STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315115	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC COAST REHAB & HEALTH	485 RIVER AVE LAKEWOOD, NJ 08701

(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 C #: NJ00153492 Census: 124 Sample Size: 3 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: C #: NJ00153492 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 4/27/2022, it was determined that the facility failed to implement their policy on abuse for 1 of 3 residents (Resident #2) reviewed for abuse investigation. This deficient practice	F 607	F607 D Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-3 Resident #2 continues to reside at this facility. She did not have any negative effects from the noted incident. CNA #1 was terminated from employment as a result of this incident due to the unpredictable behavior displayed. CNA	5/24/22

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

Electronically Signed | 05/12/2022

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F 607	Continued From page 1 was evidenced by the following: According to the Medical Record (MR), Resident #2 was admitted to the Facility on [redacted], with diagnoses which included but were not limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #2 had [redacted] and required extensive assistance for activities of daily living (ADL). Resident #2's Medical Record (MR) revealed that the Resident had a history of [redacted] and at times would become [redacted] requiring [redacted] monitoring when behaviors were present. Resident #2 also had a history of being sent out to [redacted], was on [redacted] medications and was monitored weekly by the [redacted] The "Facility Reportable Event Record/Report" (FRE), dated [redacted], revealed a staff-to-resident abuse incident reported to the New Jersey Department of Health (NJDOH) on [redacted] involving Resident #2 and Certified Nursing Assistant (CNA #1). The Director of Nursing (DON) reported that on [redacted] at approximately 8:30 a.m., CNA #1, reported to the DON that Resident #2 had [redacted] on the [redacted] After the Administration watched the surveillance video (SV), an investigation was started, CNA#1 was immediately suspended, which led to ending her employment and Resident #2 was placed under close supervision. The FRE showed that the Police and the Ombudsman were notified on [redacted]	F 607	#1 was screened appropriately upon hire and certification was in active status at the time of this isolated incident. CNA #1 also received multiple trainings on the Abuse Policy and Procedure prior to this incident with the last in-service noted on [redacted]. A review of video surveillance was complete. Other residents on the unit who were alert and oriented were interviewed. No other residents were identified as being affected by this isolated incident. The Abuse Policy and Procedure was reviewed. No required updates were identified at this time as the current policy does meet all requirements. The Director of Nursing or designee provided re-education to facility staff on the Abuse Policy and Procedure including the types of abuse, screening, training, prevention and identification, protection, investigation, and reporting. The Director of Social Services or designee will conduct monthly interviews with residents on the Manor Unit for the next three months to ensure that residents have no concerns with the care and services that are provided by staff. Any concern identified will be documented on a grievance form and addressed as appropriate. The Administrator will be notified of all concerns. The Director of Social Service will present the findings from the monthly audits at the next quarterly QAA meeting for follow-up and to determine if any additional oversight of this area is required. Compliance Date May 24 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315115	A. BUILDING _____ B. WING _____	C 04/27/2022

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ATLANTIC COAST REHAB & HEALTH	485 RIVER AVE LAKEWOOD, NJ 08701

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F 607	Continued From page 2 During interviews on 4/27/2022, the Administration verified the information on the FRE. The Administrator stated the SV showed that the CNA retaliated by hitting the Resident on the [redacted] The Administrator verified that the Nursing Board was notified about CNA #1's conduct. A review of CNA #1's employee record showed she had last received education on Abuse titled "Recognizing, Reporting, and Preventing Abuse" on [redacted] According to the facility's Policy titled "Abuse/Neglect Policy and Procedure" dated August 2017, under Policy "All residents have the right to be free from mental, physical, sexual, and verbal abuse...and to be treated with dignity and respect..." N.J.A.C. 8:39-4.1(a)5	F 607		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315115 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 5/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC COAST REHAB & HEALTH	485 RIVER AVE LAKEWOOD, NJ 08701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0607 Reg. # 483.12(b)(1)-(3) LSC	Correction Completed 05/24/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/27/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO	