:16:40 LPN #1 and CNA #3/schedule coordinator entered Resident #2's room and exited 13:23:30. A review of the email sent to the surveyor dated 3/15/2020, revealed the DON documented that she reviewed the video from multiple cameras and noted CNA #2 was in and out of the resident rooms that he was assigned to after 11:30 a.m., He was in and out of the dining room couple of times during lunch. She further stated CNA #2 also helped other CNA's with transferring residents. He transported residents to Activities Living Room. At 2:26 p.m. CNA #1 helped CNA #2 to use a Hoyer lift to transfer a resident. As per the DON, after that she did not see CNA #2 on any cameras until he left the building using the main entrance door at 3:14 p.m. A review of facility policy titled Abuse Prevention Program, dated 11/26/2013, included but was not limited to the following: Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Policy Interpretation and Implementation: Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: Facility staff. c. Identification of occurrences and patterns of potential mistreatment/abuse; d. The protection of residents during abuse investigations; f. Timely and thorough investigations of all reports and allegations of abuse. A review of the facility policy titled, Protecting of Residents During Abuse Investigations, dated 11/27/2013 indicated but was not limited to the following: Policy Statement: Our facility will protect residents from harm during investigations of abuse allegations. Policy Interpretation and Implementation: 1. During abuse investigations, residents will be protected from by the following measure: a. Employees or other persons alleged to have participated in a potentially abusive act will be barred from any further contact with residents of the facility, pending the outcome of the investigation, prosecution or disciplinary action against the Employee/other persons to be consistent with the facility Investigation and Reporting of Complaints Policy. b. Should an alleged employee(s) be reassigned to non-resident care duties, such assignment will not be in any part of the building which the residents frequent. 2. Within three (3) working days of the alleged incident, the facility will give the resident, the resident's representative (sponsor), the ombudsman, state survey and certification agencies, accused individuals, etc., a written report of the findings of the investigation and a summary of corrective action taken to prevent such incident from recurring. 3. Should the results indicate that abuse occurred, appropriate authorities will be notified. A review of the undated facility policy titled, Reporting Abuse to Facility Management indicated but was not limited to the following: Policy Statement: It is the responsibility of our employees.family member, visitors., to promptly report any incident or suspected incident of neglect or resident abuse. Policy Interpretation and Implementation. Our facility does not allow resident abuse by anyone including staff members. 1. All personnel, residents, family members, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. 2. Employees.must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. 3. Any individual observing an incident of resident abuse or suspecting abuse must immediately report such incident to the Administrator. 4. Any staff member or person affiliated with this facility who witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information. 5. Staff members and persons affiliated with this facility shall not knowingly: b. Fail to report an incident of mistreatment or other offense. 6. The Administrator, Director of Social Services or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. 7. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedure should be followed as outlined in this policy. 8. Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) (Note: If sexual abuse is suspected, DO NOT bathe the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Call the police immediately.) 9. The person performing the examination must document the examination findings in the resident's chart as well as obtain written, signed and dated statements from the person(s) reporting the incident. 10. A completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator within 24 hours of the occurrence of an incident of suspected abuse. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the Administrator within 5 working days of the occurrence of such incident. A review of the facility policy titled, Reporting Abuse to the [ST] Department of Health dated 11/26/13, indicated but was not limited to the following: All injuries of unknown origin, suspected violations and all substantiated incidents of abuse will be immediately reported to the [ST] Department of Health and the [ST] Office of the Institutionalized Elderly ([ST]OIE - Ombudsman). [ST]AC: 8:39-4.1 (a) 5
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # [ST] 1, [ST] 3 Based on surveyor observation, interview, review of Medical Records and other pertinent facility documentation on 3/11/20 and 3/12/20, it was determined that the facility failed follow their policy and procedure titled; Prevention of Abuse and Neglect-Policy and Procedure Manuel to investigate an allegation for 1 of 4 sampled residents (Resident #1), when a visitor reported an allegation of a Registered Nurse (RN) #1 lying in bed with Resident #1. This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool dated 12/26/19, Resident #1 had severe cognitive impairment. The MDS documentation included that Resident #1 required total staff assistance for all Activities of Daily Living (ADLs). A review of Resident #1's care plan (CP), initiated 5/27/16 and revised on 7/23/19, included but was not limited to: the resident had a communication problem r/t (relate to) Neurological symptoms-significant tremors associated with Dx (diagnoses) [MEDICAL CONDITION]. Other dx. Multisystem Atrophy. A Goal included that Resident will maintain current level of communication function by eye contact, smiling during interaction. Interventions included to Anticipate and meet needs. Allow adequate time to respond. Repeat as necessary. Do not rush. Face when speaking, make eye contact. Use simple, brief, consistent word/cues. On 3/12/20 at 1:30 p.m. the surveyor observed Resident #1 in bed. A body check was conducted with the staff in the room. The surveyor observed a reddened area on the resident's right side of neck under the chin that appeared rash/bruise like. As per LPN #1, the resident was seen by Dermatology, but could not recall the date of the consult or the results. A review of the Dermatology Consult dated [DATE] indicated, New problem.Right Superior Mid lateral Neck. Plan - [MEDICATION NAME] Cream 2.5% bid (twice a week) x 2 weeks to rash. Descriptor(s) Dry skin with area of mild [DIAGNOSES REDACTED]. Impression: [DIAGNOSES REDACTED]. The surveyor was unable to interview Resident #1 secondary to Resident's cognitive status. During an interview with the surveyor on 3/11/20 at 11:42 a.m., Resident #4, who was alert and oriented, with a Brief Interview of Mental Status (BI[CONDITION]) score of 15 out of 15, stated that after 12:00 a.m. approximately 2 weeks ago (not sure of the exact date) she saw a staff member walk into the room next to her room. My bathroom door was locked, so I went into the next room to go to the bathroom. As per resident the bathroom is accessible from both rooms. Resident #4 stated that the nurse (RN #1) was on top of the resident (Resident #1) with his penis in Resident #1's mouth. Resident #4 further sated, she did not inform any facility staff, however did inform another resident and family member. During the exit meeting with the surveyor on 3/11/20 at 4:45 p.m., in the presence of the Administrator, the DON stated that Resident #4 who was alert and oriented told a visitor of the allegation of a nurse lying in bed with a resident. The visitor then reported the allegation to the DON. The DON also stated that the allegation was about 2 months ago, but that she did not believe it and did not do an investigation. The DON however, did speak to RN #1 at that time, who denied the allegation. The DON indicated that a body check was not done for Resident #1 at the time of the allegation. On 3/12/20 at 11:07 a.m., during an interview with the surveyor, the DON stated that a visitor approached her and reported that a male nurse was lying in bed with a resident. The DON was not able to remember the date of this allegation but that it was 1 to 2 months ago. The DON stated that when she saw RN #1, she did ask him if he heard from Resident #4 that a male nurse was lying in bed with a resident. RN #1 informed the DON that he did not, but that Resident #4 got upset with him because one day he did not allow Resident #4 to enter the room. He stated that the reason was that he was flushing Resident #1's Feeding Tube at that time. He informed the DON, Resident #4 came into the room because Resident #4's bathroom door was closed. The DON stated that RN #1 said it was around 5:30 a.m. whereby the feeding finished and he had to flush the Feeding Tube. The DON stated that she spoke with RN #1 in her office and that she did not conduct a body check on Resident #1 after the allegation was made because, The Resident (#1) gets care every day, so no one reported to me. The DON further stated that she approached Resident #4 several times and at no point did the resident say anything to her. The DON said she did not directly ask the resident regarding the allegation, but that she approached the resident several times to give the resident the opportunity to tell her, but that the resident did not. I did not suspend him (RN #1), there was no reason for me to suspend him. I did not do anything, did not notify anyone. The DON stated that she did not inform the Administrator. I should have done it, I did not because my conclusion was that she (Resident #4) was delusional. The DON further stated that no in-services of abuse were done. The DON also stated that she did check Resident #1's skin yesterday 3/11/20 and the area on the right side of neck under the chin was a fungal rash. During an interview with the surveyor on 3/12/20 at 1:00 p.m., the Administrator stated that he was first informed of the allegation of abuse on 3/11/20 by the surveyor at 4:45 p.m. Prior to that he was not aware of the allegation of abuse by RN #1 of Resident #1. The Administrator stated that RN #1 was called into the Social Workers (SW) office. The Administrator, DON and SW informed RN #1 of the allegation and that they had to investigate the allegation. During an interview with the surveyor on 3/12/20 at 1:20 p.m., the SW stated that the facility has a no tolerance of any abuse and that any allegation of abuse must report immediately and then the DON, SW and the Administrator will do an investigation. SW stated that the perpetrator should immediately be taken out of the situation and not be put on that assignment. The facility determines suspension on a case by case incident. A review of facility policy titled Abuse Prevention Program, dated 11/26/2013 indicated but was not limited to the following: Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Policy Interpretation and Implementation: Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: Facility staff. c. Identification of occurrences and patterns of potential mistreatment/abuse; d. The protection of residents during abuse investigations; f. Timely and thorough investigations of all reports and allegations of abuse. A review of the facility policy titled, Protecting of Residents During Abuse Investigations, dated 11/27/2013 indicated but was not limited to the following: Policy Statement: Our facility will protect residents from harm during investigations of abuse allegations. Policy Interpretation and Implementation: 1. During abuse investigations, residents will be protected from by the following measure: a. Employees or other persons alleged to have participated in a potentially abusive act will be barred from any further contact with residents of the facility, pending the outcome of the investigation, prosecution or disciplinary action against the Employee/other persons to be consistent with the facility Investigation and Reporting of Complaints Policy. b. Should an alleged employee(s) be reassigned to non-resident care duties, such assignment will not be in any part of the building which the residents frequent. 2. Within three (3) working days of the alleged incident, the facility will give the resident, the resident's representative (sponsor), the ombudsman, state survey and certification agencies, accused individuals, etc., a written report of the findings of the investigation and a summary of corrective action taken to prevent such incident from recurring. 3. Should the results indicate that abuse occurred, appropriate authorities will be notified. A review of the undated facility policy titled, Reporting Abuse to Facility Management indicated but was not limited to the following: Policy Statement: It is the responsibility of our employees.family member, visitors., to promptly report any incident or suspected incident of neglect or resident abuse. Policy Interpretation and Implementation. Our facility does not allow resident abuse by anyone including staff members. 1. All personnel, residents, family members, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. 2. Employees.must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. 3. Any individual observing an incident of resident abuse or suspecting abuse must immediately report such incident to the Administrator. 4. Any staff member or person affiliated with this facility who witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information. 5. Staff members and persons affiliated with this facility shall not knowingly: b. Fail to report an incident of mistreatment or other offense. 6. The

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	315402	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARMENIAN NURSING AND REHABILITATION CENTER	**70 MAIN STREET EMERSON, NJ 07630**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Administrator, Director of Social Services or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. 7. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedure should be followed as outlined in this policy. 8. Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record. (Note: If sexual abuse is suspected, DO NOT bathe the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Call the police immediately.) 9. The person performing the examination must document the examination findings in the resident's chart as well as obtain written, signed and dated statements from the person(s) reporting the incident. 10. A completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator within 24 hours of the occurrence of an incident of suspected abuse. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the Administrator within 5 working days of the occurrence of such incident. A review of the facility policy titled, Reporting Abuse to the [ST] Department of Health dated 11/26/13, indicated but was not limited to the following: All injuries of unknown origin, suspected violations and all substantiated incidents of abuse will be immediately reported to the New Jersy Department of Health and the [ST] Office of the Institutionalized Elderly ([ST]OIE - Ombudsman). [ST]AC 8:39-4.1 (a) 5