STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	T5SN2I	A. BUILDING: _____ B. WING _____	C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, NJ 07753

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint Complaint #: 184135 Date of Survey: 10/17/2025 CENSUS: 77 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect;	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	T5SN2I	A. BUILDING: _____ B. WING _____	C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, NJ 07753

(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) COMPLETE DATE
A 389	Continued From page 1	A 389		

This REQUIREMENT is not met as evidenced by:
Complaint: 184135

Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure a resident's right to be NJ Exec Order 26.4b1 for 1 of 1 resident reviewed, Resident #3. This deficient practice was evidenced by the following:

On NJ Exec Order, a Reportable Event was received by the New Jersey Department of Health (NJDOH) for an NJ Exec Order 26.4b1 incident dated NJ Exec Order 2 (sic) at 6 AM (The incident occurred in NJ Exec Order 2. The NJ Exec Order 26.4b1 involved a Care Associate (CA #1) who entered Resident #3's room to provide NJ Exec Order 26.4b1 care. During the care Resident #3 became NJ Exec Order 26.4 and NJ Ex and NJ Ex CA #1. CA #1 stated he used NJ Exec Order 26.4b1 to NJ Exec O the residents' NJ Exec Ord while NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1. The facility immediately NJ Exec Order 26.4b1 and then NJ Exec Order 26.4b1 CA #1.

An investigation was completed by the facility including interviews with other residents on the same unit as Resident #3.

Resident #3 was admitted to the facility on NJ Exec Order 26. At the time of the incident the resident was on NJ Exec Order 26.4 services. Resident #2 medical diagnoses included, but were not limited to; NJ Exec Order 26.4b1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	T5SN2I	A. BUILDING: _____ B. WING _____	C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, NJ 07753

(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) COMPLETE DATE
A 389	Continued From page 2 NJ Exec Order 26.4b1 . Resident #3 NJ Exec Order 26. at the facility on NJ Exec Order 2 On 10/17/25 at 11:15 AM, the surveyor reviewed the complete investigation provided by the facility. The investigation revealed that the incident did occur and in conclusion the NJ Exec Order was substantiated and the employee was NJ Exec Order 26.4b1 On 10/17/25 at 11:55 AM, the surveyor interviewed a Certified Nursing Assistant (CNA #1) regarding NJ Ex Order 26.7 CNA #1 told the surveyor that she would report it "immediately" to the supervisor at the facility and if no supervisor was in the facility she would call the NJ Ex Order 26.4(b)(1). The surveyor then interviewed the second floor Wellness Manager regarding NJ Exec Order 2 She stated it would immediately be reported and an investigation would start. On 10/17/25 at 12:15 PM, the surveyor toured the second floor of the facility. In the main dining room the surveyor interviewed four unsampled residents regarding safety and if they had any concerns. The four residents told the surveyor they had no concerns and felt safe at the facility. On 10/17/25 at 1:00 PM, the surveyor reviewed Resident #3's Service Plan (SP: a written guide that focuses on medical, nursing and specialized care needs). The SP, initiated on NJ Exec Order 2 following the investigation, included a new approach which included that if the resident became NJ Exec Order 26.4 during care, staff would ensure NJ Exec Order and NJ Exec Order 26.4b1 when NJ Exec Or and provide NJ Exec Order 26.4b1 as needed. Review of the Resident Rights policy, undated, under the NJ Exec Order 2 section revealed that the	A 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	T5SN2I	A. BUILDING: _____ B. WING _____	C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	**3002 ESSEX ROAD TINTON FALLS, NJ 07753**

(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) COMPLETE DATE
A 389	Continued From page 3 resident had the right to be free from [redacted] or [redacted]	A 389		

POC #2 received 11/26/25
Accepted 11/26/25

Seabrook
BY ERICKSON SENIOR LIVING®

November 26, 2025

To whom it may concern,

Please see the below Plan of Correction (POC) from your survey on October 17, 2025.

1. Corrective Action for the Affected Resident:

Resident # 3 was immediately assessed by the Registered Nurse (RN) on [redacted] Resident was offered [redacted] on [redacted] The staff member involved was immediately removed from resident's care pending investigation effective [redacted] The residents' representative, provider, and [redacted] were notified [redacted] The resident is no longer in the community as of [redacted] The staff member involved was [redacted] effective [redacted]

2. Corrective Action to Identify Other Residents with Potential to Be Affected:

All residents have the potential to be affected. A sample of residents on the assignment were interviewed and received a comprehensive skin assessment. No findings noted. All Assisted Living residents received a copy of the Residents Rights

3. Systemic Changes to Prevent Recurrence:

The RN/designee provided re-education to clinical staff on the residents rights and abuse prevention policies between the dates of 3/6/2025 and 3/20/2025.

4. Monitoring to Ensure Ongoing Compliance:

The RN wellness manager/designee will interview 10% of residents weekly for 4 weeks and then monthly for 3 months to ensure their resident rights are being upheld and they remain free from abuse. All findings will be reported to Quality Assurance Performance Improvement (QAPI) monthly for 4 months.

Seabrook
BY ERICKSON SENIOR LIVING®

5. Completion Date

All corrective actions will be completed by: 12/20/2025.

If additional information or updates are needed, I can be reached via email at NJ Exec Order 26.4b1

NJ Exec Order 26.4b Approved 11/26/25

Thank you,

NJ Exec Order 26.4b1

Assistant Director of Continuing Care
Seabrook
3002 Essex Road
Tinton Falls, NJ 07753

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
T5SN2I (Y1)	A. Building B. Wing (Y2)	11/26/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT SEABROOK	3002 ESSEX ROAD TINTON FALLS, NJ 07753

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 12/20/2025	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
10/17/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO