

**UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD**

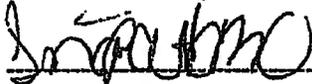
In the Matter of)) 1621 ROUTE 22 WEST OPERATING) COMPANY, LLC D/B/A SOMERSET) VALLEY REHABILITATION AND) NURSING CENTER) Respondent)) and)) 1199 SEIU UNITED HEALTHCARE) WORKERS EAST, NEW JERSEY) REGION)) Charging Party))	Case No. 22-CA-29599 22-CA-29628 22-CA-29868
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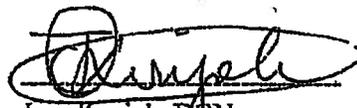
**RESPONDENT'S MOTION FOR PERMISSION TO FILE DISTRICT COURT'S
MEMORANDUM OPINION AND ORDER AND TRANSCRIPT AND EXHIBITS OF
SUPPLEMENTAL HEARING IN RELATED 10(J) PROCEEDING**

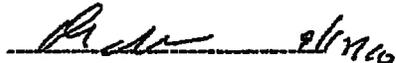
PART 3 OF 3

On 9/17/10 Inez Konjoh met with nurse Shannon Napolitano about the following issues, Shannon agrees that this is true and supported by the attached documentation.

- (1) The patient in Rm 15w was given the wrong medication on at least 4 occasions by this nurse. Medication was discontinued on 8/23/10.
- (2) Medication was left with patient at the bedside, nurse did not witness patient take medications appropriately, therefore patient was able to give medication to DON.
- (3) On patient in Rm 15D, oxygen saturation was documented as 0%, nurse agrees that this was a wrong saturation documented.

9-17-10-

 Shannon Napolitano

 9/17/10
 Inez Konjoh DON


 Doreen Illis Administrator.



Exh. No: 82 Received Rejected
 Case No.: 22-cv-29577 et al
 Case Name: Somerset Valley Club
 No. Pgs: _____ Date: 6-6-11 Rep.: AM

GRIEVANCE/COMPLAINT REPORT

This form shall be utilized to provide written documentation of any concern expressed by a resident or resident representative and to record the follow-up action taken and results thereof.

RECEIPT OF GRIEVANCE/COMPLAINT

Date received 9/16/10

Individual initiating complaint: Resident Resident representative; relationship _____

Print individual's name _____

Concern reported to: Medications & Foley catheter change.

Staff member: _____
Name and Title

DOCUMENTATION OF GRIEVANCE/COMPLAINT

Describe concern using factual terms: PT approached SW & DON, stated that she is confused about her medications, and that only nurse Shannon gives her the "pink capsule" all other nurses including the one today "CC" did not give her, her ^{pink} capsule.

Staff member: Shannon RN DON
Name and Title

DOCUMENTATION OF FACILITY FOLLOW-UP

Individual(s) designated to take action on this concern: Inez Kung'u RN

Date assigned 9/16/10 Date to be resolved by 9/29/10

Was a group meeting held? Yes; If yes, identify all individuals in attendance No
1:1 w/ pt

What other action was taken to resolve concern (be specific)? PT was educated as to foley cath & reinsertion practice. PT made aware that it is okay for nurse to encourage voiding, & if no void cath can be removed.

Results of action taken: PT made aware of disciplinary action taken.

Plan of Care updated? Yes No Date 1/1

Staff member: Shannon RN DON
Name and Title

RESOLUTION OF GRIEVANCE/COMPLAINT

Was grievance/complaint resolved? Yes, describe resolution. No, explain why not.
PT educated about foley cath. - nurse (SW) was found to have been giving pt wrong medication, disciplinary action was taken. PT made aware.

Identify the method(s) used to notify the resident and/or resident representative of the resolution:
 Written notification Phone conversation One-to-one discussion

Date of notification 9/17/10

This form was completed by: Shannon RN DON 9/17/10
Signature and Title Date

Pt Complaint cont

Pt also stated that on 9/12/10, nurse "CD" delayed in putting f/c back in after it clogged, and instead told her to try to ~~per~~ urinate on her own. Pt stated it took 20 mins before catheter was reinserted & she only voided a small amt.

Resolution Cont

reinserted if MD agrees. Investigation done as to pt getting the "pink capsule". Noted to be zinc, as she was told by nurse "SN". This nurse noted that zinc was last ordered for a 2wk duration on 8/9/10 and pt is not suppose to be getting it any more. A look back was completed by this nurse and clarified by unit mgr that medication was d/c'd on 8/23/10, but pt rec'd medication sporadically. That date by 3 separate nurses including today, 9/17/10. When pt called me to witness the pill in her Rm. I took the pill from pt and nurse (ID) witnessed it. I have informed pt that medication is d/c'd and she should not accept it from any nurse. Disciplinary action has been taken accordingly & all involved Pt made aware of resolution & findings. MD & family aware of findings.

Pt Complaint Cont

Pt also stated that on 9/12/10, nurse "CD" delayed in putting f/c back in after it clogged, and continued to tell her to try to urinate on her own. Pt stated it took 20 before catheter was reinserted & she only voided a small amt.

Resolution Cont

reinserted if MD agrees. Investigation done as to pt getting the "pink capsule". Noted to be zinc as she was told by nurse "SN". This nurse noted that zinc was last ordered for a 2wk duration on 8/9/10 and pt is not suppose to be getting it any more. A look back was completed by this nurse and clarified by unit mgr that medication was o/c'd on 8/23/10, but pt rec'd medication sporadically that date by 3 separate nurses including today (9/17/10) when pt called me to witness she pill in her room. I took the pill from pt and nurse (ID) witnessed it. I have informed pt that medication is o/c'd and she should not accept it from any nurse. Disciplinary action has been taken accordingly & all involved pt made aware of resolution & findings. MD & family aware of findings.



**PARTNERS
PHYSICIAN'S ORDERS**



NAME _____

LOCATION _____

DATE _____

ROOM 15W

DATE OF BIRTH _____

DIAGNOSIS _____

ALLERGIES ADHESION BAND PHYSICIAN RAMASWAMY

DATE	TIME	MEDICATION ORDERS
8/1/10		TIO Dr Ramaswamy / J. Scotty (R)
		D/c Reg diet
		PCS Reg diet
		Prostat 64 30ml BID
		D/c Lactulose
		D/c zinc pants
		TNF
8/1/10	24	US ET -
		TIO. DR RAMASWAMY / J. Scotty (R)
		M/C VANCOMYCIN (RASA to chest)
		Hydrocortisone Cream 1% to LABH 2x daily
		ON NOLA
8/1/10		Dr. RAMASUBRAMANI
		M/C UNASYS IV
		Stool for C-Diff Notify Dr. RAMASUBRAMANI of result
		Not

Somers003337

NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name: Sheena Claudio
Job Title: LPN

Facility: SVRNC.
Date of Hire:

Prior Disciplinary Notices in File: (include date and nature)

TYPE OF VIOLATION

Dress Code
Behavior
Absenteeism/Tardiness

Performance
Inappropriate Behavior
Patient Care

Resident Rights
Refusal to Perform Assigned Task
Other: Medication error.

DESCRIPTION

Date: 9/17/10 Time:

Specific Description of Issue, Situation or Behavior (what, where, how): On 9/5/10 an order was written on pt (tw) for ASA every other day. Pt rec'd this medication x 2 days consistently by this nurse (sheena) on 9/8/10 and on 9/9/10. This goes against pt orders and can harm this pt.

EMPLOYEE RESPONSE

I agree

I disagree for these reasons:

The every other day should have been blocked off. For every other day. It should have been properly written as well as read properly. Sheena, LPN

ACTION TO BE TAKEN

Documented Verbal Notice

Written Notice

Suspension for _____ days to start on _____ (date) and return to work on _____ (date).

Does this Disciplinary Action Constitute Final Warning: Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination

Employee's Signature

Date: 9/20/10

Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

Supervisor's Signature Date

Department Head/Administrator Date

Witness Signature Date: 9/20/10

(One copy to Employee - one copy to Personnel File - One copy to Supervisor)

**AGENDA FOR STAFF MEETING 05/18/10-
TUESDAY**

- TARS NOT SIGNED. A LOT OF BLANK SPACES
- VITAL SIGNS NOT ON NURSES NOTES
- NURSES TO MONITOR CNA TO SEE IF PATIENTS LIKE MRS. [REDACTED], MRS. [REDACTED], MR. [REDACTED], MR. [REDACTED] AND MR. [REDACTED] ARE GETTING OUT OF BED
- ADMISSION ASSESSMENT- BRADEN SCALE, IMMUNIZATION RECORD, INVENTORY LIST
- OXYGEN ROOM MUST BE CHECKED WITH SHFT ROUNDS AND AT THE TIME HANDSOFF
- CODE CARTS MUST BE CHECKED Q SHIFT
- NURSES TO HELP WITH LUNCH AND DINNER SERVICE
- LABLES ON O2, FEEDING PUMPS, IV LINES ETC.

Plan of Correction Somerset Valley Rehabilitation & Nursing Center

ID Prefix Tag	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE.	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DIFFERENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN.	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR.	HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. (IE. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE.)	Time Frame
F157 (D)	<p>All incident reports to be reviewed by shift supervisor for completion and assure physician notification before submitting to DON. DON or designee will review all incident reports daily for completion.</p> <p>An audit of all face sheets/contact information was done to update addresses and telephone numbers for all residents.</p>	<p>Nursing staff to be educated by the DON or designee regarding physician/family notification after incident/accidents, change in condition, room changes.</p> <p>Incident/accident reports to be discussed daily during clinical meeting to ensure completion and proper documentation.</p> <p>Review of P & P will be conducted during nursing orientation and annually by facility educator.</p> <p>Supervisor/Manager On Duty will verify all contact information for all newly admitted residents daily.</p>	<p>Incident reports to be reviewed daily during clinical meetings.</p> <p>DON or designee will complete monthly audits of all Incident and Accident reports.</p> <p>They will be reviewed during Performance Improvement meetings.</p>	4/23/10	

F323 (D)	Resident # 1 reassessed for proper placement and functioning of alarms. Resident care plan was reviewed and revised.	All residents requiring safety alarms to be reassessed for proper placement and functioning. Nurses will sign off on treatment administration record every shift for residents with bed and chair alarms.	Staff will be educated by DON or designee regarding residents requiring alarms to ensure proper placement and functioning. Facility educator will instruct new staff on orientation and annually to properly monitor alarms for placement and functioning.	Daily random audits will be performed by DON or designee to ensure proper placement and function of safety alarms. DON or designee to complete weekly audits of medication/treatment administration record. Results to be reported by DON or designee to the PI committee for monthly follow up.	4/23/10
F514 (B)	Resident # 1 Treatment administration record was reviewed and revised. Care plan was reviewed and updated.	All medication/treatment administration records checked for signature completion. The facility will continue to review resident records and care plans after concerns are identified on the 24 hour report/clinical meeting and quarterly assessments.	Staff reeducated by DON or designee regarding proper and timely documentation. Facility educator will educate staff on orientation and annually regarding proper documentation on clinical record policy and timely completion of documentation in medical record. Unit manager to review resident records/ care plans after any change in condition, incidents, or occurrence.	11-7 shift to check for completion of MARS/TARS daily. DON or designee to complete weekly audits of medication/treatment administration record. Results to be reported monthly by DON or designee to the PI committee for monthly follow up.	4/23/10

100 N. Route 22 West
South Bound Brook, NJ 08880

P-20

712.169.2000
FAX 712.169.2001

Somerset Valley
Rehabilitation & Nursing Center

October 21, 2010

Sheena Claudio
8 Edgewood Terrace
South Bound Brook, NJ 08880

Dear Sheena,

Please be advised that, effective immediately, you are hereby terminated from your position as an employee with Somerset Valley Rehabilitation and Nursing Center. The reason for this termination is your inappropriate and/or unprofessional conduct including, but not necessarily limited to, your failure to complete required clinical documentation. As you are aware, you have received prior discipline, including a suspension and final warning on October 4, 2010, for such performance related issues.

Please return immediately all Center property you may have in your possession, including your identification badge, keys and/or other equipment distributed to you for your use in your position with the Center. Please be further advised that unless you are seeking treatment or visiting an immediate family member, you are not to be on the Center's premises.

You will be receiving a letter notifying you of your COBRA options and explanation of other benefits to which you may be entitled.

Sincerely,


Doreen Illis
Administrator

Cc: Human Resources
Personnel File ✓

P-125



State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 358
TRENTON, N.J. 08625-0358

JON S. CORZINE
Governor

www.nj.gov/health

HEATHER HOWARD
Commissioner

IMPORTANT NOTICE - PLEASE READ CAREFULLY

December 10, 2009

Re: Initial Notice:
Recertification Survey: December 1, 2009

Elizabeth Heedles, Administrator
Somerset Valley Rehabilitation & Nursing Center
1621 Route 22 West
Bound Brook, NJ 08805

Dear Ms. Heedles:

The findings of the above survey conducted by the New Jersey Department of Health and Senior Services (Department) indicate that your facility is not in compliance with the Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. The most serious deficiency includes findings that constitute isolated actual harm that is not immediate jeopardy (Box G on the scope and severity grid). All deficiencies cited on the enclosed CMS-2567, require immediate correction. If you wish to dispute the existence of any of the cited deficiencies, you may do so through the informal dispute resolution process, which is described more fully below. If other surveys have been conducted recently at your facility, any information, including proposed remedies, concerning those surveys will be sent to you by separate notice.

This letter will advise you of actions being taken by the Department and being recommended to the Centers for Medicare and Medicaid Services (CMS) as a result of the deficiencies cited on this survey. In addition to mandatory remedies required by federal regulations, the Department has the discretion to recommend that CMS impose additional remedies based on the scope and severity of the cited deficiencies and the history of compliance of the facility or a related chain of facilities. Mandatory remedies as well as any additional remedies we are recommending are set forth in detail below.

R-33

Somers005301

Informal Dispute Resolution: (42 CFR §488.331)

The informal dispute resolution process permits one opportunity to contest the validity of the cited deficiencies. If you wish to participate in the informal dispute resolution process, you must, within ten calendar days from your receipt of this letter (this time limit shall be strictly enforced), send an original and ten (10) copies of the following: a written request for informal dispute resolution, a copy of the CMS-2567 form, a list of the specific deficiencies being disputed, an explanation of why each deficiency is being disputed, and any supporting documentation to:

New Jersey Department of Health and Senior Services
P.O. Box 358, Trenton, New Jersey 08625-0358
(609) 633-9547
Fax Number: (609) 633-9087

All submitted material must be highlighted to indicate only that information which is relevant to the disputed deficiencies. The informal dispute resolution process will not delay the effective date of any enforcement action.

Plan of Correction (POC): (42 CFR §488.402)

Notwithstanding your option to participate in the informal dispute resolution process, you must submit a Plan of Correction (POC) for the deficiencies cited on the enclosed CMS-2567 within ten calendar days after receipt of this letter. This POC will serve as your allegation of compliance. On the basis of your allegation, we may presume compliance until substantiated by revisit or other means. The POC should be sent to Patricia S. Guner, at Department of Health and Senior Services, Office of Assessment and Survey, PO Box 367, Trenton, NJ 08625-0367. Please note that POCs will not be accepted by fax. Failure to submit an acceptable POC within the mandated time frame will result in the imposition of civil money penalties of \$100 per day.

Your POC must contain the following:

What corrective action(s) will be accomplished for those residents affected by the deficient practice;

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur, and,

How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Somerset Valley Rehabilitation & Nursing Center
Page 3

Do not include information that will identify specific residents, family members, or facility staff, such as names or room numbers.

If you intend to use a computer or word processing format to print the POC, the Department requests the following:

The original 2567 face sheet be completed with the allegation of compliance date and administrator's signature.

The POC for each discrete tag number be attached behind the 2567 page(s) of deficiency text.

The completion date for the correction of each deficiency be shown at the right margin at the beginning of the POC text or at the end of the POC text.

Each page of the POC text should be identified with the citation tag number.

Remedies:

A. Mandatory Remedies:

If substantial compliance with all participation requirements has not been achieved within **three (3) months** of the date the facility was first out of substantial compliance, CMS and/or the Department must deny payment for all new admissions (42 CFR §488.417(b)(1)). This shall become effective 15 days after notification by CMS. Moreover, if substantial compliance has not been achieved within **six (6) months** of that date, CMS/the Department will terminate your provider agreement (42 CFR §488.450(d)).

Your facility was first out of compliance on December 1, 2009, and that is the date your enforcement cycle began.

B. Additional Remedies:

The following remedy is recommended for imposition by CMS:

A civil money penalty of \$200 per day, which will accrue from the date of the survey until the facility is in substantial compliance with all participation requirements. (42 CFR §488.430).

Failure to correct or a change in the nature or seriousness of the deficiency (ies) as determined on a revisit, may result in a change in the remedy selected, including from a "per day" civil money penalty (CMP) to a "per instance" CMP or a change in the amount of the CMP.

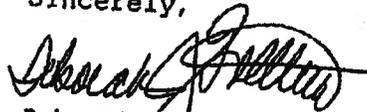
Somerset Valley Rehabilitation & Nursing Center
Page 4

Federal Remedies Only:

This letter refers only to enforcement of federal remedies based on federal law. If any state enforcement action applies, you will be notified in a separate letter.

If you have any questions regarding the contents of this letter, please contact the Office of Program Compliance at (609) 984-8128.

Sincerely,



Deborah J. Gottlieb, Director
Program Compliance &
Health Caring Financing

DJG:PC:dj

Enclosure

c Nursing Home Administrators Licensing Board
Annette Tucker-Osborne, Survey Branch Manager
Frank Skrajewski, Long Term Care Licensing
Control # 09567/WSPV11

Somers005304

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08805
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	STANDARD SURVEY			
	CENSUS 58			
F 279 SS-C	SAMPLE SIZE 16 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.			
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.			
	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to develop a care plan for a resident who was experiencing excruciating pain at times due to rectal cancer. This was evident in 1 of 4 residents reviewed for			

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

Any statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that standards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08805	
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F 279	Continued From page 1 pain (Resident #7) as evidenced by the following: Resident #7 was admitted to the facility with a diagnosis of rectal cancer for which the resident experienced excruciating pain. The resident's initial pain assessment was incomplete and the interdisciplinary team failed to develop a care plan for the resident's pain needs. Please refer to F309.	F 279		
F 309 SS-6	NJAC 8:39-11.2 (d) 2 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide effective pain relief for 1 of 4 residents reviewed for pain (Resident #7). This resulted in the resident being afraid to eat and use the toilet. The resident also experienced excruciating pain during bowel movements and for three hours every evening when she received a rectal suppository. The deficient practice was evidenced as follows: Resident #7 was admitted on 11/4/09 with a diagnosis of rectal cancer for which she was receiving radlation therapy outside the facility	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08805
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F 309	<p>Continued From page 2 Monday through Friday.</p> <p>On 11/24/09 at 1:30 p.m. the resident stated that she had such severe pain when she had a bowel movement that she had to cry out in pain which made her feel embarrassed so she put a washcloth in her mouth to muffle the scream. She further stated that there was an ointment that she was supposed to get for the rectal pain but she had not gotten it.</p> <p>On 11/25/09 at 8:50 a.m., the surveyor observed the Resident #7 sitting in her room in her wheelchair with her uneaten breakfast in front of her. When asked if she was dissatisfied with her breakfast, she said no it looked good but she couldn't eat. "I'm afraid to go to the bathroom. I have so much pain." Resident #7 explained that she had cancer of the rectum and a lesion on the inside of her rectum that hurt so badly when she had a bowel movement that she had to stuff a rag in her mouth because she was embarrassed of anyone hearing her scream. The resident also stated that she received a rectal suppository at night and that afterward she was in terrible pain for 3 hours. She said when anything touched the lesion, she could jump through the ceiling. When asked if she had told anyone about this she said "yes, they know".</p> <p>The surveyor reviewed the resident's medical record and found that when the resident was admitted, the facility failed to perform a complete pain assessment. Consequently, the interdisciplinary team did not develop a care plan for pain, and pain was not included on her list of problems despite the fact that one of her admitting diagnoses was pain. The initial MDS (Minimum Data Set) Assessment identified her as</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 ROUTE 22 WEST BOUND BROOK, NJ 08806
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 3 having moderate pain daily.</p> <p>The resident had an order for Lidocaine Ointment 5% to be applied to the rectum every 2 hours as needed for pain dated 11/16/09. This medication was never documented as having been administered according to the MAR (Medication Administration Record). The resident was receiving Percocet as needed on a daily basis and also had a Lidocaine pain patch and a Duragesic 50 mcg. pain patch every 72 hours. The resident told the surveyor that the pain medications were not working.</p> <p>On 11/26/09 at 10:15 a.m. the wound nurse told the surveyor that the resident received medication applied to her rectum at night for wound healing. The Unit Manager was asked for the resident's latest pain assessment sheet and she only provided the incomplete assessment that had been started on admission. The surveyor discussed the resident's complaints with the Unit Manager and she stated that she was aware of the resident's rectal pain and the resident received ointment applied to her rectum for pain. When she was shown the blank M.A.R. she stated "I don't know why they haven't signed for it."</p> <p>On 11/25/09 at 12:00 p.m. the same concerns were brought to the attention of the Administrative Staff. They had no verbal response but stated they would look into it.</p> <p>On 11/30/09 at 10 a.m. while the surveyor was observing the medication pass, Resident #7 told the medication nurse that she was experiencing pain at a level of 5 on a scale of 0-10. The resident expressed fear of having a bowel</p>	F 309		

If it's not documented didn't happen

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2009
NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 ROUTE 22 WEST BOUND BROOK, NJ 08805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 4</p> <p>movement while out at the radiation center. The medication nurse told the surveyor that she would give the resident Percocet when she returned from the radiation treatment because the resident's pain was always a 10 on a scale of 0-10 when she returned from her treatment. When asked why the resident was not premedicated for pain if staff was aware her pain would be a 10 after treatment, the medication nurse said the resident would complain of pain upon return whether or not she provided pain management prior to the treatment. No pain medication was provided to the resident prior to going for the radiation therapy.</p> <p>After surveyor intervention, on 11/30/09 the surveyor observed that the resident's Duragesic patch was increased to 75 mcg every 72 hours. The Lidocaine Ointment was changed to two times a day and every 2 hours as needed and the suppository that caused the resident pain for 3 hours every evening was discontinued.</p> <p>On 12/1/09, again after the surveyor had discussed Resident #7 pain concerns with facility staff, on the days following 11/25/09, there were several completed pain assessments as well as an interdisciplinary care plan for pain.</p> <p>The surveyor visited the resident on 12/1/09 at 9:20 a.m. Resident #7 told the surveyor that the ointment that she had gotten the night before and her pain pills helped her pain.</p> <p>On 12/1/09 at 1:00 p.m. the surveyor asked the Director of Nursing (DON) how the facility could have overlooked the resident's pain. She stated that the resident was most likely experiencing pain because of the lack of Lidocaine Ointment</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 318002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08805
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F 309	Continued From page 5 usage. She was also asked why there were no pain assessments for this resident who had excruciating pain. The DON stated "I can't answer that, I don't know."	F 309		
F 315 SS=D	N.J.A.C. 8:39-27.1(a) 483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to practice proper catheter care for a resident who had an indwelling catheter. This was observed in 1 of 2 residents reviewed for catheter care (Resident #13). The deficient practice was evidenced as follows: On 11/25/09 at 11:00 a.m. the surveyor observed Resident # 13 in her bed asleep. The resident had an indwelling urinary catheter and the bag which collected the urine was in a privacy bag lying on the floor next to the bed. On the same day at 12:00 p.m. the surveyor observed the resident being dressed while in her bed by a C.N.A. (Certified Nursing Assistant). The catheter bag and the associated tubing were	F 315		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08805
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F 315	Continued From page 6 observed lying on the bed. This practice could result in a backflow of urine into the bladder for this resident who had a history of urinary tract infections as well as be a source of infection by carrying bacteria from the floor into the resident's bed.	F 315		
F 364 SS=C	NJAC 8:39-27.1 (a) 483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide condiments with the meal trays in order to improve palatability of the meals as evidenced by the following: 1. On 11/24/09 at 11 a.m. during the Group Meeting, 5 of 5 residents stated that they never receive condiments on their meal trays. No ketchup, sugar, sugar substitute, salt or pepper were provided. 2. On 11/24/09 at lunch, the surveyor requested 3 test trays which did not contain condiments. 3. On 11/24/09 at lunch, two surveyors noted 16 residents eating from lunch trays which did not contain any condiments. 4. On 11/24/09 at lunch, 3 additional alert and	F 364		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 318002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 ROUTE 22 WEST BOUND BROOK, NJ 08805
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F 364 Continued From page 7
oriented residents and a family member of a resident eating lunch stated that meal trays were never delivered with condiments.

F 364

5. On 12/1/09 at 9:25 a.m. Resident #9 told the surveyor that "the food stinks, it isn't fit for a pig. I usually send my platter back and they send me something else."

F 425
SS=D N.J.A.C. 8:39-17.4(e)
483.60(a),(b) PHARMACY SERVICES

F 425

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined that the facility failed to assure that the provider pharmacy provided a

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08806
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 425	<p>Continued From page 8</p> <p>pain medication which was ordered "stat" (at once) for 1 of 22 residents, Resident #16, reviewed on the survey sample and on med pass observation. Also, the facility failed to properly secure medications stored in the med cart. The evidence is as follows:</p> <p>1. On 11/30/09 at 8:32 a.m., the surveyor was observing medication pass for Resident #16. At that time, the medication nurse informed the surveyor that the resident had received a "stat" physician's order the previous evening for "12.5 micrograms fentanyl patch transdermal. Change every 72 hours. Apply 1st dose stat." The nurse stated that the frequent use of Percocet was assessed and evaluated and it was determined that a fentanyl patch every 72 hours would provide better baseline pain control than continuing with the "prn" as needed Percocet. Though the fentanyl patch was ordered the previous night as a "stat" (at once) order, it had not been provided for administration to Resident #16 for the morning med pass. Consequently the physician modified the order on 11/30/09 to: "May hold Fentanyl patch until delivered from pharmacy." When the med nurse asked the resident what the level of pain was on a scale of 1 to 10, the resident stated her pain was an 8. The nurse then administered a pm dose of Percocet to the resident.</p> <p>The Administrator and Director of Nurses (DON) were informed of delay in providing a stat order of fentanyl at 1:30 p.m. As of 2:40 p.m., the fentanyl patch was still not provided from the pharmacy.</p> <p>On 12/1/09 at 11 a.m., the DON stated that the provider pharmacy had informed the facility that they were unable to provide the fentanyl patch on</p>	F 425		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08805
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F 425	<p>Continued From page 9</p> <p>11/29/09 at the time of the order as it was a schedule 2 narcotic and required a particular prescription which the physician had not provided. The pharmacy had been unable to get in contact with the physician for the prescription. No effort had been made by the facility or the pharmacy to contact the medical director in order to provide the "stat" fentanyl patch to the resident. The facility's back up medication box did not contain the dose of fentanyl patch the physician had ordered for the resident. Consequently, the resident did not receive the fentanyl patch but rather continued with the "prn" (as needed) Percocet.</p> <p>2. On 11/24/09 at 1:40 p.m., a medication cart was observed open and unattended in front of Room 9. The door to room 9 was closed and no staff member was observed in sight of the med cart which was unlocked and the door to the cart was ajar. When the med nurse returned to the cart, she told the surveyor, "You unlocked my med cart" to which the surveyor replied that she had no keys to the med cart and had found it open. The med nurse then told the surveyor that this was the second time that day that the med cart had been found to be unlocked and open. The first time, it had been found by the Director of Nurses (DON).</p> <p>N.J.A.C. 8:39-29.6(a), 8:39-29.4(h)</p>	F 425		
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to</p>	F 428		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08805
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F 428	<p>Continued From page 10</p> <p>the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the consultant pharmacist failed to comment on the use of an antipsychotic medication in the absence of behavioral symptoms in a resident at risk for side effects from the medication for 1 of 16 residents, Resident #11, as evidenced by the following:</p> <p>Resident #11 was admitted to the facility on 11/9/09 and was assessed by the facility as being alert and oriented. This resident was selected by the facility and participated in the group meeting on 11/24/09 at 11 a.m. At 1 p.m. on the same day, the resident was observed working on the computer. The resident had a diagnosis of diabetes mellitus. Resident #11 had a physician's order for the antipsychotic olanzepine (generic Zyprexa) 5 mg. daily. The facility identified the target behaviors of hitting and delusions on the behavior monitoring form for the use of olanzepine. On 12/1/09 at 11 a.m., the Director of Nurses (DON) stated that if no behavior was present, a "0" would be entered on the behavior monitoring form. No "0's" were entered but rather the behavior monitoring sheet was left blank. On 11/25/09 at 11 a.m., the Unit Manager told the surveyor she was unsure why the resident was receiving olanzepine therapy and that the resident had no behavioral symptoms.</p>	F 428		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 316002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
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NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08805
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F 428	<p>Continued From page 11</p> <p>On 11/30/09 at 1:30 p.m., the Director of Nurses stated that the resident had had an acute delirium episode in the hospital which resulted in the resident receiving Zyprexa therapy.</p> <p>Resident #11 had blood sugar monitoring performed 4 times a day due to the diagnosis of Diabetes. Zyprexa can increase the blood glucose level. An initial medication regimen review (MDR) was performed by FAX on 11/15/09. The consultant pharmacist performed a MDR in the facility on 11/16/09. The consultant pharmacist failed to address the fact that Zyprexa can elevate the blood sugar level in this resident with a diagnosis of diabetes. The consultant pharmacist note of 11/16/09 stated, "On Zyprexa" but did not address the blank behavior monitoring sheet or the fact that the resident was experiencing no behavioral symptoms yet was receiving antipsychotic therapy.</p> <p>On 11/30/09 at 1 p.m., the DON stated that as a result of surveyor intervention on 11/25/09 the physician ordered Zyprexa to be decreased to 2.5 mg. daily for 5 days and then discontinued the antidepressant therapy and antianxiety medications were then ordered.</p> <p>N.J.A.C. 8:39-29.(a)1</p>	F 428		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315002	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2009
NAME OF PROVIDER OR SUPPLIER SOMERSET VALLEY REHABILITATION & NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1621 ROUTE 22 WEST BOUND BROOK, NJ 08806	
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K 000	INITIAL COMMENTS LIFE SAFETY CODE 101:2000 THIS FACILITY IS IN COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED USING CMS-2786R.	K 000	(X5) COMPLETION DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the findings provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued patient participation.

1.3 Accidents / Incidents

POLICY

All accidents or incidents occurring on the center's premises must be reported. An incident is any occurrence not consistent with the routine operation of the center, normal care of the resident, a happening involving visitors, malfunctioning equipment, or observation of a condition which might become a safety hazard.

PURPOSE

To provide a safe and healthful environment for residents, visitors and employees.

PROCESS

1 Reporting of Accidents/Incidents:

- 1.1 Regardless of how minor an accident or incident may be, it must be reported to the nursing supervisor, and appropriate documentation completed on the shift that the accident or incident occurred.
- 1.2 Employees witnessing an accident or incident involving a resident, employee, or visitor must report such occurrence to the nursing supervisor as soon as practical. Do not leave an accident victim unattended unless it is absolutely necessary to summon assistance.
 - 1.2.1 Any un-witnessed accident or incident must be investigated for potential abuse. (Refer to: Abuse Reporting and Investigation)
- 1.3 The supervisor must be informed of all accidents or incidents so that medical attention can be provided.

2 Assisting Accident/Incident Victims:

- 2.1 Should an employee witness an accident, or find it necessary to aid an accident victim, the employee should:
 - 2.1.1 render immediate assistance. Do not move the victim until he/she has been examined by a Licensed professional for possible injuries;
 - 2.1.2 if it is a resident, move the resident to his or her bed once examined, if appropriate;
 - 2.1.3 if assistance is needed, summon help. If the employee cannot leave the victim, ask someone to report to the nurses' station that help is needed, or if possible, use the call system located in the resident's room to summon help.

3 Medical Attention: The nurse shall:

- 3.1 Examine all accident/incident victims. The victim will not be moved until he/she has been examined by a Licensed professional for possible injuries.
- 3.2 Notify the medical director or the victim's personal or attending physician, and inform the physician of the accident or incident.
- 3.3 Family will be notified as soon as possible concerning accident/incident.
- 3.4 If the injury appears serious or questionable, the individual will be sent to the hospital by ambulance or 911 as needed.
- 3.5 If necessary or appropriate, designate an employee to accompany the victim to the hospital.
- 3.6 When a resident sustains a blow to the head or there has been an un-witnessed fall, they shall be observed for neurological abnormalities. Neurological checks will be initiated and continued periodically

22-CA-29599
 CASE NUMBER
 EXHIBIT NUMBER: R-62
 ID'D REC'D
 DATE 6/2/11

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over a 72 hour period. Documentation of the results will be placed in the medical record.

3.6.1 If abnormal neurological symptoms occur, the physician will be notified for further orders. If the physician can not be reached in as needed, the resident will be transferred to an acute care hospital ER.

3.7 Any first aid rendered for minor injuries, cuts or abrasions will be documented in the medical record.

4 Documentation and Investigative Action

4.1 The charge nurse and/or the department director or supervisor must document the incident and initiate an immediate investigation of the accident or incident.

4.2 The Resident Accident/Incident Form will be used for residents and visitors. The Employee Accident/Incident Form will be used for employees. Investigation form and/or log must also be completed for each incident.

4.3 Witnesses, if any, will also be documented on the report. The address and telephone number of the witnesses will also be documented;

4.4 Every attempt will be made to ascertain the cause of the accident/incident thru the investigation process.

4.5 The Administrator and Director of Nursing will be made aware of all such incidents occurring in the Center and will review and sign all completed reports. If an accident is of a serious nature, it shall be reported by telephone to the Administrator immediately regardless of time or day.

4.5.1 Completed Accident/Incident Reports and investigation forms must be submitted within 24 hours to the Administrator and the Director of Nursing.

5 Medication Errors

5.1 **Omission Error:** the failure to administer an ordered dose, unless refused by the resident or not administered because of recognized contraindication.

5.2 **Unauthorized drug error:** administration to the resident of a medication dose not authorized for the resident. This category includes a dose given to the wrong resident, duplicate doses, administration of an unordered drug and a dose given outside a stated set of clinical parameters.

5.3 **Wrong dose error:** any dose that is the wrong number of preformed units (i.e., tablets) or any dose above or below the ordered dose by a predetermined amount (i.e., 20%).

5.4 **Wrong route error:** administration of a drug by a route other than that ordered by the physician, or a wrong site of administration.

5.5 **Wrong rate error:** administration of a drug at the wrong rate, the correct rate being that given in the physician's orders or as established by center policy.

5.6 **Wrong dosage form error:** administration of a drug by the correct route but in a different dosage form than that specified or implied by the physician's order. Crushing the tablet is considered an error if the medication is on the "Do Not Crush" list and/or there is no physician order to crush.

5.7 **Wrong time error:** administration of a dose of drug greater than 60 minutes from its scheduled administration time except for drugs that the time of administration is not important. That is, an error is counted only if that wrong time can cause the resident discomfort or jeopardize the resident's health and safety.

5.8 **Wrong preparation of a dose:** incorrect preparation of the medication. Examples include incorrect dilution or reconstitution, not shaking a suspension, using an expired drug, not keeping a light sensitive drug protected from the light, and mixing incompatible drugs.

5.9 **Incorrect administration technique:** situation when the drug is given via the correct route, site and so

forth, but improper technique is used. I.e. not using the Z track injection technique when indicated for a drug.

6. IV Incidents - Intravenous medication incidents are considered separate from medication errors. Examples of I.V. errors requiring incident reports are:

6.1 Infusion rate not within ten percent of that specified over a twenty-four hour period

6.2 Incorrect infusion date.

6.3 Infiltration characterized by edema of 3 centimeters or greater and/or accompanied by tenderness and pain.

6.4 Edema of less than 3 centimeters from a drug diluted in less than 250 milliliters of solution that has infiltrated.

6.5 Infiltration of a known tissue damaging drug regardless of the drug dilution.

6.6 Phlebitis along the catheterized vein beyond the venipuncture.

7. Traumas

7.1 Falls or collisions

7.2 Burns - electrical, chemical or other

7.3 Trauma involving lacerations that require sutures

7.4 Any other event which can be considered traumatic in nature

8 Other Potentially Unusual Occurrences

8.1 Any unusual documentation or evidence of tampering with a medical record.

8.2 Any resident or family verbalizing intent to sue physician, nurse, center, etc.

8.3 Any complaint of improper treatment whether made by the resident or family.

8.4 Security issues such as unauthorized entry to center, bomb threats, destruction of property, etc.

8.5 Unauthorized leave by residents.

8.6 Damage to property.

8.7 Occurrences of a serious or life threatening nature which includes but not limited to:

8.7.1 Resident death, when sudden and unexpected.

8.7.2 Unusual incident that results in serious injury or death.

8.8 The Administrator must notify the Regional Vice President/Director of Clinical Services immediately, regardless of time of day, of any potential reportable incidents.

8.8.1 The Regional Vice President /Director of Clinical Services will be notified by the Vice-President of Operations, assigned Regional Director of Operations and Clinical Services Coordinator, immediately regardless of time of day.

8.8.2 The Regional Vice President/Director of Clinical Services/Clinical Services Coordinator will ensure that staff directly involved will be suspended pending complete investigation by the center, depending on the circumstances of the incident.

8.9 The Administrator is responsible for coordinating the investigation and assuring that appropriate action is taken. This will include:

8.9.1 Notification of the following as determined:

- Ombudsman
- Department of Health
- Family
- Physician/Medical Director
- Police or appropriate authority

8.9.2 Conduct interviews, collect written statements from all staff or visitors involved in the situation. All required documentation should be completed.

8.9.3 Regional personnel will be present daily during assessment and investigation, as necessary. Regional personnel will be present at exit conference should a survey by the Health Department occur.

8.9.3.1 The assigned Regional Director of Operations and or the Clinical Services Coordinator will maintain communication and update the Regional Vice President/Director of Clinical Services.

8.9.3.2 The Regional Vice President/Director of Clinical Services will update the Vice President of Operations.

8.9.3.3 Regional personnel will continue pending investigative outcomes based upon center need.

9 Individual will be appointed to direct the safety program.

9.1 All incidents will be forwarded to the center safety officer for follow up.

10 Do not place Incident reports or investigation forms in the resident's medical record.

10.1 Do not write in the resident's medical record "Incident report filed".

10.2 Do not write "staff counseled" about incident in the medical record.

10.3 Do not use the word "incident" when documenting.

10.4 Document in the medical record all information regarding resident's status condition and treatment related to the incident.

Nurses' Meeting

October, 20, 2010

Agenda of topics;

1. Care Issues – Lack of supervision
2. Customer Service and Patient Satisfaction.
3. Callbell response – Monitor your Staff response to callbell. BE PROMPT!
Patients room are Messy
Equipments not taken out when not in use
Equipments not dated – g-tubes and nebulizers and o2.
Treatments not done but signed for
Medicating patients with sleeping pills late
4. Proper documentation – Continues to be a problem
Admission Documentation x 5 days
Incidents and Accidents x 3 days. Complete report
Neuro checks on any head injuries
Behavior Monitoring as it occurs
Vital signs daily on notes
Time line Documentation
Use medical terminology
Acute Discharge log
Always initiate treatments upon admission or new wound. Do not
Wait till wound nurse starts treatment. You are responsible.
All dialysis notes go in the chart from now on, not in binder.
24 hour book must be done daily- it is a guide
Admission assessments not completed
5. MARS and TARS - New MARS & TARS.
Double signature and double checks on all insulin and Coumadin
Orders. New Coumadin and dialysis sheets.
New PT / INR binder
24 Hour chart checks, a must on 11-7. This is the 2nd check and
The order should be co-signed / initialed.
New Pain assessment and flow sheet not completed well
New Nebulizer and o2 flow sheet not completed well
Blanks on MARS and TARS no excuse
Blanks on Behavior monitoring sheets no longer tolerated
11-7 to make a list of patients needing new MARS
Therapeutic interchange meds and med errors
6. Early Risers for PT – It is our job not a chore
7. Faxing new admission orders to the TRG Group – 11-7
8. Survey ready – reviewing other facility DOH survey.

SVRNC 001049

EMPLOYEE WARNING RECORD

Employee's Name: Napolitano Shannon

Clock or Payrol No:

Department: Nursing

Shift: 645a-315p

Date Of Warning: 09/13/2010

WARNING

Date Of Violation: 09/13/2010

Time Of Violation:

NATURE OF VIOLATION

Substandard Work

Conduct

Lateness

Carelessness

Disobedience

Time & Attendance

Reported Absent Without Leave

Unreported Absence

Abuse of Sick Leave/ Proof of Illness

Pattern Absenteeism

Late Call - Off

Excessive Absenteeism

Uncooperative

Lunch/ Rest Break Period Abuse

COMPANY REMARKS

Shannon has been late 93 times since 1/1/10 and 9 times within the last 30 days (8/13-9/13). This is excessive and unacceptable. Her attendance needs immediate improvement or may result in termination upon the next episode of lateness.

EMPLOYEE'S REMARKS

The absence of any statement on the part of the EMPLOYEE indicates his/her agreement with the report as stated.

I have entered my version of the matter above.

Employee's Signature

Shannon Napolitano

Date

9-13-10

ACTION TO BE TAKEN

a. Oral Warning

b. Written Warning

c. Suspension

d. Discharge

18

of Days

Date

Comments:

Approved By

Name

Title

Date

I have read this "warning" and understand it.

Employee's Signature

Date

Shannon Napolitano

9-13-10

Signature of the person who prepared the warning

Title

Date

Munoz

RN DOW

9/13/10

If employee refuses to sign:

" This is to certify that the employee named in this report was warned by his supervisor in my presence concerning the subject matter contained therein."

Witness:

Date

If employee refuses to accept copy of form:

" Employee refuses to accept his copy of this warning notice."

Supervisor:

Date

Nursing

645a-315

Somers003344

Napolitano Shannon Licensed Practical Nurse CO: BV1 File No: 002839

	IN	OUT	IN	OUT	IN	OUT	TOTALS	
Fri 01/01	7:00 AM	4:02 PM					9.03	9.03
Mon 01/04	7:04 AM	5:06 PM					10.03	19.07
Tue 01/05	7:07 AM	4:18 PM					9.18	28.25
Wed 01/06	6:51 AM	3:42 PM					8.85	37.10
Fri 01/08	6:53 AM	3:11 PM					8.30	45.40
Sun 01/10	7:09 AM	3:55 PM					8.77	54.17
Mon 01/11	7:04 AM	3:30 PM					8.43	62.60
Wed 01/13	7:59 AM	3:00 PM					7.02	69.62
Fri 01/15	7:00 AM	3:23 PM					8.38	78.00
Mon 01/18	7:06 AM	3:22 PM					8.27	86.27
Tue 01/19	7:04 AM	3:44 PM					8.67	94.93
Wed 01/20	7:06 AM	3:51 PM					8.75	103.68
Fri 01/22	7:01 AM	4:18 PM					9.28	112.97
Sat 01/23	7:08 AM	3:24 PM					8.27	121.23
Sun 01/24	7:06 AM	3:48 PM					8.70	129.93
Mon 01/25	7:05 AM	3:44 PM					8.65	138.58
Wed 01/27	6:58 AM	4:10 PM					9.20	147.78
Thu 01/28	7:10 AM	3:18 PM					8.13	155.92
Fri 01/29	7:05 AM	4:34 PM					9.48	165.40
Mon 02/01	7:03 AM	4:15 PM					9.20	174.60
Tue 02/02	6:47 AM	3:19 PM					8.53	183.13
Wed 02/03	6:54 AM	3:17 PM					8.38	191.52
Fri 02/05	6:46 AM	3:16 PM					8.50	200.02
Sat 02/06	7:24 AM	3:14 PM					7.83	207.85
Sun 02/07	6:48 AM	3:40 PM					8.87	216.72
Mon 02/08	6:48 AM	3:18 PM					8.50	225.22
Thu 02/11	7:10 AM	3:00 PM					7.83	233.05
Fri 02/12	6:55 AM	3:26 PM					8.52	241.57
Mon 02/15	6:53 AM	2:55 PM					8.03	249.60
Tue 02/16	6:55 AM	3:02 PM					8.12	257.72
Wed 02/17	6:51 AM	3:25 PM					8.57	266.28
Fri 02/19	6:48 AM	3:20 PM					8.53	274.82
Sat 02/20	6:51 AM	3:12 PM					8.35	283.17
Sun 02/21	6:50 AM	2:55 PM					8.08	291.25
Mon 02/22	6:48 AM	3:43 PM					8.92	300.17
Wed 02/24	6:51 AM	3:37 PM					8.77	308.93
Thu 02/25	6:56 AM	3:24 PM					8.47	317.40
Fri 02/26	9:57 AM	3:21 PM					5.40	322.80
Mon 03/01	6:50 AM	3:21 PM					8.52	331.32
Tue 03/02	6:49 AM	3:24 PM					8.58	339.90
Wed 03/03	6:51 AM	3:35 PM					8.73	348.63
Fri 03/05	6:51 AM	3:32 PM					8.68	357.32
Sat 03/06	6:45 AM	3:48 PM					9.05	366.37
Sun 03/07	6:46 AM	2:53 PM					8.12	374.48
Mon 03/08	6:49 AM	3:13 PM					8.40	382.88
Wed 03/10	7:02 AM	3:20 PM					8.30	391.18
Thu 03/11	6:52 AM	3:40 PM					8.80	399.98
Fri 03/12	6:55 AM	3:54 PM					8.98	408.97
Mon 03/15	6:45 AM	E					8.00	416.97
Tue 03/16	6:54 AM	3:13 PM					8.32	425.28
Wed 03/17	7:00 AM	3:15 PM					8.25	433.53
Fri 03/19	6:54 AM	3:37 PM					8.72	442.25
Sat 03/20	6:46 AM	3:15 PM					8.48	450.73
Sun 03/21	6:57 AM	3:07 PM					8.17	458.90
Mon 03/22	6:51 AM	3:19 PM					8.47	467.37
Tue 03/23	7:00 AM	3:15 PM					8.25	475.62

Punch Detail Report

2010-01-01 - 2010-09-30

Thu 03/25	6:52 AM	3:11 PM			8.32	483.93
Fri 03/26	7:06 AM	3:19 PM			8.22	492.15
Mon 03/29	6:56 AM	3:11 PM			8.25	500.40
Tue 03/30	6:54 AM	3:39 PM			8.75	509.15
Wed 03/31	7:19 AM	3:19 PM			8.00	517.15
Fri 04/02	6:56 AM	3:42 PM			8.77	525.92
Sat 04/03	6:55 AM	3:21 PM			8.43	534.35
Sun 04/04	6:59 AM	9:59 PM			15.00	549.35
Mon 04/05	6:58 AM	3:20 PM			8.37	557.72
Fri 04/09	7:00 AM	11:03 PM			16.05	573.77
Mon 04/12	6:58 AM	11:22 PM			16.40	590.17
Fri 04/16	7:07 AM	10:50 PM			15.72	605.88
Sat 04/17	7:02 AM	3:14 PM			8.20	614.08
Sun 04/18	6:56 AM	3:31 PM			8.58	622.67
Mon 04/19	6:56 AM	10:48 PM			15.87	638.53
Fri 04/23	7:06 AM	11:13 PM			16.12	654.65
Mon 04/26	7:54 AM	11:12 PM			15.30	669.95
Sat 05/01	6:49 AM	3:14 PM			8.42	678.37
Sun 05/02	6:53 AM	3:19 PM			8.43	686.80
Mon 05/03	7:01 AM	10:20 PM			15.32	702.12
Tue 05/04	12:00 AM					
Wed 05/05	12:00 AM					
Fri 05/07	6:54 AM	11:17 PM			16.38	718.50
Mon 05/10	7:00 AM	10:55 PM			15.92	734.42
Fri 05/14	6:55 AM	V	6:55 AM	3:22 PM	16.45	750.87
Sat 05/15	6:58 AM	3:19 PM			8.35	759.22
Sun 05/16	6:45 AM	V			8.00	767.22
Mon 05/17	7:00 AM	10:58 PM			15.97	783.18
Fri 05/21	6:55 AM	11:16 PM			16.35	799.53
Mon 05/24	7:35 AM	3:44 PM			8.15	807.68
Tue 05/25	7:03 AM	3:04 PM			8.02	815.70
Fri 05/28	6:52 AM	10:17 PM			15.42	831.12
Sat 05/29	6:56 AM	3:08 PM			8.20	839.32
Sun 05/30	7:03 AM	2:52 PM			7.82	847.13
Mon 05/31	7:00 AM	3:10 PM			8.17	855.30
Tue 06/01	7:01 AM	3:09 PM			8.13	863.43
Fri 06/04	6:45 AM	V			16.00	879.43
Mon 06/07	6:52 AM	11:01 PM			16.15	895.58
Fri 06/11	7:02 AM	2:46 PM			7.73	903.32
Sat 06/12	7:00 AM	11:06 PM			16.10	919.42
Sun 06/13	7:05 AM	2:52 PM			7.78	927.20
Mon 06/14	7:09 AM	11:55 PM		11:56 PM	16.77	943.97
Thu 06/17	8:32 AM	3:04 PM			6.53	950.50
Fri 06/18	6:54 AM	3:30 PM			8.60	959.10
Mon 06/21	7:02 AM	10:47 PM			15.75	974.85
Fri 06/25	7:00 AM	3:00 PM			8.00	982.85
Sat 06/26	7:11 AM	3:16 PM			8.08	990.93
Sun 06/27	7:01 AM	10:31 PM			15.50	1,006.43
Mon 06/28	6:58 AM	3:09 PM			8.18	1,014.62
Fri 07/02	6:56 AM	12:21 AM			17.42	1,032.03
Sun 07/04	12:00 AM					
Mon 07/05	7:16 AM	11:00 PM			15.73	1,047.77
Wed 07/07	7:18 AM	3:12 PM			7.90	1,055.67
Thu 07/08	7:00 AM	3:54 PM			8.90	1,064.57
Fri 07/09	6:45 AM	E			16.00	1,080.57
Sat 07/10	7:14 AM	11:35 PM			16.35	1,096.92
Sun 07/11	7:05 AM	10:06 PM			15.02	1,111.93
Mon 07/12	7:14 AM	11:03 PM			15.82	1,127.75
Wed 07/14	7:08 AM	3:11 PM			8.05	1,135.80
Thu 07/15	7:29 AM	3:30 PM			8.02	1,143.82
Fri 07/16	7:02 AM	12:12 AM			17.17	1,160.98

Somers003346

Punch Detail Report

2010-01-01 - 2010-09-30

Mon 07/19	7:06 AM	11:15 PM	16.15	1,177.13
Fri 07/23	7:00 AM	11:50 PM	16.83	1,193.97
Sat 07/24	7:28 AM	3:40 PM	8.20	1,202.17
Sun 07/25	7:09 AM	3:30 PM	8.35	1,210.52
Mon 07/26	7:00 AM	11:14 PM	16.23	1,226.75
Wed 07/28	7:53 AM	3:11 PM	7.30	1,234.05
Thu 07/29	7:01 AM	6:30 PM	11.48	1,245.53
Fri 07/30	7:12 AM	11:53 PM	16.68	1,262.22
Sat 07/31	7:06 AM	1:58 PM	6.87	1,269.08
Sun 08/01	3:01 PM	11:01 PM	8.00	1,277.08
Mon 08/02	7:02 AM	11:14 PM	16.20	1,293.28
Wed 08/04	6:53 AM	3:42 PM	8.82	1,302.10
Thu 08/05	7:06 AM	3:44 PM	8.63	1,310.73
Fri 08/06	7:04 AM	10:53 PM	15.82	1,326.55
Sun 08/08	12:00 AM V		8.00	1,334.55
Tue 08/10	7:07 AM	3:34 PM	8.45	1,343.00
Fri 08/13	7:00 AM	11:03 PM	16.05	1,359.05
Sun 08/15	6:48 AM	1:57 PM	7.15	1,366.20
Mon 08/16	12:00 AM V		16.00	1,382.20
Fri 08/20	7:10 AM	10:46 PM	15.60	1,397.80
Sat 08/21	6:52 AM	1:59 PM	7.12	1,404.92
Sun 08/22	7:08 AM	3:13 PM	8.08	1,413.00
Mon 08/23	7:05 AM	11:21 PM	16.27	1,429.27
Wed 08/25	7:12 AM	3:31 PM	8.32	1,437.58
Thu 08/26	7:19 AM	1:56 PM	6.62	1,444.20
Fri 08/27	6:45 AM V		8.00	1,452.20
Mon 08/30	7:03 AM	3:50 PM	8.78	1,460.98
Tue 08/31	7:08 AM	3:19 PM	8.18	1,469.17
Fri 09/03	6:48 AM	10:11 PM	15.38	1,484.55
Sat 09/04	6:53 AM	3:10 PM	8.28	1,492.83
Sun 09/05	7:03 AM	3:24 PM	8.35	1,501.18
Mon 09/06	6:51 AM	3:13 PM	8.37	1,509.55
Tue 09/07	6:51 AM	3:12 PM	8.35	1,517.90
Wed 09/08	6:51 AM	3:20 PM	8.48	1,526.38
Fri 09/10	6:55 AM	3:27 PM	8.53	1,534.92
Mon 09/13	7:24 AM			

Regular		Paid	1,292.72
Shift Differential	DWDE	Paid	221.40
Shift Differential	DWED	Paid	252.70
Shift Differential	DWEE	Paid	46.12
Shift Differential	DWEN	Paid	0.58
Over Time	OT	Paid	66.72
Sick	SICK	Paid	24.00
Vacation	VAC	Paid	64.00
RETRO Sick	RS	Paid	16.00
Holiday Unworked	HOL	Paid	7.50
Holiday Worked (100%)	HOL	Paid	29.97

Attendance Record (Display Only)

Napolitano Shannon (Licensed Practical Nurse)

Schedule

Actual

Year

2010

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January	⊙	□	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
February	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
March	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
April	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
May	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
June	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
July	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
August	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
September	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
October	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
November	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
December	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	

- 01/14/2010 Call Out
- 02/10/2010 Call Out
- 03/15/2010 Call Out
- 04/30/2010 Sick
- 04/30/2010 Sick
- 05/14/2010 Vacation
- 05/16/2010 Vacation
- 06/04/2010 Vacation
- 06/04/2010 Vacation
- 07/09/2010 Sick
- 07/09/2010 Sick
- 08/08/2010 Vacation
- 08/12/2010 Request Off
- 08/16/2010 Request Off
- 08/27/2010 Vacation

EMPLOYEE WARNING RECORD

P-25

Employee's Name: Claudio Sheena R.

Clock or Payroll No:

Department: Nursing

Shift: 645a-315p

Date Of Warning: 09/13/2010

WARNING

Date Of Violation: 09/12/2010

Time Of Violation:

NATURE OF VIOLATION

- | | | |
|---|---|--|
| <input type="checkbox"/> Substandard Work | <input type="checkbox"/> Conduct | <input type="checkbox"/> Lateness |
| <input type="checkbox"/> Carelessness | <input type="checkbox"/> Disobedience | <input type="checkbox"/> Time & Attendance |
| <input type="checkbox"/> Reported Absent Without Leave | <input type="checkbox"/> Unreported Absence | <input type="checkbox"/> Abuse of Sick Leave/ Proof of Illness |
| <input checked="" type="checkbox"/> Pattern Absenteeism | <input type="checkbox"/> Late Call - Off | <input type="checkbox"/> Excessive Absenteeism |
| | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Lunch/ Rest Break Period Abuse |

COMPANY REMARKS

Sheena has called out sick 3 times within the last 90 days (6/1, 6/21, 9/13). Of the three occurrences two have been prior to a day not scheduled (6/21 was before a six day break in schedule and 9/13 was before her normal day off of 9/14). See attached.

EMPLOYEE'S REMARKS

The absence of any statement on the part of the EMPLOYEE indicates his/her agreement with the report as stated.

was not aware that could not call out before or after day off. Was not warned after the 1st time on 6/21. Do not feel I should be written up, I should be verbally warned.

Employee's Signature

Sheena R. Claudio

Date

9/16/10

ACTION TO BE TAKEN

- a. Oral Warning
- b. Written Warning 1st
- c. Suspension # of Days _____
- d. Discharge Date _____

Comments:

Approved By _____

Name

Title

Date

I have read this "warning" and understand it.

Employee's Signature

Date

Sheena R. Claudio *9/16/10*

Signature of the person who prepared the warning

Title

Date

Monjeli RA *9/16/10*

If employee refuses to sign:

"This is to certify that the employee named in this report was warned by his supervisor in my presence concerning the subject matter contained therein."

If employee refuses to accept copy of form:

"Employee refuses to accept his copy of this warning notice."

Witness:

Date

Supervisor:

Date

GCX-14

Nursing

Somers003465

ed on 09/13/2010 by dtrain

Attendance Record (Display Only)



Claudio Sheena R. (Licensed Practical Nurse)

Schedule

Actual

Year

2010

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January	○	□	□	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
February	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
March	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
April	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
May	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
June	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
July	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
August	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
September	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
October	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
November	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
December	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

- 04/25/2010 Request Off
- 06/01/2010 Call Out
- 08/01/2010 Call Out
- 09/01/2010 Vacation
- 09/13/2010 Call Out

EMPLOYEE WARNING RECORD

P-26

Employee's Name: Claudio Sheena R.

Clock or Payrol No:

Department: Nursing

Shift: 645a-315p

Date Of Warning: 09/13/2010

WARNING

Date Of Violation: 09/12/2010

Time Of Violation:

NATURE OF VIOLATION

- | | | |
|--|---|--|
| <input type="checkbox"/> Substandard Work | <input type="checkbox"/> Conduct | <input checked="" type="checkbox"/> Lateness |
| <input type="checkbox"/> Carelessness | <input type="checkbox"/> Disobedience | <input type="checkbox"/> Time & Attendance |
| <input type="checkbox"/> Reported Absent Without Leave | <input type="checkbox"/> Unreported Absence | <input type="checkbox"/> Abuse of Sick Leave/ Proof of Illness |
| <input type="checkbox"/> Pattern Absenteeism | <input type="checkbox"/> Late Call - OIT | <input type="checkbox"/> Excessive Absenteeism |
| | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Lunch/ Rest Break Period Abuse |

COMPANY REMARKS

Sheena has been late 64 times since 1/1/2010. Within the last 30 days (8/12-9/12) she has been late 16 times. This is excessive and requires immediate improvement. See attached.

EMPLOYEE'S REMARKS

The absence of any statement on the part of the EMPLOYEE indicates his/her agreement with the report as stated.

Should be verbally warned, the few that were more than 10 mins late I had called before coming to work to inform them of my lateness. Most of them are a couple mins. late, should not be on record as entered my version of the matter above. And warning this is the first warning for lateness.

Employee's Signature: *Placed*

Date: *9/16/10*

ACTION TO BE TAKEN

- a. Oral Warning
- b. Written Warning *2nd*
- c. Suspension # of Days _____
- d. Discharge Date _____

Comments:

Approved By _____

Name

Title

Date

I have read this "warning" and understand it.

Employee's Signature

Date

Signature of the person who prepared the warning

Title

Date

If employee refuses to sign:

" This is to certify that the employee named in this report was warned by his supervisor in my presence concerning the subject matter contained therein."

SS: _____

Date _____

If employee refuses to accept copy of form:

" Employee refuses to accept his copy of this warning notice."

Supervisor: _____

Date _____

Nursing

Gx-15

Somers003467

h Detail Report

Claudio Sheena R.

Licensed Practical Nurse

CO: BVI

File No:

	IN	OUT	IN	OUT	IN	OUT	TOTALS
ge 01/19	6:45 AM	3:15 PM					8.50 3.50
ed 01/20	6:45 AM	3:15 PM					8.50 17.00
Thu 01/21	6:45 AM	3:15 PM					8.50 25.50
Fri 01/22	6:45 AM	11:15 PM					16.50 12.00
Mon 01/25	6:45 AM	5:45 PM					11.00 53.00
Tue 01/26	6:45 AM	3:15 PM					8.50 61.50
Wed 01/27	6:45 AM	4:00 PM					9.25 70.75
Thu 01/28	6:44 AM	4:10 PM					9.43 80.18
Sat 01/30	6:41 AM	4:33 PM					9.87 90.05
Sun 01/31	6:42 AM	4:30 PM					9.80 99.85
Mon 02/01	6:46 AM	4:20 PM					9.57 109.42
Wed 02/03	6:39 AM	4:14 PM					9.58 119.00
Thu 02/04	6:41 AM	3:26 PM					8.75 127.75
Fri 02/05	6:43 AM	3:22 PM					8.65 136.40
Sat 02/06	6:47 AM	3:21 PM					8.57 144.97
Mon 02/08	6:41 AM	3:57 PM					9.27 154.23
Tue 02/09	6:45 AM	9:56 PM					15.18 169.42
Wed 02/10	6:54 AM	3:15 PM					8.35 177.77
Fri 02/12	6:45 AM	3:15 PM					8.50 186.27
Sat 02/13	6:47 AM	3:23 PM					8.60 194.87
Sun 02/14	7:30 AM	3:22 PM					7.87 202.73
Wed 02/17	6:39 AM	3:17 PM					8.63 211.37
Thu 02/18	6:43 AM	4:12 PM					9.48 220.85
Fri 02/19	6:41 AM	11:00 PM					16.32 237.17
Mon 02/22	6:42 AM	3:24 PM					8.70 245.87
Tue 02/23	6:53 AM	4:25 PM					9.53 255.40
Wed 02/24	6:41 AM	3:28 PM					8.78 264.18
Thu 02/25	6:42 AM	3:51 PM					9.15 273.33
Sat 02/27	6:38 AM	3:45 PM					9.12 282.45
Sun 02/28	7:01 AM	4:00 PM					8.98 291.43
Mon 03/01	6:47 AM	10:00 PM					15.22 306.65
Wed 03/03	6:44 AM	3:38 PM					8.90 315.55
Thu 03/04	6:44 AM	4:00 PM					9.27 324.82
Fri 03/05	3:06 PM	9:00 PM					5.90 330.72
Mon 03/08	6:51 AM	3:13 PM					8.37 339.08
Tue 03/09	6:47 AM	4:05 PM					9.30 348.38
Wed 03/10	6:55 AM	3:11 PM					8.27 356.65
Thu 03/11	6:42 AM	3:16 PM					8.57 365.22
Sat 03/13	6:39 AM	8:00 PM					13.35 378.57
Sun 03/14	7:34 AM	4:30 PM					8.93 387.50
Mon 03/15	3:13 PM	12:16 AM					9.05 396.55
Tue 03/16	7:01 AM	4:09 PM					9.13 405.68
Wed 03/17	6:41 AM	4:05 PM					9.40 415.08
Fri 03/19	6:42 AM	3:56 PM					9.23 424.32
Mon 03/22	7:44 AM	3:49 PM					8.08 432.40
Tue 03/23	6:42 AM	9:00 PM					14.30 446.70
Wed 03/24	6:45 AM	3:31 PM					8.77 455.47
Fri 03/26	6:44 AM	3:16 PM					8.53 464.00
Sat 03/27	6:51 AM	7:01 PM					12.17 476.17
Sun 03/28	3:27 PM	11:15 PM					7.80 483.97
Mon 03/29	6:50 AM	4:00 PM					9.17 493.13
Wed 03/31	6:44 AM	3:17 PM					8.55 501.68
Thu 04/01	6:42 AM	3:15 PM					8.55 510.23
Fri 04/02	6:42 AM	3:31 PM					8.82 519.05
Mon 04/05	6:39 AM	3:38 PM					8.98 528.03
Tue 04/06	6:47 AM	3:19 PM					8.53 536.57

Acti Detail Report

2010-01-01 - 2010-09-30

Wed 04/07	6:53 AM	7:00 PM	12.12	518.68
Thu 04/08	6:45 AM	3:18 PM	8.55	557.23
Sat 04/10	7:12 AM	3:16 PM	8.07	565.30
Sun 04/11	6:42 AM	3:15 PM	8.55	573.85
Tue 04/13	6:47 AM	3:45 PM	8.97	582.82
Wed 04/14	6:38 AM	3:49 PM	9.18	592.00
Thu 04/15	6:53 AM	3:43 PM	8.83	600.83
Fri 04/16	6:57 AM	4:00 PM	9.05	609.88
Mon 04/19	7:32 AM	3:17 PM	7.75	617.63
Tue 04/20	6:48 AM	3:53 PM	9.08	626.72
Wed 04/21	6:51 AM	3:33 PM	8.70	635.12
Thu 04/22	6:42 AM	3:45 PM	9.05	644.47
Sat 04/24	7:22 AM	1:32 PM	6.17	650.63
Mon 04/26	6:55 AM	3:57 PM	9.03	659.67
Wed 04/28	6:51 AM	3:51 PM	9.00	668.67
Thu 04/29	7:04 AM	3:42 PM	8.63	677.30
Fri 04/30	6:54 AM	9:40 PM	14.77	692.07
Mon 05/03	7:02 AM	9:02 PM	14.00	706.07
Wed 05/05	6:49 AM	3:15 PM	8.43	714.50
Sun 05/09	7:10 AM	9:25 PM	14.25	728.75
Mon 05/10	7:01 AM	3:15 PM	8.23	736.98
Wed 05/12	7:05 AM	3:35 PM	8.50	745.48
Thu 05/13	7:04 AM	3:36 PM	8.53	754.02
Fri 05/14	7:09 AM	3:44 PM	8.58	762.60
Sun 05/16	6:57 AM	3:16 PM	8.32	770.92
Mon 05/17	7:01 AM	3:51 PM	8.83	779.75
Tue 05/18	7:05 AM	4:59 PM	9.90	789.65
Wed 05/19	7:08 AM	7:18 PM	12.17	801.82
Thu 05/20	6:56 AM	3:39 PM	8.72	810.53
Sat 05/22	8:52 AM	3:23 PM	6.52	817.05
Sun 05/23	6:56 AM	7:01 PM	12.08	829.13
Mon 05/24	6:56 AM	3:35 PM	8.65	837.78
Thu 05/27	7:01 AM	7:08 PM	12.12	849.90
Sat 05/29	7:22 AM	3:15 PM	7.88	857.78
Sun 05/30	6:51 AM	3:05 PM	8.23	866.02
Mon 05/31	7:00 AM	3:22 PM	8.37	874.38
Wed 06/02	6:38 AM	3:22 PM	8.73	883.12
Fri 06/04	6:39 AM	3:19 PM	8.67	891.78
Sat 06/05	6:42 AM	3:18 PM	8.60	900.38
Sun 06/06	6:47 AM	3:31 PM	8.73	909.12
Mon 06/07	6:55 AM	3:42 PM	8.78	917.90
Wed 06/09	6:50 AM	3:26 PM	8.60	926.50
Thu 06/10	6:49 AM	2:53 PM	8.07	934.57
Fri 06/11	6:46 AM	3:15 PM	8.48	943.05
Sun 06/13	7:04 AM	10:54 PM	15.83	958.88
Tue 06/15	6:41 AM	3:58 PM	9.28	968.17
Wed 06/16	7:13 AM	3:39 PM	8.43	976.60
Thu 06/17	6:38 AM	9:20 PM	14.70	991.30
Sat 06/19	6:58 AM	8:03 PM	13.08	1,004.38
Sun 06/20	6:46 AM	3:10 PM	8.40	1,012.78
Wed 06/23	6:47 AM	3:27 PM	8.67	1,021.45
Thu 06/24	6:47 AM	3:29 PM	8.70	1,030.15
Mon 06/28	6:45 AM	6:06 PM	11.35	1,041.50
Tue 06/29	6:52 AM	3:31 PM	8.65	1,050.15
Wed 06/30	6:42 AM	3:29 PM	8.78	1,058.93
Sat 07/03	7:57 AM	3:36 PM	7.65	1,066.58
Sun 07/04	6:51 AM	3:33 PM	8.70	1,075.28
Wed 07/07	6:39 AM	3:15 PM	8.60	1,083.88
Fri 07/09	6:53 AM	3:19 PM	8.43	1,092.32
Mon 07/12	6:54 AM	3:31 PM	8.62	1,100.93
Tue 07/13	6:59 AM	3:17 PM	8.30	1,109.23

ah Detail Report

08/01/2008 - 09/12/2008

Sat 07/17	6:53 AM	3:24 PM		8.52	1,117.75
Sun 07/18	6:38 AM	3:19 PM		8.68	1,126.41
Mon 07/19	6:41 AM	4:25 PM		9.73	1,136.17
Wed 07/21	6:41 AM	3:21 PM		8.67	1,144.83
Thu 07/22	6:41 AM	4:10 PM		9.48	1,154.32
Fri 07/26	6:55 AM	11:24 PM		16.48	1,170.80
Wed 07/28	6:41 AM	11:22 PM		16.68	1,187.48
Sat 07/31	6:48 AM	3:35 PM		8.78	1,196.27
Sun 08/01	2:49 PM	11:07 PM		8.30	1,204.57
Mon 08/02	6:56 AM	3:27 PM		8.52	1,213.08
Tue 08/03	6:48 AM	8:29 PM		13.68	1,226.77
Fri 08/06	6:40 AM	3:37 PM		8.95	1,235.72
Mon 08/09	6:48 AM	3:32 PM		8.73	1,244.45
Tue 08/10	6:59 AM	3:51 PM		8.87	1,253.32
Wed 08/11	6:58 AM	3:40 PM		8.70	1,262.02
Sat 08/14	6:44 AM	3:34 PM		8.83	1,270.85
Sun 08/15	7:01 AM	3:51 PM		8.83	1,279.68
Mon 08/16	6:55 AM	11:15 PM		16.33	1,296.02
Tue 08/17	7:00 AM	3:23 PM		8.38	1,304.40
Wed 08/18	7:11 AM	3:21 PM		8.17	1,312.57
Fri 08/20	7:04 AM	2:34 PM		7.50	1,320.07
Mon 08/23	7:07 AM	5:57 PM		10.83	1,330.90
Tue 08/24	6:55 AM	6:24 PM		11.48	1,342.38
Wed 08/25	6:54 AM	3:35 PM		8.68	1,351.07
Sat 08/28	7:07 AM	3:16 PM		8.15	1,359.22
Sun 08/29	6:54 AM	3:10 PM		8.27	1,367.48
Mon 08/30	6:52 AM	3:06 PM		8.23	1,375.72
Wed 09/01	6:53 AM	3:35 PM		8.70	1,384.42
Thu 09/02	6:50 AM	2:06 PM		7.27	1,391.68
Fri 09/03	6:53 AM	3:28 PM		8.58	1,400.27
Mon 09/06	6:55 AM	3:17 PM		8.37	1,408.63
Tue 09/07	6:45 AM	V		8.00	1,416.63
Wed 09/08	7:06 AM	3:33 PM		8.45	1,425.08
Thu 09/09	6:53 AM	2:52 PM		7.98	1,433.07
Sat 09/11	6:57 AM	3:15 PM		8.30	1,441.37
Sun 09/12	7:08 AM	3:22 PM		8.23	1,449.60

Regular		Paid	1,212.85
Shift Differential	DWDE	Paid	124.42
Shift Differential	DWED	Paid	260.27
Shift Differential	DWEE	Paid	55.65
Over Time	OT	Paid	97.45
Training	TRN	Paid	49.30
Vacation	VAC	Paid	8.00
Holiday Worked (100%)	HOL	Paid	22.50

EMPLOYEE WARNING RECORD

Employee's Name: Jacques Jillian
Shift: 245p-1115p

Clock or Payrol No:
Date Of Warning: 09/13/2010

Department: Nursing

WARNING

Date Of Violation: 09/05/2010
Time Of Violation:

- NATURE OF VIOLATION
- Substandard Work
 - Carelessness
 - Reported Absent Without Leave
 - Pattern Absenteeism
 - Conduct
 - Disobedience
 - Unreported Absence
 - Late Call - Off
 - Uncooperative
 - Lateness
 - Time & Attendance
 - Abuse of Sick Leave/ Proof of Illness
 - Excessive Absenteeism
 - Lunch/ Rest Break Period Abuse

COMPANY REMARKS

Jillian has been late 109 times since 1/1/2010. Within the last 30 days (8/5-9/5) she was late 11 times. This is excessive and requires immediate improvement. See attached.

EMPLOYEE'S REMARKS

The absence of any statement on the part of the EMPLOYEE indicates his/her agreement with the report as stated.

This is an issue that was addressed earlier in the yr by the previous DOW. I entered my version of the matter above. even though I was in writing 9/13/10

Employee's Signature: *[Signature]*

Date: 9/13/10

ACTION TO BE TAKEN

- a. Oral Warning
- b. Written Warning 1st
- c. Suspension # of Days _____
- d. Discharge Date _____

Comments:
Employee offered different shift - refused. ee

Approved By _____

Name Title Date

I have read this "warning" and understand it.
Employee's Signature _____ Date _____

Signature of the person who prepared the warning _____ Title _____ Date _____

If employee refuses to sign:
" This is to certify that the employee named in this report was warned by his supervisor in my presence concerning the subject matter contained therein."

If employee refuses to accept copy of form:
" Employee refuses to accept his copy of this warning notice."

Witness: _____ Date _____

Supervisor: _____ Date _____

Somerset

CG EXHIBIT ID
Jacques-4
5/23/11

Somers002518

EMPLOYEE WARNING RECORD

Employee's Name: Jacques Jillian

Clock or Payrol No:

Department: Nursing

Shift: 245p-1115p

Date Of Warning: 09/13/2010

WARNING

Date Of Violation: 09/05/2010

Time Of Violation:

NATURE OF VIOLATION

- | | | |
|--|---|--|
| <input type="checkbox"/> Substandard Work | <input type="checkbox"/> Conduct | <input checked="" type="checkbox"/> Lateness |
| <input type="checkbox"/> Carelessness | <input type="checkbox"/> Disobedience | <input type="checkbox"/> Time & Attendance |
| <input type="checkbox"/> Reported Absent Without Leave | <input type="checkbox"/> Unreported Absence | <input type="checkbox"/> Abuse of Sick Leave/ Proof of Illness |
| <input type="checkbox"/> Pattern Absenteeism | <input type="checkbox"/> Late Call - Off | <input type="checkbox"/> Excessive Absenteeism |
| | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Lunch/ Rest Break Period Abuse |

COMPANY REMARKS

Jillian has been late 109 times since 1/1/2010. Within the last 30 days (8/5-9/5) she was late 11 times. This is excessive and requires immediate improvement. See attached.

EMPLOYEE'S REMARKS

The absence of any statement on the part of the EMPLOYEE indicates his/her agreement with the report as stated.

I have entered my version of the matter above.

Employee's Signature _____

Date _____

ACTION TO BE TAKEN

- a. Oral Warning _____
- b. Written Warning _____
- c. Suspension _____ # of Days _____
- d. Discharge _____ Date _____

Comments:

Approved By _____

Name

Title

Date

I have read this "warning" and understand it.

Employee's Signature _____

Date _____

Signature of the person who prepared the warning

Title

Date

If employee refuses to sign:

" This is to certify that the employee named in this report was warned by his supervisor in my presence concerning the subject matter contained therein."

If employee refuses to accept copy of form:

" Employee refuses to accept his copy of this warning notice."

Supervisor: _____

Date _____

Supervisor: _____

Date _____

Somerset

Somers002519

Detail Report

2010-01-01 - 2010-09-30

Jacques Jillian

Licensed Practical Nurse

CO: BVI

File No: 000140

	IN	OUT	IN	OUT	IN	OUT	TOTALS	
rrr 01/01	3:02 PM	11:44 PM					8.70	8.70
Mon 01/04	3:00 PM	1:15 AM					10.25	18.95
Tue 01/05	2:48 PM	12:25 AM					9.62	28.57
Wed 01/06	2:50 PM	11:21 PM					8.52	37.08
Sat 01/09	3:08 PM	12:20 AM					9.20	46.28
Sun 01/10	2:56 PM	11:23 PM					8.45	54.73
Mon 01/11	2:54 PM	11:21 PM					8.45	63.18
Wed 01/13	3:00 PM	12:37 AM					9.62	72.80
Thu 01/14	3:02 PM	11:26 PM					8.40	81.20
Fri 01/15	2:56 PM	12:09 AM					9.22	90.42
Mon 01/18	2:56 PM	11:20 PM					8.40	98.82
Tue 01/19	3:00 PM	1:28 AM					10.47	109.28
Wed 01/20	2:51 PM	12:42 AM					9.85	119.13
Fri 01/22	3:04 PM	11:21 PM					8.28	127.42
Sat 01/23	2:59 PM	12:52 AM					9.88	137.30
Sun 01/24	2:54 PM	1:37 AM					10.72	148.02
Wed 01/27	2:52 PM	11:18 PM					8.43	156.45
Thu 01/28	2:54 PM	11:57 PM					9.05	165.50
Fri 01/29	2:54 PM	12:22 AM					9.47	174.97
Mon 02/01	2:52 PM	12:59 AM					10.12	185.08
Tue 02/02	2:53 PM	1:00 AM					10.12	195.20
Wed 02/03	2:51 PM	12:04 AM					9.22	204.42
Fri 02/05	2:50 PM	11:16 PM					8.43	212.85
Sat 02/06	3:02 PM	11:19 PM					8.28	221.13
Sun 02/07	2:52 PM	11:23 PM					8.52	229.65
h 02/08	2:50 PM	11:16 PM					8.43	238.08
Wed 02/10	2:49 PM	11:20 PM					8.52	246.60
Thu 02/11	2:54 PM	11:18 PM					8.40	255.00
Fri 02/12	2:54 PM	11:20 PM					8.43	263.43
Mon 02/15	2:56 PM	11:20 PM					8.40	271.83
Tue 02/16	2:50 PM	12:21 AM					9.52	281.35
Wed 02/17	2:50 PM	12:16 AM					9.43	290.78
Fri 02/19	2:52 PM	12:18 AM					9.43	300.22
Sat 02/20	2:45 PM	V					8.00	308.22
Sun 02/21	2:57 PM	11:22 PM					8.42	316.63
Mon 02/22	2:53 PM	1:08 AM					10.25	326.88
Wed 02/24	2:54 PM	12:32 AM					9.63	336.52
Thu 02/25	2:54 PM	12:15 AM					9.35	345.87
Fri 02/26	2:55 PM	11:52 PM					8.95	354.82
Mon 03/01	2:53 PM	11:20 PM					8.45	363.27
Tue 03/02	2:54 PM	11:50 PM					8.93	372.20
Wed 03/03	2:56 PM	11:57 PM					9.02	381.22
Fri 03/05	2:52 PM	2:32 AM					11.67	392.88
Sat 03/06	2:58 PM	11:51 PM					8.88	401.77
Sun 03/07	2:58 PM	12:17 AM					9.32	411.08
Wed 03/10	2:56 PM	2:00 AM					11.07	422.15
Thu 03/11	2:59 PM	1:26 AM					10.45	432.60
Fri 03/12	2:54 PM	4:00 AM					13.10	445.70
Mon 03/15	2:52 PM	11:20 PM					8.47	454.17
Tue 03/16	3:00 PM	12:58 AM					9.97	464.13
Wed 03/17	2:54 PM	1:31 AM					10.62	474.75
3/19	3:00 PM	12:03 AM					9.05	483.80
Sat 03/20	2:55 PM	11:41 PM					8.77	492.57
Sun 03/21	2:56 PM	11:33 PM					8.62	501.18
Mon 03/22	2:55 PM	11:55 PM					9.00	510.18
Wed 03/24	2:53 PM	12:33 AM					9.67	519.85

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Thu 03/25	3:01 PM	12:47 AM	9.77	529.62
Mon 03/29	3:00 PM	12:15 AM	9.25	538.87
Tue 03/30	3:43 PM	12:28 AM	8.75	547.62
Wed 03/31	2:58 PM	12:55 AM	9.95	557.57
Thu 04/02	3:00 PM	11:47 PM	8.78	566.35
Fri 04/03	2:57 PM	11:55 PM	8.97	575.32
Mon 04/05	2:58 PM	11:20 PM	8.37	583.68
Wed 04/07	2:58 PM	1:12 AM	10.23	593.92
Thu 04/08	3:03 PM	11:43 PM	8.67	602.58
Fri 04/09	2:54 PM	12:12 AM	9.30	611.88
Mon 04/12	2:58 PM	12:08 AM	9.17	621.05
Tue 04/13	3:02 PM	12:48 AM	9.77	630.82
Wed 04/14	3:02 PM	12:55 AM	9.88	640.70
Fri 04/16	3:13 PM	11:51 PM	8.63	649.33
Sat 04/17	3:04 PM	12:17 AM	9.22	658.55
Sun 04/18	3:00 PM	11:17 PM	8.28	666.83
Mon 04/19	2:58 PM	11:26 PM	8.47	675.30
Wed 04/21	3:06 PM	11:23 PM	8.28	683.58
Thu 04/22	3:01 PM	1:17 AM	10.27	693.85
Mon 04/26	3:02 PM	12:30 AM	9.47	703.32
Tue 04/27	3:02 PM	12:27 AM	9.42	712.73
Wed 04/28	3:00 PM	12:14 AM	9.23	721.97
Fri 04/30	3:04 PM	12:52 AM	9.80	731.77
Sat 05/01	3:00 PM	12:05 AM	9.08	740.85
Sun 05/02	3:06 PM	11:55 PM	8.82	749.67
Mon 05/03	2:51 PM	12:39 AM	9.80	759.47
Wed 05/05	2:56 PM	1:29 AM	10.55	770.02
Thu 05/06	2:57 PM	12:16 AM	9.32	779.33
Fri 05/07	2:53 PM	12:44 AM	9.85	789.18
Mon 05/10	2:58 PM	11:46 PM	8.80	797.98
Tue 05/11	2:51 PM	11:57 PM	9.10	807.08
Wed 05/12	2:58 PM	11:30 PM	8.53	815.62
Fri 05/14	2:58 PM	11:58 PM	9.00	824.62
Sat 05/15	2:56 PM	11:27 PM	8.52	833.13
Sun 05/16	2:58 PM	11:20 PM	8.37	841.50
Mon 05/17	2:58 PM	12:22 AM	9.40	850.90
Wed 05/19	2:52 PM	11:59 PM	9.12	860.02
Thu 05/20	2:56 PM	12:33 AM	9.62	869.63
Mon 05/24	2:59 PM	11:15 PM	8.27	877.90
Tue 05/25	2:56 PM	1:05 AM	10.15	888.05
Wed 05/26	2:55 PM	12:19 AM	9.40	897.45
Fri 05/28	3:32 PM	1:26 AM	9.90	907.35
Sun 05/30	3:08 PM	11:37 PM	8.48	915.83
Mon 05/31	2:54 PM	11:36 PM	8.70	924.53
Wed 06/02	2:58 PM	2:26 AM	11.47	936.00
Thu 06/03	2:59 PM	12:02 AM	9.05	945.05
Fri 06/04	3:05 PM	11:48 PM	8.72	953.77
Mon 06/07	2:45 PM	V	8.00	961.77
Tue 06/08	2:45 PM	V	8.00	969.77
Wed 06/09	2:45 PM	V	8.00	977.77
Fri 06/11	2:45 PM	V	8.00	985.77
Sat 06/12	2:45 PM	V	8.00	993.77
Mon 06/14	2:50 PM	1:31 AM	10.68	1,004.45
Wed 06/16	3:02 PM	12:18 AM	9.27	1,013.72
Thu 06/17	2:56 PM	1:17 AM	10.35	1,024.07
Fri 06/18	3:09 PM	12:21 AM	9.20	1,033.27
Sat 06/21	3:00 PM	12:49 AM	9.82	1,043.08
Sun 06/22	3:15 PM	12:42 AM	9.45	1,052.53
Wed 06/23	2:56 PM	12:14 AM	9.30	1,061.83
Fri 06/25	3:00 PM	12:25 AM	9.42	1,071.25
Sat 06/26	3:02 PM	12:26 AM	9.40	1,080.65

Detail Report

Sun 06/27	3:02 PM	12:07 AM			9.08	1,089.73
Mon 06/28	3:03 PM	12:59 AM			9.93	1,099.67
Wed 06/30	2:52 PM	1:08 AM			10.27	1,109.93
Thu 07/01	2:55 PM	12:44 AM			9.82	1,119.75
Fri 07/02	12:00 AM					
Mon 07/05	2:58 PM	12:22 AM			9.40	1,129.15
Tue 07/06	2:52 PM	1:50 AM			10.97	1,140.12
Wed 07/07	2:57 PM	1:18 AM			10.35	1,150.47
Sun 07/11	2:48 PM	12:30 AM			9.70	1,160.17
Mon 07/12	2:48 PM	1:50 AM			11.03	1,171.20
Wed 07/14	2:53 PM	1:57 AM			11.07	1,182.27
Thu 07/15	2:48 PM	12:21 AM			9.55	1,191.82
Fri 07/16	2:50 PM	1:54 AM			11.07	1,202.88
Mon 07/19	2:50 PM	12:50 AM			10.00	1,212.88
Tue 07/20	2:56 PM	1:27 AM			10.52	1,223.40
Wed 07/21	2:54 PM	12:59 AM			10.08	1,233.48
Fri 07/23	2:47 PM	1:33 AM			10.77	1,244.25
Sat 07/24	2:50 PM	11:43 PM			8.88	1,253.13
Sun 07/25	2:49 PM	11:58 PM			9.15	1,262.28
Mon 07/26	2:48 PM	12:11 AM			9.38	1,271.67
Wed 07/28	2:50 PM	1:09 AM			10.32	1,281.98
Thu 07/29	2:54 PM	1:53 AM			10.98	1,292.97
Fri 07/30	2:45 PM				8.00	1,300.97
Mon 08/02	2:45 PM				8.00	1,308.97
Tue 08/03	2:51 PM	12:42 AM			9.85	1,318.82
Wed 08/04	3:02 PM	11:48 PM			8.77	1,327.58
Fri 08/06	2:57 PM	2:18 AM			11.35	1,338.93
Sat 08/07	2:48 PM	12:10 AM			9.37	1,348.30
Sun 08/08	2:51 PM					
Mon 08/09	2:51 PM	12:55 AM			10.07	1,358.37
Thu 08/12	2:50 PM	12:31 AM			9.67	1,368.03
Fri 08/13	2:53 PM	2:57 AM			12.12	1,380.15
Mon 08/16	2:50 PM	11:50 PM			10.08	1,390.23
Tue 08/17	2:49 PM	2:02 AM			9.00	1,399.23
Wed 08/18	2:56 PM	1:12 AM			11.22	1,410.45
Fri 08/20	2:50 PM	1:21 AM			10.27	1,420.72
Sat 08/21	3:01 PM	12:26 AM			10.52	1,431.23
Sun 08/22	2:51 PM	12:20 AM			9.42	1,440.65
Mon 08/23	3:00 PM	1:17 AM			9.48	1,450.13
Wed 08/25	3:07 PM	1:10 AM			10.28	1,460.42
Thu 08/26	2:58 PM	12:21 AM			10.05	1,470.47
Fri 08/27	2:55 PM	2:24 AM			9.38	1,479.85
Mon 08/30	2:44 PM	12:02 AM			11.48	1,491.33
Tue 08/31	3:06 PM	12:40 AM			9.30	1,500.63
Wed 09/01	2:52 PM	12:45 AM			9.57	1,510.20
Fri 09/03	3:48 PM	7:34 PM	7:48 PM	12:51 AM	9.88	1,520.08
Sat 09/04	2:52 PM	11:38 PM			8.82	1,528.90
Sun 09/05	2:56 PM	11:55 PM			8.77	1,537.67
Mon 09/06	2:49 PM	7:45 PM	7:49 PM	11:48 PM	8.98	1,546.65
Wed 09/08	2:44 PM				8.92	1,555.57
Thu 09/09	2:46 PM					
Fri 09/10	2:46 PM	11:20 PM			8.57	1,564.13

Regular		Paid	1,331.12
Shift Differential	DWDE	Paid	1,071.62
Shift Differential	DWDN	Paid	93.72
Shift Differential	DWEE	Paid	217.45
Shift Differential	DWEN	Paid	25.22
Over Time	OT	Paid	90.82
Vacation	VAC	Paid	64.00
Holiday Unworked	HOL	Paid	8.00
Holiday Worked (100%)	HOL	Paid	31.92

EMPLOYEE WARNING RECORD

Employee's Name: Jacques Jillian

Clock or Payroll No:

Department: Nursing

Shift: 245p-1115p

Date Of Warning: 09/13/2010

WARNING

Date Of Violation: 09/05/2010

Time Of Violation:

NATURE OF VIOLATION

- Substandard Work
- Carelessness
- Reported Absent Without Leave
- Pattern Absenteeism
- Conduct
- Disobedience
- Unreported Absence
- Late Call - Off
- Uncooperative
- Lateness
- Time & Attendance
- Abuse of Sick Leave/ Proof of Illness
- Excessive Absenteeism
- Lunch/ Rest Break Period Abuse

COMPANY REMARKS

Jillian has called out 3 times within the last 60 days. Each occurrence was the day after an unscheduled day off therefore extending her period of time off. See attached.

EMPLOYEE'S REMARKS

The absence of any statement on the part of the EMPLOYEE indicates his/her agreement with the report as stated.

*I am not signing this write up I feel this is an unfair action
I've entered my version of the matter above.*

Employee's Signature

Date

9/14/10

ACTION TO BE TAKEN

- a. Oral Warning
- b. Written Warning *2nd*
- c. Suspension # of Days _____
- d. Discharge Date _____

Comments:

*Employee fails "we" new just
working for her to call at
continuing the date. ✓*

Approved By

Name

Title

Date

I have read this "warning" and understand it.

Employee's Signature

Date

Signature of the person who prepared the warning

Title

Date

If employee refuses to sign:

" This is to certify that the employee named in this report was warned by his supervisor in my presence concerning the subject matter contained therein."

Witness:

[Signature]

Date

9/14/10

If employee refuses to accept copy of form:

" Employee refuses to accept his copy of this warning notice."

Supervisor:

Date

R-79

Somerset

Somers002515

EMPLOYEE WARNING RECORD

Employee's Name: Jacques Jillian
 Shift: 245p-1115p

Clock or Payrol No:
 Date Of Warning: 09/13/2010

Department: Nursing

WARNING

Date Of Violation: 09/05/2010
 Time Of Violation:

NATURE OF VIOLATION

- | | | |
|---|---|--|
| <input type="checkbox"/> Substandard Work | <input type="checkbox"/> Conduct | <input type="checkbox"/> Lateness |
| <input type="checkbox"/> Carelessness | <input type="checkbox"/> Disobedience | <input type="checkbox"/> Time & Attendance |
| <input type="checkbox"/> Reported Absent Without Leave | <input type="checkbox"/> Unreported Absence | <input type="checkbox"/> Abuse of Sick Leave/ Proof of Illness |
| <input checked="" type="checkbox"/> Pattern Absenteeism | <input type="checkbox"/> Late Call - Off | <input type="checkbox"/> Excessive Absentecism |
| | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Lunch/ Rest Break Period Abuse |

COMPANY REMARKS

Jillian has called out 3 times within the last 60 days. Each occurrence was the day after an unscheduled day off therefore extending her period of time off. See attached.

EMPLOYEE'S REMARKS

The absence of any statement on the part of the EMPLOYEE indicates his/her agreement with the report as stated.

I've entered my version of the matter above.

Employee's Signature _____

Date _____

ACTION TO BE TAKEN

- a. Oral Warning _____
- b. Written Warnin v
- c. Suspension _____ # of Days _____
- d. Discharge _____ Date _____

Comments:

Approved By _____

Name

Title

Date

I have read this "warning" and understand it.

Employee's Signature _____

Date _____

Signature of the person who prepared the warning

Title

Date

If employee refuses to sign:

" This is to certify that the employee named in this report was warned by his supervisor in my presence concerning the subject matter contained therein."

Witness: _____

Date _____

If employee refuses to accept copy of form:

" Employee refuses to accept his copy of this warning notice."

Supervisor: _____

Date _____

Somerset

Somers002516

Attendance Record (Display Only)



Jacques Jillian (Licensed
Practical Nurse)

Schedule

Actual

Year:

2010



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January	⊙	□	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
February	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
March	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
April	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
May	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
June	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
July	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
August	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
September	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
October	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
November	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
December	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	

- 01/08/2010 Call Out
- 02/11/2010 Vacation
- 03/11/2010 Call Out
- 03/28/2010 Call Out
- 04/04/2010 Call Out
- 06/07/2010 Vacation
- 08/08/2010 Vacation
- 08/09/2010 Vacation
- 08/11/2010 Vacation
- 08/12/2010 Vacation
- 07/09/2010 Call Out
- 07/30/2010 Vacation
- 08/02/2010 Vacation
- 08/11/2010 Call Out
- 09/13/2010 Call Out

67 days
2 vacation

p-29

Nurses' Meeting

November 18, 2010

Agenda of topics;

1. Care Issues – Lack of supervision
 - Patients room are Messy
 - Equipments not taken out when not in use
 - Equipments not dated – g-tubes and nebulizers and o2.
 - Treatments not done but signed for
 - Medicating patients with sleeping pills late

2. Proper documentation – Continues to be a problem
 - Admission Documentation x 5 days
 - Incidents and Accidents x 3 days. Complete report
 - Neuro checks on any head injuries
 - Behavior Monitoring as it occurs
 - Vital signs daily on notes
 - Time line Documentation
 - Use medical terminology
 - Acute Discharge log
 - Always initiate treatments upon admission or new wound. Do not Wait till wound nurse starts treatment. You are responsible.
 - All dialysis notes go in the chart from now on, not in binder.
 - 24 hour book must be done daily- it is a guide
 - Admission assessments not completed

3. MARS and TARS - New MARS & TARS.
 - Double signature and double checks on all insulin and Coumadin Orders. New Coumadin and dialysis sheets.
 - No more dialysis binder.
 - New PT / INR binder
 - 24 Hour chart checks, a must on 11-7. This is the 2nd check and The order should be co-signed / initialed.
 - New Pain assessment and flow sheet not completed well
 - New Nebulizer and o2 flow sheet not completed well
 - Blanks on MARS and TARS no excuse
 - Blanks on Behavior monitoring sheets no longer tolerated
 - 11-7 to make a list of patients needing new MARS
 - Therapeutic interchange meds and med errors
 - Transcribing orders completely / IV'S

4. Early Risers for PT – It is our job not a chore
5. Faxing new admission orders to the TRG Group – 11-7

CP-5

6. Destruction of narcotics / Kitty litre
7. No narcotics outside the lock box.
8. All insulin should be labeled per patient and in individual bags.
9. Survey ready – reviewing other facility DOH survey.
10. Infection control – Garbage liners , Tray pick ups, handing over a dirty cart
11. Re – stock your cart before change over, Ice in buckets
12. Glucagon is now in the e-kit
13. Calling in consults
14. Charging labels on supplies – WE ARE LOOSING MONEY.
15. Leaving medication cups and water at bedside after med is given to pt
16. IV classes in January, any nurse not certified needs to let us know.
17. Physicians complaints and lack of trust.
18. Any Other Buisness

Kathleen Martin, RN, MSN, MPA, LNHA, CPHQ, WCC

368 White Oak Ridge Road, Short Hills, NJ 07078

973-218-6267

email: kathleenmartin1@me.com

fax: 973-912-9702

<http://www.jurispro.com/KathleenMartinRNMSNMPALNHA>

P-30

EXPERIENCE

Wound Healing Solutions, Barrington, NJ.

Advanced Practice Nurse/NP

October 2011-present.

Provide medical oversight for patients with wounds in Long Term Care facilities under contract; wound assessment, prescribe treatments, monitor progress, provide education on wound care for staff.

Hospicomm Management; Corp Headquarters; Phila., PA

Chief Clinical Executive

December 2009-September 2011.

Responsible for the clinical quality service delivery and financial operations of 6 SNF and 2 ALF facilities with 2 Adult Day Care Programs; performance improvement, survey readiness, enhancing standards of Nursing practice, ensuring continuity among facilities; Wound Care & Fall Programs; wound rounds; Responsible for clinical/nursing programs/operations.

- Reduced survey deficiencies by 30-60%
- Implemented programs for Case Mix Index, and MDS 3.0 RUG IV.
- Designed clinical programs for: Heart Failure, Post-Stroke, Wound care, Palliative Care.

Bayonne Medical Center, Bayonne, NJ.

Asst. Vice President, Quality, Case & Risk Management,

September 2008-November 2009.

Responsible for maintaining all regulatory and JCAHO standards for: Med Surg, TCU, Renal dialysis, Surgical/PACU/Recovery, Critical Care, ER; lead surveys and regulatory visits; report to board; patient safety; chair committees for performance improvement, etc; ensure financial viability through supervision of case managers; supervision and responsibility for infection control; and Administrator for 20 bed Transitional Care Unit; wound care-rounds; customer service, risk management, staff education, rehab svcs.; chart reviews for compliance, potential RM issues.

- **Joint Commission Survey-Full Accreditation** {March '09}, Chaired prep & survey.
- Core Measure scores increased by 20% {to 100%} in 95% of areas.
- Established Performance Improvement/Quality & Patient Safety Programs, and Customer Service Survey process.
- Falls reduced by 30% 2nd, 3rd Q '09.

- Staff productivity {in areas of responsibility} brought to 98-100% productivity to TCU, Rehab, Case Mgt.
- Deficiency DOH survey, TCU, '08. **5-Star Quality rating-CMS, 2009.**

Care One, Corp Headquarters; Fort Lee, NJ. {Feb '06-July '08}.

Administrator/Executive Director Campus, Care One-Livingston-SNF & ALF. July, 2007-August '08.

24/7 operations of 136 bed Sub-acute/Rehab/LTC facility {Private pay/Medicare}; oversight of 200 employees; financial {\$16M+ budget}, marketing, regulatory compliance; Quality Management Director; Oversight of Assisted Living, as Director-customers/clinical services, financial management; risk management.

- Decreased 'Caid #s from 65 to 32.
- Enhanced the 'Care, insur payor population by 30%.
- Decreased expenses/increased revenue so that EBITDARM was 15-22%/month.
- Increased private pay by 20%, 2 quarters.
- Collections brought to 98-105% by 2/08.
- Decreased workforce turnover to <3% with employee satisfaction programs.
- Increased Press-Ganey scores to 82-86%; 98% in Rehab.
- Deficiency Free Survey, '07; established Performance/Quality Initiative Programs.-**5-STAR Quality Rating-CMS.**

Administrator, Care One-Dunroven, Cresskill, NJ. February 2006-July 2007.

24/7 operations of 100 bed Sub-acute/Rehab/LTC facility {Private pay/Medicare}; oversight of 200 employees; financial {\$16M+ budget}, marketing, regulatory compliance.

- Won *Best Financial Operations Award* for '06.
- EBITDARM monthly from 15-20% prior to '06, to 28-35%/month in '06/'07, through increase in private pay census.
- Only facility in company at 110% of collections/monthly.
- One of 5 Highest Press-Ganey, Customer Satisfaction scores and Staff Satisfaction Scores in the company.
- Clinically Deficiency Free {1 Activities}, '06. {contributed to 5 STAR Quality Rating-CMS in '08 & '09.}

Hospicomm Management; Corp Headquarters; Phila., PA: {April 1999-Jan '06.}

Administrator; Plaza Regency at Park Ridge, NJ. Sept 2004-January 2006.

Responsible for the 24 hour operations of 210 bed LTC/Sub-Acute care rehabilitation facility, with over 200 employees; regulatory standards, Quality Management; financial management {\$22M budget}; quality of clinical services, marketing.

- Enhanced/increased revenue by 15%/month.
- Decreased expenses by 15-20%, '05.

- Nominated DON for Governor's Merit Award-Received.
- Orthopedic program/wing to enhance sub-acute revenue.
- Turnover to <2% annually.
- Established Performance Improvement/Quality initiative program.

Hospicomm: Corp. Executive Clinical Services Executive, NJ Facilities.
 March 2003-Sept 2004.

Direct and supervise the clinical services being delivered at each of the 8 statewide facilities for Philadelphia based LTC operations organization; Teach nurses and C.N.A.s policies and standards of care; wound rounds-policy/protocol development; regulatory standards and preparation; mock surveys; financial assistance; risk management. {asked to be Administrator at Plaza Regency}.

Greenbrook Manor,

Greenbrook, NJ.

Administrator, July 2002- February 2003.

Responsible for the 24 hour operations of 210 bed LTC/Sub-Acute care rehabilitation facility, with over 200 employees; regulatory standards, Quality Management; financial management; quality of clinical services, marketing. Participated in 1 annual survey-3 D deficiencies.

Hospicomm: Pope John Paul II Pavilion/St. Mary's Life Care Center,

S. Center St., Orange, NJ.

Administrator, Cathedral Healthcare System facility; October 2001-July 2002. Promotion.

Responsible for all clinical, regulatory, and financial aspects of operations in 187 bed: sub-acute care, ventilator unit, LTC units and Asst. Liv; 250+ employees, 1199 Union; {\$21M budget}; JCAHO & SDOH surveys; Chair person, CQI Committee; All facility departments and 3 contracted services reporting; Administrator reports to management company HospiComm,™ Phil., PA and owner, Cathedral Health Care System, Newark, NJ.

- Stabilized financially vulnerable facility.
- Collections brought to 95-110%.
- Grew sub-acute line by 20%.
- Vent unit maintained at 95-100% census.

Hospicomm: The Berkeley Heights Convalescent Center/Atlantic Health System,

Cottage St, Berkeley Heights, NJ.

Assistant Administrator, February 2001-October 2001. Promotion.

Responsible for the departments of Nursing, Medical Records, Maintenance and facility upgrade, Housekeeping, Dietary; Regulatory Affairs & Surveys, CQI, with over 125 employees, 2 contracted service departments, one Union in 130 bed bld.; Administrative responsibilities including financial, budgetary, staffing, Human Resource, Risk Management, Admissions procedures, JCAHO, and

SDOH compliance; Responsible for all aspects of nursing care 24/7; deficiency free SDOH survey; Fluent in Word, Excel, Power Point, Internet, Graphics programs.

Director of Nursing, April 1999-February 2001.

Responsible for 80 nursing and ancillary staff; staffing, budget of dept., standards compliance, policies and procedures, infection control, education, wound care/rounds, fall prevention programs, MDS-Clinical Reimbursement and Utilization Review.

2 SDOH surveys; 1 JCAHO survey; periodic direct patient care; Responsible for all nursing care 24/7. Some direct patient care; {Worked as Nursing Consultant from June-September 1999.)

- Obtained Joint Commission Accreditation in facility that never had prior.
- Pain Management program established.
- Re-aligned and stabilized staffing to decrease expenses, maintain quality.

Jersey City Medical Center, Jersey City, NJ. March 1990-February 1999.

Director of Nursing: Critical Care-3 units/Intermediate Care/Emergency Dept/Surgical Svc./Endoscopy Unit/Cardiac Cath Lab./PACU/Transport Svc.;
Position Titled '95: VP Crit Care/ER Services

Responsible for management of division consisting of 250+ nursing and ancillary personnel, 140 beds, 3 out-patient depts, \$28M+ budget; assist in development of dept. capital budget; develop policies and maintain standards within JCAHO and SDOH; 3 JCAHO surveys; 2 ACS (American College of Surgeons) reviews for **Trauma designation**; focus on finance and reimbursement issues in Endoscopy and ER; wrote and obtained \$200K NIRA grant dealing with work-redesign; implemented CQI and TQM programs in division; participated in mgt team in 1199-UNO contracts in 1992 and 1994; partic in Pt. Focused Care, Inc. -(work re-design) co. implementation; Chair of Pain Management Cmtee; member of Ethics cmtee, IRB cmtee; retain Joint faculty position, Rutgers University, Newark; St. Francis School of Nursing, Jersey City; Some direct patient care.
(Promoted from Asst. Director of Nursing, 1991.

Charter Behavior Health Care, Inc.,

Prospect St., Summit, NJ.

Supervisor/Staff Nurse, Per Diem, April 1994-May 1996.

Psychiatric & medical-nursing services; administration of medications, treatments, counseling with a variety of age groups. Direct patient care.

Franciscan Healthcare, Inc.

Hoboken, NJ.

Staff Nurse, ER, Per Diem, June 1994-February 1997.

Hoffman-LaRoche, Inc,

Kingsland Ave, Nutley, NJ.

Clinical Research Associate, Anesthesiology group, January 1989-March 1990.

Responsible for designing and implementing drug study protocols; monitoring studies; communicating with investigators; data collection in the field; analysis; and writing final study reports. Assisted in NDA (new drug application) to FDA for Flumazenil (Mazicon) and expanded indications for Midazolam (VERSED) as part of a team.

University Hospital-UMDNJ,

Bergen St., Newark, NJ.

Clinical Nurse Specialist (CNS), Critical Care, July 1986-December 1988.
Medical ICU, Surgical-Trauma ICU, Neuro ICU, PACU, Step-down unit.
Responsible for providing monthly critical care courses (105 hrs); Resource and consultant to staff; assisted in patient care as needed; marketed CC program to other facilities and generated income for dept (\$8,000/yr); developed and coordinated Nursing Preceptor program, performed staff work; Mock Code; CCRN Review in conjunction with Rutgers University; self-studies: ABG, ARDS, Shock & Trauma; formulated policies/procedures for division with Director and VP; Chairperson of 14 member CNS Cmtee; Appt Joint Faculty position at Rutgers University, College of Nursing, Newark.

Seton Hall University,

South Orange, NJ.

Adjunct Faculty, September 1983-June 1984. Clinical sites with students.

Muhlenberg Hospital School of Nursing,

Plainfield, NJ.

Adjunct Faculty, Evening Program, Critical Care, September 1983- June 1984.

Irvington General Hospital,

Chancellor Ave., NJ.

Nurse Manager, Critical Care Unit, March 1982-Sept 1983.

Responsible for 30 staff in 13 bed unit; 24 hour staffing, education, QA, survey, JCAHO; Operational and capital budget.

Veteran's Administration Medical Center,

Tremont Ave., East Orange, NJ.

Staff Nurse, SICU/Open Heart-Cardiac Surgery, January 1980-March 1982.

Staff Nurse, Oncology, February 1979-January 1980.

Hackensack Medical Center,

Prospect St., Hackensack, NJ.

Staff Nurse, Surgical-Burn Unit, 1977-1980.

EDUCATION

Seton Hall University, South Orange, NJ.

MSN-December 1982.
MPA-June 1996.

Pace University, Pleasantville, NY.
BSN-December 1979.

Bergen Community College, Paramus, NJ.
AAS-June 1977 (Nursing).

PROFESSIONAL ACTIVITIES/AWARDS

- Wound Care Certified, National Alliance of Wound Care, July 2011.
- **Quality Examiner, AHCA;** Review with nationwide team, Gold Applications for Quality Award, 2/10-present.
- **Malcolm Baldrige National Quality Award Board of Examiners, 5/09-present.**
- Certified by Health Care Quality Board as CPHQ: Cert Professional in Health Care Quality, Nov. 2007.
- Licensed by State of NJ as Long Term Care Administrator, 2001.
- Won **merit award**, Department of Health and Senior Services for Nursing Excellence; nominated by SR. VP of Pt. Care Services, Jersey City Medical Center, 1996.
- Won **merit award**, 1992, for hospital innovation: Restructuring of Nursing Services, THE AMERICAN COLLEGE OF PHYSICIAN EXECUTIVES.
- CCRN Certified for 12 years.
- ACLS certified, 1982, 1986, 1989, 1993, 1998.
- Listed in Who's Who in American Nursing, 1989, 1990, 1992.
- Inducted into Pi Alpha Alpha, National Honor Society for Public Affairs and Administration, 1993, Seton Hall University.
- Inducted into Sigma Theta Tau, National Nursing Honor Society, June 1982.

PUBLICATIONS

- Article published in **Provider** {national LTC publication}, "Taking Flight With Patient Safety," September 2010.
- **Book Published, 2004, by HCPro, Mass., : "60 Essential Forms for LTC Documentation."** Compendium of various forms and methods for easy documentation for staff management and administration and survey compliance.
- Article published, **Advance for Nurses**, June 2004: "Survey Prep for Long Term Care."
- "Preparing for Electronic Documentation System, Co-Author, **Nursing Management**, July 1996.
- Chapter in **Text of Legal Nurse Consulting**, by AALNC, 1998, 2001, "Setting Up The Business." Co-author.
- "Holistic Approaches in Psychophysiologic Pain Syndromes", May, 1996, **Journal of Complimentary & Alternative Therapies.**

- "A Bereavement Program for Critical Care", **Crisis, Illness, and Loss**, (Quarterly Journal), June 1995.
- "Oxygen Consumption in Septic Shock," **International Journal of Intensive Care**, December, 1991.
- "Septic Shock," in **Case Studies in Critical Care**, book, Williams and Wilkins pub., Barbara Mims, 1990.
- "Reducing Complications of Thoracic Trauma Due to Gunshot Wounds," **Dimensions of Critical Care**, November, 1989.
- "Budgetary Control for the Nurse Manager," **Nursing Management**, October, 1989.
- "Case Studies in Hemodynamic Monitoring", **Critical Care Nurse**, March 1987.

LECTURES/SPEAKING

- HCANJ-Health Care Assn of NJ, to speak full day on "Patient Safety" 9/11.
- HCANJ-Health Care Assn of NJ, "Nursing Documentation for Success," October 2010, March 2011, Atlantic City, NJ.
- Nursing Documentation Best Practices, National ACHEA Convention, Philadelphia, PA, June, 2010.
- Financial Controls for Clinical Areas/DONs, 2002, 2003, 2004.
- "DON Boot Camp," 2 day program marketed to NJ DONs, 2004, 2010.
- CQI: Pain Management Program Initiation, Northern NJ Ethics Alliance, February, 2001.
- Management, CQI, & Survey Topics, The Berkeley Heights Nursing Center, 2000-2001; St. Mary's Life Care Ctr, 2002.
- ER Course/Trauma/Neuro; ER Course, JCMC, 1994, '95, '96.
- Performance Improvement: How to For Mgt, 2001, 2002, 2003
- FMEA: Failure Mode Effect Analysis, 2002.

MEMBERSHIPS

- AHAP-Association for Healthcare Accreditation Professionals
- NAHQ-National Association for Healthcare Quality
- American Medical Directors Association
- American Society for Healthcare Risk Management
- American College of Healthcare Administrators
- Association of Infection Control Professionals
- American Association of Wound Care Professionals

Kathleen Martin RN, MSN, MPA, LNHA, CPHQ, WCC
368 White Oak Ridge Rd.
Short Hills, NJ 07078
973-218-6267 email: KathleenMartin1@me.com Fax-973-912-9702

10/15/11

Saulo Santiago, Esq.
Michael Silverstein, Esq.
Counsel for the Petitioner
National Labor Relations Board, Region 22
20 Washington Place, 5th fl
Newark, NJ 07102

RE: J. Michael Lightner, Regional Director of Region 22 of the National Labor Relations Board for and on behalf of the National Labor Relations Board.
V. 1621 Rout 22 West Operating Company LLC, d/b/a Somerset Valley Rehabilitation and Nursing Center, Civil Action No 3:11-ev-02007-MLC-LHG

Dear Mr. Silverstein and Mr. Santiago;

As requested, I am providing this report as per the above referenced action. It is my professional opinion that the Somerset Valley Rehabilitation and Nursing Center ("Center," "facility") did not have proper and reasonable justification for terminating nurses Shannon Napolitano, Sheena Claudio, and Jillian Jacques for allegations regarding their failure to provide appropriate patient care and for time and attendance violations. It is my contention that these nurses, while admitting to some of the specific allegations. The evidence shows that they are not a hazard or unsafe for patient care. Had proper staff education and guidance, along with communication provided by administration and the corporate entity, been provided, the staff would not have made the errors cited in this case testimony.

Most of the infractions by these three nurses, via discipline, and termination, are rooted in documentation issues and no actual harm. The other issue that is alleged is lateness and absenteeism. Enough testimony which shows that some staff were disciplined and others were not, calls into question management's intent.

In addition, the lack of sophistication to understand "systems" and "culture" by administration was a cause for their own frustration as well as not fixing the problems going forward in light of an impending re-survey by the DHSS.

In this report, "administration" refers to the single individual who runs the facility day to day, as well as the corporate leadership.

36 EXHIBIT ID
KM-1
11/17/11

I possess over 25 years nursing experience in variety of areas and roles:
Nursing/Hospital: Administration/LTC/Sub-Acute Care; clinical & operational administration with specific oversight and active role in wound care, fall prevention and management, various aspects of patient safety. I am also licensed as an Advanced Practice Nurse aside from the license as an RN.

I have held positions in Long Term, Sub-Acute Care, Ventilator Unit as Director of Nursing and as a Licensed Administrator, as well as other health care titles. I possess extensive experience in both CMS, DHSS, Joint Commission survey process and preparation from the provider perspective.

In addition, I am Certified by Health Care Quality Board: CPHQ (Cert Prof in Health Care Quality) and am also Certified in Risk Management. My experience also encompasses extensive JCAHO and State Department of Health surveys/audits. I have published over 10 articles; book chapters, and a book, "60 Forms for LTC" with a most recent article, "Taking Flight With Patient Safety," Provider, 9/10. I have also lectured on Patient Safety for Organizations, as well as clinical nursing topics for over 20 years and continue to do so.

As a member of the Board of Examiners for *Baldrige National Quality Program*, Dept. of Commerce, Washington, DC, as well as the *American Health Care Association (AHCA) Gold Award Examiner*, I have reviewed excellent organizations nationwide for top awards and national recognition.

I undertake legal reviews upon request by Attorneys nationwide on a less than part-time basis.

Materials Reviewed:

- 1) Petitioner {Labor Board's} supplemental memo of points and authorities
- 2) Administrative Law Judge Hearing transcript for witnesses:
 - a) Sheena Claudio, LPN
 - b) Shannon Napolitano, LPN
 - c) Jillian Jacques, LPN
 - d) Jacquie Southgate, LPN
- 3) Administrative Law Judge Hearing transcript for the {Respondent} witnesses:
 - a) Inez Konjoh, DN
 - b) Doreen Illis, Administrator, Care One
- 4) General Counsel ALJ Hearing Exhibits through trial testimony of Jacquie Southgate
- 5) Employer Expert witness reports:
 - a) William Isele
 - b) Beth Bell, RN
- 6) NJ DHSS Recertification Survey, 12/10/09
- 7) NJ DHSS Recertification Survey, 1/7/11
- 8) Declaration of Inez Konjoh, 5/6/11
- 9) Declaration of Doreen Illis, 5/6/11

- 10) Deposition Sheena Claudio 5/3/11
- 11) Deposition Jacquie Southgate, 5/27/11
- 12) Deposition Jillian Jacques, 5/23/11
- 13) Deposition Shannon Napolitano, 5/1/11
- 14) Charging party's exhibits CP-1 thru CP 11
- 15) Several Employee Educ Attendance Records, and Disciplinary Action forms

1. Sheena Claudio, LPN- terminated by Illis/Konjoh-10/21/10.

Sheena was terminated for failing to provide proper patient care in several instances, in addition to time and attendance issues.

1. In September 2010, Sheena admits that she administered a medication daily for a patient that was supposed to have the med every other day. On p. 138+, Hearing Testimony, discipline was given on 9/17/10 for not following orders. She gave the med daily and not every other day, as ordered. When the order is transcribed, by another person usually, the days are to be blocked out so that it isn't given daily, and only given in the set blocks. This is routine accepted protocol in manual transcription situations as this in the industry. What happened to this system step? When Sheena asked the DN about the 24 hour chart check as the backup that is set in the facility, and the blocking out, she was told, yes they both failed. In addition it was stated in several affidavits and hearing testimony that other nurses, such as Doreen Dande, LPN also had this happen to them causing them to make a similar error. Written warnings and not "final warnings" were given to Dande, R-93, R-98, R-83, p. 2611, Konjoh.

When asked if giving a final warning for the administration of aspirin for a patient is excessive, Ms. Konjoh stated in her testimony, p. 2610, "yes."

I conclude that there is a system problem in the facility related to medication administration that goes beyond this Nurse and the Nurses named in this case. In addition it is my opinion that the cited error/omissions in the delivery of nursing services were insufficient grounds for Ms. Claudio's termination. Her reinstatement would not place patients in any jeopardy or harm, nor be against the public interest.

2. Failure to complete medical documentation on 3 patients, 9/27/10; failed to document on a new admission; failure to document physician's orders related to a skin tear, and failure to complete an incident report.

On p. 150, Hearing Testimony, Sheena contends that her nursing note for the specific admission was done by her but was now missing. She put it in chart, but now was not there.

Based upon my experience in the industry, the nurse would be permitted to re-write her note and place it in the record. It is understood that anything could happen as there are numerous people who have access to the charts at any time of the day. Not allowing her to do that, or giving her the benefit of the doubt, was not productive. It also places the

facility at risk as in the future there could be a law suit or legal risk, and testimony at that time will reveal that parties were aware of a missing note and did nothing to remedy for chart completion.

She also explains in her Hearing Testimony, p. 268 that she and other nurses routinely implement a minor treatment {for skin tear for example} without order, then get an order later. Yes, in the strict sense, all treatments are to be done as a result of a physician's order. A prudent and reasonable nurse would address the immediate problem such as a skin tear for a patient. This is a minor treatment application with something like a band-aid. Routinely done in the industry, the order is obtained later for the treatment applied. This is done in most facilities and is another example of an aspect of this facility's and LTC's general organizational culture.

Sheena stated that she was called into the DN's office regarding her pain management documentation on the same day Shannon was fired, p. 131 Hearing Testimony. It is agreed that this documentation is important and is to be completed per policy and protocol. However, it is not uncommon in the industry for nurses to miss some areas in manual systems. On p. 146, Sheena states that other shifts did not sign for pain assessment on a consistent basis. So again, this is a system problem for this facility requiring examination of the documentation process, formats, policy, and barriers to completion. The Administration did not examine the systems in this area but terminated this nurse for this infraction.

On p. 278 of the Hearing Testimony, Sheena stated that she was not told of a part that is listed on warning—not told of paragraph or # 4. She responded to 2 items but not 3 or 4. This was not discussed with her. It is accepted practice in the health care administration industry to meet with the employee to discuss a disciplinary action/warning in full, providing them with the complete list of items for correction.

I also conclude that the cited error/omissions in the delivery of nursing services were insufficient grounds for Ms. Claudio's termination. Her reinstatement would not place patients in jeopardy or harm nor be against the public interest.

3. On p.167, of the Hearing Testimony, it is stated that on 10/7/10, Sheena had forgotten to sign the treatment {TAR} book. After leaving the facility at the end of her shift to go to another job or obligation, she returned at approximately 10:30 pm or so to finish signing the TAR book but was intercepted by Ms. Illis who told her to stop documenting and to leave the facility. Sheena continued to write what she could before this escalated. When asked why she could not finish her own documentation, Illis said that this is forgery, p. 170. Sheena argued how can it be forgery when she was signing her own work in the treatment record, and admitted not finishing the chart entry. She left the facility as instructed. This alleged statement by Illis is absolutely not true. It is not "forgery." This is the same nurse completing her own document. It is my experience that, although not ideal, this practice of filling in or completing the MAR/TAR signatures is done on a regular basis and at the management's encouragement. In the industry, management requests that staff fill in the blanks in the MAR and TAR on a regular

basis. Although not the ideal, it is routine in the industry that this is done days later in most cases, and sometimes even more time elapses. So why was this such an issue for Sheena at this time? At least she returned to finish her work which is usually admirable.

Ms. Southgate corroborates above the testimony in regards to the charting of TARs and MARs. In an ideal world, MARs and TARs are to be signed for contemporaneously with rendering the prescribed service, as previously stated. While a delay or absent signature is not supposed to occur, this is a known common practice in the industry with manual systems. There are circumstances at times, when direct patient care is a priority over manual documentation. The inherent problems are recognized by this expert. It is also recognized that the systems of the facility are imposed by the Administration and company which become multiple barriers for the staff to accomplish this task, as well as other tasks.

Jillian recalls an incident regarding Sheena Claudio (corroborates): p. 587+: Saw her at nurses's station at night trying to sign her TARs book. She was interrupted by Doreen who asked her to step away and led her away. (This corroborates Sheena's story.) Sheena was not able to complete her charting.

Southgate corroborates that it was a common practice at Somerset Center to chart for these areas the next day if unable to do right away. No discipline was given for non-compliance. They were told to get it done, and they did. Now during this period {union petition, vote} disciplines were given, p. 965-966, Hearing Testimony. She also corroborates prior testimony in that some staff did not receive disciplinary actions for the same infractions that some disciplines were given, p. 970, 984 Hearing Testimony, Confidential Witness Affidavit, April 2011. She states that Dande, and Mohamed are nurses she can recall who did not receive a discipline form who made similar errors on the MAR, as well as for completing an incident report wrong. She further recalls other errors that Mohamed made {IV missed dose}, with no disciplinary action, p. 971, Hearing Testimony.

This issue of Sheena going back later to sign her chart areas is certainly not harmful to the public, nor places any patients in harm's way. This nurse should not be denied reinstatement.

4. Time and attendance issues are also an issue in this instance. Sheena called out over a pattern over 3 months, with a call out the day prior or after a day off. She was told by the DN that the Employee Handbook states that this is a violation. The following pertains to the additional testimony points by Sheena Claudio in the Hearing Testimony:

1. p. 113. No discipline for lateness from previous DN, p. 114, nor from prior managers: Kovac, Meyers, Castro, Nair, Southgate.
2. P. 121. Inez gave the time and attendance discipline mainly relating to the call out on the day prior to day-off stating, "It's in handbook." Sheena states that she never heard of that before. P. 126, Hearing Testimony, there was nothing in

handbook regarding above as management told her {without actually showing her the handbook.}

3. It is noted that Beatrice Beauvoir called out 4 times in 60 days and received a verbal warning, yet ms. Claudio called out sick 3 times in 90 days and received a written warning, {Konjob, p. 2400}.

In summary, Sheena Claudio should not have been terminated. Her termination was arbitrary, baseless, punitive, and did not follow the prescribed protocol in a step-wise fashion for disciplinary actions, not to mention the provision of guidance, and staff development to preserve the individual as a human resource. It is my opinion that the cited error/omissions in the delivery of nursing services were insufficient grounds for Ms. Claudio's termination. Her reinstatement would not place patients in any jeopardy or harm, nor be against the public interest.

2. Shannon Napolitano, LPN Terminated on 9/17/10.

The reason provided by the Respondent for Shannon's termination was for failing to provide appropriate care in 3 areas, and declines the reinstatement of this nurse as it would place, in their view, patients in jeopardy and would be against the public interest:

1. She administered medication to a resident without a physician's order at least 4 times. The key aspect of this concerned an incident on 9/16/10 when she gave a zinc oxide capsule to a patient for whom this medication had been discontinued on 8/23/10.
2. She left this medication at the bedside for the resident which is against policy.
3. This nurse did additionally admit that she incorrectly wrote in the record a "0" to depict the pulse oximetry/oxygenation level for a resident.
4. Prior to this, she had been issued a warning for performing pain assessments at the beginning of the shift as opposed to the end.
5. Lastly, she was disciplined on 9/13/10 for being late 93 times between January and September 2010.

It is the opinion of this expert that Nurse Shannon Napolitano, LPN be reinstated to her position. The errors are not denied, however I contend that these errors were not of a serious nature, were amendable in that they could be averted in the future with proper guidance and a chance for re-evaluation. In addition, it is my opinion that the cited error/omissions in the delivery of nursing services were insufficient grounds for Ms. Napolitano's termination. Her reinstatement would not place patients in any jeopardy or harm, nor be against the public interest. In the industry, re-education with follow-up evaluation would be done, along with investigation of system breakdowns.

The following areas demonstrate questionable evaluation and conclusion by the respondent, and are numbered to correspond to the above infractions:

1. The above corresponding issue of termination had to do with the zinc medication. P. 359+ , 363. It appears that the zinc was given on dates that it was not to be administered on several occasions 8/24, 25, and other August date, and 9/17 (day of discipline). This medication was not to be given and had been discontinued some weeks prior. Shannon contends that she administered the medication and saw the patient take the medication to her mouth, p. 89 Deposition. The DN alerted the patient (in secret) that if that nurse gives it to you (the patient), "get me." Ms. Konjoh, DN knew the day before of this issue, but did not inform the nurse in question. P. 364. So, as the DN predicted, this zinc administration did occur. As instructed, the patient notified Ms. Konjoh, DN.

Ms. Konjoh, DN in her testimony (p. 2568) states that after she discovered the zinc pill was still being given after it was to be discontinued, she did not speak to Napolitano about it. She also denies that she knew about the pill stating, "I didn't know there was a pill." This statement makes no sense. She admits telling the patient not to take the pill if she gets it. On top of that, the DN admits disciplining this nurse for not ensuring that the zinc pill was in fact swallowed by the patient even though she knew it was not to be given, p 2570. The DN claims in her testimony (p. 2567) that she did not see the medication on the MAR so didn't think the nurse would give it. Why not check the actual pill box in the cart and remove the medication totally to ensure that no one would give it. In the industry, the practice is that the nurse who takes the order off or transcribes the order, ensures that the medication is taken out of the med cart and placed in the bin for discard or return to the Pharmacy. This DN set up this nurse to make a mistake, and also put the patient at risk, not to mention, share with the patient the negative issues occurring in the facility. It is clear that the DN ensured that Shannon would in fact give the pill and then be able to give her a discipline.

Ms. Southgate, Unit Manager, corroborates this in her Hearing Testimony, p. 964. With detail, she states that Inez "told me that she had told this resident if she received the medication the next day to let her know. Not to swallow it, but to let her know so she could see it."

As planned, the DN presented the pill to Shannon in the termination meeting (9/17). This is outrageous behavior by a manager/DN: to co-opt a patient who is a customer allowing them to know that you have problems with your nursing staff, enlisting their help, instead of alerting the nurse as soon as she suspected that there might be a potential error that might occur. The DN, Ms. Konjoh also had a conversation with the Unit Clerk on this very issue the day prior to her dealing with Shannon. It was demonstrated in the record that Ms. Konjoh knew or suspected that Shannon would again give this zinc to the patient, enlisted the assistance from the patient to without question, establish an error on Shannon's part (Konjoh, p. 2393-2395+). This was not only unsafe, but a deviation in the standard of care for the patient. Needless to say, in the industry, such behavior is not expected particularly in the administration of medications. The accepted practice in the

industry as stated, was for the DN, once she knew the med was not to be given, to take the pill box out of the med cart immediately, then to speak to the staff involved.

An additional question that has not been addressed in any testimony is if the zinc was in fact discontinued, then how was it still in the cart {with the patient's name on it}? Someone in the system is to take the meds out when an order to discontinue is entered, to prevent this very problem. Most importantly, the DN should have immediately removed the medication from the cart so no one could make the predicted mistake again. Ms. Konjoh agrees that the medication should have been removed from the cart {Konjoh, p. 2397}, yet she did not remove it herself. Ms. Napolitano was set up by her DN to be entrapped to make an error.

There is commentary in testimony, Ms. Bell's expert report, and in Konjoh's Declaration on the "negative" effects of this zinc for this patient, yet there is no Pharmacist who has commented. Basic research on this medication shows that Zinc Sulfate {pink pill}, is a mineral, primarily focused on dietary supplementation for the promotion of health and disease prevention. Aside from dietary zinc supplementation, zinc has been studied for therapeutic use in the common cold and wound healing. This patient was receiving zinc prior for wound healing. Typical daily doses range widely from 12 to 150 mg daily as free zinc or up to 220 mg as zinc sulfate. It would appear that receiving a few extra doses once daily for 4-5 days, would not harm the patient.

It is recognized that, yes, medication orders are to be transcribed, and followed as ordered for patients for efficacy and safety. However, there were several variables at play here which show that not just one person made an error in this situation. There are several actions in this system of med transcription, and checking that did not work. The night nurses who perform the 24 hour check, an accepted industry system put in place to catch such expected errors, also fell short in this situation.

Ms. Lezauba and Ms. Chambers also administered the zinc to this patient during this same period {Konjoh, p. 2380}. Neither nurse was issued a discipline for this error. Although she was suspicious, Konjoh states that the 3 nurses who gave the zinc also {Chambers, Lezauba, and Claudio} denied it and had crossed out parts of the MAR. Napolitano admitted giving the zinc so she received the discipline, Konjoh, p. 2382.

Blanks in general areas in the MARs were revealed in testimony {Konjoh, 2385}. This points to the fact that there is an existing problem with MAR documentation in general by all or the majority of staff. Ms. Konjoh states that she only audited the MARs for the zinc, as a patient complained, p. 2387. This does not make sense. If one is auditing and sees other blanks and problems, would that not be dealt with?

The administration of this zinc tablet, which had been discontinued, did not pose any threat or jeopardy and did not negatively impact the patient.

2. It is accepted and acknowledged that Shannon did in fact leave the medication at the bedside for this patient, who was alert, and aware. This had been a past behavior that was

now routine and a habit in many instances at Somerset Center previous to this new change in administration. Allowing the staff to learn and adopt new routines in place of the old, was not provided.

It is my opinion that the cited error/omissions in the delivery of nursing services were insufficient grounds for Ms. Napolitano's termination. Her reinstatement would not place patients in any jeopardy or harm, nor be against the public interest.

3. Shannon was confronted with writing the "0" for pulse oximetry measurement. This is obviously incorrect. She said she would have realized this when, at the end of shift note review, she would have picked this up. There was no harm to the patient. This was a manual, clerical type error which can occur when handwriting out multiple notes on perhaps 20+ patients in a shift. Shannon was disciplined for this as well on 9/17/10. This clerical mistake does not jeopardize patient safety nor would her reinstatement be against the public interest.

4. A disciplinary warning regarding pain assessment was given to Shannon in January 2010 for doing them at the beginning of the shift. Testimony states that the DN asked several nurses in a meeting how they perform this assessment. They replied, according to Shannon, that the State told them last year to do the assessments at beginning of shift. After this meeting, she was called back in and terminated.

It appears that the severity of the discipline and the very discipline in itself, was dictated by the severity score of the G level deficiency. It is understandable that Administrators and management staff become and react emotionally to such occurrences. Contrary to their actions, errors and mistakes, do not improve when handled in a punitive manner. Perhaps others should be held accountable for the lack of follow-up, education, and reminders for staff. This was the first time this had been addressed at all, and the severity it elicited is directly related to the G deficiency, and I consider it punishment to the nurse. Again, the harm was minimal to the patient, and is mainly a documentation issue. Not to minimize the purpose of the DOH survey, it is known that at times there is a subjective aspect to the survey. The similar circumstance by another surveyor would not necessarily give the same deficiency. It can be missed entirely.

5. On 9/13/10, Ms. Konjoh, DN gave a disciplinary action for lateness for 93 times, {P. 353, Hearing Testimony}. Shannon contends that this was about a week after the election, when she was given a warning for lateness. She had an explanation, which was due to a traffic accident on the road which delayed her over an hour. She had not been given warnings for this prior to this election, Confidential Witness Affidavit, September 2010. Shannon strongly asserts that she was not informed prior of this issue by any manager and was not informed that she could respond on the actual warning form. She thought she had to sign it so she did. As she states in her deposition, there was no stated permission to be late every day. The permission is implied in that management had never addressed this. From my experience, this is common and is an organizational culture issue. There is a tendency in LTC to make concessions for individuals in an attempt to be flexible with generally reliable and necessary employees. When management abruptly

changed and enforced rules during, for instance, in a union petition campaign and drive, this can result in the situation at hand: allegations of unfairness, disparate treatment and just ineffective management.

Again, this is an organizational culture issue. When routines and habits are permitted over time, it takes time to alter such behaviors not to mention alter some of the facility protocols and habits that might ultimately benefit the facility and staff. Shannon was not alerted to her lateness nor provided with the proper time for correction and evaluation for improvement.

The following are additional issues which also substantiate that Shannon Napolitano's reinstatement would not be against the public's interest or jeopardize patient care:

1. In referring to #30 exhibit, warning, Shannon said that she was never given this, P. 346, Hearing Testimony.
2. Shannon's Hearing Testimony is extensive in establishing that there was never any discipline via past managers for lateness: from Southgate and prior: Janet Meyers, Castro, Margalie (replaced Southgate), Gerlin--never received the disciplinary action from any of them regarding "lateness."
3. On 9/17, Shannon was fired, P. 355, Hearing Testimony. She was asked for her MAR to be reviewed. Southgate had to bring it to DN office. It is protocol, and considered ideal, in the industry to fill in MARs and to sign at the time of service. However, situations at times prevent this from occurring in a timely manner, with later documentation being done by the nurse. Shannon contends that the staff were routinely told by management to fill in the MARs for survey prep at Somerset Center. This implies that they are told at a much later time to fill in the documentation areas for compliance before a surveyor observes. This is a common occurrence in the long term care industry, as well as at Somerset Center, when using manual systems. Southgate (the Unit Manager) additionally corroborates this in her Hearing Testimony. It is stated here that staff were told that if they failed to sign the MAR/TAR, there was a \$1,000 fine. This is a false statement. There is no fine for not signing the MAR or TAR, p. 371, Hearing Testimony. She also adds that other staff that she knows commits errors/mistakes such as with medication, but "they aren't disciplined," Confidential Witness Affidavit, September 2010.

In summary, Shannon Napolitano's reinstatement is not against the public interest nor poses any jeopardy or harm to patients. Her termination was arbitrary, baseless, punitive, and did not follow the prescribed protocol in a step-wise fashion for disciplinary actions, not to mention the provision of guidance, and staff development to preserve the individual as a human resource. Most specifically, Ms. Napolitano was punished through termination for the alleged pain assessment citation of a G level by the DHHS. Shannon did have an explanation for her actions, which was that the DOH had previously told the

staff that pain assessments should be done at the beginning of the shift. I conclude that it was because of the G level sanction given to the facility by the DOH for pain assessment, that Shannon received punitive action.

3. Jillian Jacques, LPN-Terminated 2/10/11.

Jillian was terminated due to failure to provide appropriate patient care. It is noted that in her 3/09 evaluation which is some time prior to any of these allegations, that she was advised to be more careful with documenting specifically with new admissions and incident reports. She had been employed by the facility for some 11 years. It is my opinion that the cited error/omissions in the delivery of nursing services were insufficient grounds for Ms. Jacques's termination. Her reinstatement would not place patients in any jeopardy or harm, nor be against the public interest.

1. On 2/7/11 she failed to correctly transcribe a medication order for enteric coated aspirin to the MAR. She accidentally omitted transcribing the "enteric" part, and just put "ASA" (aspirin). Jillian contends that she did in fact make this error, p. 574, Hearing Testimony. She explained that she had 5 admissions, family members asking for things and information, and the fax machine was not working (unable to process order properly-causing much delay), and just very busy on the 7th. Jillian was approached by Jackie (Ingram) covering as DN, as Konjoh was no longer at this facility for whatever reason. (Jillian states that Konjoh was terminated as DN.) She attempted to explain the shift activity and fax machine problems with her to no avail. She was terminated on the 10th.

As stated previously, in the industry, there is to be a fail-safe system in place to mitigate this type of predictable error: the 24 hour chart check which is done on each and every night shift. This failed. When told of this, the DN said, something to the effect that, yes, both systems failed. The fact that there is a 24 hour check in place, implies that we do expect humans to transcribe from one paper to another under trying circumstances implies that we expect errors and that a system is put in place to catch the potential error. How is it that this system was not looked at, but that the most vulnerable person is punished?

There is an inconsistency in this facility as to what issue results in a discipline. For instance, a critical med error regarding coumadin was reported to Konjoh regarding a nurse, Mohamed, who was personally brought in to the facility (p. 474) from Holmdel by Ms. Illis. Mr. Mohamed ensured that his colleagues knew that he had a relationship with Illis, as he would call Illis many times from the nurses' station. He told Jillian "Let me ask Doreen first" (to let her know that he was close to Administrator). P. 475, Hearing Testimony, Jillian contends that she reported errors with coumadin before (Dec, '10)-missed for 3 days. The physician had to then be called. The Nurse involved who did this was Mohamed, p. 473, Hearing Testimony. This undisciplined error and others are also noted in her Confidential Witness Affidavit, January 2011.

Jillian told Inez first about the coumadin error made by nurse Mohamed, she replied, "it's taken care of," P. 631, Hearing Testimony. She is not sure if he was disciplined and did not hear about it {but would have usually}.

Mohamed made a 2nd error with B-12 where he gave an injection in tube instead of pill form. He spoke of this error after it occurred and realized his error, with this nurse. Jillian feels that this error did not elicit a discipline, although she cannot state as a fact that it did.

Jillian adds that Doreen Dande, LPN made a med error, also a missed coumadin dose. She is also not sure if a disciplinary action was given, p. 483, Hearing Testimony. Also Mohamed told her that Michael made several critical med errors, P. 485, Hearing Testimony, and Confidential Witness Affidavit, January 2011. She contends that nothing happened to either Mohamed or Michael as a result.

It is interesting that Jillian said that another nurse told her {Sharon Smith} that the "same thing" happened to her last week, which was the failure to transcribe an order correctly. Inez told her "just put it in." Jillian learned of this after she was terminated, P. 583, Hearing Testimony.

Konjoh agrees that giving a final warning to the nurse for giving the aspirin is excessive, p. 2610. I also believe it is excessive.

It is my opinion that this error/omission in the transcription of an aspirin order is insufficient grounds for Ms. Jacque's termination. Her reinstatement would not place patients in any jeopardy or harm, nor be against the public interest.

2. On 12/2/09 Jillian failed to assess pain for a newly admitted resident with a cancer diagnosis. This resulted in a deficiency for the facility per the DHSS survey report, 2009.

Jillian received a warning by Inez Konjoh, DN for documenting for patient RG, part of which was inaccurate as Jillian did not work one of the days cited on the warning {the 25th.-p. 558}. On P. 643, Hearing Testimony, Konjoh said she'd take one of the days off of the warning form, but didn't. Jillian said that Inez took it off of her list in her presence, but did not take that date off of the warning form.

Jillian is aware of the G level deficiency for the pain assessment issue, P. 593.-597. She was written up with a "final" warning for this 12/2/09. She didn't have the patient, but admitted the patient. When admitted, she was not in pain. Jillian did not respond on the warning sheet as she was upset as per her own testimony. But she indicated that she agreed with the warning.

This pain assessment issue occurred on 11/4/09, yet no write up until 12/2/09. P. 674, Hearing Testimony. Management waited a month after to write up. I must ask why the delay?

The cited error/omissions in the delivery of nursing services were insufficient grounds for Ms. Jacque's termination. Her reinstatement would not place patients in any jeopardy or harm, nor be against the public interest.

3. On 9/20/10 she failed to document on a resident who had fallen earlier in the week as part of the post-fall assessment. On 12/5/10 she failed to document an incident report. (Ms. Jacques did not receive a warning for the incident of 10/25. She received a warning for the incident report attached to R-88, dated 11/1/10, 2612, Konjoh.)

Jillian was written up of for not completing an incident report. Her explanation to the DN was that she was waiting for an aide to complete and explained this to Southgate, UM p. 568. She left a message on phone to Inez as well. P. 571. Ms. Konjoh, p. 2231, corroborates this voice mail left by Jacques. Jillian was trying to explain to the DN her barriers to getting the incident report done. In nearly 100% of the industry, this is acceptable. Incidents can be completed several days after the incident, and this is what usually occurs in facilities. This is not a terminable offense. It is common in LTC that to complete the report completely, several statements by other related staff had to be included. Tracking them down to obtain their statements can take time.

4. Jillian was given a warning action on 9/13/10 by Doreen and Inez for lateness 109 times. During that period, no one told her of the lateness as an issue, with an attached second warning on 9/13/10 for calling out 3 times in 60 days period after a scheduled day off, P. 527 Hearing Testimony. She was offered a different shift, but she was unable to change at that time due to family issues. It is written as "refused" on warning. Jillian refused to sign the warning. There was a second warning attached to the first one: one was for the 119 late days, the second was for the 3 call-outs in 90 day period. Jillian had explained that she had an arrangement and understanding with the previous DN as she had a family medical issue to deal with which would make her 15 minutes late. On P. 603, it is stated that she received a note from Doreen Illis shortly after this noting her improvement in this area.

Again, I assert my opinion that the cited errors/omissions in the delivery of nursing services were insufficient grounds for Ms. Jacque's termination. Her reinstatement would not place patients in any jeopardy or harm, nor be against the public interest. I base this opinion on my many years of experience as a Director of Nursing and as Administrator, and Regional Director in the long term care industry.

In addition, as contended from the Hearing Testimony,

1. On p. 463, Jillian stated that Doreen and Inez were "combing through everything." When asked what responded that her workmates would tell her, "they're searching and checking through everything...to find mistakes." It is understood that a resurvey was impending and that yes, nurses are to audit for compliance. It is unusual to see the Administrator auditing a chart when she is not a nurse. Also, communication with staff explaining the intensity of the auditing and survey prep would have been in order given the union issues and impending election.
2. Jillian called Andrea Lee who said "I'm surprised," p. 488, Hearing Testimony. Jillian contends that Andrea would look in to it and get back to her. She never did, P. 490, Hearing Testimony. On p. 493 it is stated that Andrea said if she knew about it she would have done something. Jillian said, "Well I called you and you didn't answer my call...you never returned my callyou never looked into it." Andrea did not respond. (This exchange took place at meeting in a conference room with Illis.) The company reps, including HR, ignored the staff who tried to reach out for assistance.
3. On p. 954, Southgate's Hearing Testimony she states that it is known that Jillian is attending a union meeting. She is told that if she is late, that Inez needs to take that call.
4. It was implied to Southgate, Unit Manager, by Inez (and not stated specifically), p. 1117, that she was trying to find something to write Jillian up for. "if she was given an excuse to discipline her, she would do so," P. 1117, 1118.
5. It is interesting that Ms. Konjoh, DN was removed (terminated or transferred) from this facility in December 2010. Again, there is much turmoil in this facility even with this administration (Jillian's Confidential Witness Affidavit, January 2011).
6. Jillian's most recent evaluation state that she "meets the standard" in all areas: 3/25/09. On this one, it also indicates the same for "adheres to the current attendance policy." It is written in at the bottom of the form, that she needs to improve her time, and "pay closer attention to completing assessments." Added is "Jillian is pleasant, cooperative and a good nurse." The evaluation for 11/30/09 is the same except for a "1" (needs attention), for "completes assignments in an accurate manner." There is no additional comment on the form by the manager. A "1" would call for a specific comment with expected steps on how to improve. Both evaluations are considered good or satisfactory.

In summary, Jillian Jacques, LPN, reinstatement is not against the public interest nor creates an environment of harm or jeopardy for patients. Her termination was arbitrary, baseless, punitive, and did not follow the prescribed protocol in a step-wise fashion for

disciplinary actions, not to mention the provision of guidance, and staff development to preserve the individual as a human resource.

The following is additional corroborating and related information as reviewed in the Hearing Testimony:

It is agreed that there are numerous regulations and standards of care which dictate the proper actions and interventions to be performed by staff in any long term care facility, along with facility policies. It is also recognized that Administrators, Directors of Nursing and other management staff may expect that such standards are completely fulfilled on a daily basis. However it must be accepted that it is a managerial challenge to be in 100% compliance every day with the systems and variables that we have in these facilities.

With each of the infractions and disciplines that were received by the above nurses, there is a corresponding explanation along with a remedy that could have been provided by the management to ameliorate such occurrences. Re-training, communication with staff, and guidance was not done as readily as the administration of disciplinary action to termination in each of the above cases-with some sooner than later.

It is obvious that there is great inconsistency in giving disciplinary actions. In Ms. Dande's case, as per Konjoh's testimony, p. 2575, she falsified the record, writing in the chart that she did a treatment when in fact she did not. Although a lack of further questioning on this did not specifically state, it is assumed from the testimony that she was handled differently, and not severely disciplined for that, yet for making a mistake such as putting a "0" for pulse oximetry, Napolitano was disciplined and terminated.

On p. 2577, Ms. Konjoh admits that she did not look at the personnel file first when giving disciplines for issues with staff. She later clarifies and says for 95% of the time she did not check the files, but sometimes she did. She did in the case of Jillian or Shannon, p. 2577. She said that if she did check the files she "would have fired most of them" at the first offense, p. 2576, # 14. On p. 2580, Ms. Konjoh states that she does not follow progressive discipline. When pressed, she responded, "it depends."

It is noted that Beatrice Beauvoir called out 4 times in 60 days and received a verbal warning, yet ms. Claudio called out sick 3 times in 90 days and received a written warning, {Konjoh, p. 2400}.

This is totally unacceptable managerial practice. All facilities follow some type of progressive steps in disciplining. This is to ensure fairness with or without a union present. A progressive discipline process ensures that there is a system of expectations and stated consequences for staff in the event of lateness, or errors for example. Arbitrarily giving disciplines at whim is not only not professional, but not effective.

Konjoh agrees that giving a final warning to the nurse for giving the aspirin is excessive, p. 2610.

Ms. Konjoh's Declaration only deals with a few issues: Napolitano and the zinc pill, the O2 saturation of "O," speaking with Ms. Jacques about coumadin. This is odd as there are many other issues that Ms. Konjoh was involved in and she was the driving force in the 3 Nurse terminations.

When asked further about how she came to give disciplinary actions for lateness in September, for lateness from January, she denied looking back at this date, and stated, "the computer looks back." It is obvious that a computer by itself does not do anything. It must be requested. So dates to "look back" for the lateness regarding this selected staff was put in by a manager, presumably, overseen by the Director of Nursing, Konjoh p. 2577.

There is much testimony from many venues in this case with specific areas which evidence a degree of doubt concerning Somerset Rehab at Care One's position and contention. In addition, I think it is helpful to discuss the organizational culture and systems issues as such concepts can be practically applied to this case. The following is a list of such issues with applicable discussion or comment.

Many organizational culture issues:

Organizational culture simply refers to the accepted routines and procedures as well as social interactions in a particular entity. For example, dress may be a form of culture in an organization. Many businesses, including health care, permit casual dress on Fridays, with some restrictions, for example. Some facilities are more informal than others, not requiring a strict attendance code, for example. This is a function of culture. Staff of any business adapt or even devise the culture, which can also evolve over time.

1. The Administrator, Ms. Heedles, was changed shortly before an expected survey. Based on my experience, it is not desirable to change leadership prior to a survey. Such an action "flags" the Department of Health, and is looked at in a negative light. This is very reactionary and can be a function of culture.
2. Lateness and absenteeism was tolerated and worked around for whatever reason. When changes occurred, was very abrupt-moved Administrator, fired DN, and then brought in new who immediately made strict changes. Culture change is a process. Allowance for this was not done here. Also the callout after day off that was supposed to be in handbook but wasn't, is another organizational culture issue. Ms. Southgate, for instance, was not aware of the specific time and attendance policy issues (as they were never enforced or brought up for discussion) specifically the days in 90 day period of call out, or the call out after/before a day off, p. 961, Hearing Testimony.
3. it was routine for staff to sign MARs/TARs after the shift, later was "ok." This is a function of the culture of the organization. Then suddenly, this practice was not "ok". Staff did not have time to adapt, not to mention that this aspect is a challenge for most LTC facilities in the industry.

4. The organizational culture tolerated "sloppy" practices, staff who set their own rules without oversight and guidance for a long period of time, and in this case, for the entire tenure of these nurses. This is a result of lack of leadership and not the exclusive fault of the individual staff at the lowest level in the organization. The company should have responded earlier to this to avoid the staff frustrations, as well as to avert infractions.

5. Areas of training were lacking. Jacqui Southgate states that she was not instructed on how to complete or ensure the completion of the incident reports, yet she was expected to discipline staff for not doing correctly, p. 985-986, Hearing Testimony. She stated, "I told her I wasn't clear on what she wanted. I had to redo them and she still didn't like the way I had done them..." p. 986. She states that others committed errors in the incident reports. She stated that Mohamed committed errors in the incident reports, but was not disciplined to her knowledge. She would know as a Unit Manager. The completion of incident reports is a common problem for such staff and middle managers, not to mention DNs, to perform without proper training and reminding. Again this is a lack of management oversight and responsibility from the Leadership. To further this contention, Southgate states that "One time I was writing up an incident report on Doreen (Dande), and then I was told by Inez not to give her the discipline, that she would take care of it....October 2010. It is presumed that no discipline was given, as she as manager should be aware of such things even if the DN in fact did give the action. The DN chose not to give the disciplinary action to Doreen (Dande) for whatever reason. There was a culture of inconsistency with the perception of unfairness here.

System Problems:

Simply stated, systems are sets of detailed methods, procedures and routines that are established or formulated to carry out specific activities, perform duties, or solve problems. Within a system, actions are prescribed to be performed so that the overall structure remains intact. In healthcare, there are many systems to ensure the consistency and safety of consumers. An example related to the matters here include the medication dispensing system, a much studied process in health care. Within this system of medication dispensing for example, are many steps depending on the type of institution. The steps begin with the written order to the patient receiving the med and lastly with the documentation of that event. Many manual systems were updated into computerized systems from one degree to another in both hospitals and long term care in recent years, to streamline the process for ultimate safety. The Pyxis system is a further example of a streamlined system for computerized medication dispensing, which prevents many of the errors that we have seen in this case. Another, non-clinical example of a system, would be a payroll system. There are specific steps in a process to ensure that a person is paid for the time he is working. How that is defined is up to the business, and is communicated to the employees.

1. The entire medication transcription process at Somerset Valley with several people involved in this, can easily result in staff who can make mistakes. Much is done manually, with pens and pencils. An electronic or computerized system, would not allow them to miss a dose, or to not sign. I am not saying that everyone is expected to have

computerized systems. I am making the comparison between a manual charting system with that of computerized. Manual systems, which are prevalent in long term care and tend to not be changed, or upgraded, are replete with potential sources of error. On p. 998-1000+, Jacqui Southgate's Hearing Testimony, there is a long description of the convoluted medication transcription process including the recap process. Not only did the Judge and legal personnel not understand this, but I don't even understand it. I have worked in this "system," which is common in LTC without EMRs and I have contended that it is fraught with potential areas for errors. It is a fragmented human system, which encourages work-arounds and errors. Computerization linked with the pharmacy eliminates 99% of this potential.

In addition, it is common in the industry that nurses who give out medications are very often interrupted during this critical process. There is only enough staff on duty with 2-3 nurses occupied at either treatment or medication carts on a typical shift. Visitors, Physicians, and other personnel continually interrupt the med nurse. This has been cited in the literature as a source for errors in itself.

There is a very large area of literature and research on patient safety and error management. It is known and accepted that such "systems" or lack thereof as in this case, potentiates errors and mistakes. Most errors are hidden or are latent. There exist no automated systems to pick up or prevent such errors from occurring. The "audit" is the only universally used method which is less reliable and subjective. Ms. Konjoh testified that she and Ms. Arroyo did audits, but as we saw, this was done on certain staff only, and can be viewed as to target specific staff.

The lack of sophistication to understand "systems" by Administration was a cause for their own frustration as well as not fixing the problems for the future. Disciplinary action does not fix the root cause of the problems. Hence, why we see repetitive similar issues in the testimony.

2. As discussed, the 24-hr chart check is a process designed as a fail-safe to catch potential med errors, and pick up those that have occurred. The check is implemented as an expectation that such manual errors can likely occur. This system did not work in this case. When such errors occur in the industry based on my experience, a full investigation occurs. In this case, had an investigation been done, the staff involved in not performing the 24 hour chart check would have been in question, as well as the entire process. Such investigation did not occur in this facility as a result of the medication transcription errors.

3. Lack of a practice for staff to follow on pain assessment until an issue with Napolitano arose. The State (DHSS) told them to do the pain assessments, as was done by Napolitano, at beginning of shift. These systems were not fully clarified and not in place.

4. It is not evident to any significant extent is that the company or facility made efforts to re-train, adjust workload and schedules for staff. What occurs in the industry is that when such errors surface, education and discussion is provided to not just the few that made the

error, but to all pertinent staff. It is assumed that if one or two made an error, that perhaps others may have the potential and therefore re-education and group discussion would be in order. Another accepted industry standard practice is to look further at the process that is involved to see if it is working correctly or has perhaps has broken down.

5. System changes take time and are a process. Terminating staff for these infractions (most on documentation and not actual patient care critical issues) is poor with evidence of poor leadership which continued. In my practice and experience in the industry, I operate on the leadership premise that accountability lies at many levels and not just at the lowest level. Managers are certainly accountable for the processes in their departments.

6. There was no incident investigation that was objectively done in most of the cited issues and errors by these nurses. There was no RCA (Root Cause Analysis) process which is done by a team of players in one room, documented, and lead by objective person. This process did not exist in this company.

7. Lack of unit clerks to do the manual transcriptions, faxing, etc, was evident with a lack of functioning fax equipment and the use of multiple manual systems created excess work load and fragmentation. Use of clerks increases direct costs. In this case, having such clerks might just decrease indirect costs. Creating barriers for staff, and then punishing them does not reflect progressive management or leadership.

Simply, the lack of sophistication to understand "systems" by Administration was a cause for their own frustration as well as not fixing the problems for the future.

General Concluding Opinion:

It is my professional opinion that the Somerset Valley Rehabilitation and Nursing Center did not have proper and reasonable justification for terminating nurses Shannon Napolitano, Sheena Claudio, and Jillian Jacques for allegations regarding their failure to provide appropriate patient care and for time and attendance violations. It is my opinion that the cited error/omissions in the delivery of nursing services were insufficient grounds for the termination of Ms. Napolitano, Ms. Claudio and Ms. Jacques. Their reinstatement would not place patients in any jeopardy or harm, nor be against the public interest.

Most of the infractions via discipline, and termination, are rooted in documentation issues and no actual harm. The clinical documentation and medication errors or omissions are by no means "grievous" or a threat to patient safety. The second theme of these disciplinary actions was in the area of lateness and time and attendance, which also does not harm patients. Such issues are easily remedied through discussion, mutual accommodation, and continued monitoring. Enough testimony which shows that some staff were disciplined and others were not, with a long-standing tolerance for absenteeism and lateness in months prior. In my experience in this industry, when dealing with any personnel, consistency is the hall-mark and must be used when administering discipline for deviations.

When infractions which result in a survey deficiency, it is a human response to "punish" the person who made the error. That is the first thing and the easy thing to do. It may not solve the overall problem though. If one nurse makes a mistake, perhaps others are doing the same and following the same pattern, the question must be asked: why are they making such mistakes? Discussion was provided in depth concerning the investigation of the process and not just the individual. Through demonstrated re-training, examination of systems with revision, and compliance auditing, in time, these staff would either improved to 100%. Such efforts that are routine for management or should be, were not done in this case.

It was demonstrated that there existed several organizational culture and systems issues that directly related to most of the infractions cited by Somerset Valley/Care One, et al. It is my opinion that had such issues been handled or understood, perhaps these 3 nurses could have been spared being terminated.

The cited infractions as purported by Somerset Valley Rehabilitation Center {Care One} are of a minor nature, and do not constitute grounds for termination. It is my opinion that the cited errors or omissions in the delivery of nursing services were insufficient grounds for the termination of Ms. Napolitano, Ms. Claudio, and Ms. Jacques. I reiterate that their reinstatement would not place patients in any jeopardy or harm, nor be against the public interest.

Kathleen Martin, RN, MSN, MPA, LNHA, CPHQ, WCC

DEFENDANT'S
EXHIBIT

Is Care One Administrator Doreen Illis Putting Before Resident Care?

Care One Somerset is wasting resources.

Care One, the second largest nursing home chain in New Jersey, is spending money on high-priced out-of-state lawyers to overturn our union election at their Somerset facility. Before the election, they had caregivers leave our residents to attend management's anti-union meetings. They've scared and bullied caregivers, and illegally fired and disciplined nearly 20% of Somerset employees. All because caregivers united for a voice to improve resident care and working conditions.

But Caregivers are standing strong.

The Courier News recently reported on the illegal firing of Somerset workers. Last weekend, we reached out to family members of Somerset residents to let them know about conditions for caregivers inside the facility. And we're circulating a community petition, which already has hundreds of signatures, telling Doreen Illis and Care One to stop wasting resources, to treat us with dignity and respect, and to rehire our co-workers.

PLEASE CALL AND EMAIL CARE ONE SOMERSET ADMINISTRATOR DOREEN ILLIS

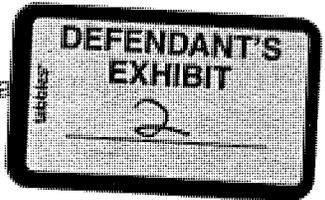
Tell her to stop wasting resources on attacking caregivers and to focus on providing the best care to nursing home residents. (800) 907-3304 / dillis@care-one.com

For more information, contact
Isabelita Sombillo at (732) 646-1659

06 EXHIBIT D

Walsh-2
7/5/11

1199SEIU
United Healthcare Workers East



NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name: Jillian Jacques
Job Title: CN

Facility: Somerset Valley
Date of Hire: _____

Prior Disciplinary Notices in File: (include date and nature)

Exh. No.: 88 Received Rejected _____

Case No.: 22-CA-29599 et al

Case Name: Somerset Valley Rehab

No. Pgs: _____ Date: 6-6-11 Rep.: cm

TYPE OF VIOLATION

- Dress Code
- Performance
- Resident Rights
- Behavior
- Insubordination
- Refusal to Perform Assigned Task
- Absenteeism/Tardiness
- Patient Care
- Other: _____

DESCRIPTION

Date: 11/10 Time: 3-11-10

Specific Description of Issue, Situation or Behavior (what, where, how):

Incident Reports Not fully completed. Missing Signatures, unclear
Statements, Interventions missing, Missing supervisor Review
CNA Statement missing

EMPLOYEE RESPONSE

- I agree
- I disagree for these reasons: I called Don next AM & flew
left msg on voicemail & plan I had advise
and 3 incidents. All incidents were given
to supervisor

ACTION TO BE TAKEN

- Documented Verbal Notice
- Written Notice
- Suspension for _____ days to start on _____ (date) and return to work on _____ (date).

Does this Disciplinary Action Constitute Final Warning: Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination of employment.

Employee's Signature _____ Date _____

Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

Jacques 12-5-10
Supervisor's Signature Date

Department Head/Administrator _____ Date _____

Abraham 11/5/10
Witness Signature Date

(One copy to Employee - one copy to Personnel File - One copy to Supervisor)

Somers002510

Room: 21W
Dr. Iorio

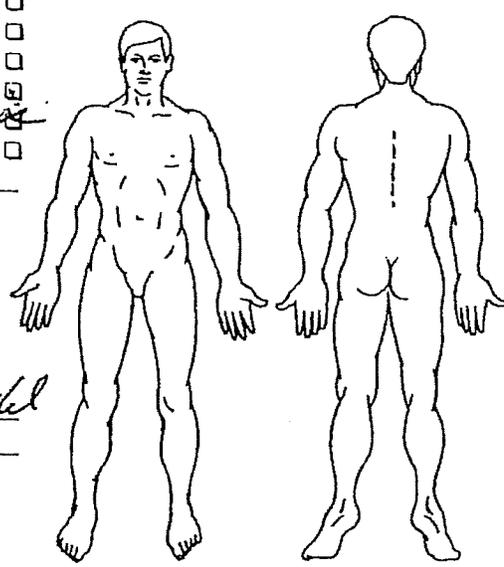
SV525434
DOB: ~~REDACTED~~
Adm: 10/27/10

HealthBrid
MANAGEMENT

ACCIDENT REPORT

PERSON INVOLVED (Middle initial) _____
 Adult Child Male Female Age 82
 Date of incident/accident 11/1/10 Time of incident/accident 7 A.M. P.M. Exact location of incident/accident _____
 Resident's room 21W Hallway Bathroom Other Specify _____
 RESIDENT Resident's condition before incident/accident basal
 Last diagnosis if contributed to location/accident: Diabetes
 Normal Confused Disoriented Sedated (Drug _____ Dose _____ Time _____) Other Specify _____
 Were bed rails ordered? Yes No Were bed rails present? Yes No If Yes, Up Down Was height of bed adjustable? Yes No If Yes, Up Down
 Was a restraint in use? Yes No Physical restraint Type _____ Chemical restraint Specify _____
 VISITOR Home address _____ Home phone _____
 OTHER Occupation _____ Reason for presence at this facility _____

Describe exactly what happened; why it happened; what the causes were. If an injury, state part of body injured.
Resident found on floor in room states he was getting trying to get in bed and slipped to c/o pain or injury.

TYPE OF INJURY
 1. Laceration Indicate on diagram location of injury:
 2. Hematoma
 3. Abrasion
 4. Burn
 5. Swelling
 6. None apparent
 7. Other (specify below)

 LEVEL OF CONSCIOUSNESS
A basal

Vital signs (if applicable) when the resident is supine and at one and three minutes after standing (if unable to stand, use supine to sitting position).

Vital Signs	Initial Incident Supine	One Minute After Standing	Three Minutes After Standing
Temperature	<u>98.3</u>	<u>98.4</u>	<u>98.3</u>
Pulse	<u>75</u>	<u>76</u>	<u>78</u>
Respirations	<u>20</u>	<u>20</u>	<u>20</u>
Blood Pressure	<u>130/83</u>	<u>129/70</u>	<u>134/60</u>

Name of physician notified: TORIO (left message) Time of notification 9:50 A.M./P.M. Time responded 9:00 A.M./P.M.
 Name and relationship of family member/resident representative notified: _____ Time of notification 9:50 A.M./P.M. Time responded 9:00 A.M./P.M.
 Was person involved seen by a physician? If Yes, physician's name: _____ Yes No
 Was first aid administered? If Yes, type of care provided and by whom: _____ Yes No
 Was person involved taken to a hospital? If Yes, hospital name: _____ Yes No
 Name, title (if applicable), address & phone no. of witness(es): Ma

Additional comments and/or steps taken to prevent recurrence:
encourage PT to call for help

SIGNATURE/TITLE/DATE
 Person preparing report: [Signature] 11/1/10 Medical Director
 Director of Nursing: [Signature] 11/2/10 Administrator

SV520922
 Room: 19W
 Dr. Patel Gita
 DOB: [redacted]
 Adm: 10/1/10

HealthBridge
 MANAGEMENT

INCIDENT/ACCIDENT REPORT

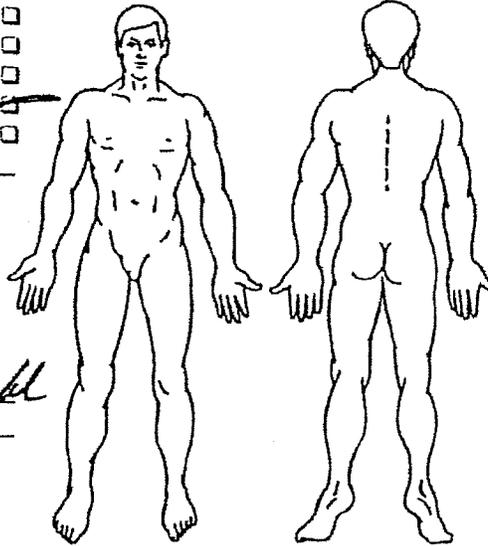
PERSON INVOLVED (Last name) (First name) (Middle initial)
 Adult Child Male Female Age 89

Date of incident/accident 11/1/10 Time of incident 6:45 A.M. P.M.
 Exact location of incident/accident Resident's room (No. 19W) Hallway Bathroom Other Specify _____

RESIDENT Resident's condition before incident/accident Forgetting
 Normal Confused Disoriented Sedated (Drug _____ Dose _____ Time _____) Other Specify _____
 Were bed rails ordered? Yes No Were bed rails present? Yes No If Yes, Up Down
 Was height of bed adjustable? Yes No If Yes, Up Down
 Was a restraint in use? Yes No
 Physical restraint Type _____ Chemical restraint Specify _____

VISITOR Home address _____ Home phone _____
 OTHER Occupation _____ Reason for presence at this facility _____

Describe exactly what happened; why it happened; what the causes were. If an injury, state part of body injured.
6:45 head used to call out alarm on - found sitting on floor - state he was reaching for my urinal and slipper & c/o verbalized.

TYPE OF INJURY
 1. Laceration
 2. Hematoma
 3. Abrasion
 4. Burn
 5. Swelling
 6. None apparent
 Other (specify below) _____
 Indicate on diagram location of injury:


Vital signs (if applicable) when the resident is supine and at one and three minutes after standing (if unable to stand, use supine to sitting position).

Vital Signs	Initial Incident Supine	One Minute After Standing	Three Minutes After Standing
Temperature	98.4	98.6	98
Pulse	64	70	71
Respirations	18	18	18
Blood Pressure	138/64	136/70	140/72

LEVEL OF CONSCIOUSNESS
Alert Verbal

Name of physician notified Patel (nurse left Hansen) Time of notification 9:45 A.M./P.M.
 Name and relationship of family member/resident representative notified _____ Time of notification 9:45 A.M./P.M.

Was person involved seen by a physician? If Yes, physician's name _____
 Yes No

Was first aid administered? If Yes, type of care provided and by whom _____
 Yes No

Was person involved taken to a hospital? If Yes, hospital name _____
 Yes No

Name, title (if applicable), address & phone no. of witness(es) N/A
 Additional comments and/or steps taken to prevent recurrence:
on case # to call for asset Keep urinal in reach

SIGNATURE/TITLE/DATE
 Person preparing report [Signature] Medical Director
 Director of Nursing _____ Administrator

Individual Statement Form

Complete the following 4 steps. Attach additional sheet(s) if necessary. Sign and date each sheet.

1. Where and when (date and time) did the incident occur?

11/1. Residual Room

2. Tell us step by step, in your words, what happened (what you actually saw and/or heard).

Called TP Room 21. Noted residual on the floor. When asked what happened PT sitting on floor. Stated he was trying to get into or closed at PT's sitting on the floor. Stated I was trying to get into

3. Print your Name and daytime telephone number:

William Jacques ()

4. Signature/Title:

William Jacques LPR

Date:

11/1/10

Individual Statement Form

Complete the following 4 steps. Attach additional sheet(s) if necessary. Sign and date each sheet.

1. Where and when (date and time) did the incident occur?

11/2/10

2. Tell us step by step, in your own words, what happened (what you actually saw and/or heard).

I received a ^{msg} call from this employee (Jillian Jacque) on 11/2/10 on my voicemail informing me that pt (MG) had fell late on her shift, and since it was found on the mat, she wasn't sure wether she had to do an incident report, but that she started one late and the CNA had already left therefore the incident report was incomplete and she would finish it next day. I was okay with employee completing the incident on that day, however other incident's completed by same employee on 11/1/10. on pt's (PH) and (WAT) were also incomplete. Unit manager was then asked to follow a discipline because employee had been warned on completing incident reports.

3. Print your Name: Inez Kinyola
Daytime Telephone number: _____

4. Signature/Title: [Signature] Date Completed: 11/8/10

Welcome to the Straus Institute for Worker Injustice

Today, we're renaming the Straus Institute for the Advanced Study of Law and Justice to more aptly reflect the values of its founder, Daniel Straus. Daniel, along with his brother Moshael Straus, runs the multi-million dollar nursing home chains, Care One and HealthBridge. His companies have violated workers' rights and Federal Labor Law.

It's great that Daniel Straus endowed an institute affiliated with NYU Law School dedicated to studying law and justice. But Care One and HealthBridge have broken the law and stripped workers of justice.



- The National Labor Relations Board, a Federal Government Agency, issued a complaint against Care One and HealthBridge in Connecticut for firing housekeepers and rehiring them as "new employees" at lower wages.
- In New Jersey, Care One illegally terminated workers after they voted to form a union. The NLRB issued a complaint and is seeking an injunction in Federal Court to reinstate the workers.
- Care One and HealthBridge are threatening to lock Connecticut workers out of their jobs at six nursing homes, and are attempting to slash safe staffing ratios, wages and benefits.

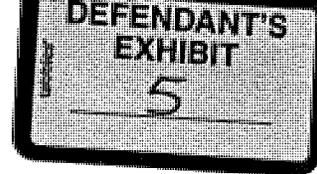
This institute will be called the Straus Institute for Worker Injustice until the Straus brothers uphold law and justice.

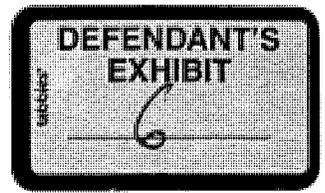
Call Daniel Straus at (201) 242-4900, ext. 5700 and tell him to show his dedication to law and justice by respecting labor law and supporting justice for nursing home caregivers. For more information, email info@careonewatch.org

	A	B	C	D
1	Somerset Hires and Terms			
2	Name	Job Description	Original Date Hired	Termination Date
3	Alexander-Chambers-Carol	Licensed Practical	09/10/2007	02/19/2011
4	Beck Patricia	Licensed Practical	03/16/1998	08/03/2011
5	Bockerle Mohamed Bakay	Licensed Practical	09/02/2009	05/24/2011
6	Bolageer- Smith Sharon	Licensed Practical	01/04/1999	08/05/2011
7	Catalano Anthony F	Licensed Practical	02/01/2010	04/14/2011
8	Conteh Salaimatu	Licensed Practical	09/22/2010	01/10/2011
9	Dacres Cheryl	Licensed Practical	09/10/2007	05/27/2011
10	Dande Doreen	Licensed Practical	01/22/2010	02/15/2011
11	D'Ovidio Irene	Licensed Practical	08/12/2002	08/18/2011
12	Garcia Blanca	Licensed Practical	05/11/2011	08/18/2011
13	Jacques Jillian	Licensed Practical	11/30/1999	02/11/2011
14	Kanjarpane Lalita	Licensed Practical	02/22/2011	03/19/2011
15	Lezuaba Henrietta	Licensed Practical	02/17/2009	02/19/2011
16	Mangal Maharanie	Licensed Practical	04/29/2002	10/18/2011
17	McGuire John S	Licensed Practical	02/07/2011	02/20/2011
18	Moore Michele	Licensed Practical	01/03/1994	05/24/2011
19	Noel Wisner	Licensed Practical	08/24/2010	11/08/2010
20	Noor Faizy Dexter	Licensed Practical	03/16/2011	08/03/2011
21	Nwaro Adanma Nkennaya	Licensed Practical	08/24/2010	01/25/2011
22	Santos Jeremias	Licensed Practical	02/18/1993	05/24/2011
23	Sesay Hewanatu	Licensed Practical	09/21/2010	05/30/2011
24	Singh-Kaur Narinder	Licensed Practical	06/14/2000	01/22/2011
25	Turay Patricia	Licensed Practical	02/25/2011	03/19/2011
26	Usharenko Vyacheslav	Licensed Practical	07/15/1997	06/13/2011
27	Abraham Gigi	Registered Nurse	07/21/2011	08/24/2011
28	Adeshina Olubunmi O	Registered Nurse	03/10/2011	05/27/2011
29	Aliseo Kimberly	Registered Nurse	10/03/2011	
30	Aversa Joan E	Registered Nurse	09/15/2011	
31	Bain Laurel	Registered Nurse	08/23/2011	
32	Birgfeld Amy E	Registered Nurse	04/28/2011	
33	Black Donna	Registered Nurse	08/01/2011	
34	Blackburn Dale E	Registered Nurse	09/15/2011	
35	Bogdan Irene	Registered Nurse	01/10/2011	04/11/2011
36	Castro Cromwell	Registered Nurse	05/13/2008	01/22/2011
37	Champagne Monica	Registered Nurse	06/02/2011	06/20/2011
38	Dale Rebecca L	Registered Nurse	09/26/2011	10/18/2011
39	Delos Reyes Florabele A	Registered Nurse	12/20/2010	05/01/2011
40	Di Quollo Philomena	Registered Nurse	11/12/1994	01/22/2011
41	Esendemir Gulhan	Registered Nurse	03/09/2011	
42	Fernandez Patricia	Registered Nurse	11/21/2011	
43	Fitzgerald Leonora Marie D	Registered Nurse	02/01/2011	
44	Ghotra Puja	Registered Nurse	09/26/2011	10/11/2011
45	Greene Danielle	Registered Nurse	09/26/2011	
46	Grishkevich Irina	Registered Nurse	05/23/2011	
47	Hawkins Antonette	Registered Nurse	11/21/2011	
48	Ibe Nicole O	Registered Nurse	07/22/2010	02/19/2011
49	Ilogu Ebele	Registered Nurse	08/25/2009	
50	Koottiyaniyi Raethamma	Registered Nurse	08/24/2010	01/25/2011
51	Lynch Debra	Registered Nurse	06/17/2010	02/19/2011
52	Mootoosammy Sandy	Registered Nurse	06/22/2010	02/20/2011
53	Odaa Silas	Registered Nurse	08/01/2011	
54	Palumbo Elaine	Registered Nurse	01/14/2011	08/03/2011
55	Pillai Helen	Registered Nurse	08/11/2011	
56	Sheriff Osman	Registered Nurse	12/09/2010	01/14/2011
57	Urbano Helen	Registered Nurse	03/07/2011	
58	Velarde Jane	Registered Nurse	01/14/2010	05/27/2011
59	Danesh Shahraki Soudabeh	RN Shift Supervisor	11/03/2011	
60	Lindower Barbara	RN Shift Supervisor	10/21/2011	
61	Mollica Diane	RN Shift Supervisor	10/21/2011	

Somerset Valley LPN and RN Staffing October and November 2011

Full Title	10/31/2011	11/25/2011
Licensed Practical Nurse	0	0
Registered Nurse	14	16
RN Shift Supervisor	2	3





Curriculum Vitae

Beth A. Bell RN

After graduating from Helene Fuld School of Nursing, Beth worked for 16 years in Acute Care before joining the state of NJ as a Field Investigator in the Office of the Ombudsman for the Institutionalized Elderly in 1984. In 1985 she transferred to the Department of Health and Senior Services (DHSS) as a Complaints Investigator. She attended Thomas Edison State College working towards a BS in Health Care Administration. From 1988 to 1990 she returned to the private sector as the Director of Staff Development, Quality Assurance and Infection Control in a Long Term Care Facility. In that capacity she was responsible for ongoing staff development, teaching the state certified nurse aide program, continuous quality improvement and tracking nosocomial infections throughout the facility.

Upon return to the DHSS, Beth became a team leader of a state survey team responsible for surveying Long Term Care Facilities in accordance with State and Federal guidelines. She also participated in a research project for the Federal Government in conjunction with the University of Wisconsin to determine the variation in Federal Surveys across the nation. She has served as a subject matter expert for the Centers for Medicare and Medicaid (CMS) in the development of the Surveyor Minimum Qualifying Test (SMQT- a standardized test required to become a state surveyor) questions on multiple occasions. Beth attended Fairleigh Dickinson University and became a Certified Public Manager. In 1998 she joined the DHSS training team. At that time she obtained state certification as a trainer and was responsible for orientation of new employees, ongoing staff development of state surveyors and development of provider educational programs. She also became the State Resident Assessment Instrument (RAI- a standardized assessment tool) Co-coordinator, responsible for answering clinical coding questions for all NJ providers. In 2003 she was promoted to Supervisor of Inspections responsible for managing three survey teams as well as the training team.

In January 2009, Beth retired from state service. She then worked part-time with the Health Care Association of NJ performing Mock Surveys for their members. In October 2010 she formed a consultant company, Professionals for Quality LLC servicing providers across the state. She continues to have a deep interest in the Quality of Life for Long Term Care Residents.

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Consulting Across the Continuum of Care



July 8, 2011

Rosemary Alito, Esq.
K&L Gates LLP
One Newark Center, 10th Floor
Newark, New Jersey 07102

Re: J. Michael Lightner, Regional Director of Region 22 of the National Labor Relations Board for and on behalf of the National Labor Relations Board. v. 1621 Route 22 West Operating Company LLC, d/b/a Somerset Valley Rehabilitation and Nursing Center, Civil Action No. 3:11-cv-02007-MLC-LHG

Dear Ms. Alito:

At your request I am providing the following report in connection with the above-referenced action. As discussed in detail herein, it is my professional opinion that the Somerset Valley Rehabilitation and Nursing Center ("Somerset Valley Center" or the "Center") had proper justification for terminating nurses Shannon Napolitano, Sheena Claudio, and Jillian Jacques for failure to provide appropriate patient care to the residents of the Center. Also, Somerset Valley Center had proper justification for terminating Staffing Coordinator Valarie Wells for failure to properly staff the clinical areas of the Center, thereby impeding the delivery of clinical services and interfering with the Center's ability to provide appropriate patient care. It is also my opinion that the Center's unorthodox prior practice of utilizing per diem employees in the nursing areas on regularly scheduled shifts was contrary to accepted practices in the health care field and had the potential to impact the continuity of care appropriate for proper patient care. It is my professional opinion that the reinstatement of these employees and the use of per diem CNAs and nurses on other than as-needed basis would impede the Center's ability to meet the standards of care required pursuant to applicable State and Federal regulatory programs, jeopardize its ability to remain licensed as a healthcare facility, place the lives and physical well-being of the Center's patients at risk, and be contrary to the public interest.

As indicated on my attached curriculum vitae, I am a Registered Nurse and the Managing Member of Professionals for Quality, LLC, providing health care consulting services, and have over 40 years experience in the health care industry, with particular experience in long term care issues. I have more than 23 years experience with the New Jersey Department of Health and Senior Services, having served as a team leader for the New Jersey state survey team responsible for surveying Long Term Care Facilities in accordance with State and Federal guidelines, as Training Coordinator responsible for orientation of new employees, ongoing staff development of state surveyors and development of provider educational programs, and as Supervisor of Inspections responsible for managing three survey teams as well as the training team.

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I have reviewed the following documents which establish the factual basis for this report:

- Declaration of Doreen Illis, Administrator of the Somerset Valley Center, dated May 6, 2011, and exhibits thereto
- Declaration of Inez Konjoh, former Director of Nursing of the Somerset Valley Center, dated May 6, 2011, and exhibits thereto
- Declaration of Jason Hutchens, Regional Director of Operations, dated July 8, 2011
- Transcript of deposition of LPN Jillian Jacques, taken May 23, 2011, and exhibits thereto
- Transcript of deposition of Staffing Coordinator Valarie Wells, taken April 26, 2011, and exhibits thereto
- Transcript of deposition of LPN Sheena Claudio, taken May 3, 2011, and exhibits thereto
- Transcript of deposition of LPN Shannon Napolitano, taken May 2, 2011, and exhibits thereto
- New Jersey Department of Health and Senior Services Centers for Medicare and Medicaid Services ("DHSS") survey report dated December 1, 2009, and Life Safety Code Report of the same date
- Initial Notice Letter from DHSS to the Somerset Valley Center, dated December 10, 2009
- Plan of Correction submitted by the Somerset Valley Center to DHSS
- Form CMS-2567B issued by DHSS to the Somerset Valley Center, dated January 14, 2010
- Determination of Compliance letter from DHSS to the Somerset Valley Center dated January 15, 2010

Based on my review of the above-referenced documents, the facts relevant to this matter as I understand them are as follows:

Following a seriously deficient Annual State Re-Certification Survey conducted in December 2009 that nearly caused the demise of the business for the Somerset Valley Center and which required a re-survey in January 2011 (this Survey will be discussed in greater detail

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elsewhere in this document), the performance of the Administrator (who was just completing her first year in an Administrator's role) and Director of Nursing was called into question. Thus, Regional operations and clinical personnel began monitoring the Center more closely and the Center's leadership team was increasingly held to higher levels of accountability for remedying the issues in the clinical areas that had resulted in the poor Survey. In April 2010, in the face of this increased scrutiny and accountability, it was determined that the Director of Nursing was incapable of turning things around in the area of patient care and she opted to resign. The Center then hired from the outside a new Director of Nursing, who "on paper" appeared to be qualified and capable of improving the Center's delivery of nursing services. Unfortunately, after only a couple of months on the job, it became clear to the regional personnel who were engaged with this Center that she was not an effective leader and was not making sufficient progress in improving the clinical operations affecting patient care. Because time was closing in on the opening of the window for the next Annual State Survey (and time was running out on Somerset Valley being able to turn-around its delivery of nursing services prior to the next Survey), Jason Hutchens, the Regional Director of Operations decided to change both the Administrator and the Director of Nursing. This time the decision was to go to an experienced Administrator at another facility and an Assistant Director of Nursing that Mr. Hutchens had worked with at another center and had confidence that she could make a difference.

Thus, in August 2010, the Administrator and Director of Nursing at the Somerset Valley Center was changed. The new Administrator, Doreen Illis, and the new Director of Nursing, Inez Konjoh, were charged with improving all aspects of the Center, and in particular patient care. The Center had not performed well in its annual state evaluation in 2009, and an improvement in 2010 was a top priority. To that end, Ms. Illis and Ms. Konjoh took numerous actions to ensure adherence to governmental and industry standards and to enhance patient care. Several of their actions are now challenged by the National Labor Relations Board ("NLRB"). Specifically, I am told that the NLRB alleges that Somerset Valley terminated four former employees because of their union activities and seeks their reinstatement. They are Shannon Napolitano, LPN ("Napolitano"); Valerie Wells, Staffing Coordinator ("Wells"); Sheena Claudio, LPN ("Claudio"); and Jillian Jacques, LPN ("Jacques"). As reflected in the records I have reviewed, the facts relevant to these terminations are largely uncontroverted. They demonstrate that these employees failed to provide appropriate patient care and/or impeded the delivery of proper patient care, and/or violated accepted nursing standards and protocols and State and Federal rules and regulations. Thus, in my professional opinion, the acts and omissions of these individuals warranted their terminations because they negatively impacted patient care and jeopardized the physical well being of the patients who depended on them. Accordingly, their reinstatement would be contrary to public interest. The facts of the terminations as I understand them are discussed in turn:

Shannon Napolitano

Shannon Napolitano LPN was terminated from employment by the Somerset Valley Center on September 18, 2010 for failing to provide appropriate patient care in three areas: 1)

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This nurse administered medication to a resident without a physician's order at least four times. The last such instance occurred on September 16, 2010 when she admitted that she administered a "pink capsule" containing zinc oxide to a patient for whom this medication had been discontinued by the physician on August 23, 2010. 2) On September 16, 2010, she also admitted that she left this unprescribed medication at the bedside of the unattended resident and admitted that she did not observe the resident take the medication. The resident was not approved to self-administer medication. 3) On September 17, 2010, Napolitano admitted that she incorrectly documented the oxygen saturation level of a resident as zero, which would indicate that the resident was deceased. (Napolitano made these admissions in her deposition at, among other places, pages 92, 93, 95-97, 98-99 and 107-108.) Prior to these incidents, she had been issued a written warning in January 2010 for documenting pain assessments for her entire shift at the beginning of the shift, creating an untrue assessment of the residents' pain. Napolitano also had attendance problems, coming into work late 93 times between January and September 2010. She received a written warning for excessive lateness on September 13, 2010. Such late arrivals of nurses impede patient care because they can cause staff shortages and overtime and interfere with proper consultation at the time of shift changes. In my opinion, Ms. Napolitano's errors and omissions in the delivery of nursing services and patient care were sufficient grounds for her termination and her reinstatement would place patients in jeopardy and be against the public interest.

Valarie Wells

Valarie Wells was terminated from employment by the Somerset Valley Center on September 21, 2010 for failing to correctly perform her duties as Staffing Coordinator. Wells was required to utilize a staffing management and scheduling program known as SmartLinks ("SMLX") in order to ensure adequate and appropriate clinical staffing for the Somerset Valley Center at all times. She also was required to prepare a manually typed schedule of room assignments indicating when every nurse on staff or per diem at the Somerset Valley Center was expected to be present. On at least six occasions, there were discrepancies between the SMLX records maintained by Wells and the manually typed assignment schedule. After a discussion on September 7, 2010 with Ms. Konjoh, the Somerset Valley Center's Director of Nursing, and Doreen Illis, the Administrator, a plan of correction was devised to require Wells to utilize the SMLX system and ensure that it was accurate. However, Wells failed to follow the plan of correction. The Somerset Valley Center's Administrator, Ms. Illis, and its Director of Nursing, Ms. Konjoh, met with Wells on three more occasions, and written warnings were issued to her on September 15, 16 and 20, 2010 regarding her failure to properly maintain the clinical staff schedule on the SMLX system and properly perform other job expectations that had been explained to her by Konjoh and Illis. Ms. Wells was terminated for failing to heed the written warnings issued to her, continuing to commit careless errors in her work, not following through on instructions given her by her superiors, and not adjusting her conduct to the required standards for a Staffing Coordinator at a facility such as the Somerset Valley Center. Significantly, Wells admitted to having made most of the errors and omissions that led to her

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discipline and ultimate termination. (Wells' made these admissions in her deposition at, among other places, pages 97, 98, 99, 100, 123 and 124.) Wells' actions resulted in confusion in scheduling the nursing staff. Such errors in staffing can result in improper staffing of clinical areas, thereby impeding the delivery of proper patient care. As a consequence, Ms. Wells' termination was justified, not just for the impact of her failures on the Center, but also for their potential adverse impact on patient care and the public interest.

Sheena Claudio

Sheena Claudio, LPN, was terminated from employment by the Somerset Valley Center on October 21, 2010, for failing to provide appropriate patient care and for insubordination. In addition to significant attendance problems, for which she received warnings, this nurse exhibited numerous failures to provide appropriate patient care. In early September 2010, she administered medication to a resident without a physician's order. The physician had ordered, as documented in the Medication Administration Record ("MAR"), that the medication was to be provided every other day. However, Claudio admitted that she medicated the resident on a daily basis. On September 27, 2010 Claudio received a final written warning for failing to complete medical documentation on three separate patients. She failed to document a new admission to the Somerset Valley Center, failed to document a physician's orders in connection with a skin tear suffered by a patient, and failed to complete documentation in response to a resident's fall in which he sustained a head injury, all of which Claudio admitted she had done. Finally, on October 7, 2010, Claudio left the facility at the end of her shift without having administered required treatments to the patients to which she had been assigned or, if actually administered, without signing the treatment records to show that the treatments were in fact administered. She returned to the facility more than eight hours later and attempted to sign the treatment records for the patients. The Somerset Valley Center Administrator, Ms. Illis, told Claudio that she could not document after her shift was over, and told her to stop. Claudio disobeyed the Administrator's directive and continued signing the records. As a result of her medication and documentation errors and omissions, and her conduct on October 7, Ms. Claudio was terminated. (Claudio's admissions are in her deposition at, among other places, pages 71, 77-78, 87, 99, and 100.) The termination of Ms. Claudio was justified by her numerous failures with regard to the delivery of proper delivery of nursing services and consequent failure to provide appropriate patient care. In my opinion, reinstatement of Ms. Claudio would jeopardize patient care and be contrary to the public interest.

Jillian Jacques

Jillian Jacques LPN was terminated from employment by the Somerset Valley Center on February 10, 2011 due to failure to provide appropriate patient care. On February 7, 2011, this nurse failed to correctly transcribe an order for medication for a patient on the physician's order sheet and failed entirely to enter the medication onto the Medication Administration Record ("MAR") for that patient. The physician had ordered Enteric Coated Aspirin and she admitted

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that she documented Aspirin and failed to transcribe the order onto the MAR. Previous to that, this nurse failed to provide appropriate patient care on a number of occasions. Jacques failed on December 2, 2009 to assess the pain level of a newly admitted resident with rectal cancer. This failure led to the lack of development of a care plan for pain, which led to a deficiency for the Somerset Valley Center on the state survey report for 2009. On September 20, 2010, Jacques failed to document a newly admitted resident at the Somerset Valley Center, and also failed to document on a resident who had fallen earlier in the week. On December 5, 2010, Jacques failed to completely document an incident report. Significantly, Jacques admitted to performing these errors and omissions. (Jacques' made these admissions in her deposition at, among other places, pages 242, 243, 258-259.) In March 2009, long before the union organizing campaign, an employee performance evaluation of Jacques noted that she needed to be more conscientious and thorough in documenting, particularly with regard to new admissions and incident reports.

Jacques had also received written warnings for attendance problems. On September 5, 2010 she received a warning for being late on 109 occasions since January 2010. This would equate to being late 12 days out of every month. She received a second warning on September 13, 2010 for calling out three times in a 60 day period immediately after a scheduled day off. Jacques' actions and omissions jeopardized patient care and justified her termination by the Center. It is my opinion that her reinstatement would undermine patient care and be contrary to the public interest.

Use of Per Diem Nurses

The NLRB also alleges that Somerset inappropriately reduced the hours of certain per diem nurses who supported the Union during the organizing campaign. The facts relevant to this claim show that prior to the arrival of a new Administrator and new Director of Nursing in August 2010, the Center followed an unorthodox practice of allowing per diem clinical staff to work regularly scheduled shifts. That practice was contrary to the norms of the nursing home industry and the Corporate policy applicable to the Center. It also conflicted with appropriate patient care and it impeded the continuity of care necessary for good patient care. The decision of new management to phase out that practice was consistent with industry norms and enhanced patient care. The facts as I understand them are as follows:

Ms Konjoh, the new Director of Nursing of the Somerset Valley Center, and Ms Illis, the new Administrator, directed that full and part-time staff should be utilized whenever possible and that per diem use should be limited to times when full or part-time employees are not available. That policy was consistent with Healthbridge Management Human Resource Policy HR 2-6 in effect at the Somerset Valley Center, which makes it clear that per diem employees are called into work on an as needed basis.

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When the new Administrator and Director of Nursing determined to adhere to this policy, several per diem nurses or CNAs working at the Somerset Valley Center during August 2010 were given the opportunity to convert to full or part time employee status. Some accepted, but some declined that invitation. Since then, the Center has maintained its policy of utilizing full or part time employees whenever possible, calling in per diem nurses and CNAs only when necessary and without any guarantee of any particular number of hours of work per week. As a consequence, per diems with only limited availability were not utilized, either because openings did not occur on the specific days or shifts they were available, or because, for purposes of continuity of care, per diems with availability on consecutive days were selected.

Based on my review of these facts, I believe that the Center's actions in seeking to limit the use of per diem employees were consistent with industry standards, best practices and the delivery of appropriate patient care. Requiring the Center to return to the unorthodox practices of prior management would not be in the best interests of patients or the public.

Department of Health and Senior Services Survey

Also at issue in this case is the significance of the Survey Report issued to the Somerset Valley Center by the New Jersey Department of Health and Senior Services ("DHSS") and the Centers for Medicare and Medicaid ("CMS") during the period when the former employees discussed above were working at the Somerset Valley Center. The facts relevant to this issue are as follows:

On December 1, 2009, the DHSS issued its Survey Report for the Somerset Valley Center, as well as a Life Safety Code Report. The Survey Report indicated six operational deficiencies in the areas of Comprehensive Care Plans, Quality of Care, Food, and Pharmacy Services.

Two of the six deficiencies identified in the 2009 survey had a scope of "G," which indicates actual harm to the resident. The first of these "G" level deficiencies was for failure to provide a comprehensive care plan and resulted because a resident admitted with rectal cancer who experienced excruciating pain had an incomplete pain assessment and no care plan in place to manage the pain. The second "G" level deficiency was for inadequate quality of care and resulted because the same resident stated to the surveyor that she had excruciating pain, but there was no documentation for nearly a month that a pain ointment which had been ordered was ever given. Additionally this same resident asked for her ordered pain medication in the presence of the state surveyor and the staff nurse did not administer it to the resident even though the resident described her pain at a level 5 out of 10. Instead the nurse told her to wait until after her radiation treatment. The third deficiency resulted because the surveyor observed a resident's indwelling catheter improperly positioned on the floor one time and a second time lying on the bed allowing back flow of urine. The fourth deficiency dealt with failure of the food service staff to provide condiments on the trays of residents resulting in bland, tasteless food, creating a poor

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quality of life. The fifth deficiency dealt with the pharmacy failing to deliver a pain medication immediately. The physician had ordered that the pain medication be administered immediately, which was not done because it was not delivered by the pharmacy. This deficiency also addressed the fact that the medication cart containing numerous medications was left unlocked and unattended in the hallway, creating a risk of accidental poisoning to residents with unrestricted access to it. The sixth deficiency was for failure to provide a comprehensive monthly drug regimen review. The pharmacist had failed to comment on use of an antipsychotic medicine in a resident with no behavior symptoms who was at risk for side effects.

An Initial Notice Letter was accordingly issued to the Somerset Valley Center on December 10, 2009, describing the findings in the Survey Report and advising the Somerset Valley Center of its rights to and the procedure for engaging in Informal Dispute Resolution. The Initial Notice Letter also described the elements of an acceptable Plan of Correction. Further, it advised of potential penalties and remedial actions against the Somerset Valley Center, including, denial of payment for new admissions if the facility is not in compliance within 3 months; termination of the provider agreement if the facility is not in compliance within 6 months; and penalties of \$200 per day for each day the facility is out of compliance.

A Plan of Correction was duly prepared and submitted to DHSS by the Somerset Valley Center. The DHSS thereafter issued a Form 2567 B to the Somerset Valley Center, which confirmed that the six deficiencies identified in the December 1, 2009 Survey Report had been corrected as of December 28, 2009, and that the Somerset Valley Center remained in compliance on a revisit conducted by DHSS on January 11, 2010. A formal Determination of Compliance letter was issued on January 15, 2010. The letter stated that a fine of \$5,400 could be assessed against the Somerset Valley Center based on 27 days of non-compliance with applicable standards of performance.

Analysis and Conclusions

Based on my review of the above-described facts and my extensive experience in the health care industry, it is my opinion that the terminations of the former Somerset Valley Center employees were for valid and appropriate reasons related to patient care; that a realignment in per diem staffing at the facility was appropriate and justified to improve patient care; and that the reinstatement of the four terminated employees and/or utilization of per diem employees other than on an as-needed basis would jeopardize patient care, could result in harm to patients, and thus, would be contrary to the public interest.

The Termination of the Former Somerset Valley Center Employees was Appropriate and Their Reinstatement Would Not be Proper or in the Public Interest as it Could Adversely Affect Patient Care

Based on my 25 years of experience both as a provider of Long Term Care and a State Surveyor of long term care facilities, I believe that it was entirely appropriate to terminate the

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four employees in question. These employees committed grievous errors in judgment and/or the performance of the duties and responsibilities of their jobs that had the potential to cause serious injury, harm and even death to the residents of the Somerset Valley Center whom they had been hired to care for and protect. Further, they clearly breached established regulatory standards of nursing care. To return these employees to the workplace would place residents of the Somerset Valley Center at serious risk, would adversely impact morale among the current employees who have performed their jobs consistent with accepted standards of nursing care, and would be contrary to the public interest.

The Somerset Valley Center must comply with both Federal and State regulations regarding quality of care necessary to maintain State of New Jersey licensure and Federal certification. The Federal regulations are set forth at 42 CFR § 483 et seq., and State of New Jersey regulations are set forth at N.J.A.C. 8:39- et seq. Pursuant to applicable federal regulations, nursing staff must conduct an assessment of each resident, and is responsible for identifying any and all problems the resident may have and document the same. 42 CFR § 483.20 (F272). Then, nursing staff and all members of the Interdisciplinary Care Team are responsible for developing a specific resident centered Plan of Care based on that assessment, which must also be documented. 42 CFR § 483.20(d) and §483.20(k) (1) (F279). These assessments and care plans must be updated whenever the resident's condition changes significantly, but at a minimum of quarterly.

There are regulations that deal with resident abuse. 42 CFR §483.13(c) (F226) state that a facility must have policies and procedures in place to prevent abuse of residents. It further requires that staff be supervised to identify any inappropriate behaviors that could be considered abusive.

There are also numerous Quality of Care regulations which state that a resident must receive the care and services necessary to attain or maintain the highest level of functioning. 42 CFR §483.25 (F309). N.J.A.C. 8:39-27.1(a) and 40 CFR §483.25(h) (F323) require that each resident receives adequate supervision and assistance to prevent accidents. This is why documentation of incident reports is critical. The facility must show with documentation that everything possible was done to prevent an accident. If an avoidable accident resulted in harm to the resident, this would result in a citation and significant fines.

42 CFR §483.25(l) (F329) requires that a resident's drug regimen must be free of unnecessary drugs. It further defines an unnecessary drug as one in excessive dose, for excessive duration, without adequate monitoring, or without adequate indication for use. This means that there must be clear documentation in the record that the resident exhibits symptoms that warrant the use of the medication, that it is administered in the dose and at the times the physician ordered and that the effects of the medication on these symptoms is monitored and documented. If the resident received pain medication, its effects must also be documented.

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Because the four employees discussed herein failed to comply with regulatory requirements, and did not meet accepted standards of nursing practice, it is my opinion that they were properly terminated from employment by the Somerset Valley Center.

Shannon Napolitano administered medication without a physician's order on multiple occasions, which is against all standards of nursing practice and a failure to comply with the requirements of 42 CFR §483.25(l) (F329). The accepted standard of practice for a nurse is to check the Medication Administration Record before administering medication. Napolitano did not follow this accepted standard of practice. Had she done so, she would have realized that the medication had not been authorized. There is a potential for a very serious adverse event with such neglectful, haphazard nursing care. Medication could be given to a resident with allergies, which could cause an anaphylactic reaction resulting in death. The fact that this did not happen to residents under Napolitano's care during the period of time relevant to these claims does not diminish the severity of this infraction. Further, Napolitano left medication in the room of an unattended resident, creating the potential for another resident to take that medication. This behavior too runs counter to every nursing standard of practice and violates 42 CFR §483.25(l) (F329).

In addition, Napolitano falsified pain assessments for Center residents by documenting all pain assessments at the beginning of her shift. It is impossible to properly assess a resident's pain before the shift has been completed. The standard of practice is to document the occurrence at the time it is happening. Incorrectly documenting an as-yet non-existent assessment creates the potential for a resident to suffer unnecessary untreated pain as was described as having occurred in the December 2009 state survey, or conversely be treated with an unnecessary medication. Falsification of records is not condoned as standard nursing practice and violates 42 CFR §483.20(k)(3) (F281).

Napolitano also failed to document the provision of a treatment on two different occasions. By any accepted standard of nursing practice and as required by 42 CFR §483.20 (k) (1) (F281) and 42 CFR §483.25(c) (F314) if a treatment is not documented it is considered not to have been provided. This may cause the treatment to be repeated by the next shift. This can result in unnecessary and completely avoidable risk to residents of the Somerset Valley Center. In the case of pressure ulcers, repeating a treatment may disturb the wound bed and prevent timely wound healing, not to mention putting the resident through an unnecessary procedure. Napolitano also incorrectly documented a resident's oxygen saturation level as 0%, which would indicate he was deceased or very near death. This could cause the resident to be treated unnecessarily. Had he actually expired at a later time in the shift and been found by another staff member, one could question why he was not treated when he had an oxygen saturation level of 0%, leaving the facility open to charges of neglect. When regulations requiring proper treatment documentation are not followed, fines may be levied, as was the case for the Somerset Valley Center as a result of the deficiencies identified in the 2009 State Survey report.

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In addition to all of the serious clinical errors this employee made, Napolitano was repeatedly late for work. In a facility that functions 24 hours a day caring for the frail elderly, when one person doesn't show up or comes in late, there is a delay in care to residents and additional burden to the staff in the facility. Returning Napolitano to work would place Somerset Valley Center residents at risk of delay in treatment, unnecessary pain, injury, and serious harm. It could also have a detrimental effect on the morale of the nursing staff that are doing their job correctly, and giving good nursing care on a daily basis.

Like Napolitano, Sheena Claudio failed to document treatments when they were provided, attempted to document them more than eight hours after her shift was over, and was insubordinate to the Somerset Valley Center Administrator when she was instructed to stop documenting when she was not on duty. She also gave medication not in accordance with the doctor's order. Some medications interact with others, residents have allergies to some medications and the physician's orders are written based on his clinical knowledge of the resident. Failing to follow these orders creates the potential for serious injury and harm to the residents and did not comply with the requirements of 42 CFR §483.25(l) (F329). Claudio also failed to document an incident when a resident fell and suffered a head injury. Head injuries require specialized assessments of the resident's neurological status to identify a potentially more serious injury that could lead to death if untreated. These assessments would not be done if there was no documentation of the fall and head injury. Thus, this patient was put at extreme risk by Claudio's failure to document the fall incident, which was in contravention of 42 CFR §483.25 (F309). Claudio also provided treatment to a resident with a skin tear but failed to document the physician's order for the treatment, which in effect is providing treatment without a physician's order. As discussed above, with no record of treatment, it is possible that duplicative treatment could be provided, or if more aggressive treatment were required, it would not be provided due to lack of any record of the initial treatment.

In addition to all the above clinical issues, Claudio was repeatedly counseled for attendance problems, which places residents at risk of delays in treatment and a poor quality of life. Returning this employee to work would place Somerset Valley Center residents at risk of serious harm. Finally, Claudio's insubordination to her superiors also makes one question if her demeanor places residents at risk of physical and verbal abuse. Residents with dementia often exhibit behavior symptoms including grabbing staff, calling them names or hitting. An employee with a volatile personality to be so boldly insubordinate to the individual with overall responsibility for the care of residents in the building is one that may pose a risk of abuse to residents, and a potential violation of 42 CFR § 483.13(c) (F226).

Like Napolitano and Claudio, the third nurse, Jillian Jacques, also demonstrated serious breaches of accepted standards of nursing care. Jacques demonstrated a history of omissions in her documentation that was brought to her attention nearly two years prior to her termination. These omissions could have serious clinical consequences. The failure to assess a resident's pain level on admission to the facility led to the lack of a care plan for pain. This resulted in a violation of 42 CFR §483.20(d) and (k) (1) (F279), which was identified on the 2009 DHSS

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survey as a deficiency. The offense that finally precipitated Jacques' termination also had the potential of harm to the resident. A patient was prescribed enteric coated aspirin on the physician's order sheet, and Jacques documented uncoated aspirin on the physician's order sheet. This put the patient at risk of stomach irritation with a gastrointestinal bleed, had the non-enteric coated aspirin been provided over a period of time. The fact that this did not happen is due only to the quality control procedures that are in place in the facility. The pharmacy sent two notes questioning the discrepancies in the orders between the hospital and the facility. Whenever a medication is improperly transcribed, the potential for severe consequences always exists. Jacques' conduct clearly failed to comply with the requirements of 42 CFR §483.25(l) (F329). Jacques also admitted other infractions for which she was never disciplined. She stated she committed some of these errors because she was busy or called away to an emergency. Caring for the frail elderly is an awesome responsibility and it requires staff with impeccable attention to detail at all times, especially when emergencies arise.

Valarie Wells failed to manage the staff at the Somerset Valley Center facility in accordance with her supervisor's direction, placing residents at risk of poor care due to understaffing. She also placed the facility at risk of an understaffing deficiency which could result in fines, as staffing requirements are established pursuant to 42 CFR § 483.30 (F353), and N.J.A.C. 8:39-25.2. Wells' failure to properly reconcile the scheduling software for the facility with records of the schedule actually worked by employees, although she had demonstrated complete mastery of the SMLX staffing program, created a risk of inappropriate staffing for the facility. Additionally by staffing with per diem employees instead of full and part-time employees she failed to adhere to the facility staffing budget as per diems are paid at a higher hourly pay rate. Returning this employee to work would be detrimental to the residents and staff of the Somerset Valley Center because the clinical operation cannot run smoothly when staffed inappropriately.

Because each of these former employees demonstrated a complete failure to comply with accepted standards of nursing care and/or the Center's expectations intended to ensure appropriate patient care, they were properly terminated from employment by the Somerset Valley Center. Reinstatement would be improper and contrary to the public interest as placing any of these individuals back in the Center could result in harm to patients.

Realignment of Per Diem Usage and Reduction in Per Diem Assignments on Regular Schedules was an Appropriate and Proper Measure to Improve Patient Care as well as Operational Efficiency

In addition to business operational concerns, it is in the clinical interests of the residents of a facility such as the Somerset Valley Center to minimize utilization of per diem employees on regular schedules and instead only use them as a last resort to fill short-term or unexpected, last minute vacancies. In my experience, good facilities use per diem employees sparingly because geriatric residents who suffer from dementia react better, are happier and experience a better quality of life when they are cared for by the same individuals on a daily basis. Because of

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the importance of this continuity of care to patient wellbeing, many facilities utilize permanent assignments and limit the use of per diem staff for this reason. Limiting use of per diem nurses and CNAs also minimizes the likelihood of violation of 42 CFR § 483.13(c) (F 226). The interpretive guidelines for this regulation specifically instruct a facility to ensure that there is sufficient staff on each shift and that the staff is knowledgeable about the individual care needs of each resident. Accordingly, the determination of the Center not to use per diem personnel on regular schedules when part-time or full-time employees were available, and to only to use per diem employees to fill short term and unexpected, last minute vacancies was appropriate and consistent with the mandate to provide the best possible care to the facility's residents. In this regard, as the Center realigned its usage of per diem personnel, it offered part-time or full-time positions to some of the per diem employees. However, those per diem employees who did not accept these positions and had limited availability to work ended up not being called when vacancies occurred for which they were unavailable or when another per diem employee was available to work consecutive shifts (when they could not), thereby providing the desired continuity of care.

The Deficiencies Identified in the 2009 DHSS Survey Report were Significant

In order to operate a long term facility in the state of New Jersey, the facility must be licensed by the State Department of Health and Senior Services. In order to receive Federal Funds the facility must also become certified by the Centers for Medicare and Medicaid Services (CMS). Licensure (State) requires the facility to comply with the NJ Administrative Code Chapter 39 and Certification (Federal) requires the facility to comply with the Code of Federal Regulations 483.10 through 483.75. Once initially licensed and certified, every facility is inspected every year during an unannounced survey by a team of professional surveyors. The team will be in the facility for three to five days depending on the size of the facility to determine compliance with these regulations.

Surveyors are required by law to observe a subsection of residents to determine if their quality of life and quality of care is in compliance with the regulations. There are many tasks in the survey including observation of the administration of medication and evaluation of staffing schedules to ensure that staffing is adequate. When problems are identified, deficiencies are cited and fines are levied that sometimes reach into thousands of dollars.

When deficiencies are identified during a survey, the subject facility is required to write a Plan of Correction stating how each of these deficiencies will be corrected. One requirement is that the Plan of Correction addresses how the facility will maintain ongoing compliance with the cited regulation. All facilities are mandated to have quality assurance committees that identify and address problems in the facility to ensure compliance with the regulations, avoid monetary fines and assist in the provision of a high quality of life. Facilities strive to have deficiency free surveys to improve their public image, attract new residents and provide the highest quality of care for their current residents. Although surveys are unannounced, since the survey is conducted at any time from 9 to 15 months since the last survey, administrative staff have some

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idea when the survey might occur. Accordingly, most facilities review regulatory requirements in preparation for an anticipated survey, especially any regulations that may have been cited on the previous survey. Fines are more severe if the same deficiency occurs a second time. Many facilities have a team of professionals, outside consultants or corporate personnel come in and conduct a "Mock Survey" to ensure that they are in compliance and avoid deficiencies during the official survey. Every Department Head is usually held responsible, with the Administrator having the overall responsibility to ensure compliance with all of the regulations. Staff members who do not perform up to par cannot continue to be employed because the ramifications are too severe. In addition to severe monetary fines, facilities can lose their ability to admit new residents or have their provider agreement terminated, which means they would not receive any federal funds for the residents residing in the facility. Additionally, licensure could be revoked.

As discussed above, the Somerset Valley Center had six deficiencies in its 2009 DHSS survey. Two of these deficiencies were "G" deficiencies, which are very serious deficiencies, and were directly attributable to poor nursing practice by individual employees. With respect to the failure to manage the pain of a resident suffering from rectal cancer, with the myriad of medications available, there is no reason for anyone to suffer such excruciating pain, especially someone entrusted to the care of a licensed Health Care Facility. Additionally the surveyor noted that this same resident asked for pain medication which was not provided because she was leaving the facility to go for radiation therapy. She had an order for the medication but the nurse did not give it to her. The nurse told the surveyor that the resident was always in more pain when she returned from radiation and she would give it to her then. For a nurse to knowingly allow a resident to be in such pain for an extended period of time is unconscionable. The accepted standard of pain management is to give medication before pain becomes unbearable, to keep the blood medication level at such a level that pain is continually alleviated. This is an extremely serious deficiency and borders on outright neglect in my opinion. Similarly, the deficiency related to the failure to properly position a catheter in a resident was a serious one. Both instances of improper positioning of the catheter placed the resident at risk of infection. Urinary Tract Infections in the elderly are very serious because the elderly do not have the capability to fight off virulent infections.

Consistent with survey requirements, Somerset Valley Center submitted a Plan of Correction. With respect to the two deficiencies related to pain, the Plan stated that pain management will be reviewed weekly by the Interdisciplinary Care Team for each resident and random audits will be completed by the Director of Nursing or designee monthly, and the findings of such audits will be reported to the quality assurance committee. Accordingly, Somerset Valley Center took all of the identified deficiencies very seriously, and particularly the deficiencies related to inappropriate management of pain.

Because the four former employees discussed above – Napolitano, Claudio, Jacques and Wells – committed grievous errors putting residents at risk for serious harm, their termination was also appropriate because of the potential their continued employment created for a poor survey report, with potentially severe financial consequences to the Somerset Valley Center. By

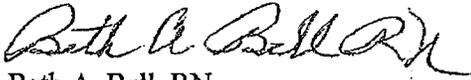
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retaining only those employees who met the appropriate standards of nursing practice, the Somerset Valley Center best positioned itself for compliance with all applicable federal and state regulatory requirements and successful DHSS surveys on a going-forward basis, and to best serve the public interest. Reinstatement of any of the former Somerset Valley Center employees would be improper and contrary to the public interest as placing any of these individuals back in the Center could result in harm to patients.

If you have any questions regarding the foregoing, please do not hesitate to contact me.

Sincerely,



Beth A. Bell, RN

Enclosure



92
Exh. No: 43 Received _____ Rejected _____
Case No.: 22-CA-29599 et al
Case Name: Somerset Valley Rehab
UN
No. Pgs: _____ Date: 4-2-11 Rep.: AM

NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name: Jillian Scoppe Facility: SURNC
Job Title: LPN Date of Hire: _____

for Disciplinary Notices in File: (include date and nature)

TYPE OF VIOLATION

- Dress Code
- Behavior
- Absenteeism/Tardiness
- Performance
- Inappropriate Behavior
- Patient Care
- Resident Rights
- Refusal to Perform Assigned Task
- Other: _____

DESCRIPTION

Date: 9/28/10 Time: 3-11 shift

Specific Description of Issue, Situation or Behavior (what, where, how): On 9/24/10 you failed to document on pt (EG), s/p adm 02 and you failed to document on pt (EB) for same date s/p adm, and on same pt on 9/25/10 s/p adm. These were topics raised in staff meeting on 9/15/10.

EMPLOYEE RESPONSE

I agree _____
I disagree for these reasons: _____

ACTION TO BE TAKEN

Documented Verbal Notice _____ Written Notice 1st
Suspension for _____ days to start on _____ (date) and return to work on _____ (date).
Does this Disciplinary Action Constitute Final Warning: Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination of employment.

[Signature] Date _____
Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

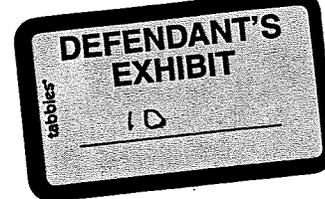
Supervisor's Signature _____ Date _____

Department Head/Administrator _____ Date _____

Witness Signature _____ Date _____

(One copy to Employee - one copy to Personnel File - One copy to Supervisor)

Gox-43



ARCHER & GREINER, P.C.
ATTORNEYS AT LAW

WILLIAM P. ISELE

700 ALEXANDER PARK
SUITE 102
PRINCETON, NJ 08540
609-580-3700
FAX 609-580-0051

Email Address:
wisele@archerlaw.com

Direct Dial:
(609) 580-3780

www.archerlaw.com

July 8, 2011

Rosemary Alito, Esq.
K & L Gates, LLP
One Newark Center, 10th Floor
Newark, NJ 07102

RE: Lightner v. 1621 Route 22 West Operating Company, LLC
Civil Action No. 3:11-cv-02007-MLC-LHG

Dear Ms. Alito:

As indicated on my attached résumé, I served as General Counsel to the New Jersey Office of the Ombudsman for the Institutionalized Elderly from June, 1998 to October, 1999. In October, 1999, Governor Whitman appointed me as the Acting Ombudsman, and nominated me as the Ombudsman, pending the advice and consent of the Senate. In May, 2000, the State Senate confirmed my nomination, and I continued to serve as the State Ombudsman until October, 2007.

As the State Ombudsman, I was the administrator and Chief Executive Officer of an agency tasked with the receipt, investigation and resolution of complaints concerning health care facilities serving the elderly (N.J.S.A. 52:27G-4). It was also my statutory responsibility to initiate actions to secure, preserve and promote the health, safety and welfare, and the civil and human rights, of the elderly patients, residents and clients of such facilities (N.J.S.A. 52:27G-1). In that capacity, it was my responsibility to represent the public interest in assuring that health facilities provided quality care to the elderly persons residing in them. That care is provided by the individuals employed by such facilities:

In preparation of this report, I have read:

- 1) Declaration of Inez Konjoh, dated May 6, 2011 (with exhibit);
- 2) Declaration of Doreen Illis, dated May 6, 2011 (with 25 exhibits);
- 3) Memorandum of Points and Authorities, undated but filed by the Petitioner electronically on April 7, 2011;

HADDONFIELD OFFICE
One Centennial Square
Haddonfield, NJ 08033-0968
P 856-795-2121
F 856-795-0574

FLEMINGTON OFFICE
Plaza One
1 State Route 12, Suite 201
Flemington, NJ 08822-1722
P 908-788-9700
F 908-788-7854

PHILADELPHIA OFFICE
One Liberty Place - 32nd Floor
1650 Market Street
Philadelphia, PA 19103-7393
P 215-963-3300
F 215-963-9999

WILMINGTON OFFICE
300 Delaware Avenue
Suite 1370
Wilmington, DE 19801
P 302-777-4350
F 302-777-4352

GEORGETOWN OFFICE
9 East Market Street
P.O. Box 977
Georgetown, DE 19947
P-302-858-5151
F-302-858-5161

NEW YORK OFFICE
2 Penn Plaza
Suite 1500
New York, NY 10121
P 212-292-4988
F 212-629-4568

HACKENSACK OFFICE
21 Main Street, Suite 353
Court Plaza South, West Wing
Hackensack, NJ 07601-7095
P 201-342-6000
F 201-342-6611

- 4) Survey documentation related to the NJ Department of Health and Senior Services December 1, 2009 and March 12, 2010 surveys of Somerset Valley Rehabilitation and Nursing Center ("SVRNC");
- 5) Three "Confidential Witness Affidavits" of Jullian [sic] Jacques, one dated September 30, 2010, and two dated January 11, 2011, with exhibits;
- 6) Transcript of oral deposition of Jillian Jacques dated May 23, 2011;
- 7) Transcript of oral deposition of Valarie Wells dated April 26, 2011;
- 8) Transcript of oral deposition of Shannon Napolitano dated May 2, 2011;
- 9) Transcript of oral deposition of Sheena Claudio dated May 3, 2011;
- 10) "Confidential Witness Affidavit" of Valarie Wells, dated October 20, 2010, with exhibits;
- 11) "Confidential Witness Affidavit" of Shannon Napolitano, dated September 29, 2010, with exhibits;
- 12) "Confidential Witness Affidavit" of Sheena Claudio, dated October 13, 2010, with exhibits.

I have also reviewed the Federal and New Jersey state regulations pertinent to long-term care facilities, such as SVRNC, in particular, 42 C.F.R. §483; the State Operations Manual, Appendix PP to 42 C.F.R. §483; and N.J.A.C. 8:39 as well as licensing information available to the public on State of New Jersey websites. I have also relied upon my years of experience in the field.

In my professional opinion, it would be inimical to the public interest and specifically to the health, safety, and welfare of the vulnerable elderly residents of SVRNC, to order the reinstatement, even temporarily, of Shannon Napolitano, LPN ("Napolitano"); Sheena Claudio, LPN ("Claudio"); Jillian Jacques, LPN ("Jacques"); and Valarie Wells, Staffing Coordinator ("Wells").

It is also my professional opinion that it would be inimical to the public interest, and specifically to the health, safety and welfare of the vulnerable elderly residents of SVRNC, to require SVRNC to increase the hours of *per diem* nursing staff, in lieu of regular full-time and part-time nursing staff. The reasons for these opinions follow.

SVRNC is licensed by the State of New Jersey to operate a 64-bed long-term health care facility, commonly known as a nursing home. Its "consumers" consist of vulnerable, elderly men and women, who, as recognized by the Legislature, may be, and often are "afflicted with physical and mental infirmities, deprived of the comfort and counsel of family and friends, and forced to exist with minimum economic resources." N.J.S.A. 52:27G-1.

SVRNC is a Medicaid approved provider, meaning that many of its residents depend on Medicaid benefits for their care, and are permitted to keep \$35/month of their own income for their personal needs.

SVRNC is also Medicare-certified, meaning that it serves as a “step-down” facility for individuals who have been hospitalized, and require rehabilitative care before they can return home. In many, if not most cases, they are totally dependent on the employees of SVRNC for their most basic care needs.

I am personally familiar with SVRNC, and I did have occasion to visit it when I was the Ombudsman.

A. Shannon Napolitano, LPN

Respondent asserts, and Petitioner does not deny, that Napolitano engaged in at least five (5) incidents of resident neglect, each of which had the potential to cause actual harm:

1) Documentation of pain assessments at the beginning of her shift, before assessing any individual residents. This is a dangerous practice. It may result in some persons who suffer from acute or chronic pain not receiving the pain medication they require. It may also result in administration of unnecessary pain medication (often narcotics) to persons who do not require them. If a nurse documents her pain assessments before she actually assesses her patients, she does harm, either way. In addition, pain assessment should not only be directed toward the pain itself, but the side effects of the medication, one of which is constipation. I am aware of instances in which people have died from an impacted bowel, because this aspect of pain assessment was overlooked.

2) Failure to document treatment records. There is an aphorism, widely used in nursing home care: “If it’s not written down, it didn’t happen.” If a treatment is not documented, another nurse may duplicate the treatment. If the treatment is administration of a medication, this could result in an overdose. Treatments should be documented in the chart contemporaneously; failure to do so puts the patient at risk.

3) Administration of oral form of Zinc Oxide at least 4 times after it was discontinued. A significant property of Zinc Oxide is that it is not water-soluble, thus it can build up in the body when taken by mouth. I am not a doctor or pharmacist, and do not know the potentially toxic effects of a Zinc Oxide overdose. Neither would an LPN. This is precisely the reason that it is dangerous to continue to administer a medication, any medication, after it has been discontinued. The attending physician has made a determination that the medication is to be stopped. The duty of the LPN is to review the physician orders, and make sure medications that have been discontinued are, in fact, discontinued.

4) Leaving a medication in the room, without observing that the patient consumed it. This is dangerous on many levels. The patient may not take a needed medication, which would put the patient at risk. Another patient, such as a roommate, might notice and take the

medication, which could be contra-indicated for that patient, or may interact harmfully with other medications that patient is taking.

5) Documentation of a patient's oxygen saturation at 0%. Many elders in nursing homes suffer from chronic obstructive pulmonary disease ("COPD") or congestive heart failure ("CHF"), both of which are carefully monitored by determining oxygen saturation levels. Physician orders often call for a patient to be transported to a hospital or given other emergency treatment if the oxygen saturation goes below 89% or 90%. An oxygen saturation level of 0% is so extreme that immediate confirmation should have been sought. To document such a low level, and expect to "catch it" at the end of a shift, 8 hours later, is simply irresponsible, and demonstrates a severe disregard of the importance of documentation on the part of this LPN.

For the above reasons, in my professional opinion, an order reinstating this LPN would be contrary to the public interest in assuring that competent care is provided at SVRNC. Taken together, items 1, 2, and 5 above demonstrate that this LPN lacks understanding of the importance of accurate and timely documentation, a hallmark of competent care. Item 3 demonstrates a reckless disregard of the documentation of others, specifically doctor's orders. At the very least, I would recommend some level of re-training before this LPN continues to practice anywhere. Item 4 is simply careless and sloppy care, which has the potential of causing harm, not only to the patient, but also to others.

B. Sheena Claudio, LPN

Respondent asserts, and Petitioner does not deny, that Claudio engaged in at least six (6) incidents of resident neglect, each of which had the potential of actual harm:

1) Failure to document treatment records. I have discussed the dangers of this practice in item A.2 above, and incorporate that discussion here.

2) Administration of "baby aspirin" daily, instead of every other day. Aspirin, in addition to its other qualities, is an effective blood-thinner. Doctors often order it for patients who are prone to developing blood clots, as a means of preventing stroke. Because it thins the blood, and because aspirin also irritates the stomach lining, too much aspirin could lead to gastric bleeding. The quantity of aspirin administered must be carefully balanced between these two effects. One should not be misled by the term "baby aspirin." This is merely a lower-dose aspirin tablet. A single pill of baby aspirin contains 81 milligrams of aspirin, as compared to a 325-milligram dose in a standard aspirin pill. Administered too frequently, it could still result in the same adverse effects as "regular" dose aspirin. It is up to the attending physician to determine the optimal dosage of aspirin for each of his or her patients. Failure on the part of an LPN to read carefully, or follow, the dosage restraints in the Doctor's Orders is dangerous and puts the patient at risk.

3) Failure to document admission nurse's note. The nursing assessment required for each patient is fundamental to his or her care. It forms the basis for all nursing services provided during the patient's stay at the facility. Without the initial nursing assessment, there is no "base-line" for any of the numerous systems and conditions of which the subsequent treating nurses must be aware. For example, if the patient is prone to falls, the nursing staff must be aware, in order to implement appropriate fall prevention techniques. Failure to complete the admission nurse's note places a patient at risk in many respects.

4) Failure to document a physician's order for treatment of a skin tear. Many elderly persons have frail skin, and skin tears occur for many reasons. Sometimes, they are benign. Occasionally, they are indicative of abuse in the form of rough-handling by staff. As the Ombudsman, I trained my investigative staff to look at the frequency and severity of skin tears documented in patient records. In isolation, a skin tear may appear to be benign. However, repeated or frequent skin tears may be a sign of abuse, or some other problem, such as impaired balance leading to falls or near-falls. The only way frequent or repeated skin tears can be identified is if each individual occurrence is properly documented. Failure of a nurse to document all orders related to skin tears, no matter how minor they may appear, puts the patient at risk that a more serious problem may go unidentified.

5) Failure to document a slip and fall in which the patient sustained a head injury. This is a very serious error. I have seen far too many instances where an apparently benign bump on the head led to the sudden death of an elderly nursing home resident. As discussed above, for good medical reasons, many elderly nursing home residents are maintained on aspirin or, in more severe cases, other pharmaceutical blood thinners, such as Coumadin, a brand-name for the drug warfarin, to prevent blood clots from forming. When such an individual sustains a head injury, the thinned blood can quickly result in a "brain bleed," and form a condition known as a subdural hematoma. This condition, if unattended, can lead to death within a matter of a few hours. It is extremely dangerous and professionally irresponsible to fail to document a head injury and the neurological checks that are required following such an injury.

6) Finally, there is the rather bizarre incident involving Claudio's return to the facility at 11:25 p.m., more than eight hours after her shift ended, to complete her treatment administration records (TARs). As discussed above, acceptable practice dictates that nurses document their treatments of patients contemporaneously. Failure to do so is dangerous neglect, as it may result in overdoses of medication, or failure to recognize the signs of a problem, whether abuse or a change in medical condition. Between the end of Claudio's shift, and her return to the facility, an entire shift had come, treated her patients, and gone, and a second shift of nurses had begun treatment of her patients. Claudio's conduct in this matter demonstrates that she has not learned from her prior discipline; she still seems to consider treatment documentation as a task to be completed, rather than as part of an ongoing treatment process.

For the above reasons, in my professional opinion, an order reinstating this LPN would be contrary to the public interest in assuring that competent care is provided at SVRNC, and would endanger its residents. Items 1, 3, 4, 5, and 6 above, all demonstrate that this LPN, too, lacks an understanding of the importance of accurate and timely documentation, a hallmark of competent care. Item 2 demonstrates a reckless disregard of the documentation of others, specifically doctor's orders. At the very least, I would recommend some level of re-training before this LPN continues to practice anywhere.

C. Jillian Jacques, LPN

Respondent asserts, and Petitioner does not deny, that Jacques engaged in at least five (5) incidents of resident neglect, each of which had the potential of actual harm:

1) On 12/2/2009, Jacques received a warning for failure properly to assess a newly-admitted resident for pain. I have discussed pain assessments in item A.1 above, and incorporate that discussion here.

2) Jacques acknowledged that, in July or August, 2010, she committed a serious medical error when she failed to observe a patient taking her medication. The dangers of this practice are discussed above, in item A.4, and are incorporated here.

3) On November 1, 2010, Jacques was disciplined for not fully completing accident reports. I reviewed two reported incidents on that date, one at 9:45 p.m., and one at 9:50 p.m. Both involved patients who fell out of bed. Doctors were notified, assessments were made, and the patients were counseled. There was no apparent injury. However, Jacques did not indicate what interventions were made, or if none, her reasoning in determining that no interventions were necessary. Such information can be extremely valuable to nurses on subsequent shifts if an injury presents subsequently. A new shift would be coming on within an hour of these falls. Again, Jacques appears to be unaware of the importance of thorough documentation.

4) On February 10, 2011, Jacques was disciplined for failure to enter an order for enteric-coated aspirin on a chart. "ASA (aspirin) 325 [mg] PO (per mouth) daily" is written on the Physician Order Sheet ("POS") (Bates #5157); it does not appear at all on the Medical Administration Record ("MAR") of this new patient's chart (Bates ##5162 and 5163). I have discussed the important balancing of the benefits and dangers of aspirin in item B.2, above. This error was not the same as that discussed in item B.2, above, however. There, Claudio was documenting the treatment she provided, in apparent disregard of the physician's order. Here, Jacques' responsibility as charge nurse was to list the medications ordered for the new patient on the POS and the MAR, so that each one could be administered and checked-off throughout her stay. Jacques apparently noted the aspirin on the POS, but failed to designate that it was enteric coated (e/c). She failed to note the aspirin altogether on the MAR. The danger in this is that the nurses treating the patient would look at the MAR and not see any order for aspirin. The Patient

would not receive the medication, and could develop a blood clot, which could in turn lead to stroke or death. Fortunately, the consulting pharmacist caught both errors. Jacques admits the errors, but explains that she was working the desk that day under very demanding conditions. Again, Jacques appears not to recognize the effect her errors could have on the patient's health. Furthermore, as an LPN, she should not have been serving as charge nurse. It appears that she may have been overwhelmed by those duties.

5) On February 9, 2011, Jacques was also disciplined for not documenting a fall, and not writing a post-fall note. As indicated above, falls are serious matters in nursing homes, especially when they involve head injuries. This fall apparently did not involve a head injury, but the post-fall note is nevertheless crucial in alerting subsequent shifts to any potential problems. What is of greatest concern in this matter is that, although Jacques admitted the error, she does not seem to appreciate the harm that could befall the patient as a result of her error.

Like Napolitano and Claudio, Jacques does not seem to have an appreciation of the importance of contemporaneous documentation. Items 2, 4, 5 and 6 demonstrate a pattern of conduct or omissions that leads me to conclude that Jacques would be a danger to the health, safety and welfare of the elderly residents of SVRNC, if an order were entered reinstating her. In addition, she appears to be easily overwhelmed by additional duties, as evidenced by items 3 and 5. As stated above in Section A, Item 3 is careless and sloppy care, which has the potential of causing harm, not only to the patient, but also to others.

In light of the foregoing, there does not appear to be a basis for an affirmative finding that reinstatement of these nurses is in the public interest. To the contrary, in my professional opinion, reinstatement of these nurses would be adverse to the health, safety and welfare of the elderly residents of SVRNC, and therefore contrary to the public interest, based upon the dangers their patterns of conduct present.

D. Valarie Wells, Staffing Coordinator

Wells is not a direct caregiver, like Napolitano, Claudio and Jacques. However, in my professional opinion, her responsibilities are equally important to the direct care provided at SVRNC. Over the years that I served in the Ombudsman's Office, and based on more than 3,000 investigations per year that came under my review as General Counsel and as Ombudsman (i.e., nearly 30,000 investigations in all) I developed the firm opinion that staffing problems were the single most frequent cause of abuse and neglect of vulnerable nursing home residents. Continuity of care is highly significant, because the nurses and aides get to know their patients well, and can detect changes in their medical conditions that, if addressed early, can avoid major problems later on. Many nursing home residents with dementia develop personality and behavioral problems that can be handled more easily by familiar nurses and aides. For these reasons, staffing is very important to their health, safety and welfare. It is my professional opinion, based on thousands of investigations over a period of 9 years, that facilities that treat

staff as “fungible,” moving them from assignment to assignment and unit to unit, consistently provide poor care. Facilities that retain long term staff, and assign them based on their demonstrated skills and competencies, consistently provide a higher quality of care.

The New Jersey Legislature recognized the public interest in careful nurse staffing, when it passed Laws 2005, chapter 21, now codified as N.J.S.A. 26:2H-5f, -5g, and -5h. Section 5f states:

The Legislature finds and declares that hospital patients and nursing home residents, in the interest of being fully informed about the quality of health care services provided at the facility where they are receiving health care services, are entitled to have access to the information that is required to be posted and otherwise provided to members of the public under this act about direct patient or resident care staffing levels at the facility.

Section 5g then requires posting of the number, and ratio to patients, of RNs, LPNs, certified nurse aides and other licensed or registered health care professionals for each unit and on each shift, and making that information available to members of the public upon request.

Respondent asserts, and Petitioner does not deny, that Wells failed, despite several meetings in August and September, 2010, to master the scheduling system upon which the administration relied, or even to reconcile discrepancies between the schedules and actual hours worked by the professional staff. Rather, she kept a private staffing spread sheet, to which the administration did not have access. In my professional opinion, an order reinstating Wells would not be in the public interest, because, if she were reinstated, SVRNC would again be incapable of complying with State Law in this regard.

E. *Per Diem* Nursing Staff

Petitioner seeks to have the number of hours of certain *per diem* nursing staff “restored.” Petitioner does not indicate any specifics regarding how this restoration is to occur.

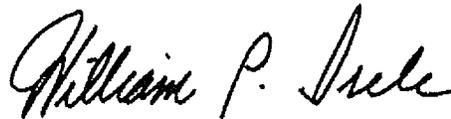
As stated above, continuity of care is highly significant in the nursing home context. *Per diem* nurses, properly used, are necessary on an as-needed basis, to replace regular staff who are sick or on vacation. *Per diem* nurses are, by definition, temporary. They are less familiar with the patients, their particular personalities and needs. As Ombudsman, I was aware of facilities which, for whatever reason, used *per diem* nursing staff in lieu of hiring full- or part-time staff. It is my professional opinion, that this is a serious mis-use of *per diem* staff. It is my professional opinion, based on personal observation and thousands of investigations over a 9-year period, that facilities that overuse *per diem* nursing staff in lieu of regular full- and part-time nursing staff, consistently provide a lower standard of care. Planned use of *per diem* staff, is also demoralizing to the regular staff.

Rosemary Alito, Esq.
July 8, 2011
Page 9

Per diem nurses should not have an expectation of a particular number of hours in a week or a month; rather, the facility should be appropriately staffed with full- and part-time nursing staff, so that use of *per diem* nurses is an infrequent occurrence. For this reason, it is my professional opinion that an order compelling SVRNC to “restore” a particular number of nursing hours to any *per diem* nurse would not be in the public interest, because it would deprive the vulnerable, elderly residents of SVRNC of the benefits of continuity of nursing care.

If you have any questions regarding the foregoing, please do not hesitate to contact the undersigned.

Sincerely,

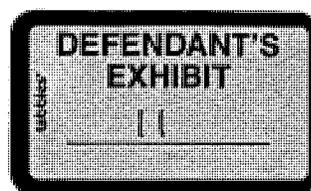
A handwritten signature in black ink that reads "William P. Isele". The signature is written in a cursive, slightly slanted style.

WILLIAM P. ISELE

WPI
Encl: Résumé



ARCHER & GREINER, P.C.
ATTORNEYS AT LAW



WILLIAM P. ISELE

700 ALEXANDER PARK
SUITE 102
PRINCETON, NJ 08540
609-580-3700
FAX 609-580-0051

Email Address:
wisele@archerlaw.com

Direct Dial:
(609) 580-3780

www.archerlaw.com

November 2, 2011

Rosemary Alito, Esq.
K & L Gates, LLP
One Newark Center, 10th Floor
Newark, NJ 07102

RE: Lightner v. 1621 Route 22 West Operating Company, LLC
Civil Action No. 3:11-cv-02007-MLC-LHG

Dear Ms. Alito:

I have read the report provided to the Petitioner by Kathleen Martin, RN, MSN, MPA, LNHA, CPHQ, WCC (hereinafter, "Nurse Martin"). To summarize, Nurse Martin opines that the three LPNs (Napolitano, Claudio and Jacques) should be re-instated because their errors were "minor" and neither hazard[ou]s nor unsafe for patient care.

At no time does Nurse Martin address the real issue here: namely that the pattern of errors and neglect committed by these three LPNs indicates in each case that the LPN is either indifferent to, or ignorant of, the clinical importance of accurate and contemporaneous documentation. Nurse Martin characterizes their errors as "minor." I do not. One cannot look at these errors in isolation. Each of these errors builds upon the others to demonstrate each LPN's critical lack of understanding that poor documentation can ultimately result in actual harm. My conclusions that each of these LPNs poses a danger to the vulnerable elderly in their care is based upon both actual harm, and also the real potential for harm caused by the pattern of errors evidenced by each of them.

I incorporate here the error-by-error analysis presented in my letter of July 8, 2011. Since Nurse Martin fails to address the issue of a pattern of errors on the part of each LPN, I stand by my opinions stated in that letter. However, I shall address the confusion of two incidents referred to by Nurse Martin in her analysis, which characterizes and impacts the credibility of her entire report, and calls into question her own professional judgment and competency.

HADDONFIELD OFFICE
One Centennial Square
Haddonfield, NJ 08033-0968
P 856-795-2121
F 856-795-0574

FLEMINGTON OFFICE
Plaza One
1 State Route 12, Suite 201
Flemington, NJ 08822-1722
P 908-788-9700
F 908-788-7854

PHILADELPHIA OFFICE
One Liberty Place - 32nd Floor
1650 Market Street
Philadelphia, PA 19103-7393
P 215-963-3300
F 215-963-9999

WILMINGTON OFFICE
300 Delaware Avenue
Suite 1370
Wilmington, DE 19801
P 302-777-4350
F 302-777-4352

GEORGETOWN OFFICE
9 East Market Street
P.O. Box 977
Georgetown, DE 19947
P-302-858-5151
F-302-858-5161

NEW YORK OFFICE
2 Penn Plaza
Suite 1500
New York, NY 10121
P 212-292-4988
F 212-629-4568

HACKENSACK OFFICE
21 Main Street, Suite 353
Court Plaza South, West Wing
Hackensack, NJ 07601-7095
P 201-342-6000
F 201-342-6611

Pain Assessment Incidents

On page 9, item #4 of her report, Nurse Martin opines that LPN Napolitano was “punished” for the G-level deficiency (actual harm) assessed against the facility by the State of New Jersey, Department of Health & Senior Services, on December 1, 2009. It was not, in fact, LPN Napolitano, but rather LPN Jacques who was disciplined for the neglect in question. See: Exhibit Jacques-5, dated 5/23/11 [Exhibit A hereto].

The State’s survey report, form CMS-2587, dated 12/01/2009, states in pertinent part: “Resident #7 was admitted on 11/4/09 with a diagnosis of rectal cancer for which she was receiving radiation therapy outside the facility Monday through Friday. On 11/24/2009 at 1:30 p.m. the resident stated [to the State surveyor] that she had such severe pain when she had a bowel movement that she had to cry out in pain which made her feel embarrassed so she put a washcloth in her mouth to muffle the scream. She further stated that there was an ointment that she was supposed to get for the rectal pain, but she had not gotten it.” The survey report continues to describe in graphic detail the excruciating pain suffered by this resident.

The State surveyor carefully described the cause-effect relationship from Jacques’ failure to perform a pain assessment to the harm suffered by the patient. Upon review of the resident’s record, it was found that, upon admission, a complete pain assessment was not done; consequently the interdisciplinary team did not develop a care plan for pain, and pain was not included in her list of problems despite the fact that one of her admitting diagnoses was pain. From 11/16/09 to 11/25/09, Lidocaine ointment ordered for this resident’s rectal pain, was never documented as having been administered.

On 12/02/2009, LPN Jacques received a Notice of Disciplinary Action, stating: “On 11/4/09 a resident was admitted to your care and was not assessed for pain which adversely affected the resident’s care.” Clearly, this was the resident who was the subject of the State’s survey report and deficiency assessment. This was indicated to be a “written notice” and a Final Warning to Jacques. Notably, Jacques admitted to the neglect, and agreed with the disciplinary action.

In my professional opinion, the facility administration took the appropriate action in disciplining LPN Jacques. Nurse Martin suggests that “administrators react emotionally to such occurrences” as a G-level deficiency, i.e., actual harm to their residents. No responsible professional could be expected to react otherwise to the State surveyor’s description of the unnecessary suffering endured by this resident. That one would have an emotional reaction to such neglect does not mean that the disciplinary action taken against Jacques was any less warranted.

Incredibly, Nurse Martin opines that “the harm was minimal to the patient, and is mainly a documentation issue” (page 9 of her report). Nurse Martin attempts to explain away the State’s

finding of actual harm, by stating: "Not to minimize the purpose of the DOH [sic] survey it is known that at times there is a subjective aspect to the survey. The similar circumstance by another surveyor would not necessarily give the same deficiency." There is no subjective aspect here. **It is a tragic fact that this patient suffered weeks of continuous, unremediated, excruciating pain, so severe that the patient would not eat, feared having a bowel movement, and stuck a rag in her own mouth to suppress her screams.** In light of these facts, it is inconceivable that any responsible health care professional could characterize such pain as "minimal." Jacques' failure to perform and document a pain assessment on this patient precipitated a series of events that resulted in the harm described above. This horrific incident is an abject example of how a "documentation issue" can, and did, have a severe negative impact on patient care.

Nurse Martin questions (page 13 of her report) why Jacques was not disciplined until December 2, 2009. The question is disingenuous. Nurse Martin cannot credibly pretend that this disciplinary action is unrelated to the December 1, 2009 survey report. Apparently, the facility administration was not aware that a pain assessment was not performed on this resident, until the State surveyor interviewed the resident. The surveyor's findings would have been pointed out to the administration during the exit conference. Jacques was then identified as the LPN who failed to perform the pain assessment, and was disciplined the day after the survey report was issued. The sequence of events makes it entirely clear why she was disciplined on December 2, 2009.

Nurse Martin seems to confuse this very serious incident with a disciplinary action taken against LPN Napolitano a month later, on January 4, 2010. There, LPN Napolitano received Notice of Disciplinary Action for the following: "You documented pain assessments for your shift at 8 AM for the entire shift. This puts the patients at risk for unaddressed pain and poor outcome. Additionally, you had previously been educated to document at the end of your shift." [Exhibit B hereto]. This notice, too, like Jacques' disciplinary action cited above, was indicated to be a Final Warning. In her commentary, Nurse Martin states that Napolitano said that "several nurses" said that the State told them last year to do pain assessments at the beginning of the shift. Notwithstanding the double-hearsay aspect of this statement, Nurse Martin's opinion is entirely disingenuous.

There is an enormous difference between *doing* pain assessments at the beginning of a shift, and *documenting* pain assessments at 8 AM, for the entire shift. Pain assessments should not wait until the end of the shift to be done. Pain assessments should be done early and often, and documented contemporaneously, so that patients receive appropriate treatment for pain throughout the shift. What Napolitano was disciplined for here was essentially creating false and fraudulent documentation: documenting pain assessments that she had not yet done. Falsification of records is a cardinal sin in health care because, as stated by the administration in its notice of disciplinary action here, it puts the patients at risk. It is truly alarming that Nurse Martin either did not make this distinction, or worse, condones such conduct on the part of Napolitano.

Although both incidents dealt with pain assessments, it is incomprehensible that an experienced nurse and licensed nursing home administrator could confuse the two, and use one to justify the other. In the case of the discipline of Jacques on 12/2/09, Jacques had never done a pain assessment of her patient on 11/4/09, who then suffered excruciating, unrelieved pain for 20 days until she spoke to a State surveyor on 11/24/09. In the case of the discipline of Napolitano in January 2010, Napolitano documented pain assessments at 8 AM, before she performed all her assessments. It is unknown whether she ever performed those assessments, but the implication from the disciplinary action is that she did not.

Despite the seriousness of these events, Jacques and Napolitano were not terminated from employment in December 2009 and January 2010, respectively. They were, however, given Final Warnings. (It should be noted that these Final Warnings occurred months before any union activity). Unfortunately, Jacques and Napolitano failed to learn from their mistakes. As discussed and analyzed in detail in my report of July 8, 2011, Jacques failed to complete an accident report on 1/1/10; did not document a fall on 2/9/11; and failed to enter a medication order on the MAR on 2/10/11. Napolitano failed to document a treatment record on 6/11/10; gave a discontinued medication 4 times between 8/23/10 and 9/17/10; failed to observe a patient taking a medication on 9/17/10; and documented a patient's oxygen saturation as 0% on 9/17/10.

Confronted with their respective histories, and the fact that each had already been given a Final Warning, the administration not only acted appropriately, but had no other choice but to terminate their employment, before another vulnerable resident could suffer actual harm at their hands. It is apparent to me that these LPNs consider documentation a nuisance, rather than a clinical imperative. As evidenced by the extreme harm caused to a resident by Jacques' failure to perform a pain assessment in 2009, poor documentation results in poor care. Napolitano's fictitious documentation of pain assessments in early 2010 was reprehensible. It is no surprise that she did not appreciate the potential harm her careless actions later in the year could cause, despite having received a Final Warning.

LPN Claudio Incident

In addition to the foregoing, I am compelled to address Nurse Martin's analysis of the incident of 10/7/2010, involving LPN Claudio. In my previous report, I referred to this incident as "bizarre." Nurse Martin opines that Claudio's return to the facility at 11:15 p.m. to "finish her work" was "admirable."

Claudio apparently worked the 7 a.m. to 3 p.m. shift at Respondent's facility that day, and left without finishing her charts. It is not clear whether someone else completed them for her, or whether she entered all the information, but failed to sign her notes, for some unknown reason. The Notice of Disciplinary Action, unsigned by her, stated that she failed to administer

Rosemary Alito, Esq.
November 2, 2011
Page 5

treatments to multiple patients. [Exhibit C hereto]. This is not “mere documentation.” This is actionable neglect. Either Nurse Martin failed to read this Notice, or she disregarded it.

Regardless, Claudio then went to another nursing facility, where she worked an additional 8-hour shift (Claudio Deposition, page 64). After working 16 hours straight, she returned to Respondent’s facility to complete her charts. In the meantime, of course, nurses on the 3 pm to 11 pm shift had cared for her patients, without benefit of her treatment notes. Nurses on the 11 pm to 7 am shift had commenced to care for these patients, still without benefit of her treatment notes. When confronted by the administrator at this late hour, she became insubordinate.

Such conduct is far from admirable; it is reckless and dangerous, exposing all her patients to unnecessary risk. Assuming that she did provide treatment to patients in her care, how could she remember details regarding any specific patient, 8 to 16 hours after the fact? After caring for other patients at another facility for those eight hours, how could she avoid confusion of patients? Add to these concerns the mental and physical tiredness one would experience after working 16 hours straight. The result is a recipe for disaster. And if, in fact, Claudio did not administer treatment to multiple patients, and intended to create fictitious treatment records, the inherent dangers are extreme.

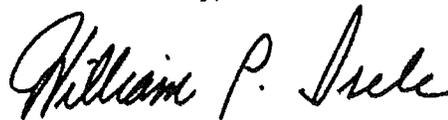
Only ten days earlier, on 9/27/10, Claudio had received a 2-day suspension for failure to document a new admission; failure to document treatment for a skin tear; and failure to document a slip and fall with a head injury. I addressed these incidents in my previous report, and incorporate that discussion here. In the best possible light, her actions on 10/7/2010 evidence a complete failure to understand the importance of contemporaneous documentation, and a complete failure to learn from her prior discipline. Like Napolitano and Jacques, Claudio seems to consider documentation as a nuisance, not a clinical imperative. For the reasons stated in my previous report, such an attitude is dangerous, and puts all of the patients she treats at risk.

Other Matters

Nurse Martin did not address the termination of Valarie Wells, nor the “restoration” of hours to unnamed *per diem* nurses. I stand by my previous opinions regarding those matters.

If you have any questions regarding the foregoing, please do not hesitate to contact the undersigned.

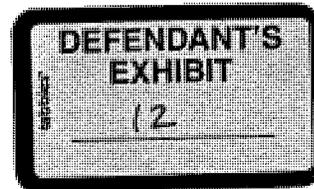
Sincerely,



WILLIAM P. ISELE

Résumé of
William P. Isele

Office: 700 Alexander Park, Suite 102, Princeton, New Jersey 08540
Home: 313 Brook Drive, Milltown, New Jersey 08850
Office: (609) 580-3780 Cell: (732) 939-4112
E-mail: Wisele@archerlaw.com



EXPERIENCE

November 2007 to present

Archer & Greiner, P.C. (Princeton, NJ) Of Counsel
Health Care and Elder Law; health care consulting.

June 1998 to October 2007

State of New Jersey, Office of the Ombudsman for the Institutionalized Elderly (Trenton, NJ)
Administrator and Chief Executive Officer (October 1999 – October 2007).
Serve as administrator & CEO of State Agency charged with protection of the Institutionalized Elderly.
General Counsel (June 1998 – October 1999)
Represent and advise independent State Agency charged with protection of the Institutionalized Elderly.

March 1992 to June 1998

The Law Offices of William P. Isele, P.C. (Milltown, NJ): Principal
General Civil Practice; emphasis on representation of health care professionals and senior citizens.

October 1989 to February 1992

Kern, Augustine, Conroy & Isele, P.C. (Bridgewater, NJ): Principal
Counsel to physicians, nurses and other healthcare professionals; represent and advise senior citizens regarding guardianships, Medicare and Medicaid; end of life decision making and bio-ethical issues.

January 1989 to September 1989

Carella, Byrne, Bain & Gilfillan, P.C. (Roseland, NJ): Of Counsel
Counsel to major health care system (Cathedral Healthcare System, Inc.), hospitals, and other health professionals; participated as court-appointed special fiscal agent in the administration of troubled inner city hospital (United Hospitals Medical Center).

August 1981 to December 1988:

Gross & Novak, P.A. (East Brunswick, NJ): Principal (1/85-12/88); Associate (8/81-12/84)
Counsel to major teaching hospital (Robert Wood Johnson University Hospital), health professionals, commercial, banking, bankruptcy, real estate and business interests; guardianships, Medicare and Medicaid, end of life decision making and bio-ethical issues.

January 1976 to July 1981:

American Medical Association, Office of General Counsel (Chicago, IL)
In-house Counsel to national professional organization of physicians.

TEACHING ACTIVITIES

September 2008 to January 2010: Rutgers University School of Social Work: Part-time Lecturer

February 2004 to October 2009: DeVry University: Adjunct Professor

January 1987 to June 1991: Seton Hall University School of Law: Adjunct Professor

May 1979 to July 1981: Southern Illinois University, Regional Health Education Programs: Instructor

EDUCATION

POST DOCTORAL

RUTGERS UNIVERSITY SCHOOL OF SOCIAL WORK, New Brunswick, NJ
Certificate in Gerontology (July 2003)

LAW

GEORGETOWN UNIVERSITY LAW CENTER, Washington, D.C.
Degree Received: **Juris Doctor** (May 1975)

GRADUATE

CATHOLIC UNIVERSITY OF AMERICA, Washington, D.C.
Degree Received: **Master of Arts** (May, 1972)

Course Emphasis: Ethics

Honors: Basselin Honors Fellowship

UNDERGRADUATE

CATHOLIC UNIVERSITY OF AMERICA, Washington, D.C.
Degree Received: **Bachelor of Arts** (May, 1971) *cum laude*
SAINT CHARLES COLLEGE, Catonsville, MD (transferred 1969)
Course Emphasis: Philosophy, Classics

BAR ADMISSIONS

Supreme Court of Virginia: October 1975 [Inactive status]
U.S. District Court, District of New Jersey: April 1976
Supreme Court of New Jersey (Limited): April 1976
Illinois Supreme Court: November 1976 [Inactive status]
U.S. District Court, Northern District of Illinois: January 1977
Supreme Court of New Jersey (Plenary): May 1977
United States Supreme Court: June 1986
Supreme Court of New York (3rd Department): May 1989
United States Court of Appeals, Third Circuit: July 2011

PROFESSIONAL ORGANIZATIONS AND OFFICES

New Jersey Supreme Court, District VIII Fee Arbitration Committee
Secretary (1994-present)
New Jersey Roster of Mediators for Civil, General Equity and Probate Cases (2008-present)
American Bar Association
Section of Administrative Law (Vice Chair, Health Committee, 1991)
Health Law Section
New Jersey State Bar Association
General Council (1988-93; 1994-95)
Health & Hospital Law Section (1st Vice Chair 1988-89; Chair 1989-91; Legislative Liaison 2009-2012)
Elder Law Section (Co-Legislative Liaison 2009-present; Vice-Chair 2011-2012)
Middlesex County Bar Association (Board of Trustees 2009-present)
Chancery Practice Committee
Early Settlement Panel (1986-1999, 2009-present)
Elder Law Committee
Middlesex County Bar Foundation (Board of Trustees 2008-present; Treasurer 2011-2012)
American Health Lawyers Association
Alternate Dispute Resolution Service (1992-2001)
Catholic Lawyers Guild, Diocese of Metuchen
Board Of Trustees (1988-91)
National Association of Elder Law Attorneys
National Committee for the Prevention of Elder Abuse

RELATED APPOINTMENTS AND CIVIC ACTIVITIES

AMA Employees Credit Union
Board of Directors (1977-81)
Vice Chairman (1978-80); Chairman (1981)
AMA Task Force on Risk Management
Harper Junior College, Palatine, Illinois (Program Advisory Committee)
Board of Health, Milltown, New Jersey (1988-92)
Municipal Advisory Committee, Milltown, New Jersey (1988-95)
Municipal Ethics Board, Milltown, New Jersey (2008-present)
Institutional Review Board (IRB), St. Michael's Medical Center, Newark, New Jersey (1989)
Central Jersey Landfill Advisory Board (1992-94)
Advisory Committee on Pedophilia & Sexual Misconduct, Diocese of Metuchen (1994-98)
Eagle Scout, 1966
Cub Scout Pack 33, Milltown, New Jersey: Cubmaster (1987-94)
Boy Scout Troop 33, Milltown, New Jersey: Scoutmaster (1994-2008); Assistant Scoutmaster (1991-94)
Joyce Kilmer District, Thomas A. Edison Council, BSA: Advancement Chairman, District Committee (1991-1997)
Catholic Committee on Scouting, Diocese of Metuchen: Chairman (1992-1995)
Courts, Health Science & the Law (Georgetown University): Editorial Associate (1989-1991)
Office of the Ombudsman for the Institutionalized Elderly Ethics Advisory Committee (1995 -1998)
New Jersey Hospice and Palliative Care Association. Ethics Committee (2008-present).
Princeton Senior Resource Center, Board of Trustees (2009-present; President 2011-2012)
New Jersey Hospice & Palliative Care Organization, Board of Trustees (2011-present)

HONORS AND AWARDS

NJ State Bar Association: Distinguished Legislative Service Award (2009)
NJ Hospice and Palliative Care Organization: Spirit of Hospice Award (2007)

PUBLICATIONS LIST

BOOKS AND MONOGRAPHS

- Health Care in Jails* (Five Monographs). Chicago, IL: American Medical Association (1977)
Confidentiality of Medical Records in New Jersey. Eau Claire, WI: Medical Educational Services (1983)
The Hospital Medical Staff: Its Legal Rights and Responsibilities. Springfield, IL: Charles C. Thomas Pub. (1984)
Model Medical Staff Bylaws with Annotations. Lawrenceville, NJ: Medical Society of New Jersey (1990)
Under Oath: Tips for Testifying. Horsham, PA: LRP Publications (1995)
NJ Elder & Disability Law Practice (Supplement) Chapter 12, "Elder Abuse and Exploitation." New Brunswick, NJ: NJICLE (2010)

ARTICLES

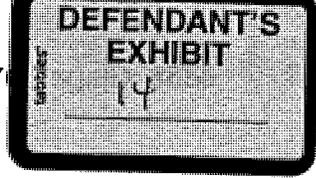
- "Vicarious Liability in the Operating Room," 3 *Journal of Legal Medicine* 18 (April, 1975)
 "Malpractice Liability of the Mental Health Professional," 6 *Professional Psychology* 399 (November 1975)
 "After *Canterbury*: The Need for Medical Experts in the Informed Consent Suit," 4 *Journal of Legal Medicine* 17 (1976)
 "Legal and Ethical Concerns of the Medical Assistant," *The Professional Medical Assistant* (July 1977)
 "Legal Aspects of Peer Review," *Hospital Medical Staff Advocate* (Sept./Nov. 1977)
 "Peer Review: A Maryland Case," 42 *Connecticut Medicine* 679 (October 1978)
 "Termination of the Physician/Patient Relationship," 69 *The Medical Record* 267 (November, 1978)
 "Legal Aspects of Accreditation," 44 *Connecticut Medicine* 237 (April 1980)
 "Peer Review: An Update," 45 *Connecticut Medicine* 191 (March 1981)
 "Medical Treatment of a Mentally Impaired Person or a Minor: Who May Consent?" 245 *JAMA* 778 (Feb.20, 1981)
 "Right to Treatment, Right to Refuse Treatment," *Corrections Today* (June, 1983)
 "N.J. Supreme Court Rules on Closed Staff Policies," 53 *Citation* 111 (1986)
 "New Jersey Court Clarifies Commitment Standard," 54 *Citation* 39 (1986)
 "Hospital/Medical Staff Relationships," 118 *New Jersey Lawyer* 21 (February 1987)
 "New Jersey Court Specifically Enforces Surrogate Birth Contract," 55 *Citation* 67 (1987)
 "N.J. Supreme Court Reviews Ethical Questions," 55 *Citation* 116 (1987)
 "New Jersey Supreme Court Decides Three Right-to-Die Cases," 55 *Citation* 147 (1987)
 "N.J. Supreme Court Rules on 'Disruptive Physician,'" 20 *Hospital Law* 174 (1987)
 "Discovery of Hospital Committee Reports," 84 *New Jersey Medicine* 869 (Dec. 1987)
 "Beware the COBRA," *Middlesex County Bar Association Monthly* (March/April 1988)
 "N.J. Supreme Court Rules on Brain Death," 21 *Journal of Health & Hospital Law* 179 (July 1988)
 "New Malpractice Liability Laws Could Prove Deadly to Hospital Bottom Lines," *ECHO* (July 1988)
 "N.J. Supreme Court Invalidates Surrogacy Contracts," 57 *Citation* 131 (1988)
 "Peer Review Activities Are Not Exempt from Antitrust Scrutiny," *ECHO* (Sept. 1988)
 "HEZ: A Legislative Experiment in Deregulation," *ECHO* (Sept. 1988)
 "Don't Dump the Baby with the Bath Water," *ECHO* (November 1988)
 "New Jersey's OOIE: Experimentation in Complexity," *ECHO* (January 1989)
 "A New Challenge for Mental Health Law," 126 *New Jersey Lawyer Magazine* 58 (Jan./Feb. 1989)
 "The NJ SEED Project: Evaluation of an Innovative Initiative for Ethics Training in Nursing Homes" *J Am Med Dir Assoc* 2005; 6: 68-75. (with Weston, C. et al.)
 "Financial Exploitation of the Elderly," 17 *New Jersey Lawyer* 305 (February 18, 2008)
 "This Year, the Day After Tax Day Is Just as Crucial," 191 *New Jersey Law Journal* 1039 (March 24, 2008)
 "N.J. Law Out of Synch on Spending by Residents of Nursing Homes," 192 *New Jersey Law Journal* 379 (May 12, 2008)
 "From Medicaid Beneficiary to Nursing Home Evictee?" *New Jersey Lawyer In Re:* (June 3, 2008), page 10
 "The Nursing Home Residents' Bill of Rights," 193 *New Jersey Law Journal* 777 (Sept. 15, 2008)
 "Garnishment of Social Security Benefits," 199 *New Jersey Law Journal* 335 (February 8, 2010)
 "Civil and Administrative Effects of a Conviction for Health Care Fraud," 201 *New Jersey Law Journal* 368 (August 2, 2010)
 "Evictions from Long-Term Care," 265 *New Jersey Lawyer Magazine* 19-22 (August 2010)
 "The Elder Justice Act as Part of Health Care Reform 2010." 201 *New Jersey Law Journal* 847 (September 13, 2010)
 "It Takes Courage to Get Older," *Mercer Business* (March 2011)
 "The Growing Problem of Financial Elder Abuse," 205 *New Jersey Law Journal* 641 (August 22, 2011)
 "Federal Court Finds PA Hospital in Violation of Stark Law," 205 *New Jersey Law Journal* 911 (September 12, 2011)
 "Power Wheelchairs and Medicare – Freedom and Fraud," *Mercer Business*, 44-45 (September 2011).

BROADCAST

- "Legally Speaking: The Baby Doe Cases," *Cable Television Network of New Jersey* (1987)
 "Legally Speaking: The Right to Die," *Cable Television Network of New Jersey* (1987)
 "Medical Care: What You Don't Know Can Hurt You," *WNET - Channel 13* (1987)
 "Rutgers Forum: Health Care Law," *New Jersey Network* (1990)
 "New Jersey Issues: Living Wills," *New Jersey Network* (1991)
 "Rutgers Forum: AIDS and the Law," *Cable Television Network of New Jersey* (1993)
 "New Jersey Journal: Elder Abuse," FOX-TV (Philadelphia) (2000)
 "On Our Own Terms – Reaching Out," *WNET – Channel 13* (2000)
 "Faces of Aging," *New Jersey Network* (2000)

REPORTED CASES

- Straube v. Emmanuel Lutheran Charity Board*, 600 P.2d 381 (Ore., 1979)
First National State Bank v. Kron, 190 N.J.Super. 510 (App. Div. 1983)
Matter of Commitment of B.S., 213 N.J.Super. 243 (App. Div. 1986)
Matter of Clark, 216 N.J.Super. 497 (App. Div. 1987)
Hirsch v. N.J. State Board of Medical Examiners, 128 N.J. 160 (1992)



NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name: Shannon Napolitano
Job Title: LPN

Facility: SVRNC
Date of Hire:

Prior Disciplinary Notices in File: (include date and nature)

TYPE OF VIOLATION

Dress Code
Behavior
Absenteeism/Tardiness

Performance
Inappropriate Behavior
Patient Care

Resident Rights
Refusal to Perform Assigned Task
Other: Documentation

R
36

DESCRIPTION

Date: 1/4/10 Time: 8AM

Specific Description of Issue, Situation or Behavior (what, where, how): On 1/4/10 you documented pain assessments for your shift at 8AM for the entire shift. This puts the patient at risk for unaddressed pain and poor outcomes. Additionally you

EMPLOYEE RESPONSE

I agree
I disagree for these reasons:

had previously been educated to document at the end of your shift

ACTION TO BE TAKEN

Documented Verbal Notice

Written Notice

Suspension for ___ days to start on ___ (date) and return to work on ___ (date).

Does this Disciplinary Action Constitute Final Warning? Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination of employment.

X Shannon Napolitano 1-4-10
Employee's Signature Date

Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

[Signature] 1/4/2010
Supervisor's Signature Date

[Signature] 1/4/10
Department Head/Administrator Date

Witness Signature Date

Exh. No: R 36 Received _____ Rejected _____
Case No.: 22-CA-29599 et al
Case Name: Somerset valley + club
No. Pgs: _____ Date: 5-31-11 Rep.: AM



NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name: Shannon Napolitano
Job Title: LPN

Facility SVRNC
Date of Hire

Handwritten notes: 22-CA-295-99, CASE NUMBER, EXHIBIT NUMBER: R-126, ID'D, REC'D, DATE 6/21/11

Prior Disciplinary Notices in File: (include date and nature)

01/04/10 - Documentation

TYPE OF VIOLATION

- Dress Code Behavior Absenteeism/Tardiness
X Performance Inappropriate Behavior Patient Care
Resident Rights Refusal to Perform Assigned Task Other: Documentation

DESCRIPTION

Date: 06/11/10, 06/14/10 Time: 3-11p

Specific Description of Issue, Situation or Behavior (what, where, how):
On 06/11/10 and 06/14/10 you were working on 3-11pm shift you failed to document treatment record on resident in Room 20 D. Failure to document resident's treatment record indicates that treatment was not done. This is your verbal notice. Similar future incidence of the same nature may result into written notice, suspension or termination. (see attached treatment record).

EMPLOYEE RESPONSE

I agree
I disagree for these reasons:

ACTION TO BE TAKEN

X Documented Verbal Notice Written Notice
Suspension for ___ days to start on ___ (date) and return to work on ___ (date).
Does this Disciplinary Action Constitute Final Warning: Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination of employment.

Employee's Signature Date
Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

Supervisor's Signature Date

Department Head/Administrator Date Witness Signature Date

(One copy to Employee - one copy to Personnel File - One copy to Supervisor) Somers003350

Handwritten note: D-126

Case 3:11-cv-02007-MLC-LHG Document 59-7 Filed 07/08/11 Page 34 of 100 PageID: 5164

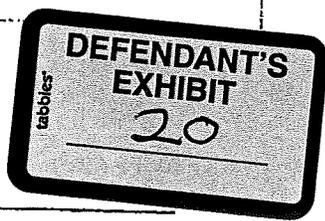
Em. No. 22-CA-29599 et al Received 6-6-11 Rejected sw
Case No. 22-CA-29599 et al
Case Name: Somerset Valley Rehab
No. Pgs: _____ Date: 6-6-11 Rep.: sw

NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name: Sheena Claudio
Job Title: LPN

Facility: SVRNC
Date of Hire: _____



Prior Disciplinary Notices in File: (include date and nature)
9/20/10 Medication Error
9/16/10 Time of attendance

TYPE OF VIOLATION

- Dress Code
- Behavior
- Absenteeism/Fardiness
- Performance
- Inappropriate Behavior
- Patient Care
- Resident Rights
- Refusal to Perform Assigned Task
- Other: _____

DESCRIPTION

Date: 9/27/10 Time: 7-3 shift

Specific Description of Issue, Situation or Behavior (what, where, how):
Employee noted to have failed to document on 3 separate patients. These documentations are critical and would be detrimental to pt care. (1) Employee failed to document on pt (EW) on 9/20 & 9/22 7-3 shift - post fall. On these occasions

EMPLOYEE RESPONSE

I agree
I disagree for these reasons: _____

pls see pg over

ACTION TO BE TAKEN

Documented Verbal Notice Written Notice
Suspension for 2 days to start on 9/29/10 (date) and return to work on 10/1/10 (date).
Does this Disciplinary Action Constitute Final Warning: Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination of employment.

Employee's Signature _____ Date _____

Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

Kunjoh EW 10/1/10
Supervisor's Signature Date

Department Head/Administrator _____ Date _____
Witness Signature _____ Date _____

(One copy to Employee - one copy to Personnel File - One copy to Supervisor)

Somers003485

pt was found on 9/20/10 = a new injury to head. I was on review check.

- 1) Employee failed to document on pt (EC) on admission. Pt had a fall on that same day, & sp fall documentation was first noted documentation in pt.
- 2) On 9/26/10 - Employee failed to document on same pt for the 5 day admission notes.
- 3) On 9/20/10 - Employee provided tx to pt (~~REDACTED~~) & an order, employee failed to write out order for skin tear tx, even though she documented on incident report that it was implemented.

Individual Statement Form

Complete the following 4 steps. Attach additional sheet(s) if necessary. Sign and date each sheet.

- 1. Where and when (date and time) did the incident occur?

9/27/10

- 2. Tell us step by step, in your own words, what happened (what you actually saw and/or heard).

I admitted Mr. REDACTED and as I recall I remember completing his assessment along with a nursing note. As informed today 9/27 there is no nursing note.

Did not complete a nurses note for Mrs. REDACTED. First day post fall, no excuse; however, did check complete neuro checks & monitored for any LOC or c/o or pain, none noted.

- 3. Print your Name: Sherrita Clavelin Daytime Telephone number: 237-470-5355

- 4. Signature/Title: S. Clavelin, LPN Date Completed: 9/27/10

Somers003487

NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name: Sheena Claudio
Job Title: LPN

Facility: SVRNC
Date of Hire: _____

Previous Disciplinary Notices in File: (include date and nature)

9/30/10 Medication Error
9/16/10 Time & attendance

TYPE OF VIOLATION

Dress Code
Behavior
Absenteeism/Tardiness

Performance
Inappropriate Behavior
Patient Care

Resident Rights
Refusal to Perform Assigned Task
Other: _____

DESCRIPTION

Date: 9/27/10 Time: 7-3 shift

Specific Description of Issue, Situation or Behavior (what, where, how):

Employee noted to have failed to document on 3 separate patients. These documentation are critical and would be detrimental to pt care. (1) Employee failed to document a pt (EW) on 9/20 & 9/22 7-3 shift - post fall. On these occasions

EMPLOYEE RESPONSE

I agree
I disagree for these reasons: _____

pls see pg over

ACTION TO BE TAKEN

Documented Verbal Notice

Suspension for 2 days to start on 9/29/10 (date) and return to work on 10/1/10 (date).

Written Notice

Does this Disciplinary Action Constitute Final Warning: Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination of employment.

Employee's Signature

Date

Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

[Signature]
Supervisor's Signature

Date

Department Head/Administrator

Date

Witness Signature

Date

(One copy to Employee - one copy to Personnel File - One copy to Supervisor):

Somers003488

DAILY SKILLED NURSES NOTES

Date: 7/11/11 Temperature: 37.5 Pulse: 72 Resp: 18 B/P: 110/70

DIRECTIONS: (X) All applicable boxes. Circle appropriate item(s) separated by "T". Signature and title of nurse for appropriate shift.

Mental Status			Cardiovascular			GI			Musculoskeletal		
N	D	E	N	D	E	N	D	E	N	D	E
Alert	<input checked="" type="checkbox"/>		Regular Rhythm			Nausea / Vomiting			Balance / Gait Unsteady		
Oriented in Person			Fluorid/Apical Irregular			Epigastric Distress			Paralysis / Weakness		
Place			Chest Pain			Difficulty Swallowing			WNL		
Time			Edema			Abdominal Distention			Nervous System		
Anxious/Agitated			Perit: Lt / Rt			Diarrhea			Syncope		
Restless/Lethargic			Pitting +1			Constipation			Headache		
Abnormal Sleep Pattern			+2			Bowel Sounds Present			Decreased Grasp		
Forgetful/Confused			+3			Absent			Rt.		
Hallucinations/Delusions			+4			Hyperactive			Lt.		
			Abnormal Peripheral Pulses			Hypoactive			Decreased Movement		
			WNL						<input type="checkbox"/> RUE <input type="checkbox"/> LUE		
									<input type="checkbox"/> RLE <input type="checkbox"/> LLE		
Respiratory			Sensory			GU			Skin		
Labored Breathing			Unclear Speech			Burning			Abnormal Pupil Reaction		
Shallow Respirations			Unable to Speak			Distention / Retention			Right		
Rales / Rhonchi			Unable to Make Self Understood			Frequency / Urgency			Left		
Wheezing			Unable to Hear			Hematuria			Tremors		
Cough			Unable to See			Catheter			Vertigo		
Dyspnea / SOB			Decreased Tactile Sensation			Urine			WNL		
O2 LPM			WNL			Discolored			Skin		
<input type="checkbox"/> PRN			Pain			Sediment			Jaundiced		
<input type="checkbox"/> Continuous			Origin:			Odor			Cyanosis		
S2O2 % % %			Location:			Discharge			Pallor		
Suctioning			Intensity: (0-10)			WNL			Clammy		
Trach Care			None						Chills		
Vent Care									Flushing of Skin		
Lungs Clear									Rash / Itching		
WNL									Abnormal Turgor/Elasticity		
									WNL		
MD Orders			Observe S/SX Infection			Wound Care Dressings			Therapy (PT, OT, ST)		
MD Notified			Transfusions			Pressure Ulcer Care			Nursing Rehabilitation		
Skilled Observation & Assessment			Gait Training/Prosthesis Care			Stasis Ulcers			Respiratory Therapy		
Diabetic Management			Self Administration of			Tracheostomy Care			Braces, Casts, Splints,		
Glucometer Readings			Injectable Meds			Suctioning			Orthotics, etc. Care/Trach		
Dehydration/Fluid Intake			Terminal Illness			IV Medication					
Chemotherapy			Care/Teach			IV Feeding / Hydration					
Management / Teaching			Diet Teaching			Intramuscular Injections					
Dialysis Management			Bowel & Bladder Training			Tube Feeding					
Observe Medication			Teach / Care IV Catheter			Pain Management					
Side Effects / Teach			Sites								

Signature / Title: N: [Signature] D: [Signature] E: [Signature]

DATE / TIME	COMMENTS	SIGNATURE / TITLE
7/11/11	11:00 AM - 12:00 PM	[Signature]
7/11/11	12:00 PM - 1:00 PM	[Signature]
7/11/11	1:00 PM - 2:00 PM	[Signature]

Room: 31W
Dr. Paris

SV513425
DOB: [REDACTED]
Adm: 8/19/10

Middle: [REDACTED] Attending Physician: [REDACTED] Record No: [REDACTED] Room/Bed: [REDACTED]

REDACTED
Somers003490

DAILY SKILLED NURSES NOTES

Date: 9/22/10 Temperature: _____ Pulse: _____ Resp: _____ B/P: _____

DIRECTIONS: (X) All applicable boxes. Circle appropriate item(s) separated by ". Signature and title of nurse for appropriate shift.

Mental Status		Cardiovascular		GI		Musculoskeletal	
N	D	N	D	N	D	N	D
Alert		<input checked="" type="checkbox"/> Regular Rhythm		<input checked="" type="checkbox"/> Nausea / Vomiting		Balance / Gait Unsteady	
Oriented to Person		<input checked="" type="checkbox"/> Radial/ Apical Irregular		Epigastric Distress		Paralysis / Weakness	
Place		<input checked="" type="checkbox"/> Chest Pain		Difficulty Swallowing		WNL	
Time		Edema		Abdominal Distention		Nervous System	
Anxious/Agitated		pedal: L / R		Diarrhea		Syncope	
Restless/Lethargic		Pitting +1		Constipation		Headache	
Abnormal Sleep Pattern		+2		Bowel Sounds		Decreased Grasp	
Forgetful/Confused		+3		Present		Rt.	
Hallucinations/Delusions		+4		Absent		Li.	
		Abnormal Peripheral Pulses		Hyperactive		Decreased Movement	
		WNL		Hypoactive		<input type="checkbox"/> RUE <input type="checkbox"/> LUE	
						<input type="checkbox"/> RLE <input type="checkbox"/> LLE	
Respiratory		Sensory		GU		Skin	
Labored Breathing		Unclear Speech		Burning		Jaundiced	
Shallow Respirations		Unable to Speak		Distention / Retention		Cyanosis	
Rales / Rhonchi		Unable to Make Self Understood		Frequency / Urgency		Pallor	
Wheezing		Unable to Hear		Hematuria		Clammy	
Cough		Unable to See		Catheter		Chills	
Dyspnea / SOB		Decreased Tactile Sensation		Urine		Flushing of Skin	
O2 LPM		WNL		Discolored		Bash / Itching	
<input type="checkbox"/> PRN				Sediment		Abnormal Turgor/Elasticity	
<input checked="" type="checkbox"/> Continuous <u>2L</u>				Odor		WNL	
S2O2 % <u>94%</u>		Pain		Discharge		Therapy (PT, OT, ST)	
Suctioning		Origin:		WNL		Nursing Rehabilitation	
Trach Care		Location:				Respiratory Therapy	
Vent Care		Intensity: (0-10)				Braces, Casts, Splints,	
Lungs Clear		None				Orthotics, etc. Care/Trach	
WNL							
MD Orders		Observe S/SX Infection		Wound Care Dressings			
MD Notified		Transfusions		Pressure Ulcer Care			
Skilled Observation & Assessment		Gait Training/Prosthesis Care		Stasis Ulcers			
Diabetic Management		Self Administration of Injectable Meds		Tracheostomy Care			
Glucometer Readings		Terminal Illness		Suctioning			
Dehydration/Fluid Intake		Care/Teach		IV Medication			
Chemotherapy Management / Teaching		Diet Teaching		IV Feeding / Hydration			
Dialysis Management		Bowel & Bladder Training		Intramuscular Injections			
Observe Medication		Teach / Care IV Catheter Sites		Tube Feeding			
Side Effects / Teach				Pain Management			

Signature / Title: _____ N: _____ D: _____ E: _____

DATE / TIME	COMMENTS	SIGNATURE / TITLE
9/22/10 4P	PT found on floor in room with alert verbal. to verbal injury not to extent. Chy made aware - Supervisor called made care - pt put into in unit	

NAME - Last: _____ First: _____ Middle: _____
 Attending Physician: _____ Record No: _____ Room/Bed: _____

DAILY SKILLED NURSES NOTES

Date: 9.26.10 Temperature: _____ Pulse: 114 Resp: 20 B/P: 135/72

DIRECTIONS: (X) All applicable boxes. Circle appropriate item(s) separated by "/". Signature and title of nurse for appropriate shift.

Mental Status			Cardiovascular			GI			Musculoskeletal		
N	D	E	N	D	E	N	D	E	N	D	E
Alert		<input checked="" type="checkbox"/>	Regular Rhythm			Nausea / Vomiting			Balance / Gait Unsteady		<input checked="" type="checkbox"/>
Oriented to Person		<input checked="" type="checkbox"/>	Radial/Apical Irregular			Epigastric Distress			Paralysis / Weakness		<input checked="" type="checkbox"/>
Place			Chest Pain			Difficulty Swallowing			WNL		
Time			Ectema			Abdominal Distention			Nervous System		
Anxious/Agitated			pedal: L / R			Diarrhea			Syncope		
Restless/Lethargic			Pitting +1			Constipation			Headache		
Abnormal Sleep Pattern			+2			Bowel Sounds			Decreased Grasp		
Forgetful/Confused		<input checked="" type="checkbox"/>	+3			Present		<input checked="" type="checkbox"/>	RL		
Hallucinations/Delusions			+4			Absent			LI		
			Abnormal Peripheral Pulses			Hyperactive			Decreased Movement		
			WNL		<input checked="" type="checkbox"/>	Hypoactive			<input type="checkbox"/> RUE <input type="checkbox"/> LUE		
Respiratory			Sensory						<input checked="" type="checkbox"/> RLE <input checked="" type="checkbox"/> LLE		<input checked="" type="checkbox"/>
Labored Breathing			Unclear Speech			GU			Abnormal Pupil Reaction		
Shallow Respirations			Unable to Speak			Burning			Right		
Rales / Rhonchi			Unable to Make Self			Distention / Retention			Left		
Wheezing			Understood			Frequency / Urgency			Tremors		
Cough			Unable to Hear			Hematuria			Vertigo		
Dyspnea / SOB			Unable to See			Catheter			WNL		<input checked="" type="checkbox"/>
O2 <input checked="" type="checkbox"/> LPM		<input checked="" type="checkbox"/>	Decreased Tactile Sensation			Urine			Skin		
<input type="checkbox"/> PRN			WNL		<input checked="" type="checkbox"/>	Discolored			Jaundiced		
<input checked="" type="checkbox"/> Continuous			Pain			Sediment			Cyanosis		
S2O2 % <input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	Origin:			Odor			Pallor		
Suctioning			Location:			Discharge			Clammy		
Trach Care			Intensity: (0-10)			WNL		<input checked="" type="checkbox"/>	Chills		
Vent Care			None		<input checked="" type="checkbox"/>				Flushing of Skin		
Lungs Clear <u>1.1.2</u>		<input checked="" type="checkbox"/>							Rash / Itching		
WNL		<input checked="" type="checkbox"/>							Abnormal Turgor/Elasticity		
									WNL		<input checked="" type="checkbox"/>
MD Orders			Observe S/SX Infection		<input checked="" type="checkbox"/>	Wound Care Dressings		<input checked="" type="checkbox"/>	Therapy (PT, OT, ST)		
MD Notified			Transfusions			Pressure Ulcer Care			Nursing Rehabilitation		
Skilled Observation & Assessment		<input checked="" type="checkbox"/>	Gait Training/Prosthesis			Stasis Ulcers			Respiratory Therapy		
Diabetic Management		<input checked="" type="checkbox"/>	Care			Tracheostomy Care			Braces, Casts, Splints,		
Glucometer Readings		<input checked="" type="checkbox"/>	Self Administration of			Suctioning			Orthotics, etc. Care/Teach		
Dehydration/Fluid Intake			Injectable Meds			IV Medication					
Chemotherapy			Terminal Illness			IV Feeding / Hydration					
Management / Teaching			Care/Teach			Intramuscular Injections					
Dialysis Management			Diet Teaching			Tube Feeding					
Observe Medication			Bowel & Bladder Training			Pain Management					
Side Effects / Teach			Teach / Care IV Catheter								
			Sites								

Signature / Title: _____ N: _____ D: _____ E: D. Beck

DATE / TIME	COMMENTS	SIGNATURE / TITLE
9/26/10	PO 240 - 9:15 AM - ordered for 100ml	
	normal - 100ml - 100ml - 100ml	
9/26/10	PO 240 - 9:15 AM - ordered for 100ml	
	normal - 100ml - 100ml - 100ml	

NAME - Last	First	Middle	Attending Physician	Record No	Room/Bed
					21W

HealthBridge
MANAGEMENT

INCIDENT/ACCIDENT REPORT

PERSON INVOLVED (Last name) _____ (First name) _____ (Middle initial) _____
 Adult Child Male Female Age 95

Date of incident/accident 9/20/10 Time of incident/accident 12 A.M. P.M.
 Exact location of incident/accident: Resident's room (No. _____) Hallway Bathroom Other Specify _____

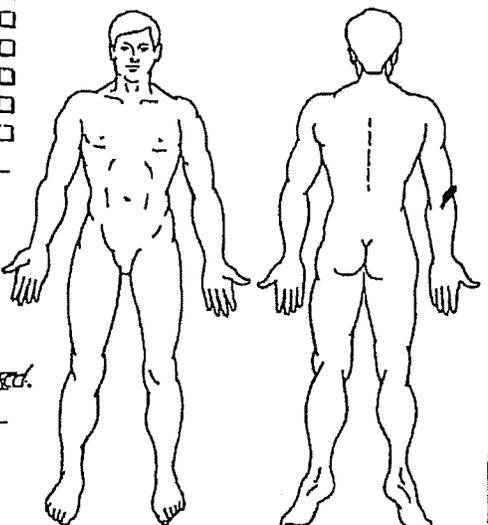
RESIDENT Resident's condition before incident/accident:
 Normal Confused Disoriented Sedated (Drug _____ Dose _____ Time _____) Other Specify _____
 List diagnosis if contributed to incident/accident: 31D
 Were bed rails ordered? Yes No Were bed rails present? Yes No If Yes, Up Down Was height of bed adjustable? Yes No If Yes, Up Down
 Was a restraint in use? Yes No Physical restraint Type _____ Chemical restraint Specify _____

VISITOR Home address _____ Home phone _____
 OTHER Occupation _____ Reason for presence at this facility _____

Describe exactly what happened; why it happened; what the causes were, if an injury, state part of body injured.
Woke skin tear (scratch) to (R) elbow.

- TYPE OF INJURY
- 1. Laceration
 - 2. Hematoma
 - 3. Abrasion
 - 4. Burn
 - 5. Swelling
 - 6. None apparent
 - 7. Other (specify below) scratch

Indicate on diagram location of injury:



Vital Signs	Initial Incident Supine	One Minute After Standing	Three Minutes After Standing
Temperature			
Pulse			
Respirations			
Blood Pressure			

LEVEL OF CONSCIOUSNESS
Alert & oriented.

Name of physician notified Dr. Kudryk, Debbie MA Time of notification 10:45 A.M./P.M. Time responded 10:45 A.M./P.M.

Name and relationship of family member/next of kin representative notified _____ Time of notification 10:45 A.M./P.M. Time responded 3:00 PM in to USIA A.M./P.M.

Was person involved seen by a physician? Yes No
 If Yes, physician's name _____ Where _____ Date _____ Time _____ A.M. P.M.

Was first aid administered? Yes No
 If Yes, type of care provided and by whom cleaned & covered Where _____ Date 9/20/10 Time 12 A.M. P.M.

Was person involved taken to a hospital? Yes No
 If Yes, hospital name _____ By whom _____ Date _____ Time _____ A.M. P.M.

Name, title (if applicable), address & phone no. of witness(es) _____
 Additional comments and/or steps taken to prevent recurrence: _____

Person preparing report <u>Stu Luedt</u>	SIGNATURE/TITLE/DATE	Medical Director
Director of Nursing <u>Margie R...</u>	SIGNATURE/TITLE/DATE	Administrator

PH0061 (1.07) • 1276 HUNTERS CREEK ROAD, SOMERS, MA 01943 • 508-833-1124

Care One
Quality Improvement Tool
Skin Tear or Bruise of Unknown Etiology

1. Check immediate environment for causes: rough edges? Near furniture? Could name band or slide rails or wheelchair have caused this? None noted.
2. Check Resident's fingernails - long or sharp? Properly positioned in chair/bed? Self-ambulatory? Painted slide rails - if yes, were the pads on? Finger nails short
3. Does Resident have periods of restlessness or agitation? Does Resident move about in chair or bed? Does Resident scratch self? Resident moves around it w/c
4. Physiological risk factors for skin tear or bruising, i.e. tissue turgor? Thin paper skin? Anemia? Dry Skin? On Anticoagulant Therapy? Skin is thin.
5. Assess age of skin tear or bruise. Dried blood? Closed healing wound? Color of bruising? Swelling? New. skin tear, little blood noted.

6. Nursing Staff: Names of those working in the previous 24 hours:

Shift	Names	Date	Statement Obtained
7-J Nurse	<u>Sheena Claudio</u>	<u>9/20/10</u>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
7-J C.N.A.	<u>Tasha</u>	<u>9/20/10</u>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
3-11 Nurse			<input type="checkbox"/> Y <input type="checkbox"/> N
3-11 C.N.A.			<input type="checkbox"/> Y <input type="checkbox"/> N
11-7 Nurse			<input type="checkbox"/> Y <input type="checkbox"/> N
11-7 C.N.A.			<input type="checkbox"/> Y <input type="checkbox"/> N
other staff			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N

Care One
Quality Improvement Tool
Skin Tear or Bruise of Unknown Etiology

7. What does Resident say about how the skin tear or bruise occurred?
Confused unable to answer Denies
falling. Denies scratching.

8. Assessed causative factors:
was sitting in w/c in dining
area. No sharp edges noted.

9. Assessed risk factors of recurrence:
Fingernails checked. Mobilizes
self in w/c. No sharp objects noted.

10. What will be done to prevent this from happening again?
Monitor pt while mobilizing in
w/c. Reinforce pt to ask for assist
before getting transferring in & out w/c.

11. Referred to following for follow up:
PT _____ OT _____ Psych _____ Eye Consult _____ Activities _____
Environmental Services _____ Physician for Medical Assessment _____

Charge Nurse Signature/Title/Date: _____

Supervisor Signature/Title/Date: _____

Director of Nurses/Date: Humphreys RN

Administrator/Date: _____

Reviewed at QA Meeting/Date: _____

Comments: Small skin tear noted to @ elbow,
pt unable to explain. fingernails checked,
trimmed & filed. No sharp edges noted
to w/c. rmb & family aware. In
and. Pt moves around in w/c propels
self. Will continue to monitor for
safety.

Individual Statement Form

Complete the following 4 steps. Attach additional sheet(s) if necessary. Sign and date each sheet.

1. Where and when (date and time) did the incident occur?

9/20/10

2. Tell us step by step, in your words, what happened (what you actually saw and/or heard).

CNA noticed bleeding, I assessed pt. seen # a scratch to elbow a little bleeding noted. Cleaned & covered. Asked pt. what happened was unable to answer, Alert: Oxl but confused. Sheena Claudio, CPN

3. Print your Name and daytime telephone number:

Sheena Claudio (732) 470-5355

4. Signature Title:

Sheena Claudio

Date:

9/20/10

STATEMENT

On Sept. 20, 2010, at 12 noon in the dining
room area. I received a cut on
my right arm near
my elbow.

John A. ...

9C
Exh. No: 70 Received _____ Rejected _____
Case No.: 22-CA-29599 et al
Case Name: Somerset Valley Club
No. Pgs: _____ Date: 5-4-11 Rep.: AM

September 7, 2010

Summary of discussion with Valarie and Inez;

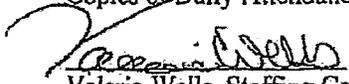
Upon comparison manually typed schedule for September 6, 2010 versus that entered in Schedule Optimizer/Smartlinx (SMLX) for September 6, 2010 there are many discrepancies;

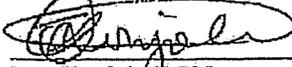
1. C.N.A 1 Pearl is on typed schedule for 7-12 noon but not in SMLX
2. Evening Supervisor Alice is on typed schedule but not in SMLX
3. C.N.A 4 Jean is typed on for 3-11 but not in SMLX
4. Nurse Shannon is entered in SMLX for a double 7-3/3-11 but only on typed schedule for 7-3 shift
5. Yendy C.N.A is scheduled in SMLX for 3-11 but not on typed schedule
6. Doreen worked 7-3 but not in SMLX

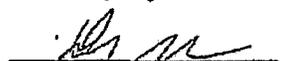
Plan of correction;

1. As a result of these significant inaccuracies moving forward Valarie needs to ensure SMLX is an accurate reflection of the staffing levels. All manually typed or hand written schedules need to be entered into SMLX today.
2. Anyone who is being added to the schedule to pick up a shift needs to be entered and updated in SMLX before she leaves every day to ensure there is accuracy
3. The typed written schedule is not to be used moving forward effective today
4. The typed master schedule needs to be entered into SMLX and a master can be produced from SMLX
5. The schedule that should be displayed tomorrow and forward is "daily attendance format 6"
6. Daily attendance format 6 should be put out by 3pm for the next day, ie this should be one of Valarie's last tasks of each day
7. If there are vacancies in the schedule before it is left Valarie needs to have a conversation with Inez, or in Inez's absence Doreen.
8. If educational assistance is required by Valarie this can be provided by Doreen or Ari Biederman (regional level of assistance)

Copies of Daily Attendance format 6 and typed schedule attached.


Valarie Wells, Staffing Coordinator


Inez Konjoh, DON


Doreen Illis, Adminsitrator



6C 70

Somers005026

NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name: Jillian Jacques
Title: LPN

Facility: SURNC
Date of Hire: _____

Blumberg No. 5114
DEFENDANT'S EXHIBIT
D-22

Prior Disciplinary Notices in File: (include date and nature)

TYPE OF VIOLATION

- Dress Code
- Behavior
- Absenteeism/Tardiness
- Performance
- Inappropriate Behavior
- Patient Care
- Resident Rights
- Refusal to Perform Assigned Task
- Other: _____

DESCRIPTION

Date: 9/28/10 Time: 3-11 shift

Specific Description of Issue, Situation or Behavior (what, where, how): On 9/24/10 you failed to document on pt (R6), s/p adm D2 and s/p fall D92. You also failed to document on pt (CB) from same date s/p adm; and on same pt on 9/25/10 s/p adm. These were topics covered in staff meeting on 9/15/10.

EMPLOYEE RESPONSE

I agree
I disagree for these reasons: _____

ACTION TO BE TAKEN

Documented Verbal Notice
Written Notice 1st
Suspension for _____ days to start on _____ (date) and return to work on _____ (date).
Does this Disciplinary Action Constitute Final Warning: Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination of employment.

Employee Signature: _____ Date: _____

Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

Supervisor's Signature _____ Date _____

Exh. No: 87 Received Rejected
Case No.: 22-CA-29599 et al
Case Name: Somerset Valley Lab
No. Pgs: _____ Date: 6-6-11 Rep.: adm

Department Head/Administrator _____ Date _____

Witness Signature _____ Date _____

(One copy to Employee - one copy to Personnel File - One copy to Supervisor)

Somers002548

DAILY SKILLED NURSES NOTES

Date: 7/25/10 Temperature: 98.6 Pulse: 74 Resp: 15 B/P: 121/81

DIRECTIONS: (X) All applicable boxes. Circle appropriate item(s) separated by ". Signature and title of nurse for appropriate shift.

Mental Status			Cardiovascular			GI			Musculoskeletal		
N	D	E	N	D	E	N	D	E	N	D	E
Alert		<input checked="" type="checkbox"/>	Regular Rhythm			Nausea / Vomiting			Balance / Gait Unsteady		<input checked="" type="checkbox"/>
Oriented to Person		<input checked="" type="checkbox"/>	Radial/Apical Irregular			Epigastic Distress			Paralysis / Weakness		
Place			Chest Pain			Difficulty Swallowing			WNL		
Time			Edema			Abdominal Distention			Nervous System		
Anxious/Agitated			Pedal: Lt / Rt			Diarrhea			Syncope		
Restless/Lethargic			Pitting +1			Constipation			Headache		
Abnormal Sleep Pattern			+2			Bowel Sounds			Decreased Grasp		
Forgetful/Confused			+3			Present			RL		
Hallucinations/Delusions			+4			Absent		<input checked="" type="checkbox"/>	LI		
			Abnormal Peripheral Pulses			Hyperactive			Decreased Movement		
			WNL		<input checked="" type="checkbox"/>	Hypoactive			<input type="checkbox"/> RUE <input type="checkbox"/> LUE		
									<input type="checkbox"/> RLE <input type="checkbox"/> LLE		
Respiratory			Sensory			GU			Skin		
Labored Breathing			Unclear Speech						Abnormal Pupil Reaction		
Shallow Respirations			Unable to Speak						Right		
Rales / Rhonchi			Unable to Make Self Understood			Burning			Left		
Wheezing			Unable to Hear			Distention / Retention			Tremors		
Cough			Unable to See			Frequency / Urgency			Vertigo		
Dyspnea / SOB			Decreased Tactile Sensation			Hematuria			WNL		<input checked="" type="checkbox"/>
O2 LPM			WNL		<input checked="" type="checkbox"/>	Catheter			Skin		
<input type="checkbox"/> PRN						Urine			Jaundiced		
<input type="checkbox"/> Continuous						Discolored			Cyanosis		
S2O2 % % %			Pain			Sediment			Pallor		
Suctioning			Origin:			Odor			Clammy		
Trach Care			Location:			Discharge			Chills		
Vent Care			Intensity: (0-10)			WNL		<input checked="" type="checkbox"/>	Flushing of Skin		
Lungs Clear			None		<input checked="" type="checkbox"/>				Rash / Itching		
WNL		<input checked="" type="checkbox"/>							Abnormal Turgor/Elasticity		
									WNL		<input checked="" type="checkbox"/>
MD Orders			Observe S/SX Infection			Wound Care Dressings			Therapy (PT, OT, ST)		
MD Notified			Transfusions			Pressure Ulcer Care			Nursing Rehabilitation		
Skilled Observation & Assessment			Gait Training/Prosthesis			Stasis Ulcers			Respiratory Therapy		
Diabetic Management			Care			Tracheostomy Care			Braces, Casts, Splints,		
Glucometer Readings			Self Administration of			Suctioning			Orthotics, etc. Care/Teach		
Dehydration/Fluid Intake			Injectable Meds			IV Medication		<input checked="" type="checkbox"/>			
Chemotherapy			Terminal Illness			IV Feeding / Hydration					
Management / Teaching			Care/Teach			Intramuscular Injections					
Dialysis Management			Diet Teaching			Tube Feeding		<input checked="" type="checkbox"/>			
Observe Medication			Bowel & Bladder Training			Pain Management					
Side Effects / Teach			Teach / Care IV Catheter								
			Sites								

Signature / Title N: Patricia Clever E: D Buckler

DATE / TIME	COMMENTS	SIGNATURE / TITLE
7/25/10 3P	H&Ox. No. c/o pain. Tube feeding in progress, tolerating well. ABT T.V to upper arm in progress, no adverse reactions noted. CAB in w/c safety precautions intact. <u>Patricia Clever</u>	

NAME - Last	First	Middle	Attending Physician	Flacard No.	Room/Bed
					10

DAILY SKILLED NURSES NOTES

Date: 9/25/10 Temperature: _____ Pulse: _____ Resp: _____ B/P: _____

DIRECTIONS: (X) All applicable boxes. Circle appropriate item(s) separated by "r". Signature and title of nurse for appropriate shift.

Mental Status		Cardiovascular		GI		Musculoskeletal	
Alert		Regular Rhythm		Nausea / Vomiting		Balance / Gait Unsteady	
Oriented to Person		Radial/Apical Irregular		Epigastric Distress		Paralysis / Weakness	
Place		Chest Pain		Difficulty Swallowing		WNL	
Time		Edema		Abdominal Distention		Nervous System	
Anxious/Agitated		Pedal: L / R		Diarrhea		Syncope	
Restless/Lethargic		Pitting +1		Constipation		Headache	
Abnormal Sleep Pattern		+2		Bowel Sounds		Decreased Grasp	
Forgetful/Confused		+3		Present		RI.	
Hallucinations/Delusions		+4		Absent		LI.	
		Abnormal Peripheral Pulses		Hyperactive		Decreased Movement	
		WNL		Hypoactive		<input type="checkbox"/> RUE <input type="checkbox"/> LUE	
						<input type="checkbox"/> RLE <input type="checkbox"/> LLE	
Respiratory		Sensory				Abnormal Pupil Reaction	
Labored Breathing		Unclear Speech				Right	
Shallow Respirations		Unable to Speak		GU		Left	
Rales / Rhonchi		Unable to Make Self Understood		Burning		Tremors	
Wheezing		Unable to Hear		Distention / Retention		Vertigo	
Cough		Unable to See		Frequency / Urgency		WNL	
Dyspnea / SOB		Decreased Tactile Sensation		Hematuria		Skin	
O2 LPM		WNL		Catheter		Jaundiced	
<input type="checkbox"/> PRN				Urine		Cyanosis	
<input type="checkbox"/> Continuous				Discolored		Pallor	
S2O2 % % %		Pain		Sediment		Clammy	
Suctioning		Origin:		Odor		Chills	
Trach Care		Location:		Discharge		Flushing of Skin	
Vent Care		Intensity: (0-10)		WNL		Rash / Itching	
Lungs Clear		None				Abnormal Turgor/Elasticity	
WNL						WNL	
MD Orders		Observe S/SX Infection		Wound Care Dressings		Therapy (PT, OT, ST)	
MD Notified		Transfusions		Pressure Ulcer Care		Nursing Rehabilitation	
Skilled Observation & Assessment		Gait Training/Prosthesis Care		Stasis Ulcers		Respiratory Therapy	
Diabetic Management		Self Administration of		Tracheostomy Care		Braces, Casts, Splints,	
Glucometer Readings		Injectable Meds		Suctioning		Orthotics, etc. Care/Teach	
Dehydration/Fluid Intake		Terminal Illness		IV Medication			
Chemotherapy		Care/Teach		IV Feeding / Hydration			
Management / Teaching		Diet Teaching		Intramuscular Injections			
Dialysis Management		Bowel & Bladder Training		Tube Feeding			
Observe Medication		Teach / Care IV Catheter		Pain Management			
Side Effects / Teach		Sites					

Signature / Title N: _____ D: _____ E: _____

DATE / TIME	COMMENTS	SIGNATURE / TITLE
9/25/10	TF Per orders. Tol well. HoB r.	
11-7	U/S 96-96-18 BP 100/82 Assist c. personal needs. No case safety. U/S. Denies pain, absent e. fing. pulses.	

NAME - Last	First	Middle	Attending Physician	Record No.	Room/Bed
			Raja		11

HEALTHBRIDGE MANAGEMENT
HUMAN RESOURCES POLICIES AND PROCEDURES MANUAL
 For Managers Only

Blumberg No. 5114
DEFENDANT'S EXHIBIT
 23

Evaluation Form

PERFORMANCE APPRAISAL

Name: Jillian Jacques
 Appraiser: Crommel Castro / R. McCarthy
 Today's Date: 13/25/09
 Facility: SU

A space is provided if you wish to elaborate on performance that exceeds the standard. Any performance factor which is considered "unacceptable or needs attention" requires additional comments.

1	Unacceptable/ Needs Attention	2	Meets Standards	3	Exceeds Standards	4	Far Exceeds Standards
	Category		Related Skill				Score
	Job Knowledge		Demonstrates the skills needed to perform the job.				2
			Understands work environment; job requirements.				2
			Identifies areas of deficiency within his/her work and is willing to ask for assistance to improve.				2
			Willing to learn new skills, as needed.				2
	Quality		Demonstrates a commitment to overall quality.				2
			Completes assignments in an accurate and thorough manner.				2
			Considers all aspects of a task, even if some aspects are outside his/her normal routine.				2
	Productivity		Completes assignments with minimal direction.				2
			Demonstrates the ability to prioritize work on an ongoing basis.				2
			Demonstrates the ability to perform more than one task at a time (multitasking).				2

Exh. No: 135 Received Rejected
 Case No.: 22-CR-29577 et al
 Case Name: Sunset Valley + Rehab
 No. Pgs: Date: 6-22-11 Rep.: AM

HEALTHBRIDGE MANAGEMENT
HUMAN RESOURCES POLICIES AND PROCEDURES MANUAL
For Managers Only

Attendance	Consistently adheres to the current attendance policy.	2
Teamwork	Establishes and maintains cooperative and productive work relationships with all employees.	2
	Consistently accepts/assists in assignments outside their normal routine, when asked.	2
	Willing to work overtime, if necessary to complete projects in a timely manner.	2
Customer Service	Provides a service that consistently exceeds the expectations of the customer.	2
	Relates well with co-workers, residents and families.	2

General	Dependability	
	Conduct: Manner - habits - personality - tact - adheres to dress code.	2
	Attitude	2
	Promotability: Capable of advancing to a position of greater responsibility. (Requires yes or no - not included in score.)	
PERFORMANCE RATING TOTAL:		36

Total Score Analysis:
0-32 UNACCEPTABLE 33-48 **MEETS STANDARDS** 49-67 EXCEEDS STANDARDS 68-76 FAR EXCEEDS STANDARDS

Strengths and areas of improvement since last review:

Jillian has learned the next charge nurse responsibilities and covers the desk on 3-11 shift on occasion she covers as supervisor.

Weaknesses and areas that need immediate improvement:

- Need to pay closer attention to completing admissions assessments.
- Usually late for work - Need to improve

HEALTHBRIDGE MANAGEMENT
HUMAN RESOURCES POLICIES AND PROCEDURES MANUAL
For Managers Only

ADDITIONAL COMMENTS

Tillian is a pleasant, cooperative, good nurse.

EMPLOYEE COMMENTS

You are encouraged to add comments to this review. If you need additional space, attach a separate sheet to this form.

SIGNATURES

My signature indicates that my manager and I have discussed this evaluation.

Employee: *[Signature]*

Date: *3/25/09*

For probationary employees only:

I recommend do not recommend this employee for continued employment.

I recommend do not recommend this employee for an increase.

Evaluating Supervisor: _____

Date: _____

This evaluation will not become part of the employee's personnel file until the reviewing manager has signed it.

Reviewing Manager: *[Signature]*

Date: *3/23/09*

Blumberg No. 6114
DEFENDANT'S EXHIBIT
 24

Exh. No. 16 Received Rejected
 Case No.: 22-CA-29599 et al
 Case Name: Somerset Valley Rehab
 No. Pgs: _____ Date: 4-24-11 Rep.: AM

Employee Education Attendance Record

Topic of In-service: PROPER Completion of Incident / Accident Report

Content: All sections of ALL forms must be completed. CNA Staff & All Statements to be obtained before end of shift.

All forms to be given to Supervisor before end of shift.

Update CARE Plans & interventions to be added.

Report Needed for EACH incident.

Objectives: At the completion of this training session the participant(s) will:
Forms will be completed in entirety & in timely manner

Date: 10/25/10 Length _____ Location: on unit

Presented By: JACQUE Southgate

- Instructional Method(s): Lecture Discussion Visual aids Group activity
 Skill demonstration Self-study module
 Other: _____

- Evidence of Learning: Post test Return skill demonstration
 Group/team presentation Participation in discussion Verbalization of content to meet objectives Other _____

Print Name	Signature	Department	Shift
Michelle Moore	<i>Michelle Moore</i>	NSG	7-3
GERRY DAKES	<i>Gerry Dakes</i>	NSG	7-3
Carol Chambers	<i>Carol Chambers</i>	NSG	7-3
LASHA SPENCER	<i>Lasha Spencer</i>	NSG	7-3
Liane Donda	<i>Liane Donda</i>	NSG	7-3
Sally Conley	<i>Sally Conley</i>	NSG	7-3
BRANNA BARNETT	<i>Branna Barnett</i>	NSG	7-3
JESSIE RICE	<i>Jessie Rice</i>	NSG	7-3
Maria Granda	<i>Maria Granda</i>	ENH	7-3
Doreen Dault	<i>Doreen Dault</i>	NSO	7-3
Ann Anderson	<i>Ann Anderson</i>	NSG	3-11
MIGUEL RAQUE	<i>Miguel Raque</i>	NSG	3-11
Annunzio Cullen	<i>Annunzio Cullen</i>	NSG	3-11
Tella In	<i>Tella In</i>	NSG	3-11

SVRNC001038

Monthly Staff Meeting

Employee Education Attendance Record

Topic of In-service: See Agenda

Content: _____

Exn. No: 17 Required Rejected

Case No: 22-A-24591 et al

Case Name: Somerset Valley Rehab

No. Pgs: _____ Date: 4-21-11 Rep: AM

Objectives: At the completion of this training session the participant(s) will

Date: 12/22/10 Length 45 mins Location: Conference Room

Presented by: _____

Instructional Method(s): Lecture Discussion Visual aids Group activity

Skill demonstration Self-study module

Other: _____

Evidence of Learning: Post test Return skill demonstration

Group/team presentation Participation in discussion Verbalization of content to meet objectives Other _____

Print Name	Signature	Department	Staff
VYACHESLAV USHARENKO	<i>[Signature]</i>	NSG	3-3
Chice Vital	<i>[Signature]</i>	NSG	3-3
Solaiman Conson	<i>[Signature]</i>	NSG	3-3
William Zaccaro	<i>[Signature]</i>	NSG	3-11
BOYICU BADUWIR	<i>[Signature]</i>	NSG	7-3
JERRY SANTOS	<i>[Signature]</i>	NSG	3-11
Osman Sheriff	<i>[Signature]</i>	NSG	7-3
Emerse	<i>[Signature]</i>	NSG	7-3
Elisa Stey	<i>[Signature]</i>	NSG	7-3
Kassandra Burke	<i>[Signature]</i>	NSG	7-3
Sharon Smith	<i>[Signature]</i>	NSG	3-11
Trene Nondu	<i>[Signature]</i>	NSG	7-3
Rathe Beck	<i>[Signature]</i>	NSG	3-11
AVIHAN JARBO	<i>[Signature]</i>	NSG	3-11 pm
Abdulai Mansaray	<i>[Signature]</i>	CNA	3-11
Kerline Silarre	<i>[Signature]</i>	CNA NSG	3-11 PM
BOB RICE	<i>[Signature]</i>	CNA	7-3
M. Moore	<i>[Signature]</i>	NSG	7-3

[Handwritten notes]
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SU RNC 000896

STAFF MEETING
December 22, 2010

1. Survey Results
2. Call Bell Response
3. Ice Coolman now kept in Clean Utility Room
4. ADL Books and Restorative Book
5. Documentation : Physicians and Pharmacy calls
Consultants reports
24 hour documentation
Patient specific documentation
Time line documentation
Change in condition
Behavior monitoring
6. Dr Paris – composition Book
7. Multiple phone calls to physicians
8. Patient Care issues : Shaving the men
Nail Care
Overall appearance
9. WORKING TOGETHER TO BUILD UP CUSTOMER SERVICE
AND CUSTOMER SATISFACTION

SM/RNC000898

Kathleen Martin, RN, MSN, MPA, LNHA, CPHQ, WCC
368 White Oak Ridge Road, Short Hills, NJ 07078
973-218-6267 email: kathleenmartin1@me.com fax: 973-912-9702
<http://www.jurispro.com/KathleenMartinRNMSNMPALNHA>

EXPERIENCE

Hospicomm Management; Corp Headquarters; Phila., PA Chief Clinical Executive

January 2010-Present.

Responsible for the clinical quality service delivery and financial operations of 6 SNF and 2 ALF facilities with 2 Adult Day Care Programs; performance improvement, survey readiness, enhancing standards of Nursing practice, ensuring continuity among facilities; Wound Care & Fall Programs; wound rounds; Responsible for clinical/nursing programs/operations.

- o Reduced survey deficiencies by 30-60%
- o Maintained census and occupancy in 80% of facilities at or above 92%.
- o Implemented programs for Case Mix Index, and MDS 3.0 RUG IV.
- o Designed clinical programs for: Heart Failure, Post-Stroke, Palliative Care.
- o Developed Customer Service and data outcome programs.

Bayonne Medical Center, Bayonne, NJ.

Asst. Vice President, Quality, Case & Risk Management,
Sept '08 to November '09.

Responsible for maintaining all regulatory and JCAHO standards for: Med Surg, TCU, Renal dialysis, Surgical/PACU/Recovery, Critical Care, ER; lead surveys and regulatory visits; report to board; patient safety; chair committees for performance improvement, etc; ensure financial viability through supervision of case managers; supervision and responsibility for infection control; and Administrator for 20 bed Transitional Care Unit; wound care-rounds; customer service, risk management, staff education, rehab svcs.; chart reviews for compliance, potential RM issues.

- o Joint Commission Survey-Full Accreditation {March '09}, Chaired prep & survey.
- o Core Measure scores increased by 20% {to 100%} in 95% of areas.
- o Established Performance Improvement/Quality & Patient Safety Programs, and Customer Service Survey process.
- o Falls reduced by 30% 2nd, 3rd Q '09.
- o Staff productivity {in areas of responsibility} brought to 98-100% productivity to TCU, Rehab, Case Mgt.
- o Deficiency DOH survey, TCU, '08. 5-Star Quality rating-CMS, 2009.

Care One, Corp Headquarters; Fort Lee, NJ. {Feb '06-July '08}.

Administrator/Executive Director Campus, Care One-Livingston-SNF & ALF. July, 2007-August '08.

24/7 operations of 136 bed Sub-acute/Rehab/LTC facility {Private pay/Medicare}; oversight of 200 employees; financial {\$16M+ budget}, marketing, regulatory compliance; Quality Management Director; Oversight of Assisted Living, as Director-customers/clinical services, financial management; risk management.

- o Decreased 'Caid #s from 65 to 32.
- o Enhanced the 'Care, insur payor population by 30%.
- o Decreased expenses/increased revenue so that EBITDARM was 15-22%/month.
- o Increased private pay by 20%, 2 quarters.
- o Collections brought to 98-105% by 2/08.
- o Decreased workforce turnover to <3% with employee satisfaction programs.
- o Increased Press-Ganey scores to 82-86%; 98% in Rehab.
- o Deficiency Free Survey, '07; established Performance/Quality Initiative Programs.-5-STAR Quality Rating-CMS.

Administrator, Care One-Dunroven, Cresskill, NJ. February 2006-July 2007.

24/7 operations of 100 bed Sub-acute/Rehab/LTC facility {Private pay/Medicare}; oversight of 200 employees; financial {\$16M+ budget}, marketing, regulatory compliance.

- o Won *Best Financial Operations Award* for '06.
- o EBITDARM monthly from 15-20% prior to '06, to 28-35%/month in '06/'07, through increase in private pay census.
- o Only facility in company at 110% of collections/monthly.
- o One of 5 Highest Press-Ganey, Customer Satisfaction scores and Staff Satisfaction Scores in the company.
- o Clinically Deficiency Free (1 Activities), '06. {contributed to 5 STAR Quality Rating-CMS in '08 & '09.}

Hospicomm Management; Corp Headquarters; Phila., PA: {April 1999-Jan '06.}

Administrator, Plaza Regency at Park Ridge, NJ. Sept 2004-January 2006.

Responsible for the 24 hour operations of 210 bed LTC/Sub-Acute care rehabilitation facility, with over 200 employees; regulatory standards, Quality Management; financial management {\$22M budget}; quality of clinical services, marketing.

- o Enhanced/increased revenue by 15%/month.
- o Decreased expenses by 15-20%, '05.
- o Nominated DON for Governor's Merit Award-Received.
- o Orthopedic program/wing to enhance sub-acute revenue.
- o Turnover to <2% annually.
- o Established Performance Improvement/Quality initiative program.

Corp. Executive Clinical Services Executive, NJ Facilities.

June 2003-Sept 2004.

Direct and supervise the clinical services being delivered at each of the 8 statewide facilities for Philadelphia based LTC operations organization; Teach nurses and C.N.A.s policies and standards of care; wound rounds-policy/protocol development; regulatory standards and preparation; mock surveys; financial assistance; risk management. {asked to be Administrator at Plaza Regency}.

**Pope John Paul II Pavilion/St. Mary's Life Care Center,
S. Center St., Orange, NJ.**

Administrator, Cathedral Healthcare System facility; October 2001-July 2002. Promotion.

Responsible for all clinical, regulatory, and financial aspects of operations in 187 bed: sub-acute care, ventilator unit, LTC units and Asst. Liv; 250+ employees, 1199 Union; {\$21M budget}; JCAHO & SDOH surveys; Chair person, CQI Committee; All facility departments and 3 contracted services reporting; Administrator reports to management company HospiComm,™ Phil., PA and owner, Cathedral Health Care System, Newark, NJ.

- o Stabilized financially vulnerable facility.
- o Collections brought to 95-110%.
- o Grew sub-acute line by 20%.
- o Vent unit maintained at 95-100% census.

**The Berkeley Heights Convalescent Center/Atlantic Health System,
Cottage St, Berkeley Heights, NJ.**

Assistant Administrator, February 2001-October 2001. Promotion.

Responsible for the departments of Nursing, Medical Records, Maintenance and facility upgrade, Housekeeping, Dietary; Regulatory Affairs & Surveys, CQI, with over 125 employees, 2 contracted service departments, one Union in 130 bed bld.; Administrative responsibilities including financial, budgetary, staffing, Human Resource, Risk Management, Admissions procedures, JCAHO, and SDOH compliance; Responsible for all aspects of nursing care 24/7; deficiency free SDOH survey; Fluent in Word, Excel, Power Point, Internet, Graphics programs.

Director of Nursing, April 1999-February 2001.

Responsible for 80 nursing and ancillary staff; staffing, budget of dept., standards compliance, policies and procedures, infection control, education, wound care/rounds, fall prevention programs, MDS-Clinical Reimbursement and Utilization Review.

2 SDOH surveys; 1 JCAHO survey; periodic direct patient care; Responsible for all nursing care 24/7. Some direct patient care; {Worked as Nursing Consultant from June-September 1999.}

- o Obtained Joint Commission Accreditation in facility that never had prior.
- o Pain Management program established.

- o Re-aligned and stabilized staffing to decrease expenses, maintain quality.

Jersey City Medical Center, Jersey City, NJ. March 1990-February 1999.

Director of Nursing: Critical Care-3 units/Intermediate Care/Emergency Dept/Surgical Svc./Endoscopy Unit/Cardiac Cath Lab/PACU/Transport Svc.; Position Titled '95: VP Crit Care/ER Services

Responsible for management of division consisting of 250+ nursing and ancillary personnel, 140 beds, 3 out-patient depts, \$28M+ budget; assist in development of dept. capital budget; develop policies and maintain standards within JCAHO and SDOH; 3 JCAHO surveys; 2 ACS (American College of Surgeons) reviews for Trauma designation; focus on finance and reimbursement issues in Endoscopy and ER; wrote and obtained \$200K NIRA grant dealing with work-redesign; implemented CQI and TQM programs in division; participated in mgt team in 1199-UNO contracts in 1992 and 1994; partic in Pt. Focused Care, Inc. -(work re-design) co. implementation; Chair of Pain Management Cmtee; member of Ethics cmtee, IRB cmtee; retain Joint faculty position, Rutgers University, Newark; St. Francis School of Nursing, Jersey City; Some direct patient care.
(Promoted from Asst. Director of Nursing, 1991.

Charter Behavior Health Care, Inc.,

Prospect St., Summit, NJ.

Supervisor/Staff Nurse, Per Diem, April 1994-May 1996.

Psychiatric & medical-nursing services; administration of medications, treatments, counseling with a variety of age groups. Direct patient care.

Franciscan Healthcare, Inc.

Hoboken, NJ.

Staff Nurse, ER, Per Diem, June 1994-February 1997.

Children's Specialized Hospital,

Mountainside, NJ.

Supervisor, Per Diem, August 1992-1994. Direct patient care.

Hoffman-LaRoche, Inc,

Kingsland Ave, Nutley, NJ.

Clinical Research Associate, Anesthesiology group, January 1989-March 1990.

Responsible for designing and implementing drug study protocols; monitoring studies; communicating with investigators; data collection in the field; analysis; and writing final study reports. Assisted in NDA (new drug application) to FDA for Flumazenil (Mazicon) and expanded indications for Midazolam (VERSED) as part of a team.

University Hospital-UMDNJ,
Bergen St., Newark, NJ.

Clinical Nurse Specialist (CNS), Critical Care, July 1986-December 1988.
Medical ICU, Surgical-Trauma ICU, Neuro ICU, PACU, Step-down unit.
Responsible for providing monthly critical care courses (105 hrs); Resource and consultant to staff; assisted in patient care as needed; marketed CC program to other facilities and generated income for dept (\$8,000/yr); developed and coordinated Nursing Preceptor program, performed staff work; Mock Code; CCRN Review in conjunction with Rutgers University; self-studies: ABG, ARDS, Shock & Trauma; formulated policies/procedures for division with Director and VP; Chairperson of 14 member CNS Cmtee; Appt Joint Faculty position at Rutgers University, College of Nursing, Newark.

Seton Hall University,
South Orange, NJ.

Adjunct Faculty, September 1983-June 1984, Clinical sites with students.

Muhlenberg Hospital School of Nursing,
Plainfield, NJ.

Adjunct Faculty, Evening Program, Critical Care, September 1983- June 1984.

Irvington General Hospital,
Chancellor Ave., NJ.

Nurse Manager, Critical Care Unit, March 1982-Sept 1983.

Responsible for 30 staff in 13 bed unit; 24 hour staffing, education, QA, survey, JCAHO; Operational and capital budget.

Veteran's Administration Medical Center,
Tremont Ave., East Orange, NJ.

Staff Nurse, SICU/Open Heart-Cardiac Surgery, January 1980-March 1982.

Staff Nurse, Oncology, February 1979-January 1980.

Hackensack Medical Center,
Prospect St., Hackensack, NJ.

Staff Nurse, Surgical-Burn Unit, 1977-1980.

EDUCATION

Seton Hall University, South Orange, NJ.

MSN-December 1984.

MPA-June 1996.

Pace University, Pleasantville, NY.
BSN-December 1979.

Bergen Community College, Paramus, NJ.
AAS-June 1977 (Nursing).

PROFESSIONAL ACTIVITIES/AWARDS

- Wound Care Certified, National Alliance of Wound Care, July 2011.
- **Quality Examiner, AHCA**; Review with nationwide team, Gold Applications for Quality Award, 2/10-present.
- **Malcolm Baldrige National Quality Award Board of Examiners, 5/09-present.**
- Certified by Health Care Quality Board as CPHQ: Cert Professional in Health Care Quality, Nov, 2007.
- Licensed by State of NJ as Long Term Care Administrator, 2001.
- **Won merit award**, Department of Health and Senior Services for Nursing Excellence; nominated by SR. VP of Pt. Care Services, Jersey City Medical Center, 1996.
- **Won merit award, 1992**, for hospital innovation: Restructuring of Nursing Services, THE AMERICAN COLLEGE OF PHYSICIAN EXECUTIVES.
- CCRN Certified for 12 years.
- ACLS certified, 1982, 1986, 1989, 1993, 1998.
- Listed in Who's Who in American Nursing, 1989, 1990, 1992.
- Inducted into Pi Alpha Alpha, National Honor Society for Public Affairs and Administration, 1993, Seton Hall University.
- Inducted into Sigma Theta Tau, National Nursing Honor Society, June 1982.

PUBLICATIONS

- Article published in **Provider** {national LTC publication}, "Taking Flight With Patient Safety," September 2010.
- **Book Published, 2004**, by HCPro, Mass., : "60 Essential Forms for LTC Documentation." Compendium of various forms and methods for easy documentation for staff management and administration and survey compliance.
- Article published, **Advance for Nurses**, June 2004: "Survey Prep for Long Term Care."
- "Preparing for Electronic Documentation System, Co-Author, **Nursing Management**, July 1996.
- Chapter in **Text of Legal Nurse Consulting**, by AALNC, 1998, 2001, "Setting Up The Business."
- "Holistic Approaches in Psychophysiologic Pain Syndromes", May, 1996, **Journal of Complimentary & Alternative Therapies.**
- "A Bereavement Program for Critical Care", **Crisis, Illness, and Loss**, (Quarterly Journal), June 1995.

- "Oxygen Consumption in Septic Shock," **International Journal of Intensive Care**, December, 1991.
- "Septic Shock," in **Case Studies in Critical Care**, book, Williams and Wilkins pub., Barbara Mims, 1990.
- "Reducing Complications of Thoracic Trauma Due to Gunshot Wounds," **Dimensions of Critical Care**, November, 1989.
- "Budgetary Control for the Nurse Manager," **Nursing Management**, October, 1989.
- "Case Studies in Hemodynamic Monitoring", **Critical Care Nurse**, March 1987.

LECTURES/SPEAKING

- HCANJ-Health Care Assn of NJ, to speak full day on "Patient Safety" 9/11.
- HCANJ-Health Care Assn of NJ, "Nursing Documentation for Success," October 2010, March 2011, Atlantic City, NJ.
- Nursing Documentation Best Practices, National ACHEA Convention, Philadelphia, PA, June, 2010.
- Financial Controls for Clinical Areas/DONs, 2002, 2003, 2004.
- "DON Boot Camp;" 2 day program marketed to NJ DONs, 2004, 2010.
- CQI: Pain Management Program Initiation, Northern NJ Ethics Alliance, February, 2001.
- Management, CQI, & Survey Topics, The Berkeley Heights Nursing Center, 2000-2001; St. Mary's Life Care Ctr, 2002.
- ER Course/Trauma/Neuro; ER Course, JCMC, 1994, '95, '96.
- Performance Improvement: How to For Mgt, 2001, 2002, 2003
- FMEA: Failure Mode Effect Analysis, 2002.

MEMBERSHIPS

- AHAP-Association for Healthcare Accreditation Professionals
- NAHQ-National Association for Healthcare Quality
- American Medical Directors' Association
- American Society for Healthcare Risk Management
- American College of Healthcare Executives
- Association of Infection Control Professionals
- American Association of Wound Care Professionals



Kathleen Martin, RN, MSN, MPA, LNHA, CPHQ
368 White Oak Ridge Road, Short Hills, NJ 07078
973-912-9154 email: martgatt@yahoo.com fax: 973-912-9702

EXPERIENCE

Administrator/Executive Campus Director, Care One at Livingston, Livingston, NJ. July 2007-present.
24/7 operations of 136 bed sub-acute/LTC facility; Oversight of 185 staff; financial, marketing, and regulatory compliance; Also responsible for Separate facility on property: Assisted Living, with 100 staff, 80 residents.

Administrator, Care One-Dunroven, Cresskill, NJ. November 2005-July 2007.
24/7 operations of 100 bed Sub-acute/Rehab/LTC facility {Private pay/Medicare}; oversight of 200 employees; financial, marketing, regulatory compliance.

Under Hospicomm Management, Philadelphia, PA:

Administrator, Plaza Regency at Park Ridge, NJ. Sept 2004-November 2005.
Responsible for the 24 hour operations of 210 bed LTC/Sub-Acute care rehabilitation facility, with over 200 employees; regulatory standards, financial management {\$22M budget}; quality of clinical services, marketing.

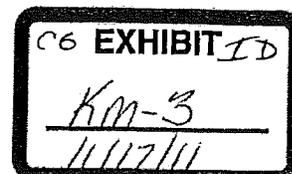
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June 2003-Sept 2004.

Direct and supervise the clinical services being delivered at each of the 8 statewide facilities for Philadelphia based LTC operations organization; Teach nurses and C.N.A.s policies and standards of care; Regulatory Standards and preparation; mock surveys; financial assistance. {asked to be Administrator at Plaza Regency}.

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Clinical sites with students.

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Irvington General Hospital,

Chancellor Ave., NJ.

Nurse Manager, Critical Care Unit, March 1982-Sept 1983.

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MSN-December 1982.
MPA-June 1994.

Pace University, Pleasantville, NY.
BSN-December 1979.

Bergen Community College, Paramus, NJ.
AAS-June 1977 (Nursing).

PROFESSIONAL ACTIVITIES/AWARDS

- Licensed by State of NJ as Long Term Care Administrator, 2001.
- Certified by Health Care Quality Board {HCQB}, Nov, 2007, as **Certified Professional in Health Care Quality, CPHQ**.
- Won merit award, Department of Health and Senior Services for Nursing Excellence; nominated by SR. VP of Pt. Care Services, Jersey City Medical Center, 1996.
- Won merit award, 1992, for hospital innovation: Restructuring of Nursing Services, THE AMERICAN COLLEGE OF PHYSICIAN EXECUTIVES.
- Board Certified as expert in Traumatic Stress, by the American Board of Experts in Traumatic Stress, 1998.
- Certified as Grief Counselor by ADEC (Assn of Death Education & Counseling), 1995.
- CCRN Certified for 12 years.
- ACLS certified, 1982, 1986, 1989, 1993.
- Listed in Who's Who in American Nursing, 1989, 1990, 1992.
- Inducted into Pi Alpha Alpha, National Honor Society for Public Affairs and Administration, 1993, Seton Hall University.
- Inducted into Sigma Theta Tau, National Nursing Honor Society, June 1982.
- On Gary Null's nationally syndicated radio show regarding article on pain syndromes and biofeedback therapy, 1996.

PUBLICATIONS

- **Book Published, 2004, by HCPro, Mass., : "60 Essential Forms for LTC Documentation."** Compendium of various forms and methods for easy documentation for staff management and administration and survey compliance.
- Article published, **Advance for Nurses**, June 2004: "Survey Prep for Long Term Care."
- "Preparing for Electronic Documentation System, Co-Author, **Nursing Management**, July 1996.

- "Holistic Approaches in Psychophysiologic Pain Syndromes", May, 1996, **Journal of Complimentary & Alternative Therapies.**
- "A Bereavement Program for Critical Care", **Crisis, Illness, and Loss**, (Quarterly Journal), June 1995.
- "Oxygen Consumption in Septic Shock," **International Journal of Intensive Care**, December, 1991.
- "Septic Shock," in **Case Studies in Critical Care**, book, Williams and Wilkins pub., Barbara Mims, 1990.
- "Reducing Complications of Thoracic Trauma Due to Gunshot Wounds," **Dimensions of Critical Care**, November, 1989.
- "Budgetary Control for the Nurse Manager," **Nursing Management**, October, 1989.
- "Case Studies in Hemodynamic Monitoring", **Critical Care Nurse**, March 1987.

LECTURES/SPEAKING

Recent:

- Financial Controls for Clinical Areas/DONs, 2002, 2003, 2004.
- "DON Boot Camp;" 2 day program marketed to NJ DONs, 2004.
- CQI: Pain Management Program Initiation, Northern NJ Ethics Alliance, February, 2001.
- Management, CQI, & Survey Topics, The Berkeley Heights Convalescent Center, 2000-2001; St. Mary's Life Care Ctr, 2002.
- ER Course/Trauma/Neuro; ER Course, JCMC, 1994, '95, '96.
- Performance Improvement: How to For Mgt, 2001, 2002, 2003
- FMEA: Failure Mode Effect Analysis, 2002.
- Financial Management for Nursing Managers, 2000, 2004.
- Care of the Geriatric Resident in LTC.

CASE NUMBER

EXHIBIT NUMBER

ID'D

REC'D

DATE

6/2/11

NOTICE OF DISCIPLINARY ACTION

EMPLOYEE INFORMATION

Name:

Title:

Lillian Jacques
LPN

Facility

Date of Hire

SURC

11/30/99

Prior Disciplinary Notices in File: (include date and nature)

- 12/2/09 performance (pain)
- 9/14/10 behavior pattern Absenteeism
- 9/28/10 performance (admission slip fill)
- 12/15/10 performance (incident reports)

TYPE OF VIOLATION

- Dress Code
- Behavior
- Absenteeism/Tardiness
- Performance
- Insubordination
- Patient Care
- Resident Rights
- Refusal to Perform Assigned Task
- Other:

DESCRIPTION

Date: 2/2/11

Time: 3-11p

Specific Description of Issue, Situation or Behavior (what, where, how):

On 2/2/11 you failed to transcribe a med order accurately. you transcribed ASA on the POS when it should have been enteric coated ASA as ordered by the MD. you also failed to the medication to the med. Additionally on 2/2/11 you were

EMPLOYEE RESPONSE

I agree

I disagree for these reasons:

The circumstances under which I did the work admission and I missed one admission not work admission pts in MISR. I agree that it may have been taken over

ACTION TO BE TAKEN

- Documented Verbal Notice
- Suspension for ___ days to start on ___ (date) and return to work on ___ (date).

Does this Disciplinary Action Constitute Final Warning: Yes No

Further problems of any kind may lead to further disciplinary action up to and including termination of employment.

Employee's Signature

Date

Signature is merely an acknowledgement that this matter was discussed and does not indicate agreement.

Employee Refused to Sign (Requires Witness Signature)

Supervisor's Signature

Date

Department Head/Administrator

Date

Witness Signature

Date

(One copy to Employee - one copy to Personnel File - One copy to Supervisor)

Somers005154

R-606

The primary nurse failed to complete the
required documentation for your shift, specifically
18w JG was not documented on. Additionally
on the same accident there was no post
fall note as required. By signing this
you are agreeing with the above & are
signing voluntarily.

document on Post Fall on 18w.



PHYSICIAN'S ORDER FORM CARE ONE @ SOMERSET 1620 ROUTE 22

FACILITY NAME CARE ONE @ SOMERSET VALLEY PERIOD FOUND BROOK, NJ

2-STEP MANTOUX ON ADMISSION, THEN 1-STEP YEARLY, IF NEGATIVE.

OTHER PHYSICIAN'S ORDERS
 INITIAL RE-ADMISSION

CIRCLE ONE: MED A PVT MANAGED CARE CAID

STEP (1) PPD STU INTRADERMALLY. READ 48-72 HOURS. AFTER 2 WEEKS IF NEGATIVE: REPEAT IN OPPOSITE ARM - STU INTRADERMALLY. READ 48-72 HOURS.

SOCIAL SECURITY # 086-18-926
 DATE OF BIRTH: 11/17/84

PNEUMOCOCCAL VACCINE 0.5ML IN
 1. GIVE IF OVER 65 YEARS OF AGE
 2. GIVE IF NOT VACCINATED WITHIN LAST 5 YEARS

"ADMIT FOR SKILLED CARE" AND "ADMIT FOR

ACETAMINOPHEN 325MG TABS (SF: TYLENOL 325MG) 2 TABS (650MG) PO Q4H PRN FOR TEMPERATURE 101 AND OVER
 YES NO

DIET: (CHECK ONE)
 REGULAR CONSISTENT CARBOHYDRATE TRENAL
 INAG FULL LIQUIDS 12GRAM SODIUM
 ILCS CLEAR LIQUIDS
 LOW CHOL/FAT NPO
 FLUID RESTRICTION ML DIETARY / ML NURSING

ACETAMINOPHEN 325MG TABS (SF: TYLENOL 325MG) 2 TABS (650MG) PO Q4H PRN FOR PAIN
 YES NO

TEXTURE:
 REGULAR (LEVEL 1) THICKENED LIQUIDS
 SOFT (LEVEL 3) NECTAR
 MECHANICALLY ALTERED HONEY
 PUREED (LEVEL 1) SPOON
 FINGER FOODS

MAY CRUSH PILLS IF NOT CONTRAINDICATED BY MANUFACTURER.

ABOVE ORDERS GOOD FOR 30 DAYS UNLESS OTHERWISE NOTED

PAIN ASSESSMENT EVERY SHIFT:
 SCALE:
 VERBAL NUMERIC SCALE
 FACE PAIN SCALE REVISED
 PAINAD SCALE

SCHEDULE II MEDICATIONS ARE VALID FOR PARTIAL FILLING FOR 60 DAYS FROM THE EXPIRE DATE IF PRESENTED FOR FILLING WITHIN 30 DAYS OF THAT DATE PURSUANT TO N.J.A.C. 17:27, 17:28, 17:29, 17:30, 17:31, 17:32, 17:33, 17:34, 17:35, 17:36, 17:37, 17:38, 17:39, 17:40, 17:41, 17:42, 17:43, 17:44, 17:45, 17:46, 17:47, 17:48, 17:49, 17:50, 17:51, 17:52, 17:53, 17:54, 17:55, 17:56, 17:57, 17:58, 17:59, 17:60, 17:61, 17:62, 17:63, 17:64, 17:65, 17:66, 17:67, 17:68, 17:69, 17:70, 17:71, 17:72, 17:73, 17:74, 17:75, 17:76, 17:77, 17:78, 17:79, 17:80, 17:81, 17:82, 17:83, 17:84, 17:85, 17:86, 17:87, 17:88, 17:89, 17:90, 17:91, 17:92, 17:93, 17:94, 17:95, 17:96, 17:97, 17:98, 17:99, 17:100

LEVEL:
 0 = NO PAIN
 1,2,3,4 = MILD PAIN
 5,6,7 = MODERATE PAIN
 8,9 = SEVERE PAIN
 10 = VERY SEVERE - HORRIBLE

I REVIEWED THE PLAN OF CARE INCLUDING GOALS & CERTIFY THIS RESIDENT REQUIRES IN THIS NURSING FACILITY

Medication: Candura
 Dosage: 4mg ROUTE: PO
 Frequency: B.I.D.
 PRN Indicator:
 Diagnosis: HTN

ABOVE ORDERS REVIEWED BY Dr. Huang Date: 7/21
 PHYSICIAN SIGNATURE DATE

ALLERGIES
 NKA

ABOVE ORDERS NOTED BY [Signature] DATE 7/21
 ADVANCED PRACTICE NURSE SIGNATURE DATE

PHYSICIAN
 Huang, Ming

DIAGNOSIS
 S/P Fall HTN
 COPD, Chronic Epilepsia

PHYSICIAN ADDRESS PHYSICIAN PHONE
 ALT. PHYSICIAN ADDRESS ALT. PHYSICIAN PHONE
 ROOM/BED/WING MED. RECORD # ADMISSION DATE SEX DATE OF BIRTH PAGE NO
 1411 D 2/7/11 M 126 1 of 1

XX DO XX NOT XX WRITE XX HERE XX

*****SOMERSET MEDICAL CENTER***
HOME HISTORY MEDICATIONS**

Name: [REDACTED]
Sex: 724 / Male
ID: 00189925
Location: 1 East 176-2

Adm-Disch: 01/31/11-No Discharge Date
Pt Type: Inpatient
Acct #: 006530933
Attend MD: HUANG, MING Y MD

Admit Dx: R HIP PAIN AND RENAL FAILURE

**Patient Instructions: Please continue to take the medications that are Initialed in the 'YES' column.
Doctor Instructions: Please Initial the YES or NO box for each medication.*

HOME HISTORY MEDICATIONS

Home Medication	YES	NO	Instructions	Last Dose
Aspirin (aspirin 325 mg oral enteric coated tablet)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	By Mouth, Dally Other Instructions: _____	
Doxazosin (Cardura 8 mg oral tablet)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	By Mouth, Dally Other Instructions: _____	
Simvastatin (simvastatin 40 mg oral tablet)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	By Mouth, at bedtime Other Instructions: _____	
Calciferol (Vitamin D3 1000 intl units oral capsule)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	By Mouth, Dally Other Instructions: _____	

Additional Medication Dose/Frequency

Other Instructions: _____

I am agreeing to share the above information with my primary care physician.

Patient Signature: _____ Date: _____

Physician Signature: [Signature] Int. _____ Date: 4/6/11

Physician Signature: _____ Int. _____ Date: _____

Physician Signature: _____ Int. _____ Date: _____

RN Signature: [Signature] Int. _____ Date: 4/6/11

Telephone Order Readback Time: _____ Date: _____ RN Sig: _____

Somers005159

*****SOMERSET MEDICAL CENTER***
ACTIVE MEDICATIONS AT DISCHARGE**

Name: [REDACTED]
Sex: 124 / Male
00188625
Location: 1 East 176-2

Adm-Disch: 01/31/11 - No Discharge Date
Pt Type: Inpatient
Acct #: 006530933
Attend MD: HUANG, MING Y MD

Admit Dx: R HIP PAIN AND RENAL FAILURE

***Patient Instructions: Please continue to take the medications that are checked in the 'YES' column.
Doctor Instructions: Please check the YES or NO box for each medication.**

ACTIVE MEDICATIONS AT DISCHARGE

Medication	YES	NO	Instructions	Last Dose
Sodium Chloride(11C*)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	2.5 mL IV Flush, every shift Other Instructions: _____	02/06/11 08:00
Morphine(Morphine IV Push)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	4 mg IV Push, every 3 hours As Needed NOTICE: High Alert Medication Other Instructions: _____	01/30/11 23:52
Zolpidem(Ambien)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	5 mg By Mouth, at bedtime & may repeat 1 time As Needed Other Instructions: _____	01/31/11 19:30
lisinazosin(Cardura)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4 mg By Mouth, 2 times a day Other Instructions: _____	02/06/11 10:00
Amlodipine(Norvasc)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	5 mg By Mouth, every 12 hours Other Instructions: _____	02/06/11 10:00
cloNIDine(cloNIDine Tab (Antihypertensive))	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0.1 mg By Mouth, every 6 hours BP systolic > 170, or Diastoll > 110 Other Instructions: _____	02/06/11 06:00
Iron polysaccharide(Niferex)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1 cap By Mouth, Daily Other Instructions: _____	02/06/11 10:00
multivitamin(NephroCaps)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1 cap By Mouth, Daily Other Instructions: _____	02/06/11 10:00
Epoetin Alfa(Procrit)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	20 SubCut, Every Thursday Other Instructions: _____	02/03/11 14:07
Paricalcitol(Zemprar)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1 mcg By Mouth, Daily Other Instructions: _____	02/06/11 10:00

Somers005160

*****SOMERSET MEDICAL CENTER***
ACTIVE MEDICATIONS AT DISCHARGE**

Name: [REDACTED]
Sex: 24 / Male
ID: 00180025
Location: 1 East 176-2

Adm-Disch: 01/31/11 - No Discharge Date
Pt Type: Inpatient
Acct #: 006530933
Attend MD: HUANG, MING Y MD

Admit Dx: R HIP PAIN AND RENAL FAILURE

**Patient Instructions: Please continue to take the medications that are checked in the 'YES' column.
Doctor Instructions: Please check the YES or NO box for each medication.*

ACTIVE MEDICATIONS AT DISCHARGE

<u>Medication</u>	<u>YES</u>	<u>NO</u>	<u>Instructions</u>	<u>Last Dose</u>
acetaminophen(Tylenol Tabs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	650 mg By Mouth, every 4 hours As Needed Other Instructions: _____	02/06/11 08:11

Somers005161

Nursing

Daily Attendance Report

Monday, February 7, 2011

OK

ADM

DAY
 Staffing CD Antiquae Charlotte 8:00A - 4:30P
 Assistant Dominique Franela 9:00A - 5:30P

MSUI

DAY

on Sweet Hongland Shelley ✓ 3:30A - 3:45P
 on Man Yamumu Michael ✓ 8:00A - 4:30P
R Registered Huglan Irene ✓ 6:45A - 3:30P
D MSUI ID Ovidio Irene ✓ 7:00A - 3:30P
F Licensed Mungul Muharante ✓ 6:45A - 4:15P
M Licensed Sessay Hawanatu ✓ 6:35A - 3:15P
M Licensed Boekarie Mohamed ✓ 6:45A - 4:05P
5 Certified Silaire Kerline ✓ 6:45A - 3:15P
4 Certified Granda Muria ✓ 6:45A - 3:15P
1 Certified Jilus Ellise ✓ 6:45A - 3:15P
2 Certified Beauvoir Beatrice ✓ 7:00A - 3:15P
3 Certified Hamaviti Joseph K ✓ 7:00A - 3:15P

EVENING

Dist. Lpd. - John McP...
M. Breen...
 Registered Hogo Ebele ✓ 2:45P - 11:15P
 Licensed Santos Jeremias ✓ 2:45P - 11:15P
 Licensed Usharenko Vyacheslav ✓ 2:45P - 11:15P
 Licensed Jacques Jillian ✓ 2:45P - 11:15P
 Certified Silaire Kerline ✓ 2:45P - 11:15P
 Certified Jarbo Avian ✓ 2:45P - 11:15P
 Certified Roque Miguel ✓ 2:45P - 11:15P
 Certified Dauruche Yendy ✓ 2:45P - 11:15P
 Certified Viol Elzin ✓ 2:45P - 11:15P

NIGHT

Registered Mootousammy Sandy 10:45P - 8:00A
 Licensed Bologee-Smith Sharda ✓ 10:45P - 7:15A
 Certified Theodore Juliana LATE 11:00P - 7:00A
 Certified Jean Garanta LATE 10:35P - 7:45A

* note
 * Sandy put out
 @ 8pm.

Handwritten circled note:
 59

The Rasa Group
55 Skyline Drive Suite 209
Ringwood, NJ 07456
Phone: 973-728-5800
Fax: 973-728-7070

Consultant Pharmacist's Progress Note

For Recommendations Created Between 2/9/2011 And 2/9/2011

Care Center: Somerset Valley Rehabilitation & Nursing Center

Print Date: 2/9/2011

Station: I Room: 14 Bed: Resident: [REDACTED]

MRR Date: 2/9/2011

Physician: Huang, Dr.

Recommendation Type: Transcribing of medication orders

Aspirin documented on transfer orders and POS, however unable to locate on MAR that was faxed. Please review, clarify and correct accordingly. Thank you.

Amy Shah, PharmD, RPh, CCP
Consultant Pharmacist

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Somers005165

The Rasa Group
55 Skyline Drive Suite 209
Ringwood, NJ 07456
Phone: 973-728-5800
Fax: 973-728-7070

Consultant Pharmacist's Progress Note

For Recommendations Created Between 2/9/2011 And 2/9/2011

Care Center: Somerset Valley Rehabilitation & Nursing Center

Print Date: 2/9/2011

Station: I Room: 14

Bed: Resident:

MRR Date: 2/9/2011

Physician Huang, Dr.

Recommendation Type: Order clarification request

Enteric coated Aspirin documented on transfer orders, however appears as Aspirin on POS that was faxed. Was the order changed upon admission? Please clarify. Thank you.

Amy Shah, PharmD, RPh, CCP
Consultant Pharmacist

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Somers005166

DAILY SKILLED NURSES NOTES

Date: 2/2/11 Temperature: _____ Pulse: _____ Resp: _____ B/R: _____

DIRECTIONS: (X) All applicable boxes. Circle appropriate item(s) separated by "/". Signature and title of nurse for appropriate shift

Mental Status		Cardiovascular		GI		Musculoskeletal	
Alert	<input checked="" type="checkbox"/>	Regular Rhythm	<input checked="" type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	Balance / Gait Unsteady	<input checked="" type="checkbox"/>
Oriented to Person	<input checked="" type="checkbox"/>	Regular/Abnormal/Irregular	<input checked="" type="checkbox"/>	Epigastric Distress	<input type="checkbox"/>	Paralysis / Weakness	<input checked="" type="checkbox"/>
Place	<input checked="" type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	WNL	<input type="checkbox"/>
Time	<input checked="" type="checkbox"/>	Edema	<input type="checkbox"/>	Abdominal Distention	<input type="checkbox"/>	Nervous System	
Anxious/Agitated	<input checked="" type="checkbox"/>	Pedal: Lt / Rt	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Syncope	<input type="checkbox"/>
Restless/Lethargic	<input checked="" type="checkbox"/>	Pitting +1	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Headache	<input type="checkbox"/>
Abnormal Sleep Pattern	<input checked="" type="checkbox"/>	+2	<input type="checkbox"/>	Bowel Sounds	<input type="checkbox"/>	Decreased Grasp	<input type="checkbox"/>
Forgetful/Confused	<input type="checkbox"/>	+3	<input type="checkbox"/>	Present	<input checked="" type="checkbox"/>	Fl.	<input type="checkbox"/>
Hallucinations/Delusions	<input type="checkbox"/>	+4	<input type="checkbox"/>	Absent	<input type="checkbox"/>	LL	<input type="checkbox"/>
		Abnormal Peripheral Pulses	<input type="checkbox"/>	Hyperactive	<input type="checkbox"/>	Decreased Movement	<input type="checkbox"/>
		WNL	<input checked="" type="checkbox"/>	Hypoactive	<input type="checkbox"/>	<input type="checkbox"/> RUE <input type="checkbox"/> LUE	<input type="checkbox"/> ALE <input type="checkbox"/> ILE
Respiratory		Sensory		GU		Skin	
Labored Breathing	<input type="checkbox"/>	Unclear Speech	<input type="checkbox"/>	Burning	<input type="checkbox"/>	Abnormal Pupil Reaction	<input type="checkbox"/>
Shallow Respirations	<input type="checkbox"/>	Unable to Speak	<input type="checkbox"/>	Distention / Retention	<input type="checkbox"/>	Right	<input checked="" type="checkbox"/>
Rales / Rhonchi	<input type="checkbox"/>	Unable to Make Self Understood	<input type="checkbox"/>	Frequency / Urgency	<input type="checkbox"/>	Left	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	Unable to Hear	<input type="checkbox"/>	Hematuria	<input type="checkbox"/>	Tremors	<input type="checkbox"/>
Cough	<input type="checkbox"/>	Unable to See	<input type="checkbox"/>	Catheter	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>
Dyspnea / SOB	<input type="checkbox"/>	Decreased Tactile Sensation	<input checked="" type="checkbox"/>	Urine	<input type="checkbox"/>	WNL	<input type="checkbox"/>
O2 LPM	<input type="checkbox"/>	WNL	<input checked="" type="checkbox"/>	Discolored	<input type="checkbox"/>	Jaundiced	<input type="checkbox"/>
<input type="checkbox"/> PRN		Pain		Sediment	<input type="checkbox"/>	Cyanosis	<input type="checkbox"/>
<input type="checkbox"/> Continuous		Origin:		Odor	<input type="checkbox"/>	Pallor	<input type="checkbox"/>
S2O2 % % %		Location:		Discharge	<input type="checkbox"/>	Clammy	<input type="checkbox"/>
Suctioning	<input type="checkbox"/>	Intensity: (0-10)		WNL	<input checked="" type="checkbox"/>	Chills	<input type="checkbox"/>
Trach Care	<input type="checkbox"/>	None	<input checked="" type="checkbox"/>		<input type="checkbox"/>	Flushing of Skin	<input type="checkbox"/>
Vent Care	<input type="checkbox"/>				<input type="checkbox"/>	Flash / Itching	<input type="checkbox"/>
Lungs Clear	<input checked="" type="checkbox"/>				<input type="checkbox"/>	Abnormal Turgor/Elasticity	<input type="checkbox"/>
WNL	<input checked="" type="checkbox"/>				<input type="checkbox"/>	WNL	<input checked="" type="checkbox"/>
MD Orders	<input type="checkbox"/>	Observe S/SX Infection	<input checked="" type="checkbox"/>	Wound Care Dressings	<input type="checkbox"/>	Therapy (PT, OT, ST)	<input checked="" type="checkbox"/>
MD Notified	<input type="checkbox"/>	Transfusions	<input type="checkbox"/>	Pressure Ulcer Care	<input type="checkbox"/>	Nursing Rehabilitation	<input checked="" type="checkbox"/>
Skilled Observation & Assessment	<input checked="" type="checkbox"/>	Gait Training/Prosthesis Care	<input type="checkbox"/>	Stoma Ulcers	<input type="checkbox"/>	Respiratory Therapy	<input checked="" type="checkbox"/>
Diabetic Management	<input type="checkbox"/>	Self Administration of Injectable Meds	<input type="checkbox"/>	Tracheostomy Care	<input type="checkbox"/>	Braces, Casts, Splints, Orthotics, etc. Care/Teach	<input type="checkbox"/>
Glucometer Readings	<input type="checkbox"/>	Terminal Illness	<input type="checkbox"/>	Suctioning	<input type="checkbox"/>		
Dehydration/Fluid Intake	<input type="checkbox"/>	Care/Teach	<input type="checkbox"/>	IV Medication	<input type="checkbox"/>		
Chemotherapy Management / Teaching	<input type="checkbox"/>	Diet Teaching	<input type="checkbox"/>	IV Feeding / Hydration	<input type="checkbox"/>		
Dialysis Management	<input type="checkbox"/>	Bowel & Bladder Training	<input type="checkbox"/>	Intramuscular Injections	<input type="checkbox"/>		
Observe Medication	<input type="checkbox"/>	Teach / Care IV Catheter	<input type="checkbox"/>	Tube Feeding	<input type="checkbox"/>		
Side Effects / Teach	<input type="checkbox"/>	Site	<input type="checkbox"/>	Pain Management	<input type="checkbox"/>		

Signature / Title: N. Schelboren RN E: _____

DATE / TIME: 2/2/11 11-7 COMMENTS: _____ SIGNATURE / TITLE: _____

Received resident in bed sleep in. Alert and slept through the night. No complaints and took his 6am medication. Working w/ bladder and bowel. To continue to monitor.

NAME: _____ Allending Physician: DR. KUBERKA Record No.: _____ Room/Bed: 18W

DAILY SKILLED NURSES NOTES

J Verlock 117

Date: 2/1/11 Temperature: _____ Pulse: 78 Resp: 20 B/P: 104/86

DIRECTIONS: (X) All applicable boxes. Circle appropriate item(s) separated by "/". Signature and title of nurse for appropriate shift.

		N	D	E			N	D	E			N	D	E				
Mental Status				Cardiovascular				GI				Musculoskeletal						
Alert					Regular Rhythm					Nausea / Vomiting					Balance / Gait Unsteady			
Oriented to Person					Radial/Apical Irregular					Epigastric Distress					Paralysis/Weakness			
Place					Chest Pain					Difficulty Swallowing					WNL			
Time					Edema					Abdominal Distention					Nervous System			
Anxious/Agitated					Pedal: Lt / Rt					Diarrhea					Syncope			
Restless/Lethargic					Pitting +1					Constipation					Headache			
Abnormal Sleep Pattern					+2					Bowel Sounds					Decreased Grasp			
Forgetful/Confused					+3					Present					Rt.			
Hallucinations/Delusions					+4					Absent					Li.			
					Abnormal Peripheral Pulses					Hyperactive					Decreased Movement			
					WNL					Hypoactive					<input type="checkbox"/> RUE <input type="checkbox"/> LUE			
															<input type="checkbox"/> RLE <input type="checkbox"/> LLE			
Respiratory				Sensory				GU				Skin						
Labored Breathing					Unclear Speech					Burning					Abnormal Pupil Reaction			
Shallow Respirations					Unable to Speak					Distention / Retention					Right			
Rales / Rhonchi					Unable to Make Self Understood					Frequency / Urgency					Left			
Wheezing					Unable to Hear					Hematuria					Tremors			
Cough					Unable to See					Catheter					Vertigo			
Dyspnea / SOB					Decreased Tactile Sensation					Urine					WNL			
O2 LPM					WNL					Discolored					Skin			
<input type="checkbox"/> PRN										Sediment					Jaundiced			
<input type="checkbox"/> Continuous										Odor					Cyanosis			
S2O2 % % %					Pain					Discharge					Pallor			
Suctioning					Origin:					WNL					Clammy			
Trach Care					Location:										Chills			
Vent Care					Intensity: (0-10)										Flushing of Skin			
Lungs Clear					None										Rash / Itching			
WNL															Abnormal Turgor/Elasticity			
															WNL			
MD Orders					Observe S/SX Infection					Wound Care Dressings					Therapy (PT, OT, ST)			
MD Notified					Transfusions					Pressure Ulcer Care					Nursing Rehabilitation			
Skilled Observation & Assessment					Gait Training/Prosthesis					Stasis Ulcers					Respiratory Therapy			
Diabetic Management					Care					Tracheostomy Care					Braces, Casts, Splints,			
Glucometer Readings					Self Administration of Injectable Meds					Suctioning					Orthotics, etc. Care/Teach			
Dehydration/Fluid Intake					Terminal Illness					IV Medication								
Chemotherapy Management / Teaching					Care/Teach					IV Feeding / Hydration								
Dialysis Management					Diet Teaching					Intramuscular Injections								
Observe Medication Side Effects / Teach					Bowel & Bladder Training					Tube Feeding								
					Teach / Care IV Catheter					Pain Management								
					Sites													

Signature / Title: _____ N: *Verlock* D: _____ E: _____

DATE / TIME: 2/1/11 COMMENTS: *Out of bed to wheelchair. pt clam in wheelchair. @ 10 am. @ distress noted in abd posthwa bowel sounds noted in all four quadrants. No stool on shift.* SIGNATURE / TITLE: _____

NAME - Last: _____ Attending Physician: _____ Record No.: _____ Room/Bed: _____

Nursing

Daily Attendance Report

Wednesday, February 2, 2011

OB

M

DAY
 Staffing CD'Antignao Charlotte 8:00A - 4:30P
 Assistant Dominique Francia 9:00A - 5:30P
MSUI

EVENING

NIGHT

Ort- RR Marie Fitzgerald w/ Miskala

DAY

EVENING

NIGHT

Unit Secr Hoagland Shelley ~~8:00A - 3:40P~~
 Unit Man Yunnous Michael 8:00A - 4:30P
 DMS S D'Ovidio Irene 7:00A - 3:30P
 F Licensed Mungal Mahomnie ~~6:45A - 3:15P~~
 R Licensed Mune Michele ~~7:15A - 3:45P~~
 M Licensed Boukarie Moha ~~7:00A - 3:00P~~
 6 Certified Silaire Kerline 6:45A - 3:15P
 3 Certified Rice Bessie 6:45A - 3:15P
 1 Certified Jilus Elfise 6:45A - 3:15P
 4 Certified Bunnavi Joseph K ~~7:00A - 3:15P~~
 2 Certified Beauvnr Beatrice ~~6:45A - 3:15P~~
 5 Certified Mansaray Abdulni ~~7:15A - 3:15P~~

D Registere Dogdan Irene ~~2:45P - 11:30P~~
 F Licensed Santos Jeremias ~~2:45P - 11:30P~~
 R Licensed Ushorenko Vyacheslav ~~2:45P - 11:30P~~
 M Licensed Jacques Jillian ~~2:45P - 11:30P~~
 5 Certified Mansaray Abdulni ~~2:45P - 11:00P~~
 6 Certified Silaire Kerline ~~2:45P - 11:15P~~
 1 Certified Jarbo Avlan ~~2:45P - 11:15P~~
 2 Certified Roque Miguel ~~2:45P - 11:10P~~
 3 Certified Dautruche Yendy ~~2:45P - 11:15P~~
 4 Certified Vial Elzira ~~2:30P - 11:15P~~

Registere Ilogu Ebele ~~2:45P - 11:30P~~
 Registere Mootoosammy Sandy ~~10:45P - 8:15A~~
 Licensed Sesay Hawanaru ~~7:15A - 7:15A~~
 2 Elzira Vetal ~~11-7~~

*Census
55*

DEFENDANT'S
 EXHIBIT
30

Employee Education Attendance Record

Topic of In-service: MEDICATION ADMINISTRATION DOCUMENTATION

Content: 1. "5 R's" of medication administration

- 2. making sure that one residents - swallow their meds before leaving one residents room.
- 3. Handing over eye gts, nebulizers, treatments, insulin needles etc for resident to administer - steps that

Objectives: At the completion of this training session the participant(s) will: must be followed

- 4. Self medication administration be able doing it
- 5. Hemodialysis policy
- Hemodialysis - plotting medications around dialysis timer

Date: 7/28/10 **Length:** 30 min **Location:**

Presented By: K. Koven Don

Instructional Method(s): Lecture Discussion Visual aids Group activity
 Skill demonstration Self-study module Other:

EXHIBIT NO. 1 RECEIVED REJECTED
 CASE NO. 20092594 CASE NAME
 NO. OF PAGES DATE 4/10/11 REPORTER

Evidence of Learning: Post test Return skill demonstration Group/team presentation Participation in discussion Verbalization of content to meet objectives Other

Print Name	Signature	Department	Shift
Margalite A. Lemaw	<i>M. Lemaw</i>	NSG	7-3
D. P. P. P.	<i>DL</i>		
William J. G. W.	<i>W. J. G. W.</i>	NSG	3-4
Jacquie Southwick	<i>J. Southwick</i>	N/A	7-3
Sharon Woodford	<i>S. Woodford</i>	NSG	7-3
Michelle Moore	<i>M. Moore</i>	NSG	7-3
Sharon Smith	<i>S. Smith</i>	NSG	7-3
JERRY SANTOS	<i>J. Santos</i>	NSG	7-3
Kwame Sarpong	<i>K. Sarpong</i>	NSG	11-7
Bobby Montasemmy	<i>B. Montasemmy</i>	NSG	11-7
Henrietta Lewis	<i>H. Lewis</i>	NSG	7-3
Sheena Cleveland	<i>S. Cleveland</i>	NSG	7-3
Debra Lynn	<i>D. Lynn</i>	NSG	7-3
ANTHONY CATALANO	<i>Anthony Catalano</i>	NSG	11-7
Navigable	<i>Navigable</i>	NSG	11-7
Janez Mathias	<i>J. Mathias</i>	NSG	11-7
Irene Dondok	<i>I. Dondok</i>	NSG	7-3
Smearal	<i>Smearal</i>	NSG	7-3

SVRNC 001060

9



Department
insert in log
126
334
0863

Nurses' Meeting
September 15, 2010

Agenda of topics;

1. Responsibility of answering phones
 - a. Many complaints from families and staff when calling 11-7am
2. Care Issues/Lack of Supervision
3. Proper Assessment and Documentation
 - a. Admissions x 5 days
 - b. Vital signs
4. MARS/TARS
 - a. Blanks
 - b. Narcotic books
 - c. Coumadin cards
5. Nebulizers/Dated items i.e. oxygen tubing
6. Incident and Accidents/Documenting Behavior
 - a. 72 hour charting
7. Med Errors/Signing for bed alarms/TED stockings
8. New Ulcers/Wounds require incident report and investigation
9. Pain Assessment/Pain Documentation ?
 - a. Delay of administration
 - b. Survey Issue (2 Gs)
10. Lunch and Dinner Assistance
11. Infection Control/Oxygen Signs/Room Rounds
12. Cell phone use prohibited on Nursing Unit/Patient Care Area
 - a. This includes texting
13. Missed Punches
 - a. "Missed Punch Form" will no longer accepted, employee must get a Supervisor to override
 - b. Not punching at all may result in not getting paid for that shift within the appropriate pay period and will result in disciplinary action
14. Admissions- Nurses 1:1 training/orientation
15. Audit tool for foley/g-tube
16. System based documentation

- *Glucometer - semi-circular*
- *Bed & chair alarm*
- *Kitty litter or coffee grounds*
- *look @ refrigerator lock box*
- *BP machine - One dynamap machine*
- *Thermometers - Post*

ID'S

<i>Green</i>
<i>Edel</i>

SVRNC001020

Blumberg No. 5114
DEFENDANT'S EXHIBIT
 32

Employee Education Attendance Record

Topic of In-service: Med pass Techniques - MAR/TAR Blankets
 Content: Med Storage - Insulin, Xopenex, nebs, Narcan
blankets; 5 rights of med pass.

Objectives: At the completion of this training session, the participant(s) will:
 RECEIVED
 22-CA-29599
 CASE NO. CASE NAME Somerset Valley
 NO. OF PAGES DATE 11/27/10 REPORTER

Date: 11/17/10 Length 15 mins Location: Unit

Presented By: _____
 Instructional Method(s): Lecture Discussion Visual aids Group activity
 Skill demonstration Self-study module
 Other: _____

Evidence of Learning: Post test Return skill demonstration
 Group/team presentation Participation in discussion Verbalization of content
 to meet objectives Other _____

Print Name	Signature	Department	Shift
Doreen Dandl	Dandl	NSG	11-7
Judy Norton	Judy Norton	NSG	11-7
JANE VELARDE	JVelarde	NSG	11-7
GREGORIO CABRERA W	G Cabrera	NSG	11-7
Janet Zydellis	J Zydellis	NSG	11-7
Salina Masun	S Masun	Nurse	7-3
HAWANAKI DELANEY	H Delaney	Nurse	7-3
WISNER NORTON	W Norton	NSG	7-3
JACQUE SATHYAK	J Sathyak	NSG	7-3
Michele Moore	M Moore	NSG	7-3
PBeck	PBeck	NSC	3-11P
Smargal	Smargal	NSC	7-3
V. Blumberg	V Blumberg	NSC	3-11P
Sheena Claudio	S Claudio	NSG	3-11P
Smargal	Smargal	NSG	7-3

SVRNC001050

