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January 23, 2026

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 second 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,

TODD BLANCHE
U.S. Deputy Attorney General

PHILIP W. LAMPARELLO
Senior Counsel

By: *s/ Thandiwe Boylan*
THANDIWE BOYLAN
Assistant United States Attorney

cc: Counsel of Record (By ECF and email)

CERTIFICATE OF SERVICE

I, Thandiwe Boylan, Assistant United States Attorney for the District of New Jersey, hereby certify that on January 23, 2026, the foregoing was served on counsel for defendants by ECF and email.

Dated: Newark, New Jersey
January 23, 2025

s/ Thandiwe Boylan
THANDIWE BOYLAN
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

12-Month Report

Monitoring Team:
Kathryn Hester, MSPH
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January 23, 2026

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Executive Summary

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

During the initial twelve months, The Hibiscus Group monitoring team conducted nine onsite visits to the New Jersey Veterans Home at Paramus and seven onsite visits to the New Jersey Veterans Home at Menlo Park. In addition to onsite visits, monitors maintained extensive in-person and virtual communication with 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 (DMAVA).

This report summarizes the results of The Hibiscus Group's first year[1] of monitoring work at each Veterans Home. The report contains a separate evaluation of each facility, including an assessment of compliance with each Substantive Remedial Measure. The monitoring team believes that both Veterans Homes continue to make progress toward achieving compliance with each Substantive Remedial Measure. The monitoring team will continue onsite monitoring visits to evaluate progress at each Veterans Home over the next six months.

Implementation

Per the Consent Decree requirements, DMAVA Leadership appointed an Agreement Coordinator to serve as the point of contact for the Parties and the Monitor. DMAVA Leadership also created an annual Implementation Plan that describes the actions needed to fulfill its Consent Decree obligations. This plan was completed within 90 days of the Consent Decree's effective date and circulated to the Parties for discussion on January 3, 2025. DMAVA circulated a final plan on February 11, 2025.

The Implementation Plan identified issues to be addressed during the first year. For each issue, the plan included: responsible persons, required resources, target completion date, completion status measure, future QAPI process integration, and

[1] This report will address the first twelve months of the consent decree because the baseline report did not contain paragraph-by-paragraph compliance determinations. Going forward, each report will address the preceding six-month period.

expected outcome. DMAVA Leadership submitted a general forecast of issues to be addressed in successive years as well. All Parties reviewed and provided comments before the plan was finalized. The monitoring team will continue to review any updates or additions to the Implementation Plans as the Veterans Homes address non-compliance areas or monitoring recommendations.

The New Jersey Veterans Home at Paramus

Introduction

During the 12-month period following execution of the Consent Decree, the monitoring team conducted nine onsite visits to Paramus: seven full monitoring evaluations and two resident and staff record review visits. Full monitoring evaluations included observations of care, formal and informal resident and staff interviews, attendance at regular weekly and quarterly meetings with leadership and clinical staff, and medical record reviews. Record review visits focused exclusively on reviewing resident and staff documentation. Throughout this period, the monitoring team maintained monthly contact with Department of Military and Veterans Affairs (DMAVA) Leadership and the NJ Veterans Home at Paramus, supplemented by virtual and in-person communication with additional staff-members.

Each onsite visit included attendance at clinical meetings such as the morning meeting, afternoon wrap-up, and weekly, monthly, and quarterly Quality Assurance and Performance Improvement (QAPI) meetings. The monitoring team reviewed medical records, resident care plans, and readmission paperwork to assess staff ability to identify changes in resident condition. The findings from these activities are described below.

General Medical & Nursing Care

Paramus has ensured that all contractors and outside providers who provide clinical care within the facility are doing so in a way that meets medical and nursing care standards. The QAPI program provides oversight of care and services delivered by these contractors and providers. Compliance related to all medical, nursing and clinical care standards is discussed in the paragraphs below and throughout the specific care area sections of this report.

Staff Credentials, Qualifications and Competency

Formal interviews with specialized clinical staff in infection prevention and control, wound care, and therapy confirmed appropriate credentials, qualifications, and

competency for their respective positions. The Baseline Report identified concerns about how the facility verifies nursing and nursing assistant competency. More recent onsite visits showed that nurse educators now use forms that capture competency determination methods. The monitoring team attended a nurse competency session that included education with return demonstrations.

The Baseline Report also identified concerns about the number of competencies evaluated in a single day. Recent onsite visits revealed that competency testing is now better aligned with care and services identified in the Facility Assessment and with high-risk, high-volume, and problem-prone skills. As defined by the Consent Decree, **Facility Assessment** refers to the facility-wide assessment of facility needs to determine what resources are necessary to care for Veterans Homes Residents during daily operations and emergencies as required by 42 CFR 783.70(e).

Documentation

Proper and timely nursing documentation is important for ensuring resident safety, providing continuity of care, facilitating communication among the healthcare team, meeting legal and compliance requirements, and supporting Quality Assurance and Performance Improvement efforts (QAPI). The Baseline Report identified concerns with documentation and the facility's ability to consistently deliver physician-ordered care, adhere to standards of care, and meet regulatory requirements. Previously identified bowel elimination concerns have been rectified; nursing assistant staff now document directly into the electronic medical record (EMR). However, the monitoring team continues to note documentation concerns during onsite visits, as described below.

Following a scabies outbreak at Paramus, the monitoring team investigated documentation leading up to each affected resident's diagnosis. During one onsite visit, the monitoring team noted and discussed with facility leadership that rash documentation was non-descriptive. Paramus leadership responded by having Heritage Wound Care conduct training on "Rashes, Types, Describing and Documentation Pearls" with nursing staff in late August. The in-service included a post-test to demonstrate competence.

Despite this training, documentation issues persisted. The monitoring team reviewed a resident record completed after the training and found that while the documentation stated the rash location, it described the rash only as "generalized." Another resident's record contained non-descriptive rash documentation stating the rash was resolving despite the resident's continued complaints of itching and ongoing use of ordered treatment. The monitoring team recommended that facility leadership implement mechanisms to ensure staff apply taught concepts and, if applicable, conduct root cause analysis to determine implementation barriers.

Additional examples of documentation not withstanding clinical scrutiny include physician notification related to medication refusals and omissions and write-overs on Medication Administration Records/Treatment Administration Records (MARs/TARs). These issues will be discussed further in the Medication Administration section.

The monitoring team has concerns about inconsistent and incomplete documentation. When residents had multiple clinical issues warranting documentation, nursing staff typically documented only one issue rather than addressing all identified issues. A binder at the nursing station directed nurses to document on specific issues, which they did. However, this resulted in nurses stopping documentation on previously identified clinical issues with no evidence that those issues had resolved.

For example, nursing staff documented one resident's wound daily. When the resident was scheduled to move from a secure unit to an unsecured unit, staff began documenting only behavioral symptoms and wandering activity for the week preceding the move. Once relocated, documentation on behaviors and wandering ceased and wound documentation resumed. The monitoring team noted this same pattern in several other medical records—documentation on previously identified issues stopped without indication that the issues had resolved. This demonstrates nurses not utilizing clinical and critical thinking skills when prioritizing documentation.

These examples do not withstand clinical scrutiny. The monitoring team continues to have 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 residents' overall well-being, including physical, mental, and psychosocial health. At an October onsite visit, the Director of Nursing (DON) stated she is developing an educational session for nurses on the importance of good documentation.

Policies/Procedures

The monitoring team continues to have concerns about consistent implementation of clinical care policies and procedures and consistent provision of appropriate nursing and medical care. For example, during an onsite visit, the monitoring team discovered that a resident had refused medication for seven consecutive days without physician notification, despite facility policy requiring such notification.

The monitor requested the Paramus medication administration policy and received a document titled "Medication Pass Protocol." Under "Right Documentation," the policy states: "Correctly document any medication refused, not given, or withheld on the MAR & notify physician." However, when questioned about the lack of notification, Paramus

and DMAVA leadership stated that New Jersey standard of practice requires physician notification only after three consecutive days of medication refusal.

The monitoring team requested evidence of this stated standard and received a Paramus Standard of Practice document confirming the three-day protocol. The monitoring team has two concerns: First, the stated standard of practice itself is questionable (discussed further in the Medication Administration section). Second, the two policies contradict each other, creating confusion about actual requirements.

This policy gap has significant implications. Physicians order medications and treatments to help residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. Failure to receive ordered medications undermines this goal. Additionally, failure to notify physicians of medication refusals prevents them from assessing the effectiveness of ordered medications and treatments.

DMAVA leadership continues to review existing policies and procedures across their three facilities, as discussed further in the Clinical Care Policies, Procedures, and Training section. The monitoring team will continue to follow up to ensure consistent provision of appropriate nursing and medical care.

Facility Assessment

Paramus conducts Facility Assessments annually and whenever services change. After each assessment, DMAVA leadership reviews the document page by page with the Medical Director, Agreement Coordinator, and department heads. This review examines census data, resident acuity levels, and clinical skills required for each resident's care. The Chief Executive Officer (CEO) communicates these findings to education coordinators, who then ensure staff training addresses the resident care needs identified in the Facility Assessment.

Electronic Medical Records

The consent decree requires the Veterans Hoes to implement and maintain appropriate resident medical records. As discussed in the Baseline Report, Paramus has not implemented and maintained appropriate electronic medical records in an organized and readily accessible manner. The facility has made some progress: Certified Nursing Assistants (CNAs) and Life Enhancement staff now document directly into the EMR. However, significant gaps remain and are described below.

- Critical components of residents' records are still not in the EMR, including physician orders, MARs, and TARs. The monitoring team has noted that DMAVA

leadership decided not to include the MAR and TAR components of the EMR due to safety concerns.

- Despite DMAVA having a system to ensure practitioners have access to the EMR, a newly hired nurse practitioner (NP) interviewed stated she had to ask other nurses to view nurses' notes, vital signs, weights, and other information. The monitoring team recommends implementing oversight to make sure all care providers are using the EMR as directed.
- Nursing leadership reported a known software issue that sometimes records incorrect timestamps on nurses' notes. Care provider documentation that is clear, concise, complete and in chronological order is essential for healthcare teams to provide coordinated care and make informed and timely decisions. An inaccurate timestamp on a nurse's note can mislead clinicians and/or delay needed treatment, potentially allowing a condition to worsen.

DMAVA has identified a new EMR vendor and is negotiating contract terms. The new system will be comprehensive, replacing the current system entirely and incorporating all aspects of clinical care, including physician orders, MARs, TARs, and immunizations. This should resolve the cumbersome and duplicative processes and errors associated with paper physician orders and medical records. DMAVA anticipates beginning implementation in late 2026 or 2027.

The monitors recognize there is no short-term resolution. The current EMR and clinical care record remain disorganized and not readily accessible.

Minimum Data Set Assessments

The monitoring team believes the Resident Assessment Coordinators at Paramus have the necessary skills and qualifications to accurately and appropriately complete the Minimum Data Set (MDS). The MDS is a federally mandated, standardized clinical assessment completed at admission, quarterly, annually and with significant changes to capture a nursing home resident's functional, clinical and psychosocial status. It is essential for developing and updating individualized care plans, ensuring regulatory compliance and monitoring care quality.

Compliance Determination: Based on the above observations and discussions, the Paramus facility has not reached substantial compliance with the General Medical & Nursing Care requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	30, 32, 33, 34, 37
Substantially Compliant	31, 35, 36, 38

Changes in Condition

The Baseline Report identified concerns with nurses' ability to perform comprehensive assessments and document changes in resident condition. These concerns persist, though the monitoring team has noted some improvement. The DON reports that the nursing team is improving in responding appropriately to changes in condition in some clinical areas, such as cardiovascular changes, which has helped prevent avoidable hospitalizations. Additional efforts to improve residents' overall health include hydration carts and the "Move on the 2s" program to increase resident activity and movement. At an October 2025 QAPI meeting, the monitoring team reviewed data showing decreased hospitalizations and emergency room visits. The facility goal is to maintain hospitalizations at 9% or less and ER visits at 4% or less monthly.

Interdisciplinary team members (e.g. pharmacy, therapy and dietary) are contributing more to problem-solving activities during clinical meetings. This more robust discussion results in better planning, implementation, and evaluation of residents' care and care plans.

The Baseline Report identified concerns with completing Situation, Background, Assessment, and Recommendation worksheets (SBARs). The SBAR is a documentation method that is used to quickly and effectively share critical patient information, improving patient safety by ensuring clear, concise and organized communication between healthcare professionals. DMAVA facilities use this method to report resident changes in condition to the physician. ‘Situation’ explains the current problem; ‘Background’ includes relevant history and context related to the problem; ‘Assessment’ includes a professional analysis of the situation; ‘Recommendation’ includes what is needed or what the professional suggests is needed to remediate the problem. These concerns remain. Several months ago, monitors reviewed numerous SBARs that simply stated residents' symptoms and vital signs. In body system assessment sections, nurses routinely checked "no change." During the October 2025 visit, several SBARs showed some improvement. The DON stated she is working one-on-one with nurses to improve their ability to identify changes in resident condition. Without this ability, SBARs will continue to contain inadequate information. While education was provided in several areas, including cardiopulmonary assessments and

skin (rashes), the DON stated education needs to be ongoing and reinforced to be effective. October's education focus is improving nursing documentation.

The following example illustrates nursing staff recognizing a change in condition but failing to perform a comprehensive assessment or demonstrate clinical and critical thinking skills. The monitoring team reviewed a resident's record with a diabetes-related change in condition (high blood glucose readings) and found that the nurse failed to fully assess the resident. With this lack of a comprehensive assessment and inadequate documentation, there was a high probability of missed communication, delay in treatment, and lack of continuity of care. After the resident was admitted to the hospital, supervisory staff inaccurately recorded the hospital admission diagnosis as hypoglycemia (low blood sugar), further demonstrating a lack of clinical and critical thinking.

Nursing staff at Paramus routinely assess residents at heightened risk of respiratory infection, including COVID (coronavirus disease), and monitor for material changes in presenting symptoms or changing conditions indicative of possible or worsening infection. Medical record review confirmed that when respiratory infections were suspected, clinical staff appropriately noted and reported any related symptom to infection control and other necessary staff, regardless of how minor, even if testing was negative or inconclusive.

The Baseline Report confirmed that Paramus clinical staff routinely assess residents for pain symptoms, both in response to change in condition, when pain would reasonably be expected, and when other staff, residents, or visitors communicate suspected pain when residents cannot verbalize it. During recent onsite visits, the monitoring team determined that clinical staff remain responsive, provide timely treatment, communicate with physicians as needed, and continue treatments and assessments to ensure effective pain management.

Compliance Determination: Based on the above observations and discussions, Paramus has not reached substantial compliance with the Changes in Condition requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	39, 40(a-e)
Substantially Compliant	41, 42

Resident Care Plans

The Baseline Report identified concerns with lack of person-centered and individualized care plans and missed care areas. The monitoring team has noted significant improvement. In April and May, the Paramus QAPI team initiated care plan audits that resulted in impactful improvements. The monitoring team reviewed several care plans and found they contained specific, individualized interventions. Nurses completing the care plans are now setting timeframes for meeting resident goals and outcomes such as wound healing and infection recovery.

Despite this improvement, some care plans still need greater specificity. For example, the monitoring team reviewed the record of and interviewed the care team for a resident who consistently refuses medications. While the care plan identified this issue, the plan was generic with nonspecific approaches and interventions. During an interview, a nurse stated that if the resident's son was called, he could convince the resident to take his medications. This individualized approach was neither documented in the care plan nor discussed at an interdisciplinary meeting.

After the monitoring team discussed this with the Paramus clinical team, the care plan was updated to include: explaining the importance of medications and re-offering them, documenting refusal on the MAR and in nurses' notes, and notifying the MD for evaluation. However, the critical information about calling the resident's son was not included in the revisions.

During a separate visit, the monitoring team saw a nurse's note indicating that hospital staff said a resident was more likely to accept medications if given with soda. This information should have been added to the care plan so all care team members could access it. Other nursing team members would be unlikely to read the individual nurse's note, and there is no documentation that this information was communicated to other staff.

When a resident has a material change in health status or an incident indicating significant health risk, staff must document it on the 24-hour report. Staff must update care plans and Kardexes (DMAVA's documentation system for tracking key resident information) within two business days in response to the root cause of the change. The monitoring team continues to observe Paramus staff correctly using the 24-hour report, with changes noted in the 24-hour log book and reported at clinical meetings. As discussed in previous sections, the monitoring team notes care plan improvement but continues to see lack of thorough nursing assessments and root cause analyses of changes in residents' health status or health risk. This impedes nurses' ability to identify individualized interventions for care plans, particularly when the MDS facilitator/coordinator is not involved when a change in condition is identified.

Care plans are readily available to staff, and updates are reported during shift changes to all staff responsible for implementing care-planned interventions (including nurses, CNAs, and restorative and physical therapy staff). In recent months, several disciplines—including nursing assistants, life enrichment staff, and restorative nursing assistants—have been trained and are now using the EMR. This critical step keeps care plans written and organized in a readily understandable and accessible manner.

A particularly positive aspect: nursing assistants must sign into the EMR at shift start. Immediately upon signing in, they see the care plan (assigned cares) for each resident. Any care plan changes are identified in an Alert. Nursing assistants must acknowledge they have read the care plan and any Alerts.

The monitoring team has noted significant improvement in developing person-centered and individualized care plans, with nurses now including specific interventions and timeframes for achieving resident goals and outcomes. However, greater specificity is needed in some care plans, particularly regarding individualized approaches for medication refusal and consistent communication of crucial resident information among all care team members. While the 24-hour report is being used correctly for communicating condition changes, concerns persist about nursing staff's ability to conduct thorough assessments to determine root causes, which is essential for identifying appropriate care plan and Kardex interventions.

Compliance Determination: Based on the above observations Paramus has not reached substantial compliance with the Resident Care Plans requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	**Corresponding Consent Decree Paragraphs**
Non-Compliant	
Partially Compliant	43(a-c), 45, 46
Substantially Compliant	47, 48

Vascular Wounds and Pressure Injuries

Recent onsite visits indicate that Paramus staff are not ensuring all interventions are implemented to prevent skin breakdown and help residents maintain or attain healthy skin integrity. Specific examples are provided in the paragraphs below.

Paramus staff continue to provide appropriate oversight of the contracted wound care company. The wound care specialist team provides appropriate wound documentation including wound characteristics, wound evaluation, and treatment modifications according to healing progress. This treatment and documentation occurs weekly and between weekly visits when new wounds are discovered or significant wound changes are noted.

The Paramus nursing team performs dressing changes between wound care team visits. The Baseline Report identified concerns with RN wound care competency. During recent onsite visits, the monitoring team observed a nurse performing dressing changes and noted demonstrated competency in several areas: she correctly described certain wound characteristics, relayed the wound history and progression, noted the resident's comfort level, and ensured the resident did not experience pain during the process. However, the nurse did not obtain wound measurements nor adequately describe the wound bed.

Between weekly treatments by the contracted wound care company, Paramus nursing staff provide wound treatments and document completion in treatment administration records (TAR). While nurses initial the treatment record when performing dressing changes, they do not document typical wound characteristics such as measurements, drainage presence, odor, and pain. This lack of documentation potentially interferes with facility nurses' ability to detect wound worsening or improvement between wound care specialist visits. During facility-rendered dressing changes, facility nurses can only compare the wound to the wound care specialist team's weekly description. If facility nurses perform multiple dressing changes during the week, no objective information is recorded to enable comparison with the most recent dressing change.

The monitor asked the nurse who performed the dressing change how she knew whether the wound had changed since the most recent dressing change. She replied that she performs all dressing changes on her unit and knows when wounds are different. The nurse relies on her memory of all wounds for which she performs dressing changes. The monitoring team discussed this concern with Paramus leadership. In response, leadership reviewed skin and wound care policies and provided monitors with updated policies that will be implemented in January 2026. The monitoring team will follow up to ensure implementation of the updated policies address documentation requirements for wound characteristics during facility-performed dressing changes.

The Medical Director was involved in the wound program, attended monthly and quarterly QAPI meetings where wounds are discussed, and participated in discussions about wound statistics and trends. As the current Medical Director left in November, the

monitoring team will continue monitoring the new Medical Director's role in the wound program.

The therapy department manager performs regular audits ensuring residents' positioning devices are properly placed. Additionally, a QAPI department staff member will begin auditing to validate that residents are being turned and repositioned.

In reviewing four newly admitted residents' medical records, the monitoring team found that Paramus staff did not identify upon admission, and on an ongoing basis thereafter, residents at risk of pressure injury. Nurses performed a Braden Scale risk assessment (a nursing tool predicting pressure injury risk) upon admission but did not complete Braden Scale assessments weekly for four weeks. Regulatory requirements mandate skin assessment using a tool (such as the Braden Scale) upon admission, then weekly for four weeks after admission or readmission, and quarterly thereafter. The monitoring team also noted that in two of five additional records reviewed, quarterly Braden Assessments were not completed when due.

CNAs observe resident skin integrity during daily care and report skin issues verbally to nurses without written documentation. Paramus licensed nurses are to conduct weekly skin assessments; however, the monitoring team found they are not consistently conducting and documenting them. For example, out of nine medical records reviewed, two had weekly skin assessments documented when due; the remaining seven had 1-3 weeks elapsed between assessments.

Paramus contracts with a wound care specialist whose physicians appropriately ensure that interventions and preventative measures for wound healing are documented, appropriate, monitored, evaluated, and modified as necessary.

In September, the monitoring team attended a QAPI Meeting on Pressure Ulcers and Other Wounds. The QAPI team reported data sufficient to identify overall trends related to pressure injuries and vascular wounds. Attendees included relevant Paramus team members: Medical Director, DON, Quality Improvement Manager, Heritage Wound Care representative, Infection Prevention, and Therapy Manager. Two direct care staff were also present. Several interventions including wheelchair cushions, repositioning, and new dressing materials and techniques were presented from educational and outcomes perspectives. The Heritage Wound Care representative and DON expressed enthusiasm about the positive impact of new dressing materials in preventing new wounds and promoting more efficient healing.

The monitoring team reviewed 2nd quarter QAPI data on Braden scale and weekly skin assessment audits. Data collected for April and May was recorded for each resident by unit and included: resident name and room, whether weekly Braden scale was

completed, whether weekly skin assessment was completed in entirety, and what steps were taken if not. The threshold was 100%. Audit results were reported at the quarterly QAPI meeting as percentage compliance for each week and each unit during April and May. Reported data indicated compliance during April's four weeks averaged 95-100%, and during May's four weeks it was 84-100%. The variation analysis stated "All indicators were in compliance," but this did not accurately reflect the data. Stating compliance prohibits further discussion of root cause analysis, and their recommendation was simply to continue the audit.

The monitoring team observed dressing changes and interviewed residents regarding pain management. Residents did not demonstrate verbal or non-verbal evidence of pain during dressing changes, and those interviewed stated they were satisfied with staff response to pain concerns.

The Paramus QAPI department has a facility-wide system to track pressure injuries and vascular wounds with accurate and timely statistics. Wound statistics include monthly recapitulation of new wounds, new facility-acquired wounds, new community-acquired wounds, new facility-acquired pressure ulcers, total pressure ulcers, and residents with multiple wounds. The facility also compares its performance with state and national performance via the quality measure report.

The MDS 3.0 Facility-Level Quality Measure Report for Report Period 04/01/25 - 09/30/25 shows the facility adjusted percent for pressure ulcer at 9.2%, higher than state and national comparison group percentages of 7.7% and 6.3% respectively. The percentile ranking is 79th, meaning 79% of other facilities performed better while 21% performed the same or worse. This is higher than data in the Baseline Report for Report Period 08/01/2024 - 01/31/25, which showed facility adjusted percentage at 6.7%—lower than state and national comparison group percentages of 7.4% and 6.6% respectively, with a percentile ranking of 58th. 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 skin integrity issues, and monitors encourage continued work toward pressure injury prevention.

Compliance Determination: Based on the above observations and discussions, Paramus has not reached substantial compliance with the Vascular Wounds and Pressure Injuries requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	49a, 49c, 49d-ii, 49g, 49h, 49j, 49k
Substantially Compliant	49b, 49d-i(1-9), 49e, 49f, 49i, 49l, 49m

Medication Administration

The Paramus facility has not ensured safe medication dispensation and administration. During a recent onsite visit, the monitoring team observed an envelope of medications labeled for 9:00 am that day sitting on top of the medication cart in the medication room. The resident's medication administration record (MAR) documented that the medications were administered. The nurse in the medication room at the time had been working on the opposite wing and did not know why the medications were still on the cart.

The monitoring team discussed this finding with the CEO, DON, and DMAVA Leadership, who suggested the new PassPort medication dispensing system may have dispensed multiple medication packets and the nurse had not yet returned the extras. (Note: PassPort is a fully automated and remotely monitored system that prepackages resident medications in an envelope labeled with the resident’s name,room number, and a list of the medications in the envelope.) The monitoring team requested follow-up about why the medications were on the cart and whether the PassPort system had dispensed a duplicate packet. Upon completion of this report, the monitoring team had not received follow-up information.

The Baseline Report identified concerns about Paramus's ability to ensure residents receive medications and treatments as prescribed with correct dosages and within correct timeframes. In response, DMAVA and Paramus leadership, including the Medical Director, DON, and a pharmacist, developed a Corrective Action Plan (CAP) to review medications and streamline the administration process. The CAP addressed consistent application of medication parameters, setting administration times based on medication classification, discontinuing unnecessary medications, reorganizing the monthly recapitulation of physician orders, and assigning the night shift responsibility for organizing medication rooms and carts. This work resulted in significant improvement in the timeliness and efficiency of the med pass.

Despite significant improvement in the medication administration process, the monitoring team has concerns about Paramus staff's ability to ensure residents receive

prescribed medications. During a recent onsite visit, record review showed that a resident repeatedly refused oral medications for three consecutive days on multiple occasions without documented physician notification. The same resident then refused medications the following month for seven consecutive days, again without evidence of physician notification or explanation of refusal consequences. The refused medications included Depakote, which is critical for seizure treatment and requires a therapeutic level for effectiveness.

During a separate onsite visit, the monitoring team reviewed six days of MARs for a resident who had consistently refused all medications, including those for cardiac conditions and Parkinson's disease. During those six days, only one nurse's note adequately documented a discussion of the risks of refusing the medications with the resident. The nurse's note also included a statement explaining why the resident was refusing the medications and that the nurse had given the medication with soda following a hospital staff recommendation after a recent hospital stay. During the six days this resident refused medications, there was no documentation that the physician or the resident's Medical Power of Attorney had been notified.

The monitoring team has also noted documentation concerns regarding Treatment Administration Records (TARs). In one example, a resident had an order to discontinue a stockinette and implement a Geri-sleeve. The nurse documented applying both the stockinette and the Geri-sleeve for six days despite the discontinuation order. In another example, nursing did not document treatment to a Stage 2 buttock wound for seven days. The monitoring team found no explanation for the omission on either the treatment record or in nursing notes.

The Baseline Report identified several documentation concerns on the MAR, including staff signing for medications long after administration. The CAP described above successfully corrected these documentation and reporting issues. The monitoring team will continue evaluating CAP implementation to ensure documentation and reporting remain accurate, effective, and timely.

Paramus maintains a Medication Variance Committee (MVC) that meets monthly with members including the CEO, Assistant CEO, Pharmacy Consultant, DON, Assistant DON, Instructor of Nursing, QAPI coordinator, and a floor nurse. Paramus also maintains a quarterly Pharmacy and Therapeutics meeting including the CEO, Medical Director, and several other DMAVA and Paramus Leadership members such as ACEOs, QAPI Coordinators, Nursing Education, Infection Prevention, Detection and Control, and facility admin.

The monitoring team reviewed three months of Medication Variance Committee meeting minutes. The committee continues to note that medications are not always available—a

concern identified in the Baseline Report. The reason given for missing medications is that they are not reordered, but meeting notes do not indicate the committee discussed a solution.

As discussed in the General Medical and Nursing Section and earlier in this section, the monitoring team found examples (in both September and October 2025) of nurses not notifying physicians when residents refused medications. Meeting minutes showed that in both July and August, the Medication Variance Committee raised concerns about confusion surrounding the policy for notifying physicians when residents refuse medications. The Committee also noted in both meetings that a Standard of Practice needs verification. As of this report's writing, these concerns remain unresolved.

The monitoring team has observed the pharmacist taking an active role in communicating with Paramus staff. The CAP development process was interdisciplinary, involving the Medical Director, nursing leadership, and pharmacists. The process included thorough review of medications for efficacy, suitability, and continued appropriateness. As a result, some medications and parameter needs were modified or discontinued. As previously noted, the pharmacist actively participates in morning clinical meetings. These are noted improvements. The monitoring team will continue evaluating this direct communication and collaboration to ensure medications are consistently monitored for efficacy, side effects, and appropriateness/suitability.

Compliance Determination: Based on the above observations and discussions, Paramus has not reached substantial compliance with the Medication Administration requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	50a, 50b, 50c, 50d, 50f
Substantially Compliant	50e, 50g, 50h

Falls

Paramus continues to maintain a system to prevent resident falls. According to Paramus quarterly QAPI Meeting Minutes, the Paramus goal for falls is to "Limit monthly fall average to 16 or less on average quarterly and to sustain zero falls with major injury." The Facility Level Quality Measure (QM) Report for reporting period

4/1/25-9/30/25 shows the Facility Adjusted Percent of Falls (the percentage of residents who experience any fall) as 38.8% compared to the State Average of 38.1% and the National Average of 44.4%. Paramus performs at or better than 69% of facilities nation-wide. The Facility Level QM for Falls with Major Injury (fracture, head injury, or death) is 2.8% compared to the State Average of 2.3% and the National Average of 3.4%. The Paramus facility performs at or better than 48 percent of facilities nationwide.

Fall risk assessments must be completed upon admission, quarterly, and as needed using a standardized tool. The monitoring team reviewed nine medical records, including four admissions, to validate that nursing staff performed fall risk assessments. All newly admitted residents had fall risk assessments completed upon admission. However, one newly admitted resident experienced two falls within the first month—one occurring two days after admission—without fall risk assessments completed after either fall. Of the remaining five medical records reviewed, two had fall risk assessments documented approximately five months apart rather than quarterly.

The Agency for Healthcare Research and Quality (AHRQ) recommends multifactorial assessments because they enable coordinated interdisciplinary care, reduce fall incidence and related injuries, and support quality monitoring and regulatory compliance. Failure to perform timely assessments delays protective actions, impedes root-cause analysis after events, and increases preventable harm risk.

When residents experience falls, Paramus protocol requires immediate team investigation of circumstances and development of interventions to prevent future falls. A Nurse Investigator completes an investigative report including information such as previous falls, where and when the fall occurred, and resident and/or witness statements. The monitoring team reviewed a fall investigative report to determine if the Paramus clinical team developed and implemented individualized interventions on a timely basis and incorporated them into the resident's care plan.

One resident experienced five falls within approximately six weeks. The Investigative Nurse documented dates and times of previous falls in the Recent Occurrences section. All falls occurred between 8:00 pm and 11:45 pm. The resident was on at least two medications administered at bedtime with side effects including orthostatic hypotension and/or dizziness. The resident used a high-low bed in the lowest position at the time of the fall. While low bed positioning can decrease fall distance and minimize injury, low beds can increase fall risk if the resident has poor judgment and attempts to stand instead of calling for help, lacks strength to stand, or has poor gait and/or balance issues. This resident had moderately impaired judgment, muscle weakness, abnormal posture, and was unsteady on his feet.

The intervention for this fall was to increase the resident's sleeping medication dosage. The monitoring team saw no documentation that the Paramus team considered whether bedtime (the CNA stated putting the resident to bed at 7:45 pm) corresponded with the resident's preferences. There was no evidence staff considered whether bedtime medications impacted the resident. There was no evidence the Paramus team evaluated whether the low bed was appropriate for this resident. The resident told staff he fell while trying to stand up. Several days after this most recent fall, the provider ordered an increase in the resident's antidepressant dose—also used as a sleep aid with side effects including dizziness and impaired coordination. The care plan was updated to note the psychiatric evaluation and antidepressant increase. The Investigative Report correctly identified that no fall risk assessment was completed prior to the fall.

The monitoring team reviewed four additional fall investigative reports. The root cause section for all four falls stated, "Due to resident action or internal risk factors." The Recommendations section stated "None noted." The Recent Changes to Resident Status section—including medical status, psychosocial status, mood status, Activities of Daily Living (ADL) status, medications, and environment—indicated "no changes" for all four records. No resident's medication regimen was listed. The monitoring team encourages more thorough investigation and documentation of factors that might impact falls, such as fall risk assessment scores, medications, ambulatory status, and the risk/benefit of using a low bed.

In May, the monitoring team attended a Falls Performance Improvement Project (PIP) Meeting where the following data was presented: number of falls, falls with major injury per unit, location of falls, and hours when falls occurred with specific attention to change-of-shift falls. The Paramus team followed up on interventions and discussions from previous Falls PIP meetings, including floor staff concerns with completing rounds while engaged in another resident's care when a fall occurs, implementation of new wireless alarm boards, post-incident fall rounds, and addition of recreational staff to cover day rooms during staff lunch periods. The meeting minutes included a written report of individual fall incidents with information about date/time, shift and unit, location, and a brief summary of each resident fall. Additionally, a root cause analysis was included which resulted in suggested interventions that were specific to the analysis. The meeting minutes concluded with each resident's fall risk assessment date and score, and whether the fall was avoidable. This meeting demonstrated improvement in a few areas. First, the Paramus team presented additional and more in-depth information which allowed them to identify potential patterns and trends. More significantly, the team demonstrated a better use of the QAPI process as they included input from pertinent staff and analyzed the effectiveness of previously implemented interventions.

Paramus staff, including nurses and nursing assistants, frequently round to prevent residents from falling or experiencing other accidents. Additionally, nursing assistants are assigned to supervise common areas where residents frequently gather. During the monthly Falls QAPI meeting in May, several interventions were identified to resolve floor staff concerns about consistently completing rounds during certain periods, such as just before and during mealtimes. These interventions included: determining whether additional assistance is needed to help residents with dining; CNAs notifying the unit clerk, charge nurse, or supervisor if unable to complete rounds as assigned; and providing coverage for residents when CNAs are unavailable (while providing care to residents or during lunch breaks).

During onsite visits, the monitoring team attends clinical meetings in which interdisciplinary staff and contracted therapists identify residents who could benefit from therapy evaluation and treatments to reduce fall and injury risk. On a few occasions,, the monitoring team observed residents being transported in wheelchairs without leg/foot rests in place. Residents were observed holding their legs straight out in front of them. This poses high accident risk because residents' feet may drag and become tangled in wheels or under the wheelchair. The staff transporting residents stated they were unable to locate leg rests to attach to chairs. As a result, the Paramus team implemented a new labeling device that ensures residents' names are attached to wheelchairs and leg rests. The new labeling prevents leg rests from getting lost, and during the most recent visit, the monitoring team noted significant improvement in this area. Both of these examples indicate that Paramus is ensuring that residents receive appropriate assistive devices to prevent accidents and falls.

Paramus staff use safety devices such as bed and chair silent alarms, fall mats, and high-low beds. The monitoring team encourages Paramus staff to include thorough evaluation of these devices' effectiveness when performing post-fall investigations.

Paramus staff perform environmental rounds to ensure resident rooms and common areas are as free of accident hazards as possible. On several onsite visits earlier in 2025, the monitoring team observed cluttered unit hallways with various equipment on both sides. For example, one hallway had a medium-sized garbage can, housekeeping carts (2), vital sign machines (4), large engineering carts (4), treatment carts (3), various chairs and wheelchairs, and computers on wheels used for education (3). Both staff and residents stated the hallway was experiencing a "traffic jam." One staff member stated some equipment could be put in the day room and didn't know why this wasn't done. This presented an unsafe and obstructed passageway for residents traversing hallways. During the last two onsite visits, the monitoring team has not had concerns with cluttered hallways and commends Paramus staff for making it a priority to keep hallways clear and easy to pass through.

Compliance Determination: Based on the above observations and discussions, Paramus has not reached substantial compliance with the Falls requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	51a, 51b, 51c, 51h, 51i
Substantially Compliant	51d, 51e, 51f, 51g

Oversight and Management of Medical Care

Paramus had a well-qualified, licensed, and credentialed Medical Director and several contracted physicians who regularly visit the facility. The Medical Director recently resigned with a last day of November 19, 2025. DMAVA Leadership has selected a qualified replacement who is committed to ensuring uninterrupted supervision and management of clinical services for residents, and sustaining compliance in the Consent Decree provisions (as described below).

The Medical Director took an active role in the QAPI program. His participation in monthly and quarterly meetings led to interdisciplinary discussion and root cause analysis. He regularly challenged staff to produce more definitive data when necessary and present it purposefully to prompt discussion rather than simply reading raw data.

The Medical Director also actively participated in staff education. He and the DON recently held an in-service for nursing staff on cardiopulmonary assessment and hydration to improve their ability to detect and assess resident condition changes. He was instrumental in the facility's progress in holding staff accountable. The monitoring team observed several interactions where he challenged nurses to bring relevant information to clinical meetings that fostered discussion rather than simply reporting data. However, the Medical Director had not participated in an annual review of educational plans.

The monitoring team met with the Medical Director to discuss Consent Decree requirements related to performance expectations and peer review of other physicians, and his own external peer review. As of his resignation, he had not completed these actions.

Compliance Determination: Based on the above observations and discussions, Paramus has not yet reached substantial compliance with the Oversight and Management of Medical Care requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	54e
Partially Compliant	54b, 54c, 54d
Substantially Compliant	52, 53, 54a

Infection Prevention, Detection & Control

The Paramus team continues to implement and maintain appropriate infection prevention, detection, and control practices, including written infection control policies consistent with applicable federal and state guidelines. Reporting to and communicating with state and local departments of health is completed as required.

The Paramus facility has assigned an individual with appropriate training to the Infection Control (IC) department on a full-time basis. At the time of this report, the lead IC position is vacant following the previous occupant's resignation. A staff member who has been in the IC department since 2022 is temporarily filling the lead Infection Preventionist (IP) position. The monitoring team confirmed this person has completed the necessary training in infection prevention and control through the Center for Disease Control program. The IP stated her goal is certification through the Association for Professionals in Infection Control and Epidemiology. The IP works full-time, sharing weekend coverage with other department staff. They are also available 24/7 via text messaging, phone calls, or email. On a typical day, the IP attends meetings, reviews 24-hour reports, and receives and responds to staff emails to detect infections in the building.

During the past several months, two residents presented with skin rashes that resulted in scabies diagnoses. The monitoring team believes appropriate scabies identification was delayed due to inadequate resident skin assessments, failure to provide consistent and accurate records of the skin's appearance, and communication breakdown between staff, including nursing, the residents' medical provider, and clinical management. As a result, diagnosis and treatment—including isolation and proper personal protective equipment (PPE) use by staff—was delayed by several weeks. A member of the

Paramus leadership team also reported that two staff members presented with scabies during this period.

The Education Department includes proper PPE use information during orientation and as part of annual training. Additionally, the IP makes regular infection prevention and control rounds to observe that staff appropriately use, handle, and implement PPE. During an onsite visit in July, the monitoring team observed both the IP and the ACEO Clinical - Non Nursing making environmental rounds. Hand hygiene and PPE donning/doffing are audited and reported at quarterly QAPI meetings. Overall hand hygiene audit results were 82% in July and 73% in October. Overall PPE donning/doffing audit results were 97% in July and 95% in October.

The monitoring team listened to morning clinical meeting reports and reviewed monthly infection control logs to confirm that Paramus continues to implement and maintain adequate infectious disease testing protocols. The morning clinical meeting reports include the general practice of the IP questioning whether staff performed proper assessment of infection signs and symptoms when a provider orders lab tests. The monitoring team also interviewed the IP, who stated she has regular calls with the local department of health and the infection control consultant at DMAVA to ensure all protocols are updated.

The facility continues to have one unit designated for isolation. This unit does not house residents under normal circumstances, allowing residents to be relocated or isolated immediately if necessary. Paramus staff have been particularly diligent about isolating residents with respiratory infections.

Housekeeping and maintenance staff complete environmental infection prevention and control rounds every Tuesday. Audits related to resident room disinfection are reported at quarterly QAPI meetings.

Paramus demonstrates effective response capabilities for infectious disease outbreaks. Consistent with its protocol of treating a single occurrence (such as COVID-19) as an outbreak, the facility implemented response protocols multiple times over the past year. The monitoring team confirmed the appropriate use of Personal Protective Equipment (PPE), resident cohorting, and isolation procedures during these incidents. Therefore, the monitoring team finds that a formal rehearsal of outbreak response procedures is not warranted at this time.

Compliance Determination: Based on the above observations and discussions, Paramus has not reached substantial compliance with the Infection Prevention, Detection and Control requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	56b, 56f, 57
Substantially Compliant	55, 56a, 56c, 56d, 56e, 56g, 56h

Clinical Care Policies, Procedures & Training

The Baseline Report documented the Intranet system that DMAVA Leadership and Paramus established to maintain and communicate new policies and procedures. This system remains in place, with staff reporting high satisfaction levels.

The Baseline Report highlighted concerns with how clinical care competency was documented, and the monitoring team was not able to determine whether staff members were receiving competency-based training suitable for their positions. As discussed in the General Medical and Nursing section, recent onsite visits revealed nurse educators are now using the forms correctly and capture how competency is determined. In addition, the monitoring team attended a nurse competency session which now includes education with return demonstrations. Lastly, competency testing is now more aligned with care and services identified as needed in the Facility Assessment, and skills that are high-risk, high-volume, and problem-prone.

In an effort to understand the oversight and accountability system in place to ensure that policies and procedures are reliably implemented, and communicated, the monitoring team asked for more information on a specific policy. Given the confusion around the policy for notifying physicians when residents refuse medication (discussed previously in the Medication Administration section), the monitoring team chose that policy. The document provided indicated that it had been reviewed most recently in April 2025. The monitoring team asked the reason it was reviewed in April 2025, what changes (if any) were made, and who was part of that review process. DMAVA Leadership said that the previous ACEO - Clinical Nursing led a clinical team to review and update policies and that policy reviews were typically done in the classroom with the policy up on the screen for the team to discuss. If no change was made, the date on the bottom was updated to the date of the review. The review team did not make note of the changes that were made as they would be evident by looking at the previous version of the policy.

In meeting with leadership staff at another facility, the monitoring team learned that the process for policy review and updating has changed. Policies are now developed collaboratively across all three facilities, with clinical and administrative representatives

from each home participating in policy review and development. When creating standardized policies, each facility submits its existing policy on the topic. Representatives then identify which version to incorporate into a single standardized policy applicable to all three homes. DMAVA leadership coordinates the final review process and retains marked-up versions (showing all changes) electronically.

Leadership reported significant progress in standardizing policies across the three facilities. Since 2022, the homes have standardized major policy areas including infection control, emergency preparedness, wound care, and medication administration. Approximately 87 policies were standardized in the first year, with similar numbers in subsequent years. The facilities have established a review schedule that organizes policy reviews around key annual compliance requirements, such as facility assessments, emergency preparedness and infection control. When policies are reviewed, the review date is updated, and any revisions are documented. Marked-up versions are retained electronically for reference.

DMAVA Leadership acknowledged the confusion with the Medication Administration policy, specifically related to when physicians should be notified of residents refusing medications, and the need for a more specific policy. However, in reviewing minutes from the Medication Variance Committee meetings in both July and September, the monitoring team noted that the committee expressed confusion with their policy and discussed the need for a standard of practice. There is a statement in August that says "SOP needs verified (and is being looked into further by DVHS/DMAVA)." Resident refusal of medication without timely notification of the physician is a high risk, problem prone occurrence. The monitoring team is concerned that the oversight system currently in place did not make this issue a priority until it was discussed during an onsite visit in September. Furthermore, it calls into question the ability of Paramus leadership to provide appropriate oversight and accountability of their policies and procedures.

Compliance Determination: Based on the above observations and discussions, the Paramus facility has not yet reached substantial compliance with the requirements outlined in the Clinical Care Policies, Procedures, and Training section of the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	**Corresponding Consent Decree Paragraphs**
Non-Compliant	
Partially Compliant	58, 59
Substantially Compliant	60, 61

Quality Assurance and Performance Improvement

Paramus collects data and performs numerous audits of facility services and scope. These audits provide the basis for QAPI meetings.

Paramus has numerous QAPI Initiatives and Corrective Actions relating to clinical service quality. The QAPI team responds to concerns from various sources (DOH, VA surveys, monitoring reports), addressing each from the reviewing entity's perspective. For example, both the IP and a QAPI management team member reported on infection prevention and control data. The reports contained repetitive information, and the monitoring team suggested combining duplicative reports and reporting on specific topics only once per meeting.

In care delivery areas with CMS Quality Measures (QMs), Paramus compares facility performance with state and national averages and percentile rankings. QAPI Special Services staff also track performance trends monthly and quarterly.

According to the CMS Facility Characteristics Report, the Paramus population consistently has higher percentages of males, older residents, residents entering from home or community, and residents not expected to discharge back to the community compared to state and national averages. Paramus leadership has approached DMAVA to determine if data exist for comparing facility performance with state and/or national veterans homes having more comparable resident populations. The monitoring team believes this comparison would help assess performance in care delivery areas such as falls, ADL decline, and level of independence.

While the Paramus QAPI team has identified goals and thresholds for falls (average of 16/month and 0 falls with major injury), hospitalizations (9%), and emergency room visits (4%), the QAPI team has not identified goals or thresholds for other areas. For example, the monthly Infection Control Report contains an Antimicrobial Use Summary Report including the percentage of infections that "Met Criteria for Initiation Antibiotic Therapy," but no threshold or goal has been established. This makes it unclear when the facility would initiate a performance improvement project.

The monitoring team believes that implementing preventative, corrective, and improvement actions to address identified trends, patterns, strengths, and problems is affected by QAPI team members' education and experience, as well as by the strength of data collected in audit tools. In areas such as falls, pressure injuries, and hospitalizations, QAPI teams continue identifying improvement actions like improving data collection, implementing new dressing types, and educating nurses to improve assessment skills. In other areas, poorly designed audit tools result in inadequate and sometimes incorrect data.

Additionally, many audits consist of yes/no questions. Yes/no questions can create a "check the box" mentality rather than critical process evaluation and improvement-seeking. Also, audit question responses may be nuanced and not accurately captured by simple yes or no answers. Open-ended questions can capture additional information that could assist problem-solving. The facility QAPI Special Services staff is redesigning some audit tools to include open-ended questions and will audit the auditors to ensure the tools are completed correctly.

The Paramus QAPI team continues to collect, report on, and provide some analysis of data in all care delivery systems (66a-j) identified in the Consent Decree. Monitors have heard reports from several managers that a leadership team member requested audits be redone until better outcomes were received. The monitoring team recommends that QAPI team members perform "audits of the auditor" to ensure reporting accuracy, especially where audits are "self audits."

During a recent onsite visit the monitoring team attended a well-run QAPI Meeting on Pressure Ulcers and Other Wounds. The QAPI team reported data sufficient to identify overall trends related to pressure injuries and vascular wounds. Attendees included relevant Paramus team members: Medical Director, DON, Quality Improvement Manager, Heritage Wound Care representative, Infection Preventionist, and Therapy Manager. Two direct care staff members were also present and actively participated. The Therapy Department manager, Heritage Wound Care team representative, and DON presented information on several interventions including new dressing materials and techniques and different wheelchair cushion benefits. The QAPI Special Services staff facilitator kept the meeting focused and engaged all committee members, including direct care staff.

Performance measures included comparing Paramus's Quality Measure performance to state and national averages. The facility remains slightly above state and national averages (8.1%, 7.9%, and 6.8% respectively). Several departments presented data including: MDS Coordinator (MDS Accuracy), Dietitian Supervisor (weights, supplements, laboratory test results), Education (in-services on low-air loss pressure mattresses and pressure injuries/ulcers), and Regulatory Compliance Audits (VA Survey, DOH Plan of Correction, DOJ Consent Decree). The meeting was focused, informative, and addressed current intervention efficacy and possible new interventions.

The QAPI program continues to be coordinated by a quality improvement director overseeing QAPI activity. Over the summer months, several Paramus leadership team members completed the American Association of Post Acute Nursing training module on QAPI to assist QAPI program development.

Paramus continues to maintain all QAPI process data in a reasonably accessible manner. However, as discussed in previous report sections, the monitoring team has observed inadequate staff documentation concerns in some areas including assessments, medication and treatment administration, and physician notifications. Incorrect or absent documentation also creates problems for the QAPI program because the data underlying the QAPI process is subsequently inadequate.

DMAVA and Paramus leadership continue participating in the QAPI program, including various QAPI meetings, to track clinical outcomes and QAPI project progress. The monitoring team recognizes that information from resident council meeting minutes is part of QAPI team data collection and helps identify and resolve resident complaints.

The Paramus Quality Assurance Consultant reports to the ACEO-Clinical Non-Nursing. That position was recently vacated and, until a replacement is found, the Consultant reports to the CEO. The DMAVA QAPI Coordinator is also involved in monitoring the facility's QAPI Program quality and effectiveness.

In Spring 2025, the monitoring team asked the Instructor of Nursing about QAPI training content and whether management positions, especially QAPI committee members, received additional training. The Instructor stated training was part of Healthcare Academy and used for all staff—managers did not receive additional training. "QAPI for Healthcare Staff" is a half-hour class covering topics including Background, How It Works, Why It Matters, and How Staff Can Help.

Upper-level management, department heads, and other appropriate management team members participated in American Association of Post Acute Care Nursing training on Quality Improvement Performance Improvement. Team members were required to complete training by September 2025. When asked how this training improved the QAPI program, a QAPI team member stated staff and managers are more willing participants. It has also resulted in QAPI department staff initiating efforts to improve audit veracity and changing audits to obtain more meaningful data.

The Veterans Homes have provided comprehensive training and education that is sufficient for all entities responsible for implementing corrective action.The monitoring team will continue evaluating whether corrective action plans are fully implemented in a timely manner and modified as necessary to ensure effectiveness.

Compliance Determination: Based on the above observations Paramus has not reached substantial compliance with the Quality Assurance Performance Improvement requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	62, 63b, 63c, 63e, 65a-e, 66a, 66c, 66e, 66f, 66i, 66j, 67, 68, 69, 70, 72, 73
Substantially Compliant	63a, 63d, 64, 66b, 66d, 66g, 66h, 71

Emergency Operations & Preparedness

Paramus maintains a comprehensive Emergency Preparedness Program designed to shift operations during emergencies—such as disasters and public health emergencies—to meet the health, safety, and security needs of residents and staff, communicate effectively with staff, residents, and family members, and ensure continuity of Veterans Homes operations in accordance with applicable regulations. Various emergency scenarios are outlined, and policies have been developed to ensure operational continuity and essential service provision during disasters, public health emergencies, and other emergencies.

The Facility Assessment is reviewed and updated annually, and includes specific plans and resources needed to provide competent support and care for residents daily and during emergencies. The Facility Assessment includes the following Emergency Preparedness items:

- Written procedures for facility staffing, including nursing staff and a process for determining when additional staff is needed
- Facility and community-based risk assessment
- An infectious disease outbreak response plan with written procedures for isolation, PPE, screening, interventions, testing, and communication
- Protocol for testing residents and healthcare personnel for COVID-19
- Communication plan during emergencies and/or disasters
- 2025 Hazard and Vulnerability Assessment Tool assessing risk of natural hazards, technological hazards, human hazards, and hazardous materials
- List of completed drills including fire drill training, evacuation drill, elopement drill, and infection control tabletop exercise for outbreak plan

The monitoring team reviewed the Facility Assessment, Emergency Preparedness Program, and completed drill results. DMAVA has ensured that Paramus can meet the

clinical and psychosocial needs of residents during disasters and emergency situations, including public health emergencies. Paramus management are familiar with the Emergency Preparedness Program provisions and are trained on the program in a manner suitable to their positions.

Compliance Determination: Based on the above observations and discussions, Paramus has reached substantial compliance with the Emergency Operations & Preparedness requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	
Substantially Compliant	74, 75, 76, 77, 78, 79, 80

Staffing

Paramus continues to maintain sufficient clinical staff to meet resident acuity needs. Clinical staffing aligns with New Jersey State Guidelines for nursing assistants and often exceeds those ratios based on residents' acuity levels. Paramus assigns sufficient clinical staff providing direct care to meet resident acuity needs, regulatory requirements, and safety needs. Clinical staffing needs are managed using a daily acuity worksheet and at least an annual review of the Facility Assessment. Positions budgeted for the quarantine unit, which is used sporadically, have been filled, and that staff is reassigned to other units based on resident acuity when the quarantine unit is unoccupied.

The Baseline Report identified concerns about nursing staff competency and training. As discussed in previous sections, recent onsite visits revealed nurse educators now use forms correctly and document how competency is determined. The monitoring team attended a nurse competency session that included education with return demonstrations. Competency testing is now better aligned with care and services identified in the Facility Assessment and with high-risk, high-volume, and problem-prone skills.

Paramus has assigned supervisory staff and facility leadership in sufficient numbers to ensure resident safety and well-being. These staff members are assigned in ways that

comply with Consent Decree mandates, appropriate care provision, and, to the monitor's knowledge, DMAVA's policies and procedures.

The monitoring team remains impressed with the DON and her dedication to developing her nursing staff's clinical skills. She continues to educate nurses through facilitated discussions about residents rather than simple reporting, in-services specific to staff and resident needs, an annual education plan, and updated onboarding procedures for new nursing staff. Additionally, the DON continues investigating the extent to which issues are systemic rather than reacting quickly to fix individual issues. This is an important step in empowering clinical staff and creating systems that continue to function despite leadership turnover.

Paramus continues using a contracted company to provide therapy and restorative care. The workload and responsibilities allocated to staff with specialized duties are adequate, and the monitoring team confirmed these staff members are not regularly reassigned to provide direct clinical care.

Paramus continues to maintain an emergency staffing plan that preserves resident safety during emergencies. The monitoring team confirmed this plan has been reviewed annually. Additional information is discussed in the Emergency Preparedness section earlier in this document.

CMS Staffing Performance

Paramus has a 5-Star staffing rating on CMS Nursing Home Compare. The following payroll-based journal (PBJ) staffing data reflects information about direct clinical care staff reported through the second calendar quarter of 2025:

- Total nurse staff hours per resident per day: 5 hours and 52 minutes compared to a national average of 3 hours and 54 minutes
- Weekend nurse staffing: 5 hours and 11 minutes compared to a national average of 3 hours and 25 minutes
- RN hours per resident per day: 1 hour and 23 minutes compared to a national average of 41 minutes
- LPN/LVN hours per resident per day: 57 minutes compared to a national average of 52 minutes
- Nursing assistant hours per resident per day: 3 hours and 32 minutes compared to a national average of 2 hours and 21 minutes
- Total nursing staff turnover: 21.4% compared to a national average of 46.4%
- RN staff turnover: 27.4% compared to a national average of 43.6%

The utilization of agency nurses in long-term care introduces potential risks to the continuity and consistency of care, primarily due to their limited familiarity with residents and facility protocols. This may increase the potential for adverse events, such as medication errors. Paramus leadership continues addressing reliance on agency staffing by increasing wages and pay for certified nursing assistants. Leadership believes this has been successful as it shows respect for CNAs and demonstrates that Paramus values their work. While RN agency staff needs have remained unchanged, agency staff needed for CNA and LPN shifts has decreased, except in July and August 2025. The monitoring team reviewed PBJ data revealing a 5x or 6x increase in agency staff use during these months. Paramus staff indicated this was due to high vacation time requests typical for that time of year. Resident Council minutes reveal increased complaints about nursing staff during these months, specifically calling out agency staff as the reason. Paramus leadership recognizes concerns with agency staff use and its impact on resident care. The DON and her team are working on addressing this and better managing agency staff needs and use going forward.

Leadership transitions

Paramus has experienced turnover in three significant leadership areas. The ACEO - Clinical Nursing was reassigned, the ACEO - Clinical Non-Nursing resigned, and the Infection Prevention Nurse Consultant was terminated. All three positions are currently unfilled, but DMAVA Leadership is actively searching for replacements. A member of the infection prevention, detection, and control department—previously a manager in that department—has sufficient training and has been assigned to lead the department until a new Infection Preventionist is hired. The CEO and DON are currently filling the gaps left by vacant ACEO positions, providing leadership to ensure resident safety and well-being and to comply with Consent Decree mandates, policies and procedures, and appropriate care provision. The monitoring team has no concerns directly related to this Consent Decree portion. Furthermore, the monitoring team believes that replacing the individuals who previously occupied the ACEO positions is a positive development, paving the way for enhanced leadership and improved oversight. This change is anticipated to cultivate a more positive and supportive work environment, ultimately benefiting both staff and residents.

Compliance Determination: Based on the above observations Paramus has reached substantial compliance with the Staffing requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	
Substantially Compliant	81, 82a, 82b, 82c, 82d

Organizational Accountability

As discussed in the Baseline Report, the State designated an Agreement Coordinator and established a succession plan. The Agreement Coordinator was involved in creating the Implementation Plans and continues to collect accurate clinical care outcome data, routinely review QM, QAPI reports and CASPERs, and meet regularly with Paramus leadership. Additionally, the Agreement Coordinator maintains stakeholder engagement by attending town hall and Resident Council meetings and regularly visiting Paramus. The three compliance officers are the DMAVA Quality Assurance Coordinator, the Menlo Park CEO, and the Paramus CEO; the Agreement Coordinator meets with them regularly.

Addressing fear of retaliation

The Baseline Report identified concerns related to fear of retaliation and staff reluctance to speak with monitors. At the June status conference, the monitoring team discussed this fear and concerns with Paramus leadership. The leadership team was not holding staff accountable and quickly remedied single or individual issues rather than investigating whether problems were systemic. As discussed in the Staffing section, several members of the Paramus leadership team are no longer employed at Paramus. The monitoring team saw immediate improvement with respect to greater accountability and openness, and believes these changes will significantly alleviate the fear of retaliation and reluctance to share information. The monitoring team recognizes DMAVA leadership for prioritizing these changes, which pave the way for enhanced leadership and improved oversight.

Leadership development initiatives

To further develop leadership and enhance workplace culture and climate at both Paramus and Menlo Park, the Agreement Coordinator held two separate offsite events for facility leadership staff. The first event included CEOs from Menlo Park, Paramus, and Vineland facilities; the second event included ACEOs from each of the three facilities. With assistance from the Director of Veterans Healthcare Services and the

Director of Human Resources and Employee Relations, participants shared ideas and suggestions for facility improvement. Specifically, they reviewed recent climate survey results and discussed improving communication and collaboration, strategies for fostering stronger team relationships, and the importance of diversity, inclusion, and respect in the workplace.

Compliance Determination: Based on the above observations and discussions, Paramus has reached substantial compliance with the Organizational Accountability requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	
Substantially Compliant	83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94

The New Jersey Veterans Home at Menlo Park

Introduction

During the twelve-month period following execution of the Consent Decree, the monitoring team conducted seven onsite visits to Menlo Park: five full monitoring evaluations and two record review visits. Full monitoring evaluations included observations of care, formal and informal resident and staff interviews, attendance at regular weekly and quarterly meetings with leadership and clinical staff, and medical record reviews. Record review visits focused exclusively on resident and staff documentation. Throughout this period, the monitoring team maintained monthly contact with Department of Military and Veterans Affairs (DMAVA) Leadership and the NJ Veterans Home at Menlo Park, supplemented by virtual and in-person communication with additional staff members.

Each onsite visit included attendance at clinical meetings such as the morning meeting, afternoon wrap-up, and weekly, monthly, and quarterly Quality Assurance and Performance Improvement (QAPI) meetings. The monitoring team reviewed medical records, resident care plans, and readmission paperwork to assess staff ability to identify changes in resident condition. The findings from these activities are described below.

General Medical & Nursing Care

Menlo Park has ensured that all contractors and outside providers who provide clinical care within the facility are doing so in a way that meets medical and nursing care standards. The QAPI program provides oversight of care and services delivered by these contractors and providers. In addition, the Menlo Park leadership team has established systems to identify, investigate and remediate issues which has resulted in care delivery systems that generally produce positive outcomes for the resident population. The monitoring team has identified some areas for improvement which are described in the paragraphs and sections below.

Documentation

The Menlo Park clinical team does not consistently document in a manner that withstands clinical scrutiny. The monitoring team reviewed medical records and found that while the documentation process has generally improved, the following concerns remain: lack of follow-up on weight fluctuations, and inconsistent documentation of fall and pressure ulcer risk assessments when indicated. The monitoring team also identified late entries that were not appropriately documented, write-overs that were illegible, and physician orders and changes to MARs/TARs that lack adequate or appropriate documentation (e.g., a single strikethrough line leaving the original entry legible, date, time, and initials of the person making the change).

Policies/Procedures

Due to confusion regarding the Administration of Medication Standard of Practice (SOP), the monitoring team is reviewing the process by which DMAVA and the Veterans Homes establish and implement uniform clinical care policies and procedures, as well as the process DMAVA leadership uses to review and implement consistent policies and procedures. This issue is discussed further in the Clinical Care Policies, Procedures, and Training section of the report. The monitoring team will continue to monitor this process to ensure consistent provision of appropriate nursing and medical care.

Facility Assessment

Menlo Park conducts Facility Assessments annually and when services change. After completing each assessment, DMAVA leadership, the Medical Director, Agreement Coordinator, and Department Heads conduct a page-by-page review of the document, examining census data, resident acuity levels, and the clinical skills required to care for each resident. The Chief Executive Officer (CEO) at Menlo Park then communicates

this information to education coordinators to ensure staff receive training based on resident care needs identified in the Facility Assessment.

Electronic Medical Record

As discussed in the Baseline Report, Menlo Park has not implemented and maintained electronic resident medical and clinical care records in an organized and readily accessible manner. While Menlo Park has made progress—with more disciplines now using the Electronic Medical Record (EMR), such as Certified Nursing Assistants (CNAs) and Life Enhancement staff—important components of residents' records remain outside the EMR, including physician orders, medication administration records (MARs), and treatment administration records (TARs).

DMAVA has identified a new EMR company and is negotiating contract terms. This comprehensive new system will completely replace the current EMR and include all aspects of clinical care: physician orders, MARs, TARs, immunizations, and other documentation. This integration will eliminate paper documents and resolve the cumbersome, duplicative processes and errors associated with paper orders and records. DMAVA anticipates beginning implementation in late 2026.

The monitoring team recognizes that no short-term resolution exists for the EMR situation. The current EMR and clinical care record system remains disorganized and not readily accessible.

Minimum Data Set Assessments

The Resident Assessment Coordinators at Menlo Park have the necessary skills and qualifications to accurately and appropriately complete Minimum Data Sets (MDS).

Compliance Determination: Based on the above observations the Menlo Park facility has not reached substantial compliance with the General Medical & Nursing Care requirements outlined in the consent decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	**Corresponding Consent Decree Paragraphs**
Non-Compliant	
Partially Compliant	30, 32, 33, 34, 37
Substantially Compliant	31, 35, 36, 38

Changes in Condition

The monitoring team continues to observe that staff appropriately monitor residents for changes in condition. MDS nurses complete comprehensive nursing assessments according to the Centers for Medicare and Medicaid Services (CMS) MDS schedule; however, MDS staff do not conduct assessments for changes in condition that do not meet significant change criteria. The monitoring team could not definitively determine whether staff nurses perform comprehensive assessments both routinely and when changes in condition necessitate them. For example, during an onsite monitoring visit, staff reported at the morning clinical meeting that a resident required a specific lab test. This test is only appropriate when an individual presents with signs and symptoms meeting specific criteria. The monitoring team's review of this resident's record revealed no appropriate assessment to determine whether the required signs and symptoms were present. Ultimately, this test was not necessary.

Menlo Park clinical staff communicate changes in residents' condition during change-of-shift reports and document these changes in a 24-hour logbook at the nurses' station. Supervisory nurses from each unit then report changes in condition during morning and afternoon clinical meetings, which are interdisciplinary and include representatives from clinical departments such as nursing, dietary, therapy, and infection control.

Menlo Park clinical leadership staff continue to mentor staff in completing SBAR (Situation, Background, Assessment, and Reporting/Recommendation) Communication Forms. These forms ensure that necessary information has been gathered before notifying a physician about a change in resident condition. The monitoring team reviewed several SBAR forms and found them complete and informative.

The Menlo Park facility continues to maintain a robust infection prevention, detection, and control surveillance program that guides and reminds clinical staff to report any changes in condition indicative of possible or worsening infections. The infection control team attends all clinical meetings to monitor infections and performs daily reviews of resident records to detect any signs or symptoms of infection and orders for labs and x-rays. The monitoring team found that residents at heightened risk of infection are appropriately assessed and treated.

Menlo Park clinical staff routinely assess residents for pain symptoms in two situations: when changes in resident condition would reasonably cause pain, and when staff, residents, or visitors report suspected pain if the resident is unable to verbalize pain. The monitoring team observed no residents who appeared to be in pain, and residents did not report pain symptoms. Clinical staff respond appropriately, provide treatment in a

timely manner, communicate with physicians as needed, and continue treatments and assessments to ensure pain is effectively managed.

Compliance Determination: Based on the above observations the Menlo Park facility has not reached substantial compliance with the Changes in Condition requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	40a, 40d
Substantially Compliant	39, 40b, 40c, 40e, 41, 42

Resident Care Plans

The monitoring team's review of several resident records found that care plans contain generalized rather than resident-specific interventions. For example, one care plan encouraged the resident to attend activities without specifying which activities the resident enjoys, and another encouraged fluid intake without indicating the amount the resident should consume or preferred fluid types.

While some interventions for monitoring disease or illness signs and symptoms remain undefined (e.g., hypo/hyperglycemia), other examples identified specific signs and symptoms (e.g., a specific elevated laboratory value). Such specificity assists nurses unfamiliar with the signs and symptoms requiring monitoring.

Completed one-time interventions, such as obtaining a consult or "resident sent to the emergency room," are unnecessary on care plans. Similarly, standard practice interventions, such as "administer medications as ordered," need not appear on care plans. The monitoring team encourages staff to add nursing interventions that can resolve issues without physician orders. For example, individualized nonpharmacological sleep interventions can include soothing music, lighting adjustments, or consultation with the resident or family member about usual bedtime and bedtime rituals.

Most reviewed care plans identify the next evaluation date as the problem resolution timeframe (e.g., next quarterly MDS assessment or wound care team visit). While

acceptable for some problems, others—such as acute infections or minor skin injuries—require shorter resolution timeframes (e.g., 10-14 days).

During the morning meeting, the clinical team discussed a new admission, sharing information important for establishing the resident's initial care plan. The conversation included the resident's medically defined conditions and prior history, psychosocial wellbeing and support system, cognitive status, skin injuries, and nutritional status. During the meeting, staff identified interventions for the resident, including the need for encouragement to take medications and the need for pressure-relieving devices. Because several people had laptops at this meeting, staff immediately entered the notes and modifications into the medical record and care plan.

The monitoring team reviewed information on a resident's Kardex (the documentation system used by DMAVA to track key resident information) and compared it to the resident's care plan. The Kardex, which is also part of the electronic medical record, allows staff to enter information by selecting prepopulated options or adding narrative information in designated locators. It compiles essential resident data into one reference document for staff. Information such as the resident's code status (DNR, DNI, DNH, etc.), level of staff assistance needed for Activities of Daily Living (ADLs), fall interventions, and skin interventions have specific locators for data entry.

The monitoring team found that Kardex sections did not include information from the resident's care plan. For example, while the care plan identified heel booties, a wedge, and a ROHO cushion, these items were not listed in the Kardex's Skin Intervention section. The team also found inconsistencies between the resident's Kardex and care plan. For example, the Kardex indicated the resident needs one staff member with partial/moderate assistance, while the care plan indicated the resident needs two staff members with substantial assistance for transfers. The concise Kardex and the detailed care plan must be congruent. Inconsistencies can lead to staff confusion, increasing the risk of adverse resident outcomes, such as falls, by making the required level of assistance unclear.

The monitoring team recommends additional staff education on completing the Kardex to improve its effectiveness as a tool. Staff inconsistently entered information in appropriate sections. For example, Do Not Intubate (DNI) was entered in the Miscellaneous section rather than the Code Status section, despite the availability of a DNI option. Similarly, a resident's snack preference was listed in the Miscellaneous section rather than the Meal Preference section, where staff can enter narrative notes.

Care plans are readily available to staff. During shift changes, staff communicate updates to all personnel responsible for care plan interventions, including nurses, CNAs, and restorative and physical therapy staff. The recent onboarding of CNAs,

restorative nursing assistants, and life enhancement staff has positively contributed to keeping care plans organized, understandable, and accessible.

Compliance Determination: Based on the above observations the Menlo Park facility has not reached substantial compliance with the Resident Care Plans requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	43b, 43c, 46
Substantially Compliant	43a, 44, 45, 47, 48

Vascular Wounds and Pressure Injuries

Recent onsite visits indicate that Paramus staff are not ensuring all interventions are implemented to prevent skin breakdown and help residents maintain or attain healthy skin integrity. Specific examples are provided in the paragraphs below.

Menlo Park staff continue to provide appropriate oversight of the contracted wound care company. The wound care specialist team appropriately documents wounds, including wound characteristics, wound evaluation, and treatment modifications based on healing progress. Treatment and documentation occur weekly and between scheduled visits when staff discover new wounds or note significant changes in existing wounds.

The Menlo Park nursing team performs dressing changes between wound care team visits. During an onsite visit, the monitoring team observed two nurses perform a dressing change. The nurses used good technique, including compliance with infection prevention interventions. The wound had healed, and the nurses stated they were awaiting orders to discontinue dressing changes. The nurses remained attentive to the resident, communicated their actions, and assessed the resident's comfort. The monitoring team also observed properly placed bilateral heel booties that were being used to prevent heel skin breakdown.

The wound care specialist team fully assesses and documents wounds at least weekly. When facility nurses perform dressing changes, they consistently initial the treatment administration record but do not document typical wound characteristics such as measurements, drainage, odor, and pain in residents' medical records. This

documentation gap prevents nurses from detecting whether wounds are worsening or improving between wound care specialist visits. During facility dressing changes, nurses can only compare wounds to the specialist team's weekly descriptions. When nurses perform multiple dressing changes during the week, the absence of objective recorded information prevents comparison with the most recent dressing change.

The Menlo Park Medical Director, Director of Nursing (DON), and Assistant Director of Nursing (ADON) coordinate and oversee the facility's wound care program. Data and trends are reported and discussed at the facility's monthly and quarterly QAPI meetings.

Long-term care facility regulations require an initial Braden Scale assessment upon admission, followed by weekly re-assessments for the first month, and then quarterly or upon a change in condition. Menlo Park staff demonstrated inconsistent practices in initially identifying and subsequently assessing residents at risk for developing pressure injuries. Specifically, assessment deficiencies were noted across two groups.

First, four newly admitted residents received the mandatory initial Braden Scale assessment upon admission but were missing required weekly Braden assessments for the subsequent four-week period; and one newly admitted resident had three consecutive weekly Braden Scale assessments completed but was missing the fourth weekly assessment. Second, four residents who were not recent admissions lacked any quarterly Braden Scale assessments within the last six months. These issues represent a systemic lapse in following established pressure injury risk assessment protocols.

Similarly, Menlo Park nurses inconsistently conduct and document weekly skin assessments. CNAs observe resident skin integrity during daily care and verbally report any skin issues to nurses without written documentation. The monitoring team reviewed eight medical records: three contained weekly skin assessments documented when due, while the remaining five showed gaps of two to five weeks between assessments. Additionally, two assessment forms with identical content but different titles exist—Weekly Skin Assessment and Interim Skin Assessment. The monitoring team considered both forms when determining whether weekly skin assessments were completed.

During the first quarter of 2025, nursing leadership launched a QAPI project to improve weekly skin assessment documentation accuracy. The goal was to achieve 90% monthly compliance in recording scheduled skin assessments in both the treatment administration record (nurses' initials) and electronic medical record (assessment results). Initial compliance was 58%, though the baseline audit date is not specified. Leadership implemented an action plan involving staff education on completing skin assessments, delivered by charge nurses and supervisors. Following implementation, compliance rates for April, May, and June reached 90–91%.

The monitoring team interviewed several residents about pain management during dressing changes and wound-related pain in general. None of the interviewed residents complained about pain management or demonstrated verbal or nonverbal evidence of pain during dressing changes.

The Menlo Park QAPI department maintains a facility-wide system to track pressure injuries and vascular wounds with accurate and timely data. Wound data includes monthly recapitulation of new wounds, new facility-acquired wounds, new community-acquired wounds, new facility-acquired pressure ulcers, total pressure ulcers, and residents with multiple wounds. The facility compares its performance with state and national benchmarks through the quality measure report.

The MDS 3.0 Facility-Level Quality Measure (QM) Report for Report Period 04/01/25 - 09/30/25 shows the facility adjusted percent for pressure ulcer at 8.3%, higher than the state and national comparison group percentages of 7.8% and 6.3%, respectively. The measure tracks *new* ulcers or existing ones getting *worse*, not the total number of ulcers present. The facility adjusted percent takes into consideration resident risk factors, such as mobility and malnutrition, in order to make comparisons with other facilities more fair. The percentile ranking is 73rd, meaning 73% of other facilities performed better in this area while 27% performed the same or worse. This represents an improvement from data in the Baseline Report for the January 2025 report period. At that time, the facility adjusted percentage was 8.4%, still higher than the national comparison group percentage of 6.6% (state comparison data was unavailable), with a percentile ranking of 86th. According to the National Institutes of Health, a percentile ranking greater than 75 is cause for concern. The decrease in percentile ranking from January 2025 to September 2025 indicates improvement.

Compliance Determination: Based on the above observations the Menlo Park facility has not reached substantial compliance with the Vascular Wounds and Pressure Injuries requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	**Corresponding Consent Decree Paragraphs**
Non-Compliant	
Partially Compliant	49a, 49c, 49g, 49h, 49i, 49j, 49k
Substantially Compliant	49b, 49d-i(1-9), 49e, 49f, 49l, 49m

Medication Administration

Menlo Park continues to educate and competency test nursing staff on safe medication dispensation and administration. The leadership team has established a system to accurately track medication administration variances. Quarterly QAPI meetings include reports on medication variances with data on total medication errors, errors resulting in resident adverse outcomes, nurse type (registered nurse or licensed practical nurse), error type (e.g., transcription, wrong time, wrong dose), and the shift when the error occurred. During the second quarter of 2025, only five errors were reported with no adverse effects on residents. Staff received education, and the Consultant Pharmacist, Pharmacy, Physicians, and interdisciplinary team investigated all errors and provided recommendations for improvement.

Menlo Park nursing staff continues to struggle with consistently administering residents' medications and treatments within the correct timeframe, particularly during the 9:00 a.m. medication pass. Recognizing this issue, the clinical team, including the medical director, reviewed the most common medications to reduce the 9:00 a.m. medication administration burden. The team eliminated sliding scale insulin administration, adjusted vital sign parameters, and modified medication times when possible (e.g., changing from 9:00 a.m. to 1:00 p.m.).

Nursing leadership initiated a QAPI study during the first quarter of 2025 to improve timely medication administration performance. Data collected over the second quarter of 2025 showed 73% compliance on the 7-3 shift, 79% on the 3-11 shift, and 100% on the 11-7 shift. Overall quarterly compliance was 84%, an improvement from the first quarter's 76% compliance. A root cause analysis identified the most common reasons for late medication administration: starting the medication pass late, large quantities of medications (particularly on the day shift), and interruptions during medication administration, including answering phone calls, assisting with care delivery, answering questions, and performing necessary treatments. The team identified improvement actions including staff education, Medication Variance Committee involvement, and continued auditing until reaching at least 80% compliance. Staff education included reinservicing nursing staff on Medication Administration Policy & Procedure, providing 1:1 education to minimize or stop medication pass interruptions, and ensuring timely medication pass starts.

In August 2025, Menlo Park implemented the Passport Medication Administration System (Passport). The monitoring team interviewed several nurses who expressed confidence that the system will increase efficiency once nurses become more comfortable with it. However, during the October 2025 onsite visit, the monitoring team observed that on two units, three of four nurses did not complete the 9:00 a.m.

medication pass on time. One nurse stated that when a resident's scheduled medication is not in the dispensed envelope, she must go to the Passport dispensing machine to retrieve it, causing delays in medication administration completion.

The monitoring team's review of Treatment Administration Records (TARs) found that nurses do not consistently document treatment completion. One TAR lacked any initials indicating completion for treatments scheduled on a weekend 3-11 shift. The monitoring team discussed this with the DON, who determined an agency nurse was responsible for those treatments. The DON contacted the agency nurse, who reported completing all treatments despite the missing documentation. Another TAR lacked initials for all treatments scheduled on a weekday 7-3 shift. The monitoring team could not determine whether treatments were completed but not documented, or not completed at all. Per usual and customary practice, nurses should document treatments as they complete them.

Menlo Park nursing staff do not consistently ensure accurate, effective, and timely medication administration documentation. During two separate onsite visits, the monitoring team observed two nurses paging through medication administration binders and making entries on various pages after completing medication administration. Standard of practice requires documenting medications at the time of administration.

Prior to the Consent Decree requirements, Menlo Park's Pharmacy and Therapeutics committee met quarterly to address medication variances. Menlo Park recently increased meeting frequency to monthly to comply with Consent Decree requirements. The committee includes at least one QAPI committee member and a nurse involved in day-to-day medication administration. The monitoring team confirmed that all committee members have received QAPI training.

The October 2025 Medication Variance Committee meeting included interdisciplinary discussion about Passport implementation. The Committee identified problems and received valuable input from nursing supervisors to help identify solutions. The discussion revealed that Passport capacity concerns are the biggest issue. Specifically, physicians order large quantities of medications with varying doses for each resident. Each dose requires its own Passport slot, limiting capacity for additional medications. The committee also identified that census growth may result in insufficient machine capacity. The committee will continue reviewing currently dispensed medications and doses to determine whether greater efficiencies can be achieved.

Menlo Park nursing staff record the effectiveness of as-needed medication on the reverse side of the medication administration record. Nurses' notes also show documentation of the effectiveness of ordered lotions and creams. The pharmacy consultant routinely reviews residents' medication regimens and makes

recommendations regarding medication appropriateness and suggested modifications. Physicians review these documented consults in residents' medical records.

Compliance Determination: Based on the above observations the Menlo Park facility has not reached substantial compliance with the Medication Administration requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	50c, 50d
Substantially Compliant	50a, 50b, 50e, 50f, 50g, 50h

Falls

Menlo Park staff inconsistently complete fall risk assessments and do not always adhere to the required schedule of admission, quarterly, and as-needed assessments.

A review of four newly admitted residents showed admission assessments were completed for all four. However, one new resident who fell approximately one week after admission did not receive the required post-incident fall risk assessment. After a second fall approximately two months later, different nurses completed two separate fall risk assessments on consecutive days, both determining the resident was at high risk.

Additionally, a review of four non-newly admitted residents revealed no evidence of required quarterly fall risk assessments in their medical records.

The monitoring team found that all eight residents reviewed for fall risk or actual falls had care plans in place. Menlo Park nursing staff modified care plans following actual falls. However, care plans included generalized interventions—such as "include in the life of the facility," "use non-skid socks," and "keep room clutter free"—and lacked individualized, resident-centered approaches.

Menlo Park nursing staff regularly conduct rounds to identify environmental hazards and monitor resident activities, including observing residents who might attempt transfers without required assistance—an action that deviates from their care plans and increases fall risk. The monitoring team reviewed a QAPI report detailing a study on CNA 30-minute rounding that outlined audit instructions, frequency, and review items. Key audit points included CNAs entering rooms, ensuring call bells and water were

accessible, and completing documentation. June audits showed positive results: 50 of 55 observations confirmed appropriate 30-minute rounds.

When a resident experiences a fall, staff initiate a therapy referral for evaluation. This procedure ensures residents receive appropriate assistive devices.

The monitoring team's review of resident records revealed a documentation discrepancy regarding assistive safety devices. While these devices—essential for accident and fall prevention—were included in residents' formal care plans, they were inconsistently documented in the Fall Intervention or other pertinent Kardex sections. This inconsistency is significant because staff rely on both care plans and the Kardex to accurately record and implement resident care and interventions.

The monitoring team's site visits found that Menlo Park maintains both resident rooms and shared communal areas in a condition that reduces accident risk. Maintenance personnel uphold this standard through weekly safety inspections.

Menlo Park leadership maintains continuous monitoring of resident falls. The facility collects fall data and analyzes trends during weekly fall committee meetings. The MDS 3.0 Facility-Level QM Report for Report Period 04/01/25 - 09/30/25 shows the facility adjusted percentage of residents with falls was 39.7%, compared to state and national averages of 38.0% and 44.5%, respectively. The facility's percentile ranking is 32nd, meaning 32% of other facilities nationwide performed better while 68% performed the same or worse.

The monitoring team observed various fall prevention safety devices in use for residents identified as at risk for falls. These devices are designed to prevent falls or reduce injury severity if falls occur. Examples included silent bed and wheelchair alarms, low-height (hi/lo) beds, and floor mats placed alongside residents' beds.

Compliance Determination: Based on the above observations the Menlo Park facility has not reached substantial compliance with the Falls requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	**Corresponding Consent Decree Paragraphs**
Non-Compliant	
Partially Compliant	51a, 51b, 51c, 51f
Substantially Compliant	51d, 51e, 51g, 51h, 51i

Oversight and Management of Medical Care

Menlo Park's licensed, credentialed, and well-qualified Medical Director continues to provide consistent, competent, and appropriate supervision of clinical services. He remains significantly involved in the facility's daily operations through his attendance and participation in morning clinical meetings, wrap-up sessions, and various QAPI meetings. The monitoring team continues to be impressed by his ability to initiate interdisciplinary discussions that frequently incorporate valuable teaching moments.

Drawing on his experience with The Society for Post-Acute and Long-Term Care Medicine (formerly the American Medical Directors Association), the Medical Director has been conducting chart reviews. At the July quarterly QAPI meeting, he reported completing 20 reviews for residents under the care of three other attending physicians. He reaffirmed his dedication to clinical excellence by emphasizing SBARs, documentation, and communication, and by holding staff accountable in these specific areas.

The Medical Director actively educates staff and defines clear performance expectations for all healthcare professionals, including other physicians. In June 2025, the Medical Director and other Menlo Park leaders hosted a physician meeting addressing several key topics: Consent Decree updates, CMS regulatory requirements, hospitalizations and emergency department utilization, antibiotic stewardship, pharmacy recommendations, the Medical Director's role, and unnecessary medication use.

During an interview with the monitoring team, the Medical Director reported that two providers are no longer employed at the facility. He expressed concern that they were not meeting appropriate performance standards. When he communicated these expectations, both providers chose to resign rather than commit to necessary performance improvement. The Medical Director and his colleagues have since assumed care of these residents.

The monitoring team noted inadequate resident assessment documentation by a provider, including repeated vital signs for three months and a question mark notation for significant weight changes. The Medical Director stated he identified these concerns, addressed them with the provider, and resolved the situation.

He has also The Medical Director has not received an external review of his own direct care performance. DMAVA Leadership intends to have the Medical Directors at Menlo Park and Paramus conduct peer reviews for each other. This process will begin in early 2026 after the new Medical Director at Paramus has been in place for several months.

Compliance Determination: Based on the above observations the Menlo Park facility has reached substantial compliance with the Oversight and Management of Medical Care requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	54e
Substantially Compliant	52, 53, 54a-d

Infection Prevention Detection & Control

The Menlo Park team continues to implement and maintain robust infection detection and control practices. The facility consistently maintains written infection control policies that adhere to applicable federal and state guidelines. The team also ensures required reporting and communication with state and local health departments are completed as necessary.

Menlo Park maintains at least one full-time, certified infection prevention and control specialist supported by two assistants. Together, they provide full-time, on-site management of the infection prevention and control program.

The infection prevention department conducts rounds 1-2 times per week to monitor staff compliance with transmission-based precautions, enhanced barrier precautions, handwashing, and personal protective equipment (PPE) use. The education department provides annual staff education and competency testing focused on handwashing, hand hygiene, and proper PPE donning and doffing. The education department tracks staff completion rates and employs strategies to ensure timely completion.

Menlo Park has established and maintains comprehensive disease testing protocols, including rapid antigen and polymerase chain reaction (PCR) tests for flu, respiratory syncytial virus (RSV), and COVID. Protocols clearly specify when testing should be performed and which test should be used. Exposed staff members are also tested. The facility has established protocols for testing non-respiratory infections, including skin and soft tissue, urinary tract, and gastrointestinal infections.

The Menlo Park team effectively managed a COVID-19 outbreak that occurred during a monitoring visit. Following identification of the first positive cases, the CEO reminded

department heads to implement infection prevention strategies: masking, distancing, keeping resident doors closed, and proper disinfection. The Infection Preventionist (IP) emailed staff reminding them of all required prevention strategies. Staff moved twelve positive residents to the designated isolation unit. The IP initiated contact tracing and COVID testing for early detection. The facility awaited Paxlovid delivery for resident treatment. Most residents were asymptomatic; only a few experienced mild symptoms (cough, runny nose, no fever). In following days, managers discussed outbreak status and reminded staff to monitor residents for symptoms of other COVID variants, such as sore throat or gastrointestinal upset. Management demonstrated vigilant attention to ensuring proper infection protocols were followed.

To proactively prevent infection spread, the housekeeping department implemented a Quality Assurance and Performance Improvement (QAPI) project ensuring resident room cleaning adheres to industry guidelines. An auditor uses GloGerm and ultraviolet light, along with the CDC Checklist for Terminal Cleaning, to evaluate cleaning effectiveness. By accompanying housekeepers during cleaning sessions, the auditor identifies areas of inadequate cleaning and immediately corrects deficient practices.

Compliance Determination: Based on the above observations Menlo Park has reached substantial compliance with the Infection Prevention, Detection & Control requirements set forth in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	**Corresponding Consent Decree Paragraphs**
Non-Compliant	
Partially Compliant	
Substantially Compliant	55, 56(a-h), 57

Clinical Care Policies, Procedures & Training:

The Baseline Report documented the Intranet system that DMAVA Leadership and Menlo Park established to maintain and communicate new policies and procedures. This system remains in place, with staff reporting high satisfaction levels.

To better understand how DMAVA and the Veterans Homes maintain systems for establishing, implementing, and providing oversight of uniform clinical care policies and procedures, the monitoring team met with facility leadership. Leadership explained that policies are developed collaboratively across all three facilities, with clinical and

administrative representatives from each home participating in policy review and development.

When creating standardized policies, each facility submits its existing policy on the topic. Representatives then identify which version to incorporate into a single standardized policy applicable to all three homes. DMAVA leadership coordinates the final review process and retains marked-up versions (showing all changes) electronically.

New or revised policies become effective only after the education department provides mandatory training to all affected staff across all shifts. The timeframe for completing education varies based on the policy's scope. Policies affecting only nurses may require one to two weeks for education completion, while policies affecting all nursing staff may require several weeks.

Leadership reported significant progress in standardizing policies across the three facilities. Since 2022, the homes have standardized major policy areas including infection control, emergency preparedness, wound care, and medication administration. Approximately 87 policies were standardized in the first year, with similar numbers achieved in subsequent years. The facilities have established a review schedule that organizes policy reviews around key annual compliance requirements, such as facility assessments, emergency preparedness, and infection control. When policies are reviewed, the review date is updated, and any revisions are documented. Marked-up versions are retained electronically for reference.

Menlo Park clinical staff continue to demonstrate necessary competence in clinical areas, as evidenced by education records and discussions with the Instructor of Nursing. This includes competency-based training for all staff, contractors, and volunteers in infection prevention, detection, and control practices.

Additionally, DMAVA has maintained a responsible leadership team that has implemented an appropriate system of oversight and accountability mechanisms to ensure reliable policy implementation. While monitors believe Menlo Park staff are properly trained and possess the competency to complete assigned responsibilities, the monitoring team has concerns about consistency, specifically related to fall risk, Braden Scale, and weekly skin assessments.

For example, during a recent record review, monitors noted that Braden Scale and fall risk assessments were still missing. In response to these findings, Menlo Park assembled a clinical leadership team—including the ACEO, DON, ADON, QAPI consultant, and MDS staff—to conduct a root cause analysis (RCA) to address the incomplete and inconsistent completion of quarterly assessments.

The comprehensive RCA plan identified five core issues and corresponding action plans, which will form the basis for the formal QAPI program. During future onsite visits, monitors will continue to review the corresponding QAPI efforts and follow up on documentation concerns to ensure that policies and procedures are fully implemented.

Compliance Determination: Based on the above observations, Menlo Park has not reached substantial compliance with the Clinical Care Policies, Procedures, and Training requirements set forth in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	58
Substantially Compliant	59, 60, 61

Quality Assurance and Performance Improvement (QAPI)

Menlo Park collects data and performs audits that address the scope of services provided at the facility. This information forms the basis for developing QAPI projects and monitoring activities.

The monitoring team discussed the QAPI process and procedures with facility leadership during onsite visits. Menlo Park leadership and management staff identify concerns by reviewing multiple data sources: CMS data, internal logs (e.g., Infection Control and Wound Care), and evaluation results from entities including the Department of Health, DMAVA, and the Hibiscus Group monitoring team.

The QAPI process includes identifying the concern (what are we trying to fix?), establishing baseline measures, setting a goal, defining study specifications, presenting findings (data), conducting analysis, determining whether immediate concerns were found and how they were corrected, and creating an action plan specifying the study duration and personnel involved. Current and past study topics include room cleaning evaluation (Housekeeping), resident grievances (Social Services, Administration, and relevant system representatives such as nursing or housekeeping), medication variance, staffing, infection prevention and control, wound care, weight loss, and falls.

Data and information presented at QAPI meetings are compiled from multiple sources: Resident Council Minutes, committees (e.g., Medication Variance and Falls), and direct

contact with residents and family members. Staff contribute through committee participation and one-on-one communication with the management and leadership team. Residents and family members provide input through Town Hall meetings, individual meetings, and email messaging.

The Menlo Park team deserves commendation for its robust QAPI process. The monitoring team's review of these projects found that the team clearly identifies problems, collects reliable data, analyzes trends, pinpoints triggers for negative outcomes, and implements effective corrective action plans.

Project reports are thorough, detailing specific audit instructions and required compliance evidence. The reports also include root cause analysis evidence and structured evaluations of whether interventions successfully resolved problems. When interventions are unsuccessful, reports detail planned modifications for process and outcome improvement.

While some projects have not yet reached their stated goals, the underlying process is fundamentally sound, giving the team high potential for success.

A manager effectively oversees the Menlo Park QAPI program and its quality management processes. The program uses weekly and monthly QAPI subcommittees to address specific projects focused on falls, pressure injuries, and weight loss. These subcommittees include representatives from all relevant departments, including direct care staff, ensuring comprehensive input. The full QAPI Committee convenes quarterly and comprises the Medical Director, DON, nurse educator, IP, wound coordinator, and representatives from all facility disciplines and departments. These quarterly meetings review results and recommendations from various QAPI projects. To strengthen the program, key Menlo Park leadership team members recently completed the American Association of Post-Acute Care Nursing QAPI training module during summer 2025.

Menlo Park staff fully cooperated with the monitoring team, providing access to essential QAPI data. However, the monitoring team identified documentation issues related to resident assessments following changes in condition and for fall and pressure injury risks. Addressing these documentation concerns is important for strengthening the QAPI process and improving resident care and outcomes.

Menlo Park and DMAVA leadership actively participate in the QAPI program. Through regular QAPI meeting attendance, they monitor QAPI project progress and track clinical outcomes. Leadership also uses comparative clinical data from the CMS QM Report and 5-Star Program to benchmark performance against other long-term care facilities at state and national levels.

In February 2025, Menlo Park leadership used a CMS-recommended tool to self-assess its QAPI program. The evaluation covered QAPI culture, organizational support, training, pilot project approach, and structured processes using ratings from "Not started" to "Doing great." The team consistently rated itself positively: "On our way," "Almost there," or "Doing great." The monitoring team agrees with this positive assessment and notes the Menlo Park QAPI team's strong performance.

The facility's QAPI efforts have progressed significantly due to the QAPI QA Specialist's expertise. The specialist completed the American Association of Post-Acute Care Nursing QAPI training and is now certified. Other management team members are also completing this training.

Drawing on her extensive experience and deep understanding of QAPI, including potential pitfalls, the QA Specialist recently enhanced the facility's audit effectiveness by modifying audit questions to require more than simple "yes/no" answers. This shift from binary questions encourages critical process evaluation beyond a "check-the-box" mentality. Open-ended questions capture nuanced responses and valuable additional information that aids problem-solving and process improvement.

Compliance Determination: Based on the above observations the Menlo Park facility has reached substantial compliance with the QAPI requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	68
Substantially Compliant	62, 63a-e, 64, 65a-e, 66a-j, 67, 69, 70, 71, 72, 73

Emergency Operations and Preparedness

The monitors reviewed the Emergency Preparedness Program and found that the facility has created, maintains, and regularly updates a plan defining how operations will shift during emergencies such as disasters and public health emergencies. This plan details how Menlo Park will meet the health, safety, and security needs of residents and staff, communicate effectively with staff, residents, and family members, and ensure continuity of operations in accordance with applicable regulations.

Menlo Park created, maintains, and regularly updates its comprehensive Emergency Plan, which establishes written procedures for continuing operations and providing essential services during disasters, public health emergencies, and other emergencies. Monitors found Menlo Park's Emergency Preparedness Plan to be extremely well-organized and thorough.

The CEO shared plans with monitors for a 2,500-square-foot, climate-controlled external building that will be available for emergencies. The building will house 20 low beds, six vital sign machines, oxygen concentrators, and ultraviolet disinfection equipment.

Monitors found the Emergency Preparedness Plan provides information and direction for staff, volunteers, and third-party individuals to meet residents' clinical and psychosocial needs during disasters and emergencies, including fire, tornado, hurricane, elopement, earthquake, infectious disease outbreak, and public health emergencies. The facility has collaborated with the county Office of Emergency Management and signed contracts with outside resources including hospitals, nursing facilities, and ambulance and transportation services. Additionally, the Plan lists supplies and equipment necessary for the facility to function for six to eight weeks and identifies where these supplies are stored.

Menlo Park has developed and maintains communication procedures for residents, staff members, and resident family members that ensure family members with legal authority over a resident's care have sufficient information to act in the resident's best interest. The facility communicates through email blasts to all resident representatives, designees, residents, and staff with email access. These emails communicate changes to restrictions and operational alterations and are sent weekly. Emails also include information on menus, activity calendars, and special events. The facility posts outbreak update notices at the Main Entrance Reception Desk and on the in-house TV channel. Staff notify families and representatives by 5:00 p.m. of the next calendar day of positive diagnoses. For resident representatives, designees, residents, and staff who do not have or choose not to communicate by email, all notices are sent via United States Postal Service. Members of the Recreational Therapy Department arrange virtual visits, and the facility schedules regular virtual meetings to answer questions.

The Emergency Plan includes procedures to maintain sufficient clinical staff to ensure resident safety during emergencies, including contingency procedures for additional staff members and processes for shifting staff duties within the facility when necessary. To ensure sufficient staffing, the facility plans to offer overtime pay to staff, use agency staff, engage National Guard and VA staff from sister facilities, obtain per diem staff from the DOH per diem staff list, actively recruit additional staff, and follow Centers for

Disease Control and Prevention guidelines for staff return to work. The Emergency Plan includes a list of staff, volunteers, third-party contractors, and their contact information. The Plan defines volunteer training required for emergency response, including infection prevention and control measures, and defines staff reallocation and responsibilities. Quick Guides are placed throughout the facility as instant references.

Compliance Determination: Based on the above observations and discussions, the Menlo Park facility has reached substantial compliance with the Emergency Operations and Preparedness requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	Corresponding Consent Decree Paragraphs
Non-Compliant	
Partially Compliant	
Substantially Compliant	74, 75, 76, 77, 78, 79, 80

Staffing

Menlo Park continues to maintain sufficient clinical staff to meet resident acuity needs. Clinical staffing aligns with New Jersey State Guidelines for nursing assistants and often exceeds those ratios based on residents' acuity levels. Clinical staff demonstrated competence when providing direct care to residents.

For example, the monitor observed a CNA perform a competent bed bath and transfer for a resident. The CNA was gentle, respectful, and ensured privacy, allowing the resident to choose clothing. Despite the resident being uncooperative with foot and genital/buttocks care, the CNA showed patience and explained the need for thorough cleansing to maintain skin integrity.

The monitoring team examined a QAPI project, led by nursing leadership, that focuses on consistent adherence to staffing standards. This study's data collection involves auditing all shifts to verify compliance with New Jersey's minimum staffing requirements based on residents' daily acuity levels and to track instances where Restorative CNAs (RNAs) are diverted from their restorative roles to general CNA duties.

The June QAPI report confirmed that New Jersey's minimum staffing requirements, based on resident acuity, were met or exceeded during April, May, and June. The report also indicated the reassignment of Registered Nurse Assistants (RNAs) to Certified

Nursing Assistant (CNA) duties for a total of six days: three days in April, two days in May, and one day in June. Information specific to June staffing detailed the following use of agency staff and home health aides:

- Agency Staff: 72 nursing shifts were covered by agency staff
    - 7am - 3pm shift: 26
    - 3pm - 11pm shift: 25
    - 11pm - 7am shift: 24
- Home Health Aides: 53 shifts utilized Home Health Aides as 1:1 companions
    - 7am - 3pm shift: 36
    - 3pm - 11pm shift: 9
    - 11pm - 7am shift: 8

The utilization of agency nurses in long-term care introduces potential risks to the continuity and consistency of care, primarily due to their limited familiarity with residents and facility protocols. This may increase the potential for adverse events, such as medication errors. This specificity of agency staff and home health aid data reported above demonstrates the facility's use of data to help determine if there is a particular shift on which recruitment efforts should be focused.

In response to the need to use RNAs as CNAs, four full-time RNAs were hired for the Restorative Program, which transitioned from RNAs reporting to the Rehab Department (a contracted service) to the Nursing Department. The previous five RNAs were transitioned back to their assigned units on July 14, 2025. (The monitoring team does not know how many hours per week those five RNAs worked.)

CMS Staffing Performance

Menlo Park has a 5-Star staffing rating on CMS Care Compare. The following payroll-based journal (PBJ) staffing data reflects information about direct clinical care staff reported through the second calendar quarter of 2025:

- Total nurse staff hours per resident per day: 5 hours and 43 minutes compared to the national average of 3.9 hours
- Weekend nurse staffing: 5 hours and 18 minutes compared to the national average of 3.42 hours
- RN hours per resident per day: 1 hour and 1 minute compared to the national average of 0.68 hours
- LPN/LVN hours per resident per day: 1 hour and 10 minutes compared to the national average of 0.87 hours

- Nursing assistant hours per resident per day: 3 hours and 22 minutes compared to the national average of 2.34 hours
- Total nursing staff turnover: 21.5% compared to a national average of 46.4%
- RN staff turnover: 38.9% compared to the national average of 43.6%

Leadership Transitions

The Menlo Park DON recently resigned, and a new staff member recently hired in the ADON position is serving as interim DON. This appointment represents a positive development for the facility, as the individual is highly qualified for the role and brings extensive nursing experience, including prior tenure as a DON. The monitoring team observed her excellent leadership skills, and her valuable background in education positions her as a strong resource for mentorship within the nursing staff. Accordingly, the monitoring team has no reservations regarding her ability to fill the role.

Compliance Determination: Based on the above observations Menlo Park has reached substantial compliance with the Staffing requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	**Corresponding Consent Decree Paragraphs**
Non-Compliant	
Partially Compliant	
Substantially Compliant	81, 82(a-d)

Organizational Accountability

As discussed in the Baseline Report, the State designated an Agreement Coordinator and established a succession plan. The Agreement Coordinator was involved in creating the Implementation Plans and continues to collect accurate clinical care outcome data, routinely review QM, QAPI reports and Community Assessment for Public Health Emergency Response (CASPER) reports, and meet regularly with Menlo Park leadership. Additionally, the Agreement Coordinator maintains stakeholder engagement by attending town hall and Resident Council meetings and regularly visiting Menlo Park. The three compliance officers are the DMAVA Quality Assurance Coordinator, the Menlo Park CEO, and the Paramus CEO; the Agreement Coordinator meets with them regularly.

Leadership development initiatives

To further develop leadership and enhance workplace culture and climate at both Paramus and Menlo Park, the Agreement Coordinator held two separate offsite events for facility leadership staff. The first event included CEOs from Menlo Park, Paramus, and Vineland facilities; the second event included ACEOs from each of the three facilities. With assistance from the Director of Veterans Healthcare Services and the Director of Human Resources and Employee Relations, participants shared ideas and suggestions for facility improvement. Specifically, they reviewed recent climate survey results and discussed improving communication and collaboration, strategies for fostering stronger team relationships, and the importance of diversity, inclusion, and respect in the workplace.

Compliance Determination: Based on the above observations Menlo Park has reached substantial compliance with the Organizational Accountability requirements outlined in the Consent Decree. The table below details the compliance status for each provision within this Remedial Measure.

Compliance Status	**Corresponding Consent Decree Paragraphs**
Non-Compliant	
Partially Compliant	
Substantially Compliant	83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94