STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315125	A. BUILDING _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	**395 LAKESIDE BLVD BAYVILLE, NJ 08721**

(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 COMPLAINT #: NJ171869, NJ172508, NJ176503, NJ178530, NJ178766, NJ178770 CENSUS: 211 SAMPLE SIZE: 7 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F600L Based on interviews, medical record review, and review of other pertinent facility documentation on NJ Exec Order 26.4b1 it was determined that the facility: a) failed to provide services necessary to prevent NJ Ex Order 26.4(b)(1) for a resident (Resident #1), b) used a NJ Ex Order 26.4(b)(1) for a resident (Resident #1) with a known history of NJ Exec Order 26.4b1 towards others and diagnoses of NJ Exec Order 26.4b1 . On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 NJ Exec Order 26.4b1 with CNA #2 and the U.S. FOIA (b)(6) NJ Exec Order Resident #1, at which time she ran to get the Licensed Practical Nurse (LPN#1) who was already on her way to the hallway. LPN #1 stated she heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 in the hallway. LPN #1 responded to the hallway and saw Resident #1 NJ Exec Order 26.4b1	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 program participation.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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F 000	Continued From page 1	F 000		

NJ Exec Order 26.4b1 ." LPN #1 stated she observed CNA #2 NJ Exec Order 26 Resident #1 and the NJ Exec (NJ Exec Order Resident #1 with U.S. FOIA (b)(6). LPN #1 told both staff members (CNA #2 and U.S. FO) to NJ Exec Order 26.4b1 . LPN#1 stated CNA #2 and the U.S. FO did not immediately stop and NJ Ex Order 26 the resident. She had to repeat the request. LPN#1 stated the U.S. FO said, "Its ok we are told to do this." LPN #1 stated she assisted Resident #1 NJ Exec Order 26.4b1 to the nursing station and immediately reported the incident to the U.S. FOIA (b)(6)). CNA #2 and the U.S. FOIA went down to the other side of the hallway and passed the lunch trays.

The Social Worker (SW#1) stated the U.S. FOIA (b)(6) got her to come to the unit. SW #1 stated Resident #1 was NJ Exec Order 26.4b1 " SW#1 stated while at the nursing station, she observed the resident's U.S. FOIA (b) when Resident #1 NJ Exec Order 26.4b1 . SW #1 reported the observation to the U.S. FOIA (b)(6). SW#1 stated she was asked by LPN#1 to take Resident #1 to her office on the first floor. SW #1 stated Resident #1 complained of NJ Exec Order 26.4b1 . During an interview with the NJ Exec O the U.S. FOIA stated while Resident #1 stated " NJ Exec Order 26.4b1 while attempting to pick up food from NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) stated Resident #1 told her that he/she NJ Exec and an order was obtained from the U.S. FOIA (b)(6) to send Resident #1 to the hospital NJ Exec Order 26.4b . On NJ Exec Order 26.4b1 , Resident #1 was admitted to the hospital with diagnoses of NJ Exec Order 26.4b1 .

The facility failed to follow its policy titled "Abuse Policy and Procedure" and the facility job description titled "Certified Nursing Assistant Job Description." This placed Resident #1 and all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CRYSTAL LAKE HEALTHCARE AND REHABILITATION	**395 LAKESIDE BLVD BAYVILLE, NJ 08721**

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F 000	Continued From page 2 other residents experiencing NJ Exec Order 26.4b1 [redacted] at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 10/22/2024 at 8:50 PM and was reported to the U.S. FOIA (b)(6) [redacted] The U.S. FOIA (b)(6) [redacted] were presented with the IJ template. The IJ began on NJ Exec Order 26.4b1 [redacted] and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan. On 10/29/2024, a revisit to verify the Removal Plan was conducted. The facility implemented the Removal Plan, which included re-educating all facility staff on the importance of preventing abuse, ensuring resident safety, and the importance of following the facility's abuse policy. The facility also provided re-education on incident investigations, importance of collecting all written statements, utilizing the U.S. FOI [redacted] to assist in obtaining the resident statements, assuring the original signed statements are turned into the abuse coordinator, and reporting all incidents to the abuse coordinator immediately. The facility initiated an audit to monitor compliance with the education and conducted staff assessment and testing to ensure true understanding of the facility's abuse policy. The noncompliance remained on 10/29/24 as a level G for actual harm that is not an IJ based on the following: Resident #1 is no longer at the facility, CNA #2 and the U.S. FO [redacted] no longer work at the facility, and all facility staff have been re-educated on the facility's NJ Ex Order 26 [redacted] policy. F610L Based on interviews, medical record review, and	F 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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F 000	Continued From page 3 review of other pertinent facility documentation on NJ Exec Order 26.4b1 it was determined that the facility failed to conduct a timely and thorough investigation for an allegation of witnessed and reported staff to resident NJ Exec Order 26.4b1 toward a resident (Resident #1). On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 NJ Exec Order 26.4b1 with CNA #2 and the U.S. FOIA (b)(6) NJ Exec Order Resident #1, at which time she ran to get the Licensed Practical Nurse (LPN#1) who was already on her way to the hallway. LPN #1 stated she heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 in the hallway. LPN #1 responded to the hallway and saw Resident #1 NJ Exec Order 26.4b1 NJ Exec Order 2 NJ Exec Order 26.4b1 LPN #1 stated she observed CNA #2 NJ Exec Order 26 Resident #1 and the NJ Exec Order 26.4b1 Resident #1 with NJ Exec Order 2. LPN #1 told both staff members (CNA #2 and U.S. FO) to stop and to NJ Ex Order 26.4(b)(1) resident. LPN#1 stated CNA #2 and the U.S. FO did not immediately stop and get off the resident. She had to repeat the request. LPN#1 stated the U.S. FOIA said, "Its ok we are told to do this." LPN #1 stated she assisted Resident #1 NJ Exec Order 26.4b1 to the nursing station and immediately reported the incident to the U.S. FOIA (b)(6)). CNA #2 and the U.S. FOIA went down to the other side of the hallway and passed the lunch trays. The Social Worker (SW#1) stated the U.S. FOIA (b)(6) got her to come to the unit. SW#1 stated Resident #1 was NJ Exec Order 26.4b1 SW#1 stated while at the nursing station, she observed the resident's U.S. FOIA (b) when Resident #1 NJ Exec Order 26.4b1. SW#1 reported the	F 000		

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CRYSTAL LAKE HEALTHCARE AND REHABILITATION	**395 LAKESIDE BLVD BAYVILLE, NJ 08721**

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F 000	Continued From page 4	F 000		

observation to the [U.S. FOIA (b)(6)]. SW#1 stated she was asked by LPN#1 to take Resident #1 to her office on the first floor. SW#1 stated Resident #1 complained of [U.S. FOIA (b)(6)]. During an interview with SW#1, she stated Resident #1 stated '[redacted] when he/she attempted to pick food [NJ Ex Order 2] [redacted] The [U.S. FOIA (b)(6)] stated Resident #1 told her that he/she [NJ Exec O] and an order was obtained from the U.S. FOIA (b)(6) to send Resident #1 to the hospital for [NJ Exec Orde]

On [NJ Ex Order 26.4(b)(1)], Resident #1 was admitted to the hospital with diagnoses of NJ Exec Order 26.4b1 [redacted].

The facility also failed to follow its policy titled "Conducting an Investigation of all Incidents/Accidents" and "Abuse Policy and Procedure".

This placed Resident #1 and all other residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 10/22/2024 at 8:50 PM and was reported to the U.S. FOIA (b)(6) [redacted] were presented with the IJ template. The IJ began on [NJ Exec Order 26.4b1] and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan.

On 10/29/2024, an onsite revisit was conducted to verify the facility implemented the Removal Plan. The facility re-educated all staff on incident investigations, the importance of collecting all written statements, utilizing the social worker to assist in obtaining the resident statements, assuring the original signed statements are turned into the abuse coordinator, and reporting

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F 000	Continued From page 5 all incidents to the abuse coordinator immediately. The noncompliance remained on 10/29/24 as a level G for actual harm that is not an IJ based on the following: Resident #1 is no longer at the facility, CNA #2 and the [redacted] no longer work at the facility, and all facility staff have been re-educated on incident investigations, importance of collecting all written statements, utilizing the social worker to assist in obtaining the resident statements, assuring the original signed statements are turned in to the abuse coordinator, and reporting all incidents to the abuse coordinator immediately. F656L Based on interviews, medical record review, and review of other pertinent facility documentation on NJ Exec Order 26.4b1 [redacted], it was determined that the facility failed to a.) implement care plan (CP) interventions for a resident (Resident #1) with a known history of NJ Exec Order 26.4b1 towards others and diagnoses of NJ Exec Order 26.4b1 [redacted]. On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 NJ Exec Order 26.4b1 with CNA #2 and the NJ Exec Order 26.4b1 [redacted] Resident #1, at which time she ran to get the Licensed Practical Nurse (LPN#1) who was	F 000		

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F 000	Continued From page 6	F 000		

already on her way to the hallway. LPN #1 stated she heard [redacted] and [redacted] in the hallway. LPN #1 responded to the hallway and saw Resident #1 [redacted] LPN #1 stated she observed CNA #2 [redacted] Resident #1 and the [redacted] Resident #1 with [redacted]. LPN #1 told both staff members (CNA #2 and [redacted]) to stop and [redacted] the resident. LPN#1 stated CNA #2 and the [redacted] did not immediately stop and [redacted] the resident. She had to repeat the request. LPN#1 stated the [redacted] said, "Its ok we are told to do this." LPN #1 stated she assisted Resident #1 [redacted] to the nursing station and immediately reported the incident to the [redacted]. CNA #2 and the [redacted] went down to the other side of the hallway and passed the lunch trays.

The Social Worker (SW#1) stated the [redacted] got her to come to the unit. SW #1 stated Resident #1 was yelling [redacted] SW#1 stated while at the nursing station, she observed the resident's [redacted] when Resident #1 [redacted]. SW #1 reported the observation to the [redacted]. SW#1 stated she was asked by LPN#1 to take Resident #1 to her office on the first floor. SW #1 stated Resident #1 complained of [redacted]. During an interview with the [redacted], the [redacted] stated while Resident #1 stated [redacted] while attempting to pick up food from [redacted]. The [redacted] stated Resident #1 told her that he/she [redacted] and an order was obtained from the [redacted] to send Resident #1 to the hospital for [redacted]. On [redacted], Resident #1 was admitted to the hospital with diagnoses of [redacted] The facility also failed to follow its policy titled

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F 000	Continued From page 7 "Care Plan". This placed Resident #1 and all other residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 10/22/2024 at 8:50 PM and was reported to the U.S. FOIA (b)(6) [redacted] were presented with the IJ template. The IJ began on [redacted] and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan. On 10/29/2024, a revisit to verify the Removal Plan was conducted. The facility implemented the Removal Plan, which included education on ensuring CP interventions were implemented, the location of the CPs, how to read the CPs, the importance of following the CPs, and how to update the CPs. Audits were conducted that monitor compliance with the implementation and following of the CP interventions or if updates to the CP were required. The noncompliance remained on 10/29/24 as a level G for actual harm that is not an IJ based on that the facility staff have been educated on how to ensure CP interventions were implemented, the location of the CPs, how to read the CPs, the importance of following the CPs, and how to update the CPs. Audits were conducted that monitor compliance with the implementation and following of the CP interventions and if updates to the CP were required. F835L Based on interviews, medical record review, and review of other pertinent facility documentation on	F 000		

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F 000	Continued From page 8	F 000		

NJ Exec Order 26.4b1 it was determined that the facility's U.S. FOIA (b)(6) failed to: a.) provide services necessary to prevent NJ Ex Order 26.4(b)(1) for a resident (Resident #1), b.) follow the facility's NJ Ex Order 26 policy by allowing staff members to continue to work with other residents after an NJ Ex Order 26 allegation occurred, c.) conduct a timely and thorough investigation for a reported witnessed allegation of staff to resident NJ Ex Order 26.4(b)(1), d.) provide accurate and original witness statements to the surveyors for an abuse investigation e.) implement care plan (CP) interventions for a resident (Resident #1) with NJ Exec Order 26.4b1 towards others and diagnoses of NJ Exec Order 26.4b1

On NJ Ex Order 26.4(b)(1) at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 NJ Exec Order 26.4b1 with CNA #2 and the U.S. FOIA (b)(6) NJ Exec Order Resident #1, at which time she ran to get the Licensed Practical Nurse (LPN#1) who was already on her way to the hallway. LPN #1 stated she heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 in the hallway. LPN #1 responded to the hallway and saw Resident #1 NJ Exec Order 26.4b1 in the hallway LPN #1 stated she observed CNA #2 NJ Exec Order 26 Resident #1 and the NJ Exec NJ Exec Order Resident #1 with NJ Exec Order 2. LPN #1 told both staff members (CNA #2 and U.S. FO) to stop and NJ Ex Order 26.4(b)(1 the resident. LPN#1 stated CNA #2 and the U.S. FO did not immediately stop and get off the resident. She had to repeat the request. LPN#1 stated the U.S. FO said, "Its ok we are told to do this." LPN #1 stated she assisted Resident #1 NJ Exec Order 26.4b1 to the nursing station

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F 000	Continued From page 9	F 000		

and immediately reported the incident to the U.S. FOIA (b)(6). CNA #2 and the U.S. FOIA went down to the other side of the hallway and passed the lunch trays.

The Social Worker (SW#1) stated the U.S. FOIA (b)(6) got her to come to the unit. SW#1 stated Resident #1 was #1 stated while at the nursing station, she observed the resident's NJ Ex Orde when Resident #1 NJ Exec Order 26.4b1. SW #1 reported the observation to the U.S. FOIA (b)(6). SW#1 stated she was asked by LPN#1 to take Resident #1 to her office on the first floor. SW #1 stated Resident #1 complained of . During an interview with the SW#1, she stated Resident #1 stated while attempting to pick up food from NJ Ex. The U.S. FOIA (b)(6) stated Resident #1 told her that he/she NJ Exec, and an order was obtained from the U.S. FOIA (b)(6) to send Resident #1 to the hospital for . On , Resident #1 was admitted to the hospital with diagnoses of NJ Exec Order 26.4b1 The facility also failed to follow its job description titled U.S. FOIA (b)(6)

This placed all residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 10/22/2024 at 8:50 PM and was reported to the U.S. FOIA (b)(6) were presented with the IJ template. The IJ began on NJ Ex Order 26.4(b)(1) and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan.

On 10/29/2024, the surveyors conducted an onsite revisit to verify the Removal Plan was implemented. The facility implemented the

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Removal Plan, which included the two staff members identified (CNA #2 and the [redacted]) were terminated from the facility. Disciplinary action was initiated for the three employees (CNA #1, LPN#1, and SW#1) who witnessed the incident on [redacted] and did not report it to the [redacted]. Education was provided to all administrative staff about the facility's [redacted] and investigation policy which included immediate steps taken when an [redacted] allegation was made and ensuring the safety of all residents. Education was provided to all staff on the importance of preventing [redacted] ensuring resident safety, and the importance of following the facility's [redacted] policy to protect all residents. Education was provided to all staff on the importance of collecting all truthful statements in their original form, utilizing the [redacted] to assist in obtaining resident statements, and assuring the original signed statements were all submitted to the U.S. FOIA (b) (6) . Education on ensuring implementation of care plan interventions was provided to all the staff. This education included the location of care plans, how to read the care plans, the importance of following the care plans, and how to update the care plans. Audits were conducted that monitor compliance with the implementation, following of care plan interventions, and if updates to the care plan were required. Audits were initiated by the [redacted] that monitor compliance with all staff education. The [redacted] conducted staff assessments and testing to ensure that staff have a true understanding of the facility's abuse policy.

The noncompliance remained on 10/29/24 as a level G for actual harm that is not an IJ based on the following: Resident #1 is no longer at the facility, CNA #2 and the [redacted] no longer work at the

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F 000	Continued From page 11 facility, and all facility staff have been re-educated on the facility's abuse and investigation policy, importance of preventing abuse and ensuring resident safety, importance of collecting all truthful statements in their original form, utilizing the [U.S. FOI] to assist in obtaining resident statements, and assuring the original signed statements were all submitted to the[U.S. FOIA (b) (6)]. All facility staff have also been re-educated on ensuring implementation of care plan interventions. The facility began audits on compliance with all staff education and conducted staff assessments and testing to ensure that staff have a true understanding of the facility's abuse policy.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint # NJ178530 Based on interviews, medical record review, and review of other pertinent facility documentation on	F 600	Immediate Action On 10/14/24, Resident #1 was [NJ Exec Order 2] [redacted] and was not accepted back to facility.	12/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315125	A. BUILDING _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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F 600	Continued From page 12 10/22/2024, 10/23/2024, 10/24/2024 and 10/29/2024, it was determined that the facility: a) failed to provide services necessary to prevent NJ Ex Order 26.4(b)(1) for a resident (Resident #1), b) used a NJ Ex Order 26.4(b)(1) for a resident (Resident #1) with a known history of NJ Exec Order 26.4b1 towards others and diagnoses of U.S. FOIA (b)(6) On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 NJ Exec Order 26.4b1 with CNA #2 U.S. FOIA (b)(6) NJ Exec Order Resident #1, at which time she ran to get the Licensed Practical Nurse (LPN#1) who was already on her way to the hallway. LPN #1 stated she heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 in the hallway. LPN #1 responded to the hallway and saw Resident #1 NJ Exec Order 26.4b1 NJ Exec Order 26 NJ Exec Order 26.4b1 ." LPN #1 stated she observed CNA #2 NJ Exec Order 26 Resident #1 and the NJ Exec Order 26.4b1 Resident #1 with NJ Exec Order 2. LPN #1 told both staff members (CNA #2 and U.S. FOIA) to NJ Exec Order 26.4b1 . LPN#1 stated CNA #2 and the U.S. FOIA did not immediately stop and NJ Ex Order 26 the resident. She had to repeat the request. LPN#1 stated the U.S. FOIA said, "Its ok we are told to do this." LPN #1 stated she assisted Resident #1 to the nursing station and immediately reported the incident to the U.S. FOIA (b)(6)). CNA #2 and the U.S. FOIA went down to the other side of the hallway and passed the lunch trays. The Social Worker (SW#1) stated the U.S. FOIA (b)(6) got her to come to the unit. SW #1 stated Resident #1 was NJ Exec Order 26.4b1 SW#1 stated while at the nursing station,	F 600	On NJ Ex Order 26.4(b)(1) , C.N.A #2 and smoking monitor #1 were terminated. On 10/24/2024 disciplinary action was given to staff LPN #1, C.N.A. #1, and SW #1, who did not follow company policy on NJ Ex Order 26 NJ Ex Order 26 and report immediately to the coordinator the incident of Other residents having potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not return. On 10/22/24, the Director of Nursing/or designee immediately educated all staff on the facilities policy on abuse and the importance of reporting all incidents to the abuse coordinator immediately. The DON/designee will conduct monthly education on the facilities policy on abuse for the next six months. Administrator/DON /ADON designee will audit education each month to assure all employees have had education. Audits will be conducted weekly for the next four weeks and then monthly for four months. DON/ADON/designee will monitor compliance with education and conduct staff assessment and testing to assure	

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F 600	Continued From page 13 she observed the resident's [NJ Exec Or] when Resident #1 [redacted]. SW #1 reported the observation to the [U.S. FOIA (b)(6)]. SW#1 stated she was asked by LPN#1 to take Resident #1 to her office on the first floor. SW #1 stated Resident #1 complained of [U.S. FOIA (b)(6)]. During an interview with SW#1, she stated while Resident #1 stated [NJ Exec] [redacted] while attempting to pick up food from [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA (b)(6)] stated Resident #1 told her that he/she [NJ Exec], and an order was obtained from the U.S. FOIA (b)(6) to send Resident #1 to the hospital for [redacted] On [NJ Exec Order 26.4b1], Resident #1 was admitted to the hospital with diagnoses of NJ Exec Order 26.4b1 [redacted]. The facility failed to follow its policy titled "Abuse Policy and Procedure" and the facility job description titled "Certified Nursing Assistant Job Description." This placed Resident #1 and all other residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 10/22/2024 at 8:50 PM and was reported to the [U.S. FOIA (b) (6)] [redacted] the [U.S. FOIA (b) (6)] [redacted]), and [U.S. FOIA (b) (6)] The [U.S. FOIA (b) (6)] [U.S. FOIA (b)] and [NJ Ex Order 26.] were presented with the IJ template. The IJ began on [U.S. FOIA (b)(6)] and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan. On 10/29/2024, a revisit to verify the Removal Plan was conducted. The facility implemented the Removal Plan, which included re-educating all facility staff on the importance of preventing [NJ Ex Order 26.4] ensuring resident safety, and the importance of following the facility's [NJ Ex Order 26] policy. The facility also provided re-education on incident investigations, importance of collecting all written statements, utilizing the [U.S. FOI] to assist in obtaining	F 600	staff has true understanding of our abuse policy. Audits will be completed 3x weekly for the next four weeks and then monthly for the next four months. The education on the facilities abuse policy and the importance of reporting all incidents to the abuse coordinator immediately will become part of our orientation education as well as our annual education. DON/ADON/designee with the IDT will screen all referrals as they come in for behavior, care plans, medical/psychiatric history and determine if appropriate for our facility and if we can meet their crisis care plan from their PASSRR II recommendations. This screening process will take place as they come in for the first four weeks and then monthly for four months. How the facility plan to monitor its performance to make sure that solutions are sustained. The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on January 16, 2024.	

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F 600	Continued From page 14	F 600		

the resident statements, assuring the original signed statements are turned into the [redacted] and reporting all incidents to the abuse coordinator immediately. The facility initiated an audit to monitor compliance with the education and conducted a staff assessment and testing to ensure true understanding of the facility's abuse policy.

The noncompliance remained on 10/29/24 as a level G for actual harm that is not an IJ based on the following: Resident #1 is [redacted] the facility, CNA #2 and the [redacted] no longer work at the facility, and all facility staff have been re-educated on the facility's [redacted] policy.

This deficient practice was identified for 1 of 7 residents (Resident #1) and was evidenced by the following:

According to the Facility's Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents with a report date of [redacted], Resident #1 was [redacted] while in his/her room and [redacted] table at a staff member outside of Resident #1's room on [redacted] While [redacted], Resident #1 [redacted], Resident #1 continued to be a [redacted] to the staff and others. Staff attempted to [redacted] Resident #1 by using [redacted] Resident #1 was sent to the hospital for further evaluation. While at the hospital, Resident #1 stated to hospital staff that he/she had [redacted]. The [redacted] notified the facility on [redacted] of Resident #1's allegation. According to the FRE, "a full investigation was

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F 600	Continued From page 15 initiated" on NJ Exec Order 26.4b1. Both staff members were suspended pending an investigation on NJ Exec Order 26.4b1 According to the facility's document titled "Summary of Investigation" with a "date reported" of U.S. FOIA (b)(6) under "Summary", Resident #1 sustained injuries when he/she NJ Exec Order 26.4b1 while trying to continue an NJ Exec Order 26.4b1 Resident #1 had a history of NJ Exec Order 26.4b1 towards others and staff were protecting residents and themselves while trying to keep Resident #1 from continuing NJ Exec Order 26.4b1. The staff were concerned for everyone's safety and tried to keep Resident #1 NJ Exec Order 26.4b1 Resident #1 from NJ Exec Order 26.4b1. "They were NJ Exec Order 26.4b1 while trying to keep Resident #1 down to prevent further NJ Exec Order 26.4b1 from Resident #1." According to the Admission Record (AR), Resident #1 was admitted to the facility on NJ Exec Order 26.4b1, with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 According to the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 The MDS further indicated Resident #1 was on NJ Exec Order 26.4b1 medications and had no behaviors that were exhibited towards others.	F 600		

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According to the Discharge MDS dated [redacted], Section A, a discharge assessment indicated "return anticipated." Section E revealed that Resident #1 [redacted]

A review of Resident #1's Care Plan (CP) initiated on [redacted] revealed under "Focus:" Resident #1 is the [redacted] The "Goal" included "Resident #1 will not harm others through the review date." "Interventions" initiated on [redacted] included: "When Resident #1 becomes [redacted], intervene before [redacted]. [redacted] from source of [redacted] Engage calmly in conversation. If response is [redacted] staff to [redacted] and approach later."

A review of Resident #1's Progress notes (PNs) dated [redacted] written by the [redacted] revealed Resident #1 became [redacted] while in the room and [redacted] at a staff member outside the room door. During the [redacted], Resident #1 [redacted] While [redacted] Resident #1 continued to be [redacted] to the staff. Staff attempted to subdue Resident #1 using [redacted]. Resident #1 was [redacted] Resident #1 was taken off the unit with Social Services (SS) to [redacted]. The Physician was informed of Resident #1's [redacted] An order was secured to send Resident #1 to the hospital for a [redacted] and [redacted]

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F 600	Continued From page 17 A review of Resident #1's PNs dated 10/14/2024 at 9:35 PM revealed at 5:30 PM, Resident #1 was picked up by NJ Exec Order 26.4b1 and [redacted] A review of CNA#2 and the [redacted] personnel files revealed that both staff had training on [redacted] and how to deal with [redacted] residents. During an interview with the surveyors on NJ Exec Order 26.4b1, CNA #1 stated that on NJ Exec Order 26.4b1 she walked out of the dayroom, heard NJ Ex Order 26.4(b)(1), and observed Resident #1 [redacted] in the hallway [redacted] Resident #1's room and the dayroom on his/her [redacted] She observed CNA#2 and the [redacted] resident with [redacted]. CNA #1 stated "the camera could show you better." CNA #1 further stated she ran to get LPN#1, who responded to the incident. CNA #1 stated that CNA# 2 and the [redacted] continued to work the rest of the shift on another unit. She stated that Resident #1 went to the [redacted] the same day the incident occurred but was unsure of the time. CNA #1 stated that Resident #1 can be [redacted] at times but NJ Exec Order 26.4b1 CNA #1 stated she heard both CNA #2 and the [redacted] tell LPN #1 that Resident #1 got [redacted] because resident was told NJ Exec Order 26.4b1. During an interview with the surveyors on 10/22/2024 at 1:27 PM, LPN #1 stated she worked on [redacted] and was assigned Resident #1. LPN #1 stated she was in the charting room speaking with the NJ Exec Order 26.4b1 [redacted] and heard NJ Ex Order 26.4(b)(1) and [redacted] LPN #1 stated the [redacted] and herself immediately got up and as she was coming out of the charting room door, she was met by CNA #1 who was coming to get	F 600		

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her. LPN #1 stated she looked down the hallway where [redacted] was coming from and observed Resident #1 [redacted] in front of his/her room. LPN #1 stated she heard Resident #1 [redacted]." LPN #1 further stated that the [redacted] was behind her and stated, [redacted], [redacted] LPN #1 stated she observed CNA #2 [redacted] Resident #1 and the [redacted] Resident #1. LPN #1 stated Resident #1 was [redacted] LPN #1 stated she told CNA #2 and the [redacted] to [redacted] CNA #2 and the [redacted]. She had to repeat the request to CNA#2 and the [redacted] to [redacted] resident. CNA #2 and the [redacted] then [redacted] LPN #1 further stated that the [redacted] said, "its ok, we are told to do this." LPN #1 did not state who told the [redacted] that it was okay to [redacted]. LPN #1 stated she assisted the [redacted] to the nursing station and immediately reported the incident to the [redacted]. She stated that CNA #2 and the [redacted] went down the other hallway and passed out the lunch trays. LPN #1 further stated "I don't know what time, but CNA #2 and the [redacted] were moved off the floor to the other units." LPN #1 stated SW#1 and the [redacted] came to the unit after the incident. SW#1 stayed with her and the resident at the nursing station. LPN #1 stated, "I don't know where the [redacted] went." LPN #1 further stated Resident #1 [redacted] all over and asked her [redacted] because he/she wanted to [redacted]. LPN #1 stated SW#1 [redacted] Resident #1's [redacted], and they both observed [redacted] on the resident's [redacted]. She stated that SW#1 told the [redacted] that the resident had [redacted]. LPN #1 stated she asked the [redacted] "what are we doing with the resident." LPN #1 stated SW#1 took Resident #1

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downstairs to her office. LPN #1 heard an overhead page for CNA#2 and the [U.S. FO] to report to the first floor, was unsure how long it was after the incident occurred, but it was not immediate. LPN#1 stated CNA #2 and the [U.S. FO] left the unit after the overhead page. LPN #1 stated she received a call from the [U.S. FOIA (b)] asking her and CNA#1 to write a witness statement. LPN #1 stated she wrote her witness statement and brought both her and CNA #1's original witness statements to the [U.S. FOIA (b)(6)] office. Upon her return to the unit, she received a phone call from the [U.S. FOIA (b)(6)] stating that Resident #1 was going to the hospital. LPN#1 further stated that the [U.S. FOIA (b)(6)] told her that Resident #1 and their roommate (Resident #4) were being moved to the [NJ Exec Order 26.4b]-floor unit. Resident #1 was not moved to the [NJ Exec Order 26.4b] floor unit because he/she was NJ Exec Order 26.4b1. She stated she received Resident #1's universal transfer form (UTF) already completed by the [U.S. FOIA (b)(6)]. She took Resident #1's chart and the UTF to the [NJ Exec Order 26.4b]-floor unit and observed CNA #2 on that unit. LPN #1 stated she did not observe Resident #1 on the [NJ Exec Order 26.4b]-floor unit. She stated CNA #2 came to work on [NJ Exec Order 26.4b1], but the [U.S. FO] had called out. LPN #1 further stated that CNA #2 did not work on her unit on [NJ Exec Order 26.4b1]. LPN #1 stated "no administrative staff came to talk to me after the incident had occurred."

During an interview with the surveyors on 10/22/2024 at 2:48 PM, CNA #3 stated that she was watching the residents in the dayroom around NJ Exec Order 26.4b1 when she heard [NJ Ex Order 26.4(b)(1)] in the hallway. She came out from the dayroom and observed Resident #1 [NJ Exec Order 2] CNA #3 stated she observed the [U.S. FO] NJ Exec Order 26.4b1

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NJ Exec Order 26.4b and CNA #2 was standing there. CNA #3 further stated SW#1 and the U.S. FOIA (b)(6) came and took Resident #1 downstairs. She stated that when the lunch tray came to the unit, all the CNAs including CNA #2 and the U.S. FO passed out the lunch trays. CNA #3 stated she did not see CNA #2 and the U.S. FO on the unit after lunch but saw CNA #2 and the U.S. FO when she clocked out at the end of her shift at 3:00 PM. CNA #3 stated CNA #2 was assigned as the monitor for Resident #1 on the day of the incident. She stated on the morning of NJ Exec Order 26.4b1 she saw CNA #2 on the NJ Exec O floor.

During an interview with the surveyors on 10/22/2024 at 4:06 PM, SW #1 stated she met the U.S. FOIA (b)(6) by the elevators on NJ Exec Order 26.4b1, and the U.S. FOIA (b)(6) told her that Resident #1 was U.S. FOIA (b) and wanted her to go to talk with the resident. She stated when she got upstairs, she observed LPN #1 and Resident #1 at the nursing station. She further stated that the resident was NJ Exec Order 2 SW #1 stated Resident #1 NJ Ex Order 26.4(b)(1) and she observed NJ Exec Order 26.4b1. She told the NJ Exec Order 2 about the NJ Exec Order 26.4b1. SW #1 stated she was asked by LPN #1 to take the resident off the unit. SW#1 stated she took the resident to her office on the first floor, and LPN #1 brought the resident's lunch tray. She stated the resident appeared NJ Exec Order 26.4 , had NJ Exec Order 26.4b1, and was NJ Exec Order 26.4b. SW #1 stated while Resident #1 was eating he/she NJ Ex Order 26.4(b)(a piece of mashed potato NJ Ex Order 26.4(b)(1), the resident attempted to NJ Ex Order 26.4 the mashed potato and stated, NJ Exec Order 26.4b1". She stated the resident was still in her office for approximately 45 minutes when she texted the U.S. FOIA (b)(to let her know the resident was still in her

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office.

During an interview with the surveyors on 10/22/2024 at 4:47 PM, the [U.S. FOIA (b)(6)] stated on [NJ Exec Order 26.4b1], "I was told that Resident #1 was having some [NJ Exec Order 26.4b1] and took the [NJ Exec Order 26.4b1] [redacted]." The [U.S. FOIA (b)(6)] stated she did not know where the resident got the [redacted] from and was unsure of the staff involved in the incident. She further stated that she was called to the unit by LPN #1. She stated LPN #1 told her that Resident #1 tried to [NJ Exec Order 26.4b1] at the aide and the resident and the [NJ Exec Order 26.4b1] The surveyor asked the [U.S. FOIA (b)(6)] if LPN#1 made her aware of the [NJ Ex Order 26] allegation and she stated, "LPN#1 did not say anything else." The [U.S. FOIA (b)(6)] stated that when she got to the unit, she did not see anyone on the floor but saw the [NJ Exec Order 26.4b1] [redacted] The [U.S. FOIA (b)(6)] further stated she saw Resident #1 and he [NJ Exec Order 26.4b1] and she tried to get the resident somewhere quiet. She asked Resident #1 what happened with the [NJ Exec Order 26.4b1], and the resident stated he/she [NJ Exec]. According to the [U.S. FOIA (b)(6)] the resident refused an assessment. The [U.S. FOIA (b)(6)] called the doctor and got an order to send Resident #1 to the hospital because the resident [NJ Exec Order 26.4b1] The [U.S. FOIA (b)(6)] stated the reason for Resident #1's transfer to the hospital was because the resident [NJ Exec Order 26.4b1] [redacted]. The [U.S. FOIA (b)(6)] was unsure of what time Resident #1 went to the [NJ Exec Order 26.4].

During an interview with the surveyors on 10/22/2024 at 5:01 PM, the [U.S. FOIA (b)] stated that LPN #1 told her "Resident #1 was [NJ Ex Order 26.4(b)(1)]." The [U.S. FOIA (b)] stated that when she came to work on [NJ Exec Order 26.4b1] there were [NJ Exec Order 26.4b1] and a

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

(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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NJ Ex Order 26.4(b)(1) at the facility. The U.S. FOIA (b) stated she was asked if she knew what happened to the resident. The U.S. FOIA (b) stated she was asked by the police if she had heard that Resident #1 had been NJ Ex Order 26.4(b) the day before and the U.S. FOIA (b) stated she told them "No."

During an interview with the surveyors on 10/22/2024 at 5:03 PM, the U.S. FOIA (b)(6) stated on NJ Exec Order 26.4b1 the NJ Exec Order asked her if she knew Resident #1 had been NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) stated she knew that the resident had NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1, and the resident had NJ Exec Order. The NJ Exec Order stated she did not NJ Ex Order 26.4(b)(1) because she thought it was a resident to staff incident. The U.S. FOIA (b)(6) further stated she normally would have NJ Ex Order 26.4(b)(1) for a resident to resident, staff to resident, and resident to staff incident but did not for this incident. The U.S. FOIA (b)(6) further stated she would have NJ Ex Order 26.4(b)(1) if the resident NJ Ex the staff or if the resident was a NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) stated she would have considered a resident U.S. FOIA (b)(6) NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) stated the NJ Ex Order 2 should have been notified. The NJ Exec Order stated the NJ Exec Order came to the facility on NJ Exec Order 26.4b1 and talked to the staff and were trying to determine if abuse had occurred. The U.S. FOIA (b)(6) further stated she reviewed the camera surveillance on NJ Exec Order 26.4b1 in the presence of the NJ Ex Order 2 and observed the NJ Exec Order 26.4b1. She also observed CNA#2 and the U.S. FO NJ Exec Order 26.4b Resident #1 NJ Exec Order 2. When asked by the surveyor if the camera surveillance was reviewed on NJ Exec Order 26.4b1, the U.S. FOIA (b)(6) stated "no, I was told the resident NJ Ex Order 2 an NJ Exec Order 26.4b1 and hac NJ Exec Orde. I didn't think to review the camera because it was reported as a

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NJ Exec Order 26.4b1." The U.S. FOIA (b)(6) stated after reviewing the camera surveillance with the NJ Exec Order, she was informed by them that they were taking CNA #2. The U.S. FOIA (b)(6) further stated the U.S. FOIA was not at the facility on 1NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) determined through the investigation CNA #2 and the U.S. FOI were trying to NJ Ex Ord Resident #1 after the resident NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) stated a NJ Ex Order 26.4(b)(1) was not a part of how to deal with NJ Ex Order 26.4(b)(1) residents and NJ Ex Order 26.4(b)(1) would be considered NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated the facility did not have a policy on NJ Ex Order 26.4(b)(1)

The surveyors requested a copy of surveillance footage from the U.S. FOIA (b)(6) throughout the complaint survey. During exit conference on NJ Exec Order 26.4b1 at 3:24 PM, the U.S. FOIA (b)(6) stated that the facility was not able to access the footage because 14 days had passed since the incident occurred on U.S. FOIA (b)(6).

During a post survey telephone interview with the surveyors on 10/30/2024 at 2:52 PM, the ST stated she was on the U.S. FOIA-floor unit to use the bathroom and did not witness the incident with Resident #1 that occurred on U.S. FOIA (b)(6).

Review of the facility policy titled "Abuse Policy and Procedure" updated 8/2014, revealed under "Policy" that "This facility requires that any allegations of abuse be addressed immediately in accordance with all federal and state regulations. All allegations will be evaluated in a prompt and thorough manner. Under "Procedure", "6. Any employee alleged to have participated in abusive activity will be removed from care of the involved resident immediately. 9. The RN supervisor will contact the Director of Nursing immediately upon suspicion or confirmation of abuse. If the Director

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F 600	Continued From page 24 of Nursing is unable to be contacted, the Administrator will be contacted. 10. The Administrator will be contacted regarding all cases of physical and verbal abuse ...11. The supervisor/Nurse Manager/Director of Nursing/designee will interview all staff who have provided care. 13. Confused residents will be interviewed with a witness present. 16. Employee statement forms and an incident form will be filled out completely. An Incident Report form will include the following information: a. The name of the involved resident, b. the date and time the incident occurred, c. the circumstances surrounding the incident, d. where the incident took place, e. the name(s) of those participating in the act, f. physician and family notification, g. treatment rendered. 22. Employees who have had allegations of physical abusive treatment will be removed from direct resident care." Review of the facility job description titled "Certified Nursing Assistant Job Description" updated 10/4/2016 revealed under "Patient Care", "Treat residents with respect and dignity at all times. Observes and reports unusual symptoms, changes, accidents, and injuries to the charge nurse."	F 600		
F 610 SS=J	N.J.A.C:8:39-4.1(a)(5) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		12/28/24

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F 610	Continued From page 25 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # NJ178530 Based on interviews, medical record review, and review of other pertinent facility documentation on NJ Exec Order 26.4b1 it was determined that the facility failed to conduct a timely and thorough investigation for an allegation of witnessed and reported staff to resident NJ Ex Order 26.4(b)(1) toward a resident (Resident #1). On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 NJ Exec Order 26.4b1 with CNA #2 and the U.S. FOIA (b)(6)) NJ Exec Order Resident #1, at which time she ran to get the Licensed Practical Nurse (LPN#1) who was already on her way to the hallway. LPN #1 stated she heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 in the hallway. LPN #1 responded to the hallway and saw Resident #1 NJ Exec Order 26.4b1 NJ Exec Order 26 NJ Exec Order 26.4b1 LPN #1 stated she observed CNA #2 U.S. FOIA (b)(6) Resident #1 and the U.S. FO Resident #1 NJ Exec Order 26.4b1. LPN #1 told both staff members (CNA #2 and U.S. FO) to	F 610	Immediate Action On 10/14/24, Resident #1 was NJ Exec Order 26 and was not NJ Ex Order 26.4(b)(1) to facility. On NJ Ex Order 26.4(b)(1), CAN #2 and smoking monitor #1 were terminated. On 10/24/2024 disciplinary action was given to staff LPN #1, C.N.A. #1, and SW #1, who did not follow company policy on abuse and report immediately to the abuse coordinator the incident of 10/14/2024. Other residents having potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not return.	

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F 610	Continued From page 26 stop and to [NJ Ex Order 26] the resident. LPN#1 stated CNA #2 and the [U.S. FOIA] did not [redacted] She had to repeat the request. LPN#1 stated the [U.S. FO] said, "Its ok we are told to do this." LPN #1 stated she assisted Resident #1 [NJ Exec Order 26.4b1] to the nursing station and immediately reported the incident to the U.S. FOIA (b)(6) CNA #2 and the [U.S. FO] went down to the other side of the hallway and passed the lunch trays. The Social Worker (SW#1) stated the [U.S. FOIA (b)(6)] got her to come to the unit. SW#1 stated Resident #1 was [U.S. FOIA (b)(6)] NJ Exec Order 26.4b1 [redacted] SW#1 stated while at the nursing station, she observed the resident's [NJ Exec Orde] when Resident #1 NJ Exec Order 26.4b1. SW#1 reported the observation to the [U.S. FOIA (b)(6)]. SW#1 stated she was asked by LPN#1 to take Resident #1 to her office on the first floor. SW#1 stated Resident #1 NJ Exec Order 26.4b1. During an interview with SW#1, she stated Resident #1 stated [NJ Exec Order 26] [redacted] when he/she attempted to pick food up [NJ Ex] [redacted]. The [U.S. FOIA (b)(6)] stated Resident #1 told her that he/she [NJ Exec], and an order was obtained from the U.S. FOIA (b)(6) to send Resident #1 to the NJ Exec Order 26.4b1. On 10/14/2024, Resident #1 was admitted to the hospital with NJ Exec Order 26.4b1 [redacted]. The facility also failed to follow its policy titled "Conducting an Investigation of all Incidents/Accidents" and "Abuse Policy and Procedure". This placed Resident #1 and all other residents at risk for an Immediate Jeopardy (IJ) situation. This	F 610	On 10/22/24, the Director of Nursing/or designee immediately educated all staff on abuse investigation protocols, importance of collecting all statements, utilizing the social worker to assist in obtaining the residents statements, assuring the original signed statements are turned into the abuse coordinator, reporting all incidents to the abuse coordinator immediately and within 5 days turn in all findings of investigation to Administrator. The DON/designee will conduct this education on abuse investigation protocols for the next six months. Administrater/DON/ADON/designee will audit education each month to assure all employees have had education. The audits will be completed weekly for four weeks and then monthly for next four months. DON/ADON/designee will monitor compliance with education and conduct staff assessments and testing to assure staff have a true understanding of our abuse policy. Audits will be completed 3x's weekly for four weeks and then monthly for next four months. The education on the facility protocols on abuse investigations will become part of our orientation education as well as our annual education. Administrator/DON/ADON/designee will audit abuse reportable events to observe and to assure completeness of	

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F 610	Continued From page 27 IJ was identified on 10/22/2024 at 8:50 PM and was reported to the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)), and U.S. FOIA (b) (6) The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (b) (6) were presented with the IJ template. The IJ began on NJ Exec Order 26.4b1 and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan. On 10/29/2024, an onsite revisit was conducted to verify the facility implemented the Removal Plan. The facility re-educated all staff on incident investigations, the importance of collecting all written statements, utilizing the social worker to assist in obtaining the resident statements, assuring the original signed statements are turned into the abuse coordinator, and reporting all incidents to the abuse coordinator immediately. The noncompliance remained on 10/29/24 as a level G for actual harm that is not an IJ based on the following: Resident #1 is no longer at the facility, CNA #2 and the U.S. FO no longer work at the facility, and all facility staff have been re-educated on incident investigations, importance of collecting all written statements, utilizing the social worker to assist in obtaining the resident statements, assuring the original signed statements are turned in to the abuse coordinator, and reporting all incidents to the abuse coordinator immediately. This deficient practice was identified for 1 of 7 residents (Resident #1) and was evidenced by the following: According to the Facility's Reportable Event (FRE), a New Jersey Department of Health	F 610	investigation and that all statements are collected and are in their original signed form, and results of investigation are turned in to administrator within 5 days, 3x's weekly for four weeks and then monthly for the next four months. How the facility plan to monitor its performance to make sure that solutions are sustained. The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on January 16, 2024.	

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(NJDOH) document used by healthcare facilities to report incidents dated NJ Exec Order 26.4b1, Resident #1 was NJ Exec Order 2 while in his/her room and [redacted] at a staff member outside Resident #1's room on NJ Exec Order 26.4b1. While NJ Exec Order 26.4b1, Resident #1 NJ Exec O. While U.S. FOIA (b)(6), Resident #1 continued to be NJ Exec Order 26.4b1 to the staff and others. Staff attempted to NJ Exec Order 26 Resident #1 by using NJ Exec Order 26.4b1. Resident #1 was sent to the hospital for further evaluation. While at the hospital, Resident #1 stated to hospital staff that he/she had been NJ Exec Order 26.4b1. The NJ Ex Order 2 notified the facility on NJ Exec Order 26.4b1 of Resident #1's allegation. According to the FRE, a full investigation was initiated on NJ Exec Order 26.4b1. Both staff members were suspended pending an investigation on NJ Exec Order 26.4b1

According to the facility's document titled "Summary of Investigation" with a "date reported" of NJ Exec Order 26.4b1 under "Summary", Resident #1 sustained injuries when he/she NJ Exec Order 26.4b1 while trying to NJ Ex Order 26.4(b)(1) on the staff member. Resident #1 had a history of NJ Exec Order 26.4b1 towards others and staff were protecting residents and themselves while trying to keep Resident #1 from continuing NJ Exec Order 26.4b1. The staff were concerned for everyone's safety and tried to keep Resident #1 NJ Exec Order 26.4b1 Resident #1 from NJ Exec Order 26.4b1. "They were NJ Ex Order 26.4(b)(1) while trying to keep Resident #1 NJ Ex Order 2 to prevent NJ Ex Order 26.4(b)(1) from Resident #1."

According to the Admission Record (AR), Resident #1 was admitted to the facility on NJ Exec Order 26.4b1, with diagnoses which included but were not limited to: NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1 [redacted]

According to the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 [redacted] The MDS further indicated Resident #1 was on NJ Exec Order 26.4b1 medications and had no behaviors that were exhibited towards others. According to the Discharge MDS dated NJ Exec Order 26.4b1, Section A, a discharge assessment indicated "return anticipated." The MDS further indicated that Resident #1 had NJ Exec Order 26.4b1 [redacted]

A review of Resident #1's Care Plan (CP) initiated on NJ Exec Order 26.4b1 revealed under "Focus": Resident #1 is the NJ Exec Order 26.4b1 [redacted]. The "Goal" included "Resident #1 will not NJ Ex Order 26.4(b)(1) through the review date." "Interventions" initiated on NJ Exec Order 26.4b1 included: "When Resident #1 becomes NJ Exec Order 26.4b1 [redacted] NJ Ex Order 26.4(b)(1) from source of NJ Ex Order 26.4(b)(1) Engage calmly in conversation. If response is NJ Exec Order 26.4b1, staff to walk calmly away and approach later."

A review of Resident #1's Progress notes (PNs) dated NJ Exec Order 26.4b1 written by the U.S. FOIA (b)(6) revealed Resident #1 became NJ Exec Order [redacted] while in the room and NJ Exec Order 26.4b1 [redacted] at a staff member outside the room door. During the

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NJ Exec Order 26.4b1 , Resident #1 NJ Exec Order 26.4b1 . While NJ Ex Resident #1 continued to be a NJ Exec Order 26 to the staff. Staff attempted to NJ Ex Order 26.4(Resident #1 NJ Exec Order 26.4b1 . Resident #1 was given time to NJ Ex Order 26.4(b)(1) before being assisted to NJ Ex Order 26.4(b)(1). Resident #1 was taken off the unit with Social Services (SS) to further NJ Ex Order 26.4(b)(1). The physician was informed of Resident #1's NJ Exec Order 26.4b1 An order was secured to send Resident #1 to the hospital for a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1

A review of Resident #1's PNs dated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 , Resident #1 was NJ Exec Order 26.4b1

A review of CNA #2 and the U.S. FOIA (personnel files revealed that both staff had training on NJ Ex Order 26 and how to deal with NJ Ex Order 26.4(b)(1) residents.

During an interview with the surveyors on 10/22/2024 at 1:04 PM, CNA #1 stated that on NJ Exec Order 26.4b1 she walked out of the dayroom, she heard a commotion and observed Resident #1 NJ Exec Order 26.4b1 between Resident #1's room and the dayroom on his/her back with CNA#2 and the U.S. FOI NJ Exec Order resident NJ Exec O . CNA #1 stated "the camera could show you better." CNA #1 further stated she ran to get LPN#1 who responded to the incident. CNA #1 stated that CNA# 2 and the U.S. FO continued to work the rest of the shift on another unit. She stated that Resident #1 went to the hospital the same day the incident occurred but was unsure of the time. CNA #1 stated that Resident #1 can be NJ Exec Order 26.4b1 times NJ Exec Order 26.4b1 CNA #1 stated she heard both CNA #2

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and the [U.S. FO] tell LPN #1 that Resident #1 got [NJ Ex Order 2] because resident was NJ Exec Order 26.4b1

During a subsequent interview with the surveyors on 10/23/2024 at 3:23 PM, CNA #1 stated "I wrote my statement on U.S. FOIA (b)(6) and gave the original copy to LPN#1."

During an interview with the surveyors on 10/22/2024 at 1:27 PM, LPN #1 stated she worked on NJ Exec Order 26.4b1 and was assigned Resident #1. LPN #1 stated she was in the charting room speaking with the NJ Exec Order 26.4b1) and heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 LPN #1 stated the U.S. FOIA and herself immediately got up and as she was coming out of the charting room door, she was met by CNA #1 who was coming to get her. LPN #1 stated she looked down the hallway where NJ Ex Order 26.4(b)(1) was coming from and observed Resident #1 NJ Exec Order 26.4b1 LPN #1 stated she heard Resident #1 U.S. FOIA (b)(6) LPN #1 further stated that the [U.S. FO] was behind her and stated, 'NJ Exec Order 26.4b1 " LPN #1 stated she observed CNA #2 NJ Exec Order 26 Resident #1 and the [U.S. FO] NJ Exec Order 26.4b1 Resident #1. LPN #1 stated Resident #1 was NJ Exec Order 26.4b1 LPN #1 stated she told CNA #2 and the U.S. FO to stop and NJ Ex Order 26 the resident. CNA #2 and the U.S. FOIA did not immediately stop. She had to repeat the request. CNA#2 and the [U.S. FO] NJ Exec Order 26.4b1 the resident. LPN #1 further stated that the U.S. FO said, "its ok, we are told to do this." LPN#1 was unsure of who told both staff they could NJ Exec Order 26 . LPN #1 stated she assisted the resident NJ Exec Order 26.4b1 to the nursing station and immediately reported the incident to the U.S. FOIA (b)(6) She stated that CNA #2 and the [U.S. FO] went down

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

(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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the other hallway and passed out the lunch trays. LPN #1 further stated "I don't know what time, but CNA #2 and the [U.S. FO] were moved off the floor to the other units." LPN #1 stated Social Worker (SW#1) and the [U.S. FOIA (b)(6)] came to the unit after the incident. SW#1 stayed with her and the resident at the nursing station. LPN#1 stated, "I don't know where the [U.S. FOIA (b)(6)] went." LPN #1 further stated Resident #1 [NJ Exec Order 26.4b1] all over and asked her to call [NJ Ex Order 26.4(b)(1)] because he/she wanted to [NJ Ex Order 26.4(b)(1)]. LPN #1 stated SW#1 [NJ Exec Or] Resident #1's [NJ Exec Order 26.4b], and they both observed [NJ Exec Order 26.4b1]. She stated that SW#1 told the [U.S. FOIA (b)(6)] that the resident had [NJ Exec Order 26.4b1]. LPN #1 stated she asked the [NJ Exec Order 2] "what are we doing with the resident." LPN #1 stated SW#1 took Resident #1 downstairs to her office. LPN #1 heard an overhead page for CNA#2 and the [U.S. FO] to report to the first floor, was unsure how long it was after the incident occurred, but it was not immediate. LPN#1 stated CNA #2 and the [U.S. FO] left the unit after the overhead page. LPN #1 stated she received a call from the [U.S. FOIA (b)] asking her and CNA#1 to write a witness statement. LPN #1 stated she wrote her witness statement and brought both her and CNA #1's original witness statement to the [U.S. FOIA (b)(6)] office.

Upon her return to the unit, LPN #1 received a phone call from the [U.S. FOIA (b)(6)] stating that Resident #1 was going to the hospital. LPN#1 further stated that the [U.S. FOIA (b)(6)] told her that Resident #1 and their roommate (Resident #4) were being moved to the [NJ Exec Order 26.4b]-floor unit. Resident #1 was not moved to the [NJ Exec Order 26.4b]-floor unit and was [NJ Exec Order 26.4b1] l. She stated she received Resident #1's universal transfer form (UTF) already completed by the [U.S. FOIA (b)(6)]. She took

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Resident #1's chart and the UTF to the [redacted]-floor unit and observed CNA #2 on that unit. LPN #1 stated she did not observe Resident #1 on the [redacted]-floor unit. She stated CNA #2 came to work on [redacted], but the [redacted] had called out. LPN #1 further stated that CNA #2 did not work on her unit on [redacted] LPN #1 stated "no administrative staff came to talk to me after the incident had occurred", but LPN #1 wrote a statement for the incident that occurred on [redacted]. LPN#1 stated the process after an incident was for the nurse on the unit to complete the incident report, obtain witness statements from all staff on the unit, and complete an assessment of the resident(s) involved. She stated "they (Administration) did not make me fill it out (incident report)."

During an interview with the surveyors on 10/22/2024 at 3:22 PM, the [redacted] stated when an incident occurs the nurse assigned the resident is responsible for completing an incident report. The [redacted] stated, "I guess that day it was not filled out." The [redacted] confirmed that no incident report was completed for Resident #1 on [redacted]. The [redacted] stated the expectation was that the charge nurse should have filled out an incident report and gathered witness statements after the incident occurred. The [redacted] further stated the next day either the [redacted] or herself would review the incident report and were responsible to ensure there was an incident report with witness statements. The [redacted] further stated, "We did not ask the nurse why an incident report was not completed." The [redacted] confirmed there was no incident report or witness statements regarding [redacted] incident involving Resident #1. The [redacted] stated the expectation was to have an incident report and witness statements completed

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after an incident occurred.

During an interview with the surveyors on 10/22/2024 at 3:22PM, the [redacted] stated "as a team, we go over the incident reports in morning meeting. This has not happened in this case with Resident #1."

During an interview with the surveyors on 10/22/2024 at 4:06 PM, SW #1 stated she met the [redacted] by the elevators on [redacted], and the [redacted] told her that Resident #1 was [redacted] and wanted her to go to talk with the resident. She stated when she got upstairs, she observed LPN #1 and Resident #1 at the nursing station. SW #1 stated Resident #1 [redacted] She told the [redacted] about the [redacted] on the resident's [redacted]. SW #1 stated she was asked by LPN #1 to take the resident off the unit. SW#1 stated she took the resident to her office on the first floor, and LPN #1 brought the resident's lunch tray. SW #1 stated she believed Resident #1 said to call the cops. She stated the resident [redacted]. SW #1 stated while Resident #1 was eating he/she [redacted] a piece of mashed potato [redacted], the resident attempted to [redacted] the mashed potato and stated, [redacted]. She stated the resident was still in her office for approximately 45 minutes when she texted the [redacted] to let her know the resident was still in her office. SW #1 stated she came to work the next day and [redacted] were at the facility. SW#1 stated she did not speak with [redacted]. SW #1 stated she did not recall why [redacted] were at the facility. SW#1 stated she did not know anything until she read an article online about two staff members at the facility that

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were [redacted] and a resident was [redacted]. SW #1 further stated she was not asked to write a statement. SW #1 stated she did not speak to any staff or residents about the incident that occurred. SW #1 stated if an [redacted] allegation occurred, it was to be reported to the [redacted] who was the U.S. FOIA (b)(6). SW #1 stated that if the [redacted] was not there she would report the allegation to the U.S. FOIA (b)(6). SW #1 further stated that she would await instruction from the [redacted]. SW #1 stated the [redacted] would tell her to interview the resident. SW #1 stated she would report the [redacted] allegation and then await further instruction from the [redacted]. SW #1 stated she did not ask Resident #1 [redacted] SW #1 stated that Resident #1 pointed to the two staff members in the hallway after the incident occurred and the resident stated, [redacted] SW #1 stated she assumed the two staff members were CNA #2 and the [redacted] because she had seen their pictures on the internet after the incident occurred. SW #1 further stated she had not spoken to any residents on CNA #2 and the [redacted] assignments. SW#1 stated the [redacted] did not ask her to speak to any of the residents cared for on [redacted] by CNA #2 and the [redacted] as of 10/22/2024. SW#1 stated she did not speak to Resident #1 about the incident.

During an interview with the surveyors on 10/22/2024 at 5:01 PM, the [redacted] stated that LPN #1 told her "Resident #1 [redacted]." The [redacted] stated that when she came to work on [redacted] there were two police officers and a detective at the facility. The [redacted] stated she was asked if she knew what happened to the resident. The [redacted] stated she was asked by [redacted] if she had heard that Resident #1 had [redacted]

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F 610	Continued From page 36 up the day before and the [U.S. FOIA (b)] stated she told them "No". During an interview with the surveyors on 10/22/2024 at 5:03 PM, the [U.S. FOIA (b)] stated on NJ Ex Order 26.4(b)(1) asked her if she knew Resident #1 had NJ Ex Order 26.4(b)(1) or NJ Exec Order 26.4b1 The [U.S. FOIA (b)] stated she knew that the resident had NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1, and the resident had [NJ Exec Or]. The [U.S. FOIA (b)] stated she did not NJ Ex Order 26.4(b)(1) because she thought it was a resident to staff incident. The [U.S. FOIA (b)] further stated she normally would have NJ Ex Order 26.4(b)(1) for a resident to resident, staff to resident, and resident to staff incident but did not for this incident. The [U.S. FOIA (b)] further stated she would have NJ Ex Order 26.4(b)(1) if the resident [NJ Ex] the staff or if the resident was a NJ Ex Order 26.4(b)(1) The [U.S. FOIA (b)] stated she would have considered a resident NJ Exec Order 26.4b1, a [NJ Ex Order 26.4] to resident's NJ Ex Order 26.4(b)(1). The [U.S. FOIA (b)] stated [NJ Ex Order 26.4(b)(1)] should have been notified. The [U.S. FOIA (b)] stated [NJ Ex Order 26.4(b)(1)] came to the facility on U.S. FOIA (b)(6) and talked to the staff and were trying to determine if [NJ Ex Order 26] had occurred. The [U.S. FOIA (b)] stated she reviewed the camera surveillance on NJ Exec Order 26.4b1 in the presence of [NJ Ex] and observed the U.S. FOIA (b)(6) come out of the resident's room. She also observed CNA#2 and the [U.S. FO] [NJ Exec Order 26.4] Resident #1 [NJ Exec Order] When asked by the surveyor if the camera surveillance was reviewed on [NJ Exec Order 26.4b1], the [U.S. FOIA (b)] stated "no, I was told the resident [NJ Ex Order] an NJ Exec Order 26.4b1 and had [NJ Exec Or]. I didn't think to review the camera because it was reported as a NJ Exec Order 26.4b1 The [U.S. FOIA (b)(6)] further stated an incident report should have been completed for the [NJ Exec O] and the incident that occurred on [NJ Exec Order 26.4b1].	F 610		

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F 610	Continued From page 37 During an interview with the surveyors on 10/23/2024 at 12:48 PM, the [NJ Exec Order 26] stated she was the U.S. FOIA (b) (6) . The [U.S. FOIA (b)(6)] stated once an [NJ Ex Order 26] allegation was made, the staff was to report it to the [U.S. FOIA] and herself and they would start the investigation. She stated the nurse on the floor would collect the witness statements and the [U.S. FOIA] would interview and gather statements from the resident(s) involved. The [U.S. FOIA (b)(6)] stated there were no instances where the [U.S. FOIA] would not have collected resident statements when an [NJ Ex Order 26] allegation occurred. She further stated, "I cannot speak to why there were no statements gathered for the other residents for the incident on U.S. FOIA (b)(6)." The [U.S. FOIA (b)(6)] stated, "I know the [U.S. FOIA] talked to the other residents after the incident." The [U.S. FOIA (b)(6)] further stated [NJ Ex O] expectation was that the [U.S. FOIA] should have talked to Resident #1 and other residents on CNA #2 and the [NJ Exec Ord] assignments after the incident occurred. The [U.S. FOIA (b)(6)] stated that she agreed that some of the steps of the [NJ Ex Order 26] and investigation policies were not followed for the incident on U.S. FOIA (b)(6) The [U.S. FOIA (b)(6)] confirmed that SW#1 should have started an investigation and reported the incident to her on U.S. FOIA (b)(6). The [U.S. FOIA (b)(6)] stated "I was not made aware of the marks seen by SW#1 and the [U.S. FOIA (b)(6)] on U.S. FOIA (b)(6). All I knew was the resident [NJ Exec]" The [U.S. FOIA (b)(6)] stated the witness statements were written and collected on U.S. FOIA (b)(6) During a third interview with the surveyors on 10/23/2024 at 3:05 PM, the [U.S. FOIA (b)(6)] stated she was told the employees' written statements were left in the [U.S. FOIA (b)(6)] mailbox. The [U.S. FOIA (b)(6)] stated "I think the employees have the original statements and left the copies in the [U.S. FOIA (b)(6)] mailbox." The [U.S. FOIA (b)(6)] stated the nurse would collect the statements and	F 610		

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put them in the mailbox. The [U.S. FOIA (b)(6)] stated "The [U.S. FOIA (b)(6)] would be the first person to collect and look at the statements if they are put in her mailbox." The [U.S. FOIA (b)(6)] further stated, "Yes, for the [NJ Exec Order 26.4b1] incident the witness statements were all put in the [U.S. FOIA (b)(6)] mailbox."

During an interview with the surveyors on 10/23/2024 at 3:23 PM, CNA #1 stated "I wrote my statement on [U.S. FOIA (b)(6)] and gave the original copy to LPN #1."

During an interview with the surveyors on 10/23/2024 at 3:27 PM, the [U.S. FOIA (b)(6)] stated copies of the written statements were in her mailbox on [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] further stated, "I don't remember off the top of my head, who the statements were from." The [U.S. FOIA (b)(6)] stated she does not review the witness statements and the final investigation. The [U.S. FOIA (b)(6)] stated she has not reviewed the witness statements for the incident that occurred on [NJ Exec Order 26.4b1]. The [U.S. FOIA (b)(6)] confirmed she took the witness statements regarding the [NJ Exec Order 26.4b1] incident out of her mailbox on [NJ Exec Order 26.4b1]. The [U.S. FOIA (b)(6)] stated, "I don't know who would read the witness statements."

The facility was unable to provide written statements from CNA #2 and the [U.S. FOIA (b)(6)].

The surveyors requested a copy of the surveillance footage from the [U.S. FOIA (b)(6)] throughout the complaint survey. During exit conference on 10/29/2024 at 3:24 PM, the [U.S. FOIA (b)(6)] stated that the facility was not able to access the footage because 14 days had passed since the incident occurred on [NJ Exec Order 26.4b1].

Review of the facility policy titled "Abuse Policy

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and Procedure" updated 8/2014, revealed under "Policy" that "This facility requires that any allegations of abuse be addressed immediately in accordance with all federal and state regulations. All allegations will be evaluated in a prompt and thorough manner. Under "Procedure", "9. The RN supervisor will contact the Director of Nursing immediately upon suspicion or confirmation of abuse. If the Director of Nursing is unable to be contacted, the Administrator will be contacted. 10. The Administrator will be contacted regarding all cases of physical and verbal abuse ...11. The Supervisor/Nurse Manager/Director of Nursing/designee will interview all staff who have provided care. 13. Confused residents will be interviewed with a witness present. 16. Employee statement forms and an incident form will be filled out completely. An Incident Report form will include the following information: a. The name of the involved resident, b. the date and time the incident occurred, c. the circumstances surrounding the incident, d. where the incident took place, e. the name(s) of those participating in the act, f. physician and family notification, g. treatment rendered."

Review of the undated facility policy titled "Conducting an Investigation of all Incidents/Accidents" revealed under "Policy Statement", "It is the policy of this Center to make every effort to investigate any/all incidents/accidents of residents." Under "Purpose", "to provide appropriate action that can be taken to correct the situation and prevent reoccurrence by gathering all pertinent information about the incident that is reported through a complaint or other report." Under "Policy Interpretation and Implementation", "A. Initial Investigation: 4. If there appears to be a

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F 610	Continued From page 40 possibility of abuse, mistreatment, or neglect, the RN supervisor or designee: a. Completes the Resident Incident report, b. Notifies the DON and Administrator. 5. If the incident involves an allegation of abuse, neglect, or mistreatment against an employee, the RN supervisor or designee interviews the employee, gets a written statement, and suspends the employee pending an investigation. The employee is removed from duty for the protection of the residents during the investigation. 7. The Director of Nursing Services or designee reviews the investigation to determine if the incident should be reported as suspected abuse. B. Organizing and conducting the investigation: 1. The RN supervisor or designee starts the investigation immediately. 4. The police should be notified in cases of assault. D. Taking Statements: 1. Never take a statement until you have interviewed them. 3. Remain with the witness as they write the statement." NJAC 8:39-4.1(a)5	F 610		
F 644 SS=G	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		12/28/24

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F 644	Continued From page 41 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Complaint#: NJ176503, NJ178530 Based on interviews and medical record review on 10/22/2024, 10/23/2024, 10/24/2024, and 10/29/2024, it was determined that the facility failed to implement the recommendations from a resident's Pre-Admission Screening and Resident Review (PASARR) level II determination. This deficient practice was identified for 1 of 2 residents reviewed for the PASARR (Resident #1), and was evidenced by the following: According to the Admission Record (AR), Resident #1 was admitted to the facility on NJ Exec Order 26.4b1, with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] According to the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 [redacted]. The MDS further indicated Resident #1 was on NJ Exec Order 26.4b1 medications and had no	F 644	Immediate Action On 10/25/2024 all PASSAR II of all residents currently residing in facility were audited by the Don/designee to assure incorporation of recommendations from the PASSRR Level II determination and the PASSRR evaluation reports were incorporated into the resident□s assessment, care planning, and transitions of care. Other residents having potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not return. Care Plan and PASSRR education to ensure care plan interventions are followed and implemented by staff for all residents, where care plans are located, how to read the care plans, and the importance of following care plans in a nursing facility. Updating care plans, instructions on how to update care plans and assuring Pasaar II recomendations	

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	315125	A. BUILDING _____ B. WING _____	C 10/29/2024

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F 644	Continued From page 42 NJ Exec Order 26.4b1 that were exhibited towards others. A review of the PASARR Level II Determination Notification letter by the New Jersey Department of Human Services Division of Mental Health and Addiction Services dated NJ Exec Order 26.4b1 revealed that Resident #1 had NJ Ex Order 26.4(b)(1) treatment needs that could be met in a nursing facility. According to the notification, the recommendations made for the resident included the following: 1. NJ Ex Order 26.4(b)(1) consult upon admission to the nursing facility. 2. Routine follow up visits with the Primary Care Physician and U.S. FOIA (b) (6) 3. Medication Monitoring 4. NJ Ex Order 26.4(b)(1) 5. Routine NJ Ex Order 26.4(b)(1) 6. Formulate and implement a NJ Ex Order 26.4(b)(1) modification plan to address any NJ Ex Order 26.4(b)(1) 7. Provide education to the client and family on NJ Ex Order 26.4(b)(1) and medication. 8. Develop a Crisis Intervention/Safety Plan with the client. A review of Resident #1's medical record revealed an initial assessment from the U.S. FOIA (b) (6) titled with a date of service of NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b) after resident's admission into the facility). Resident #1's medical record did not reveal any visits from the U.S. FOIA (b) (6) while in the facility. During an interview with the surveyors on 10/24/2024 at 1:32 PM, the Social Worker (SW#2) stated "I put the PASARR results and recommendations on the resident's baseline care plan." SW#2 stated the interdisciplinary team	F 644	are incorporated into the residents assessment, care planning and transitions of care. DON/designee will audit education sign in sheets to assure all staff have been educated on the PASRR II protocols as well as assuring recommendations are incorporated into the resident's assessment, care planning and transitions of care. The audits will be completed weekly for four weeks and then monthly for next four months. The education of PASRR II protocols as well as assuring recommendations are incorporated into the resident's assessment, care planning and transitions of care will continue for 6 months. Thereafter, education on PASRR II will become part of our orientation education as well as our annual education. DON/ADON/designee will monitor compliance with the education and conduct staff assessment and testing to assure staff has true understanding of our Care Plan policy. Audit will be completed three times weekly for the next four weeks and monthly for the next four months. Administrator/DON/designee with audit be behaviors, care plans, medical/psychiatric history and determine if alternate placement is required or if updates to the care plan are required. Audits will be completed 3x's weekly for the first four weeks and then monthly for four months.	

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F 644	Continued From page 43 (IDT) was responsible for ensuring the PASARR recommendations were implemented. SW#2 further stated, "the resident's plan of care would not be comprehensive or complete if recommendations were not followed." During an interview with the surveyors on 10/24/2024 at 1:47 PM, SW#1 stated most of the PASARR recommendations such as a NJ Ex Order 26.4(b)(1) consult was already a part of the admission process for a resident. SW #1 stated "I think the NJ Ex Order 26.4(b)(1) U.S. FOIA (b) (6) consults were scheduled when the U.S. FOIA (b) (6) comes to the building." SW #1 further stated she had seen the NJ Ex Order 26.4(b)(1) at least three times a month in the building. SW#1 stated she implemented a Performance Improvement Plan (PIP) for ensuring the PASARR recommendations were on a resident's chart and that recommendations were implemented. SW #1 further stated the PIP was started in NJ Ex Order 26 and ended in NJ Ex Orde SW#1 further stated she was not aware of issues with the PASARR recommendations being implemented. SW#1 stated the IDT was responsible for implementing the PASARR recommendations. SW #1 further stated it could be a problem for all areas of a resident's care if the PASARR recommendations were not implemented. During an interview with the surveyors on 10/24/2024 at 3:37 PM in the presence of the U.S. FOIA (b)(6)), the U.S. FOIA (b)(6)) stated Resident #1's PASARR recommendations were not followed because the resident was never seen by a NJ Ex Order 26.4(b)(1) since being admitted to the facility. The U.S. FOIA (b) stated she could not speak to why Resident #1 was not seen by a NJ Ex Order 26.4(b)(1)	F 644	How the facility plan to monitor its performance to make sure that solutions are sustained. The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on January 16, 2024.	

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F 644	Continued From page 44 During an interview with the surveyors on 10/24/2024 at 3:37 PM in the presence of the [redacted], the [redacted] stated the [redacted] was responsible for putting the PASARR in the resident's electronic medical record. The [redacted] stated the resident's care plan was updated based on the PASARR recommendations. The [redacted] stated if the resident's care plans were not updated with the PASARR recommendations and were not implemented, the staff would be unable to properly care for the resident. The [redacted] further stated she could not speak to why Resident #1 was not seen by a [redacted] The surveyors requested a facility policy on PASARR recommendations, and the facility was unable to provide a policy. NJAC 8:39-27.1 (a)	F 644		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		12/28/24

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F 656	Continued From page 45 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint #: NJ178530 Based on interviews, medical record review, and review of other pertinent facility documentation on NJ Exec Order 26.4b1 [redacted], it was determined that the facility failed to a.) implement care plan (CP) interventions for a resident (Resident #1) with a known history of NJ Exec Order 26.4b1 [redacted]	F 656	Immediate Action On NJ Ex Order 26.4(b)(1) [redacted], Resident #1 was NJ Exec Order 26 [redacted] and was NJ Ex Order 26.4(b)(1) to facility. On NJ Ex Order 26.4(b)(1) C.N.A #2 and smoking monitor #1 were NJ Ex Order 26.4(b)(1)	

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F 656	Continued From page 46 towards others and diagnoses of NJ Exec Order 26.4b1 [redacted] On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 NJ Exec Order 26.4b1 the hallway with CNA #2 and the U.S. FOIA (b)(6) NJ Exec Order Resident #1, at which time she ran to get the Licensed Practical Nurse (LPN#1) who was already on her way to the hallway. LPN #1 stated she heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 in the hallway. LPN #1 responded to the hallway and saw Resident #1 NJ Exec Order 26.4b1 in the hallway NJ Exec Order 26.4b1 LPN #1 stated she observed CNA #2 NJ Exec Order 26 Resident #1 and the U.S. FOI/NJ Exec Order Resident #1 with NJ Exec Order 26 LPN #1 told both staff members (CNA #2 and U.S. FO) to stop and to get off the resident. LPN#1 stated CNA #2 and the U.S. FO did not immediately stop and get off the resident. She had to repeat the request. LPN#1 stated the U.S. FO said, "Its ok we are told to do this." LPN #1 stated she assisted Resident #1 NJ Exec Order 26.4b1 to the nursing station and immediately reported the incident to the U.S. FOIA (b)(6) CNA #2 and the U.S. FO went down to the other side of the hallway and passed the lunch trays. The Social Worker (SW#1) stated the U.S. FOIA (b)(6) got her to come to the unit. SW #1 stated Resident #1 was NJ Exec Order 26.4b1 " SW#1 stated while at the nursing station, she observed the resident's NJ Exec Orde when Resident #1 NJ Exec Order 26.4b1. SW #1 reported the	F 656	On 10/24/2024 disciplinary action was given to staff LPN #1, C.N.A. #1, and SW #1, who did not follow company policy on abuse and report immediately to the abuse coordinator the incident of NJ Ex Order 26.4(b)(1). 10/25/2024 all care plans for current residents were audited by the DON/designee to assure the PASRR II recommendations are incorporated into the resident□s assessment, care planning and transitions of care Other residents having potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not return. On 10/22/24 the Director of Nursing/designee began education to ensure care plan interventions were followed and implemented, by staff, for all residents. Education for all staff further included, where the care plans are located, how to read the care plans, and the importance of following care plans in a nursing facility. In addition, , Licensed nursing staff were educated on how to update the care plan timely as changes in condition occur. Education on Care plan protocols will be given monthly for six months.	

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F 656	Continued From page 47 observation to the U.S. FOIA (b)(6). SW#1 stated she was asked by LPN#1 to take Resident #1 to her office on the first floor. SW #1 stated Resident #1 complained of NJ Exec Order 26.4b1. During an interview with the U.S. FOIA, the U.S. FOIA stated while Resident #1 stated NJ Exec Order 26.4b1 while attempting to pick up food from NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) stated Resident #1 told her that he/she NJ Exec and an order was obtained from the U.S. FOIA (b) (6) to send Resident #1 to the hospital for NJ Exec Order. On NJ Exec Order 26.4b1, Resident #1 was admitted to the hospital with diagnoses of NJ Exec Order 26.4b1 [redacted]. The facility also failed to follow its policy titled "Care Plan". This placed Resident #1 and all other residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 10/22/2024 at 8:50 PM and was reported to the U.S. FOIA (b)(6) [redacted] were presented with the IJ template. The IJ began on NJ Exec Order 26.4b1 and continued through NJ Exec Order 26.4b1 when the facility submitted an acceptable Removal Plan. On 10/29/2024, a revisit to verify the Removal Plan was conducted. The facility implemented the Removal Plan, which included education on ensuring CP interventions were implemented, the location of the CPs, how to read the CPs, the importance of following the CPs, and how to update the CPs. Audits were conducted that monitor compliance with the implementation and following of the CP interventions or if updates to the CP were required. The noncompliance remained on 10/29/24 as a	F 656	The care plan protocol education will become part of our orientation education as well as our annual education. Administrator/DON/ADON/designee will audit education each month to assure all employees have had educaitn. Audits will be completed 3x weekly for the next 4 weeks and monthly for the next 6 months. DON/ADON/designee will monitor compliance with education and conduct staff assessment and testing to assure staff has true understanding of our care plan policy. Audits will be completed 3x weekly for the next 4 weeks and monthly for the next 4 months. How the facility plan to monitor its performance to make sure that solutions are sustained. The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on January 16, 2024.	

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F 656	Continued From page 48	F 656		

level G for actual harm that is not an IJ based on that the facility staff have been educated on how to ensure CP interventions were implemented, the location of the CPs, how to read the CPs, the importance of following the CPs, and how to update the CPs. Audits were conducted that monitor compliance with the implementation and following of the CP interventions and if updates to the CP were required.

This deficient practice was identified for 1 of 7 residents (Resident #1) and was evidenced by the following:

According to the Facility's Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents dated NJ Exec Order 26.4b1, Resident #1 was NJ Exec Order 2 while in his/her room and NJ Exec Order 26.4b at a staff member outside of Resident #1's room on NJ Exec Order 26.4b1. While NJ Exec Order 26.4b1, Resident #1 NJ Exec While NJ Exec Order 26.4b1 Resident #1 continued to be a NJ Exec Order 26.4b1 Staff attempted to NJ Exec Order 25 Resident #1 by using NJ Exec Order 26.4b1" while NJ Exec Order 26.4b1. Resident #1 was sent to the hospital for further evaluation. While at the hospital, Resident #1 stated to hospital staff that he/she had been NJ Exec Order 26.4b1. The police department notified the facility on NJ Exec Order 26.4b1 of Resident #1's allegation. According to the FRE, "a full investigation was initiated" on NJ Exec Order 26.4b1 Both staff members were suspended pending an investigation on NJ Exec Order 26.4b1.

According to the facility's document titled "Summary of Investigation" with a "date reported"

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of 10/15/2024 under "Summary", Resident #1 sustained injuries when he/she NJ Exec Order 26.4b1 while NJ Exec Order 26.4b1 . Resident #1 had a history of NJ Exec Order 26.4b1 towards others and staff were NJ Ex Order 26.4(b)(1) residents and themselves while trying to keep Resident #1 from NJ Exec Order 26.4b1 The staff were concerned for everyone's safety and tried to keep Resident #1 NJ Exec Order 26.4b1 Resident #1 from NJ Exec Order 26.4b1. "They were NJ Exec Order 26.4b1 while trying to keep Resident #1 NJ Ex Order to prevent NJ Exec Order 26.4b1 from Resident #1."

According to the Admission Record (AR), Resident #1 was admitted to the facility on NJ Exec Order 26.4b1, with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 .

According to the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 The MDS further indicated Resident #1 was on NJ Exec Order 26.4b1 medications and had no NJ Exec Order 26.4b1 that were exhibited towards others.

According to the Discharge MDS dated NJ Exec Order 26.4b1, Section A, a discharge assessment indicated "return anticipated." Section E revealed that Resident #1 had NJ Exec Order 26.4b1 directed toward others.

A review of Resident #1's CP initiated on NJ Exec Order 26.4b1 revealed under "Focus": "Resident #1 is the NJ Exec Order 26.4b1 " Under

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F 656	Continued From page 50 "Goal" revealed "Resident #1 NJ Exec Order 26.4b1 through the review date." Under "Interventions" initiated on 8/25/2024 revealed the following: "When Resident #1 NJ Exec Order 26.4b1 . Guide away from source of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 If response is NJ Exec Order 26.4b1, staff to walk calmly away and approach later. Resident #1 was sent to NJ Exec Order 26.4b1 ." A review of Resident #1's Progress notes (PNs) dated NJ Exec Order 26.4b1 written by the U.S. FOIA (b)(6) revealed Resident #1 NJ Exec Order 26.4b1 while in the room and NJ Exec Order 26.4b1 During the NJ Exec Order 26.4b1, Resident #1 . While on the , Resident #1 NJ Exec Order 26.4b1 to the staff. Staff attempted to Resident #1 using NJ Exec Order 26.4b1 . Resident #1 was NJ Exec Order 26.4b1 before being NJ Exec Order 26.4b1 . Resident #1 was taken off the unit with Social Services (SS) to NJ Exec Order 26.4b1. The Physician was informed of Resident #1's . An order was secured to send Resident #1 to the hospital for a NJ Exec Order 26.4b1 A review of Resident #1's PNs dated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 revealed at , Resident #1 was NJ Exec Order 26.4b1 . During an interview with the surveyors on 10/22/2024 at 5:01 PM, the stated the expectation was that the staff should follow a resident's CP. The further stated that a resident could be if the CP was not followed. The confirmed that Resident #1's	F 656		

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F 656	Continued From page 51 CP was not followed for the incident that occurred on [redacted]. During an interview with the surveyors on 10/22/2024 at 5:03 PM, the [redacted] stated she was told by the staff that Resident #1 was [redacted] and CNA#3 and the [redacted] held Resident #1 down to prevent any further [redacted] The [redacted] further stated the expectation was to remove either the [redacted] or other people from the situation which ever was [redacted] The [redacted] agreed that Resident #1's CP intervention was not followed for the incident that occurred on [redacted]. During an interview with the surveyors on 10/24/2024 at 3:11 PM, the [redacted] stated the importance of the CPs were for staff to know how to care for the residents. The [redacted] stated the expectation was that CP interventions should be implemented by the staff. The [redacted] further stated if the care plan interventions were not implemented, it could cause harm to the resident. The [redacted] stated the interdisciplinary team (IDT) was responsible for implementing interventions on a resident's CP. A review of the facility's undated policy titled "Care Plan" revealed under "Policy Interpretation and Implementation...2. The comprehensive care plan has been designed to: d. reflects treatment goals and objectives in measurable outcomes., e. identifies the professional services that are responsible for each element of care., f. prevent declines in the resident's functional status and/or functional levels." NJAC 8:39-11.2 (b)	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		12/28/24

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	315125	A. BUILDING _____ B. WING _____	C 10/29/2024

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F 657	Continued From page 52 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint #: NJ178766, NJ178770 Based on interviews, medical record review, and review of other pertinent facility documents on [redacted], it was determined that the facility failed to update the care plan (CP) with interventions for 2 of 7 residents (Resident #3 & #4) for making an	F 657	Immediate Action Resident #3 and Resident #4 care plans were updated 10/24/2024. What Other residents having potential to be affected by the same deficient practice.	

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F 657	Continued From page 53 allegation about staff to the local authorities. The facility also failed to follow its policy titled "Care Plan". This deficient practice was evidenced by: According to the Facility Reportable Events (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents dated NJ Exec Order 26.4b1, with an event date of NJ Exec Order 26.4b1 and a "time of event" of NJ Exec Order 26.4b1 pertaining to Resident #3: NJ Ex Order 26.4b1 came to the facility stating they were investigating an anonymous call stating, the resident was NJ Ex Order 26.4(b)(1) by staff. An investigation was immediately started in the presence of the NJ Ex Order 26.4(b)(1). A NJ Ex Order 26.4(b)(1) was completed with the NJ Ex Order 26.4(b)(1) present in the facility with NJ Exec Order 26.4b1 observed on the NJ Exec Order 26.4b1 of the resident's NJ Exec Order 26.4b1 According to the FRE dated NJ Ex Order 26.4(b)(1), with an event date of NJ Exec Order 26.4b1 and a "time of event" of NJ Exec Order 26.4b1 pertaining to Resident #4: NJ Ex Order 26.4b1 came to the facility stating they were investigating an anonymous call stating the resident was NJ Ex Order 26.4(b)(1) by staff. An investigation is immediately started in the presence of the NJ Ex Order 26.4(b)(1). A NJ Ex Order 26.4(b)(1) is completed with the NJ Ex Order 26.4(b)(1) present in the facility with NJ Exec Order 26.4b1 observed. Review of the Electronic Medical Records (EMRs) was as follows: 1.The surveyor reviewed Resident #3's medical record on NJ Exec Order 26.4b1 The Admission Record (AR) reflected Resident #3 was admitted to the facility with medical diagnosis which included but not limited to; NJ Exec Order 26.4b1	F 657	All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not return. 10/25/2024 all care plans for current residents were audited by the DON/designee to assure the PASRR II recommendations are incorporated into the resident□s assessment, care planning and transitions of care and that updates to care plan are taking place as changes in the resident□s condition occur. On 10/22/24 the Director of Nursing/designee started education to ensure care plan interventions were followed and implemented, by staff, for all residents. Education for all staff further included where the care plans are located; how to read the care plans; and the importance of following care plans in a nursing facility; in addition, Licensed nursing staff were educated on how to update the care plan, with the importance of updating Care plan as changes in the resident□s condition occur. Education completed 10/25/2024. The Administrator/DON/designee will audit compliance with the education on care plans and conduct 5 staff assessments and test to assure staff have a true understanding of our Care plan protocols. Education will be given monthly for six months. This will become part of our orientation	

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F 657	Continued From page 54 NJ Exec Order 26.4b1 [redacted].	F 657	education as well as our annual education. The DON/or designee will audit 5 care plans to assure they are being updated per the facility protocols of care plans. The audits will be conducted weekly for the first month and then monthly for the next four months. How the facility plan to monitor its performance to make sure that solutions are sustained. The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on January 16, 2024.	

According to the Minimal Data Set (MDS) an assessment tool dated NJ Exec Order 26.4b1, Resident #3 had NJ Ex Order 26.4(b)(1) [redacted]. The resident's CP initiated on NJ Exec Order 26.4b1 with a Focus of "Resident #3 makes NJ Exec Order 26.4b1 about staff and or peers."

2. The surveyor reviewed Resident #4's medical record on NJ Exec Order 26.4b1. According to the AR Resident #4 was admitted to the facility with medical diagnosis which included but was not limited to; NJ Exec Order 26.4b1 [redacted]).

According to the MDS dated NJ Exec Order 26.4b1, the resident had a NJ Exec Order 26.4b1 [redacted]. The resident's CP initiated on NJ Exec Order 26.4b1 with a Focus of "Resident #4 makes NJ Exec Order 26.4b1 about staff and or peers."

Resident #3's and #4's CP included no new updates with interventions for NJ Exec Order 26.4b1 [redacted] about staff and peers for the FRE dated NJ Exec Order 26.4b1 4, with an event date of NJ Exec Order 26.4b1 and a "time of event" of NJ Exec Order 26.4b1

During an interview on 10/24/2024 with the U.S. FOIA (b)(6) [redacted]), she stated "the importance of the CP is how everyone is

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F 657	Continued From page 55 aware of how to care for residents." She further stated the CP should be updated and revised with interventions by any member of the Interdisciplinary Clinical Team (IDC Team). She said the CP should be updated quarterly, annually, and with any significant changes or events in the resident's status. When asked by the surveyor if the [redacted] allegation made by Resident #3 and #4 on [redacted] was a significant event, the [redacted] said "Yes, the CP should had been updated with new interventions." The [redacted] acknowledged the CP for Resident #3 and #4 was not updated and revised with new interventions after the [redacted] Review of the facility undated policy titled "Care Plan, under "Policy," reveals: Our facility develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. Under "Policy Interpretation and Implementation" #6. Care plans are revised as changes in the resident's condition dictate. Reviews are made at least quarterly.	F 657		
F 835 SS=J	N.JA.C.: 8:39-11.2(d)(2) Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 835		12/28/24

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F 835	Continued From page 56 This REQUIREMENT is not met as evidenced by: Complaint # NJ178530 Based on interviews, medical record review, and review of other pertinent facility documentation on NJ Exec Order 26.4b1 and U.S. FOIA (b)(6), it was determined that the facility's U.S. FOIA (b)(6) failed to: a.) provide services necessary to prevent NJ Ex Order 26.4(b)(1) for a resident (Resident #1), b.) follow the facility's NJ Ex Order 26 policy by allowing staff members to continue to work with other residents after an NJ Ex Order 26 allegation occurred, c.) conduct a timely and thorough investigation for a reported witnessed allegation of staff to residen NJ Ex Order 26.4(b)(1), d.) provide accurate and original witness statements to the surveyors for an NJ Ex Order 26 investigation e.) implement care plan (CP) interventions for a resident (Resident #1) with a known history of NJ Exec Order 26.4b1 towards others and diagnoses of NJ Exec Order 26.4b1 On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 NJ Exec Order 26.4b1 with CNA #2 and the U.S. FOIA (b)(6) NJ Exec Order Resident #1, at which time she ran to get the Licensed Practical Nurse (LPN#1) who was already on her way to the hallway. LPN #1 stated she heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 in the hallway. LPN #1 responded to the hallway and saw Resident #1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 LPN #1 stated she observed CNA #2 NJ Exec Order 26 Resident #1 and the U.S. FO U.S. FOIA (b)(6 Resident #1 with NJ Exec Order 2. LPN #1 told both staff members (CNA #2 and U.S. FO) to	F 835	Immediate Action On 10/22/2024 the U.S. FOIA (b) (6) was educated by corporate consultant on her job description, roles, and responsibilities to ensure that policies and procedures and effective systems were implemented to assure services are provided to prevent physical abuse, facilities abuse policy is followed, timely and thorough investigation are conducted for reported witnessed allegations of staff to resident physical abuse, accurate and original witness statements are provided to surveyors when requested for an abuse investigations, care plans are implemented with interventions for residents. Other residents having potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not return. On 10/22/24, the entire department head team was educated on abuse protocols, which includes the importance of collecting all statements, utilizing the social worker to assist in obtaining the residents statements, assuring the original	

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stop and to get off the resident. LPN#1 stated CNA #2 and the [U.S. FO] did not immediately stop and get off the resident. She had to repeat the request. LPN#1 stated the [U.S. FO] said, "Its ok we are told to do this." LPN #1 stated she assisted Resident #1 [NJ Exec Order 26.4b1] to the nursing station and immediately reported the incident to the U.S. FOIA (b)(6)). CNA #2 and the [U.S. FOI] went down to the other side of the hallway and passed the lunch trays.

The Social Worker (SW#1) stated the [U.S. FOIA (b)(6)] got her to come to the unit. SW#1 stated Resident #1 was NJ Exec Order 26.4b1 " SW#1 stated while at the nursing station, she observed the resident's [NJ Exec Or] when Resident #1 NJ Exec Order 26.4b1. SW #1 reported the observation to the [U.S. FOIA (b)(6)]. SW#1 stated she was asked by LPN#1 to take Resident #1 to her office on the first floor. SW #1 stated Resident #1 complained of [NJ Exec Order 26.4b1]. During an interview with the SW#1, she stated Resident #1 stated [NJ Exec Order 26] while attempting to pick up food [NJ Ex Order 26.4(b] . The [U.S. FOIA (b)(6)] stated Resident #1 told her that he/she [NJ Exec], and an order was obtained from the U.S. FOIA (b)(6) to send Resident #1 to the hospital for [NJ Exec Or]. On NJ Exec Order 26.4b1 Resident #1 was admitted to the hospital with diagnoses of NJ Exec Order 26.4b1 . The facility also failed to follow its job description titled U.S. FOIA (b)(6)

This placed all residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 10/22/2024 at 8:50 PM and was reported to the U.S. FOIA (b)(6) were presented with the IJ template. The IJ began on U.S. FOIA (b)(6)

signed statements are turned into the abuse coordinator, and reporting all incidents to the abuse coordinator immediately.

On 10/22/24, the Director of Nursing/or designee immediately educated all staff on abuse protocols, which include importance of collecting all statements, utilizing the social worker to assist in obtaining the residents statements, assuring the original signed statements are turned into the abuse coordinator, and reporting all incidents to the abuse coordinator immediately.
The DON/ADON/designee monitor compliance with education and conduct staff assessment and testing to assure staff has true understanding of our care plan policy. Audits will be conducted weekly for four weeks and then monthly for four months.

The Administrator/DON/ADON/designee will audit education each month to assure all employees have had education. Audits will be conducted three times a week for four weeks and then monthly for four months.

This education will become part of our orientation education as well as our annual education.

How the facility plan to monitor its performance to make sure that solutions are sustained.

The results of the weekly and monthly

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F 835	Continued From page 58 and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan. On 10/29/2024, the surveyors conducted an onsite revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included the two staff members identified (CNA #2 and the U.S. FO) were terminated from the facility. Disciplinary action was initiated for the three employees (CNA #1, LPN#1, and SW#1) who witnessed the incident on NJ Exec Order 26.4b1 and did not report it to the U.S. FOIA (b)(6) U.S. FOIA (b)(6). Education was provided to all administrative staff about the facility's abuse and investigation policy which included immediate steps taken when an abuse allegation was made and ensuring the safety of all residents. Education was provided to all staff on the importance of preventing abuse, ensuring resident safety, and the importance of following the facility's abuse policy to protect all residents. Education was provided to all staff on the importance of collecting all truthful statements in their original form, utilizing the SW to assist in obtaining resident statements, and assuring the original signed statements were all submitted to the Abuse Coordinator. Education on ensuring implementation of care plan interventions was provided to all the staff. This education included the location of care plans, how to read the care plans, the importance of following the care plans, and how to update the care plans. Audits were conducted that monitor compliance with the implementation, following of care plan interventions, and if updates to the care plan were required. Audits were initiated by the DON that monitor compliance with all staff education. The DON conducted staff assessments and testing to ensure that staff have a true	F 835	audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on January 16, 2024.	

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understanding of the facility's abuse policy.

The noncompliance remained on 10/29/24 as a level G for actual harm that is not an IJ based on the following: Resident #1 is no longer at the facility, CNA #2 and the [U.S. FO] no longer work at the facility, and all facility staff have been re-educated on the facility's abuse and investigation policy, importance of preventing abuse and ensuring resident safety, importance of collecting all truthful statements in their original form, utilizing the SW to assist in obtaining resident statements, and assuring the original signed statements were all submitted to the abuse coordinator. All facility staff have also been re-educated on ensuring implementation of care plan interventions. The facility began audits on compliance with all staff education and conducted staff assessments and testing to ensure that staff have a true understanding of the facility's abuse policy.

This deficient practice was identified for 1 of 7 residents (Resident #1) and was evidenced by the following:

According to the Facility's Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents dated [NJ Exec Order 26.4b1], Resident #1 [NJ Exec Order 26.4b1] while in his/her room and [NJ Exec Order 26.4b1] at a staff member outside of Resident #1's room on [NJ Exec Order 26.4b1]. While NJ Exec Order 26.4b1, Resident #1 NJ Exec Order 26.4b1. While [NJ Exec Order 2], Resident #1 continued to U.S. FOIA (b)(6) to the staff and others. Staff attempted to [NJ Exec Order 26.] Resident #1 by using U.S. FOIA (b)(6) " [NJ Exec Order 26.4b] Resident #1 was . While at the hospital, Resident

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F 835	Continued From page 60 #1 stated to hospital staff that he/she had been NJ Exec Order 26.4b1 . The NJ Ex Order 2 notified the facility on U.S. FOIA (b)(6) of Resident #1's allegations. According to the FRE, "a full investigation was initiated" on NJ Exec Order 26.4b1 Both staff members were NJ Exec Order 26.4b1 pending an investigation on NJ Exec Order 26.4b1 According to the facility's document titled "Summary of Investigation" with a "date reported" of NJ Ex Order 26.4(b)(1) under "Summary", Resident #1 sustained injuries when he/she NJ Exec Order 26.4b1 while trying to NJ Ex Order 26.4(b)(1) on the staff member. Resident #1 had a history of NJ Exec Order 26.4b1 towards others and staff were protecting residents and themselves while trying to keep Resident #1 from NJ Exec Order 26.4b1 The staff were concerned for everyone's NJ Ex Order 26 and tried to keep Resident #1 NJ Exec Order 26.4b1 to avoid Resident #1 from NJ Exec Order 26.4b1 "They were NJ Ex Order 26.4(b)(1) while trying to keep Resident #1 NJ Ex Order 2 to prevent NJ Ex Order 26.4(b)(1) from Resident #1." According to the Admission Record (AR), Resident #1 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1). According to the Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1	F 835		

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F 835	Continued From page 61 NJ Exec Order 26.4b. The MDS further indicated Resident #1 was on NJ Exec Order 26.4b1 medications and had no behaviors that were exhibited towards others. According to the Discharge MDS dated NJ Exec Order 26.4b1, Section A, a discharge assessment indicated "return anticipated." Section E revealed that Resident #1 had NJ Exec Order 26.4b1 directed toward others. A review of Resident #1's Care Plan (CP) initiated on NJ Ex Order 26.4(b)(1) revealed under "Focus": Resident #1 is the NJ Exec Order 26.4b1 Under "Goal" revealed "Resident #1 will not NJ Ex Order 26.4(b)(1) through the review date." Under "Interventions" initiated on NJ Ex Order 26.4(b)(1) revealed the following: "When Resident #1 NJ Exec Order 26.4b1 intervene before NJ Exec Order 26.4b1. NJ Ex Order 26.4(b)(1) from source of NJ Ex Order 26.4(b) NJ Exec Order 26.4b1 in conversation. If response is NJ Ex Order 26.4(b)(1) staff to walk calmly away and approach later." A review of Resident #1's Progress notes (PNs) dated NJ Ex Order 26.4(b)(1) at 2:24 PM written by the U.S. FOIA (b)(6) revealed Resident #1 NJ Exec Order 26.4b1 while in the room and NJ Exec Order 26.4b1 at a staff member outside the room door. During the NJ Exec Order 26.4b1, Resident #1 NJ Exec Order 26.4b1. While NJ Exe Resident #1 continued to NJ Exec Order 26.4b1 to the staff. Staff attempted to NJ Exec Order 26. Resident #1 using NJ Exec Order 26.4b1NJ Exec Order 26.4b1 Resident #1 was given time before being assisted to NJ Ex Order 26.4(b)(1). Resident #1 was taken off the unit with Social Services (SS) to further NJ Exec Order 26.4b1. The Physician was informed of Resident #1's NJ Exec Order 26.4b1. An order was secured to send Resident #1 to the hospital for a	F 835		

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F 835	Continued From page 62 NJ Ex Order 26.4(b)(1) evaluation and NJ Ex Order 26.4(b)(1) A review of Resident #1's PNs dated NJ Ex Order 26.4(b)(1) at 9:35 PM revealed at 5:30 PM, Resident #1 was picked up by transport via stretcher and taken to the Emergency Room (ER). During an interview with the surveyors on 10/22/2024 at 1:04 PM, CNA #1 stated that on NJ Ex Order 26.4(b)(1) at 11:58 AM, she walked out of the dayroom, heard NJ Ex Order 26.4(b)(1), and observed Resident #1 NJ Exec Order 26.4b1 Resident #1's NJ Exec Order 26.4b1 She observed CNA#2 and the U.S. FO NJ Exec Order resident NJ Exec Order 26.4b1. CNA #1 stated "the camera could show you better." CNA #1 further stated she ran to get LPN#1, who responded to the incident. CNA #1 stated that CNA# 2 and the U.S. FO continued to work the rest of the shift on another unit. She stated that Resident #1 went to the hospital the same day the incident occurred but was unsure of the time. CNA #1 stated that Resident #1 can be NJ Exec Order 26.4b1 but NJ Exec Order 26.4b1. CNA #1 stated she heard both CNA #2 and the U.S. FO tell LPN #1 that Resident #1 NJ Exec Order 26.4b1 because resident was told to NJ Exec Order 26.4b1. During an interview with the surveyors on 10/22/2024 at 1:27 PM, LPN #1 stated she worked on NJ Exec Order 26.4b1 and was assigned Resident #1. LPN #1 stated she was in the charting room speaking with the U.S. FOIA (b)(6)) and heard NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 LPN #1 stated the U.S. FO and herself immediately got up and as she was coming out of the charting room door, she was met by CNA #1 who was coming to get her. LPN #1 stated she looked	F 835		

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down the hallway where [redacted] was coming from and observed Resident #1 [redacted]. LPN #1 stated she heard Resident #1 [redacted] LPN #1 further stated that the [redacted] was behind her and stated, [redacted] LPN #1 stated she observed CNA #2 [redacted] Resident #1 and the [redacted] Resident #1. LPN #1 stated Resident #1 was [redacted]. LPN #1 stated she told CNA #2 and the [redacted] to stop and [redacted]. CNA #2 and the [redacted] did not immediately stop. She had to repeat the request. CNA #2 and the [redacted] then [redacted] the resident. LPN #1 further stated that the [redacted] said, "its ok, we are told to do this." When asked by the surveyor if the [redacted] said who told him to this, the [redacted] said, "No, he did not say who told him to do this." LPN #1 stated she assisted the resident [redacted] to the nursing station and immediately reported the incident to the [redacted] She stated that CNA #2 and the [redacted] went down the other hallway and passed out the lunch trays. LPN #1 further stated "I don't know what time, but CNA #2 and the [redacted] were moved off the floor to the other units." LPN #1 stated Social Worker (SW#1) and the [redacted] came to the unit after the incident. SW#1 stayed with her and the resident at the nursing station. LPN#1 stated, "I don't know where the [redacted] went." LPN #1 further stated Resident #1 [redacted] and asked her to [redacted] because he/she wanted to [redacted]. LPN #1 stated SW#1 [redacted] Resident #1's [redacted], and they both observed [redacted]. She stated that SW#1 told the [redacted] that the resident had [redacted]. LPN #1 stated she asked the [redacted] "what are we doing with the resident." LPN#1 stated SW#1 took Resident #1

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downstairs to her office. LPN #1 heard an overhead page for CNA #2 and the [U.S. FO] to report to the first floor, was unsure how long it was after the incident occurred, but it was not immediate. LPN#1 stated CNA #2 and the [U.S. FO] left the unit after the overhead page. LPN#1 stated she received a call from the [U.S. FOIA (6)] asking her and CNA#1 to write a witness statement. LPN #1 stated she wrote her witness statement and brought both her and CNA #1's original witness statements to the [U.S. FOIA (b)(6)] office. Upon her return to the unit, she received a phone call from the [U.S. FOIA (b)(6)] stating that Resident #1 was going to the hospital. LPN#1 further stated that the [U.S. FOIA (b)(6)] told her that Resident #1 and his/her roommate (Resident #4) were being moved to the [NJ Exec Order 26.4b]-floor unit. Resident #1 was not moved the [NJ Exec Order 26.4b]-floor unit because he/she was transferred to the hospital. She stated she received Resident #1's universal transfer form (UTF) already completed by the [U.S. FOIA (b)(6)] She took Resident #1's chart and the UTF to the [NJ Exec Order 26.4b]-floor unit and observed CNA #2 on that unit. LPN #1 stated she did not observe Resident #1 on the [NJ Exec Order 26.4b]-floor unit. She stated CNA #2 came to work on [NJ Exec Order 26.4b1], but the [U.S. FO] had called out. LPN #1 further stated that CNA #2 did not work on her unit on [NJ Exec Order 26.4b1] LPN #1 stated "no administrative staff came to talk to me after the incident had occurred." She stated the process after an incident was for the nurse on the unit to complete the incident report, obtain witness statements from all staff on the unit, and complete an assessment of the resident(s) involved. She stated, "they [Administration] did not make me fill it out [incident report]."

During an interview with the surveyors on 10/22/2024 at 2:48 PM, CNA #3 stated that she

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was watching the residents in the dayroom around NJ Exec Order 26.4b1 when she heard NJ Ex Order 26.4(b)(1) in the hallway. She came out from the dayroom and observed Resident #1 NJ Exec Order 2 CNA #3 stated she observed the U.S. FO NJ Exec Order 26.4b1 the resident NJ Exe and CNA #2 was standing there. CNA #3 further stated SW#1 and the U.S. FOIA (b)(6 came and brought Resident #1 downstairs. She stated that when the lunch tray came to the unit, all the CNAs including CNA #2 and the U.S. FOI passed out the lunch trays. CNA #3 stated she did not see CNA #2 and the U.S. FO on the unit after lunch but however, she saw CNA #2 and the U.S. FO when she clocked out at the end of her shift at 3:00 PM. CNA #3 stated CNA #2 was assigned as the monitor for Resident #1 on the day of the incident. She stated on the morning of NJ Exec Order 26.4b1 she saw CNA #2 on the NJ Exec O-floor unit.

During an interview with the surveyors on 10/22/2024 at 3:22 PM, the U.S. FOIA (b) stated when an incident occurs the nurse assigned the resident is responsible for completing an incident report. The U.S. FOIA (b) stated, "I guess that day it was not filled out." The U.S. FOIA (b) confirmed that no incident report was completed for Resident #1 on NJ Exec Order 26.4b1. The U.S. FOIA (b) stated the expectation was that the charge nurse should have filled out an incident report and gathered witness statements after the incident occurred. The U.S. FOIA (b) further stated the next day either the U.S. FOIA (b)(6) or herself would review the incident report and were responsible to ensure there was an incident report with witness statements. The U.S. FOIA (b) further stated, "We did not ask the nurse why an incident report was not completed." The U.S. FOIA (b) confirmed there was no incident report or witness statements regarding NJ Exec Order 26.4b1 incident involving Resident #1. The

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U.S. FOIA (b)(6) stated the expectation was to have an incident report and witness statements completed after an incident occurred.

During an interview with the surveyors on 10/22/2024 at 3:22PM, the U.S. FOIA (b)(6) stated "as a team, we go over the incident reports in morning meeting. This has not happened in this case with Resident #1."

During an interview with the surveyors on 10/22/2024 at 4:06 PM, SW #1 stated she met the U.S. FOIA (b)(6) by the elevators on NJ Exec Order 26.4b1, and the U.S. FOIA (b)(6) told her that Resident #1 was NJ Exec Order 2 and wanted her to go to talk with the resident. She stated when she got upstairs, she observed LPN #1 and Resident #1 at the nursing station. She further stated that the resident was NJ Ex Order 26 'NJ Exec Order 26.4b1 SW #1 stated Resident #1 NJ Exec Order 26.4b1 and she observed NJ Exec Order 26.4b1. She told the U.S. FOIA (b)(6) about the U.S. FOIA (b)(6) resident's NJ Exec Ord. SW #1 stated she was asked by LPN #1 to take the resident off the unit. SW#1 stated she took the resident to her office on the first floor, and LPN #1 brought the resident's lunch tray. She stated the resident appeared NJ Exec Order 26.4b1 SW #1 stated while Resident #1 was eating he/she NJ Ex Order 26.4(b)(a piece of mashed potato NJ Ex Order 26.4(b)(1), the resident attempted to NJ Ex Order 26.4(b)(1) mashed potato and stated, NJ Exec Order 26.4b1 She stated the resident was still in her office for approximately 45 minutes when she texted the U.S. FOIA (b)(6) to let her know the resident was still in her office. SW #1 stated she came to work the next day and NJ Ex Order 26.4(b)(1) were at the facility. SW#1 stated she did not speak with NJ Ex Order 26.4(b)(1). SW #1 stated she did not recall why NJ Ex Order 2 were at the

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facility. SW#1 stated she did not know anything until she read an article online about two staff members at the facility that were detained, and a resident was in the hospital NJ Ex Order 26.4(b)(1). SW #1 further stated she was not asked to write a statement. SW #1 stated she did not speak to any staff or residents about the incident that occurred. SW #1 stated if an NJ Ex Order 26 allegation occurred, it was to be reported to the U.S. FOIA (b)(6) who was the U.S. FOIA (b)(6). SW #1 stated that if the U.S. FOIA (b)(6) was not there she would report the allegation to the U.S. FOIA (b)(6). SW #1 further stated that she would await instruction from the NJ Exec Order. SW #1 stated the U.S. FOIA (b)(6) would have told her to interview the resident. SW #1 stated she would report the NJ Ex Order 26 allegation and then await further instruction from the U.S. FOIA (b)(6). SW #1 stated she did not ask Resident #1 who NJ Ex Order 26.4(b)(1). SW #1 further stated she had not spoken to any residents on CNA #2 and the U.S. FOIA (b)(6) assignments. SW#1 stated the U.S. FOIA (b)(6) did not ask her to speak to any of the residents cared for on NJ Exec Order 26.4b1 by CNA #2 and the U.S. FOIA (b)(6) as of NJ Exec Order 26.4b1. SW#1 stated she did not speak to Resident #1 about the incident.

During an interview with the surveyors on 10/22/2024 at 4:47 PM, the U.S. FOIA (b)(6) stated on NJ Exec Order 26.4b1 that "I was told that Resident #1 was having NJ Ex Order 26.4(b)(1) and took the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) the CNA." The U.S. FOIA (b)(6) stated she did not know where the resident got the NJ Exec Order 26.4b1 from and was unsure of the staff involved in the incident. She further stated that she was called to the unit by LPN #1. She stated LPN #1 told her that the resident tried to NJ Exec Order 26.4b1 at the aide, the resident and the NJ Exec Order 26.4b1. The surveyor asked the U.S. FOIA (b)(6) if LPN#1 made

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her aware of the [NJ Ex Order 26] allegation and she stated, "LPN#1 did not say anything else." The [U.S. FOIA (b)(6)] stated that when she got to the unit, she did not see anyone on the floor but saw the [NJ Exec Order 26.4b] [redacted] The [U.S. FOIA (b)(6)] further stated she saw Resident #1 and NJ Exec Order 26.4b1 and tried to get the resident NJ Ex Order 26.4(b)(1). The [U.S. FOIA (b)(6)] stated she asked Resident #1 what happened with the NJ Exec Order 26.4b1, and the resident U.S. FOIA (b)(6). The [U.S. FOIA (b)(6)] stated the resident refused an assessment. The [U.S. FOIA (b)(6)] stated she called the doctor and got an order to send Resident #1 to the [NJ Exec Order 26.4] because NJ Exec Order 26.4b1 The [U.S. FOIA (b)(6)] stated the reason for Resident #1's transfer to the hospital was because resident NJ Exec Order 26.4b1 [redacted]. The [U.S. FOIA (b)(6)] stated she was unsure of what time Resident #1 [redacted]

During an interview with the surveyors on 10/22/2024 at 5:01 PM, the [NJ Exec Or] stated that LPN #1 told her " Resident #1 U.S. FOIA (b)(6) The [U.S. FOIA (b)] stated that when she came to work on [NJ Exec Order 26.4b1] there were NJ Ex Order 26.4(b)(1) and a [NJ Ex Order 26.4(b)(1)] at the facility. The [U.S. FOIA (b)(6)] stated she was asked if she knew what happened to the resident. The [U.S. FOIA (b)] stated she was asked by [NJ Ex Order 26.4(b)(1)] if she had heard that Resident #1 had been [redacted] and the [U.S. FOIA (b)] stated she told them "No". The [NJ Exec Orde] further stated the expectation was that staff should follow a resident's care plan. The [U.S. FOIA (b)] further stated that a resident could be in danger if the care plan was not followed. The [U.S. FOIA (b)] confirmed that Resident #1's care plan was not followed during the incident that occurred on U.S. FOIA (b)(6).

During an interview with the surveyors on 10/22/2024 at 5:03 PM, the [redacted] stated on

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NJ Exec Order 26.4b1 NJ Ex Order 2 asked her if she knew Resident #1 had NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6 stated she knew that the resident had NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1, and the resident had NJ Exec Orde. The U.S. FOIA (b)(6 stated she did not NJ Ex Order 26.4(b)(1) because she thought it was a resident to staff incident. The U.S. FOIA (b)(6 further stated she normally NJ Ex Order 26.4(b)(1) for a resident to resident, staff to resident, and resident to staff incident but did not for this incident. The U.S. FOIA (b)(6 further stated she would have NJ Ex Order 26.4(b)(1) if the resident NJ Ex the staff or if the resident was a NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6 stated she would have considered a resident NJ Exec Order 26.4b1, a NJ Exec Order 26 to resident's self and others. The U.S. FOIA (b)(6 stated NJ Ex Order 26.4(b)(1) should have been notified. The U.S. FOIA (b)(6 stated NJ Ex Order 26.4(b)(1) came to the facility on NJ Exec Order 26.4b1 and talked to the staff and were trying to determine if NJ Ex Order 26 had occurred. The NJ Exec Order stated she reviewed the camera surveillance on NJ Exec Order 26.4b1 in the presence of NJ Ex Order 26.4(b)(1) and observed the come out of the resident's room. She also observed CNA#2 and the U.S. FO NJ Exec Order 26 Resident #1 NJ Exec Order 26.4b1. When asked by the surveyor if the camera surveillance was reviewed on NJ Exec Order 26.4b1, the U.S. FOIA (b)(6 stated "no, I was told the resident NJ Exec Order 26.4b1 and had NJ Exec Orde I didn't think to review the camera because it was reported as a NJ Exec Order 26.4b1." The U.S. FOIA (b)(6 stated after reviewing the camera surveillance, with NJ Ex Order 26.4(b)(1), she was informed by them that they were arresting CNA #2. The U.S. FOIA (b)(6 further stated the U.S. FO was not at the facility on NJ Exec Order 26.4b1. The U.S. FOIA (b)(6 stated she finalized her investigation, and that CNA #2 and the U.S. FOIA were trying NJ Ex Order 26.4 Resident #1 after he/she NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. She stated a NJ Ex Order 26.4(b)(1) was not a part of how to deal with NJ Exec Order 26.4b1

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residents. The [redacted] stated she would consider a [redacted] as [redacted]. The [redacted] stated the facility did not have a policy on [redacted] The [redacted] further stated an incident report should have been completed for the [redacted] and the incident. The [redacted] stated she was told by staff that Resident #1 [redacted] and CNA#3 and the [redacted] Resident #1 [redacted] to prevent any further [redacted]. The [redacted] further stated the expectation was to remove either the [redacted] or other people from the situation whatever was safer. The [redacted] agreed that Resident #1's care plan intervention was not followed for this incident.

During an interview with the surveyors on 10/23/2024 at 12:48 PM, the [redacted] stated she was the [redacted]. The [redacted] stated once an [redacted] allegation was made, the staff was to report it to the [redacted] and herself and they would start the investigation. She stated the nurse on the floor would collect the witness statements and the [redacted] would interview and gather statements from the resident(s) involved. The [redacted] stated there were no instances where the [redacted] would not have collected resident statements when an [redacted] allegation occurred. She further stated, "I cannot speak to why there were no statements gathered for the other residents for the incident on [redacted]. The [redacted] stated, "I know the [redacted] talked to other residents after the incident." The [redacted] further stated the expectation was that the [redacted] should have talked to Resident #1 and other residents on CNA #2 and [redacted] assignments after the incident occurred. The [redacted] stated that she agreed that some of the steps of the [redacted] and investigation policies were not followed the incident on [redacted]. The [redacted] confirmed that SW#1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315125	A. BUILDING _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

(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 835	Continued From page 71	F 835		

should have started an investigation and reported the incident to her on NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) stated "I was not made NJ Exec Order 26.4b1 seen by SW#1 and the U.S. FOIA (b)(6) on NJ Exec Order 26.4b1. All I knew was the resident NJ Exec" The U.S. FOIA (b)(6) stated the witness statements were written and collected on NJ Exec Order 26.4b1

During an interview with the surveyors on 10/23/2024 at 1:11 PM, CNA #1 was shown her witness statement that the facility provided to the surveyors. CNA #1 stated "Yes, I am confirming that my statement was altered." CNA #1 stated in her original statement she wrote that she had seen her co-workers NJ Exec Orde Resident #1 while resident NJ Exec Order 26.4b1. CNA #1 further stated "Yes, I am confirming that the witness statement you are showing me, does not have all the information I put in my original statement."

During an interview with the surveyors on 10/23/2024 at 3:05 PM, the U.S. FOIA (b)(6) stated she was told the employees' written statements were left in the U.S. FOIA (b)(6) mailbox. The U.S. FOIA (b)(6) stated "I think the employees have the original statements and left the copies in the U.S. FOIA (b)(6) mailbox." The U.S. FOIA (b)(6) stated the nurse would collect the statements and would put them in the mailbox. The U.S. FOIA (b)(6) stated "The U.S. FOIA (b) would be the first person to collect and look at the statements if they are put in her mailbox." The U.S. FOIA (b)(6) further stated, "Yes, for the U.S. FOIA (b)(6) incident the witness statements were all put in the U.S. FOIA (b)(6) mailbox."

During an interview with the surveyors on 10/23/2024 at 3:23 PM, CNA #1 stated "I wrote my statement on U.S. FOIA (b)(6) and gave the original copy to LPN#1."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315125	A. BUILDING _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	**395 LAKESIDE BLVD BAYVILLE, NJ 08721**

(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 835	Continued From page 72	F 835		

During an interview with the surveyors on 10/23/2024 at 3:25 PM, LPN #1 stated "I took my original statement and CNA #1's statement as requested by the [redacted]. I was going to make copies, but the copier was down. I took a screenshot of the original statements."

During an interview with the surveyors on 10/23/2024 at 3:27 PM, the [redacted] stated copies of written statements were in her mailbox on [redacted]. The [redacted] further stated, "I don't remember off the top of my head, who the statements were from." The [redacted] stated she does not review the witness statements and the final investigation. The [redacted] stated she has not reviewed the witness statements for the incident that occurred on [redacted]. The [redacted] confirmed she took the witness statements regarding [redacted] incident out of her mailbox on [redacted]. The [redacted] stated, "I don't know who would read the witness statements."

Review of the facility document titled "Job Description" revealed under "Job Title", "Administrator". Under "Duties and Responsibilities" revealed 2. Ensure the development of, implementing and enforcing all policies and procedures. 3. Exercise full and complete authority relative to the employment and placing of all staff within the facility."

Review of the facility policy titled "Abuse Policy and Procedure" updated 8/2014, revealed under "Policy" that "This facility requires that any allegations of abuse be addressed immediately in accordance with all federal and state regulations. All allegations will be evaluated in a prompt and thorough manner. Under "Procedure", "6. Any employee alleged to have participated in abusive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315125	A. BUILDING _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	**395 LAKESIDE BLVD BAYVILLE, NJ 08721**

(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 835	Continued From page 73 activity will be removed from care of the involved resident immediately. 9. The RN supervisor will contact the Director of Nursing immediately upon suspicion or confirmation of abuse. If the Director of Nursing is unable to be contacted, the Administrator will be contacted. 10. The Administrator will be contacted regarding all cases of physical and verbal abuse ...11. The supervisor/Nurse Manager/Director of Nursing/designee will interview all staff who have provided care. 13. Confused residents will be interviewed with a witness present. 16. Employee statement forms and an incident form will be filled out completely. An Incident Report form will include the following information: a. The name of the involved resident, b. the date and time the incident occurred, c. the circumstances surrounding the incident, d. where the incident took place, e. the name(s) of those participating in the act, f. physician and family notification, g. treatment rendered. 22. Employees who have had allegations of physical abusive treatment will be removed from direct resident care." NJAC 8:39-9.2(a)	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061501	A. BUILDING: _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILI	395 LAKESIDE BLVD BAYVILLE, NJ 08721

(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
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. 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 the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ171869, NJ172508, NJ176503, NJ178530, NJ178766, NJ178770 Based on interviews and review of facility documents on 10/22/2024, 10/23/2024, and 10/24/2024, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts and 6 of 14 overnight shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	Immediate Action Staffing coordinator was educated on New Jersey state staffing ratio requirements on 10/22/2024. Efforts to hire facility staff will continue until there is adequate staff to meet the minimum staff to resident ratios. Until that time, the facility will use staffing agencies and offer additional shifts to current staff with bonuses as required. Facility Administrator worked with Human resources to secure additional staffing agency contracts. Interdisciplinary team met on 12/13/2024	12/28/24

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

Electronically Signed | 12/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061501	A. BUILDING: _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILI	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of Complaint staffing from 10/06/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts and deficient in total staff for residents on 6 of 14 overnight shifts as follows: On 10/06/24 had 20 CNAs for 212 residents on the day shift, required at least 26 CNAs. On 10/07/24 had 22 CNAs for 212 residents on the day shift, required at least 26 CNAs. On 10/08/24 had 20 CNAs for 212 residents on the day shift, required at least 26 CNAs. On 10/08/24 had 14 total staff for 212 residents on the overnight shift, required at least 15 total staff. On 10/09/24 had 21 CNAs for 212 residents on the day shift, required at least 26 CNAs. On 10/10/24 had 22 CNAs for 212 residents on the day shift, required at least 26 CNAs. On 10/11/24 had 21 CNAs for 212 residents on	S 560	to discuss recruitment and retention interventions which included scheduling a job fair to be held on January 8, 2025. Other residents having potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not return. Weekly recruitment, retention and employee appreciation meeting was initiated and will be led by the Director of Human Resources and/or designee. Hiring and recruitment efforts including pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives. The facility administrator/designee will continue to track and document all recruitment and retention efforts weekly for the first 4 weeks and then monthly for four months. How the facility plan to monitor its performance to make sure that solutions are sustained. The results of the weekly and monthly	

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	061501	A. BUILDING: _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILI	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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S 560	Continued From page 2 the day shift, required at least 26 CNAs. On 10/12/24 had 19 CNAs for 213 residents on the day shift, required at least 27 CNAs. On 10/12/24 had 14 total staff for 213 residents on the overnight shift, required at least 15 total staff. On 10/13/24 had 20 CNAs for 213 residents on the day shift, required at least 27 CNAs. On 10/13/24 had 13 total staff for 213 residents on the overnight shift, required at least 15 total staff. On 10/14/24 had 18 CNAs for 213 residents on the day shift, required at least 27 CNAs. On 10/15/24 had 17 CNAs for 211 residents on the day shift, required at least 26 CNAs. On 10/16/24 had 20 CNAs for 210 residents on the day shift, required at least 26 CNAs. On 10/16/24 had 14 total staff for 210 residents on the overnight shift, required at least 15 total staff. On 10/17/24 had 19 CNAs for 210 residents on the day shift, required at least 26 CNAs. On 10/17/24 had 14 total staff for 210 residents on the overnight shift, required at least 15 total staff. On 10/18/24 had 21 CNAs for 210 residents on the day shift, required at least 26 CNAs. On 10/19/24 had 18 CNAs for 210 residents on the day shift, required at least 26 CNAs. On 10/19/24 had 14 total staff for 210 residents on the overnight shift, required at least 15 total staff.	S 560	audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on January 16, 2024.	
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director	S1680		12/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1680	Continued From page 3 of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

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CRYSTAL LAKE HEALTHCARE AND REHABILI	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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S1680	Continued From page 4	S1680		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ171869, NJ172508 NJ176503, NJ178530, NJ178766, NJ178770

Based on review of the Nurse Staffing Reports for the weeks of 10/06/2024 and 10/13/2024, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows:

For the week of 10/06/2024
Required RN Staffing Hours: 546.75

On 10/12/24 had 536 actual staffing hours, for a difference of -10.75 hours.

For the week of 10/13/2024

Immediate Action

Staffing coordinator was educated on the mandatory nurse staffing requirement that the facility shall provide nursing services by registered professional nurses based on the required RN staffing hours on 12/13/2024

Other residents having potential to be affected by the same deficient practice.

All residents have the potential to be affected by this deficient practice.

What measures will be put into place or systemic changes made to ensure that the

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	061501	A. BUILDING: _____ B. WING _____	C 10/29/2024

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S1680	Continued From page 5 Required RN Staffing Hours: 541.75 On 10/19/24 had 528 actual staffing hours, for a difference of -13.75 hours.	S1680	deficient practice will not return. The DON/designee will audit the staffing schedules weekly for the first 4 weeks and then monthly for four months to assure that the required RN staffing hours are scheduled. How the facility plan to monitor its performance to make sure that solutions are sustained. The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on January 16, 2024.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315125 Y1	A. Building B. Wing Y2	1/30/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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 F0600	Correction	ID Prefix F0610	Correction	ID Prefix F0644	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(e)(1)(2)	Completed
LSC	12/28/2024	LSC	12/28/2024	LSC	12/28/2024
ID Prefix F0656	Correction	ID Prefix F0657	Correction	ID Prefix F0835	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.70	Completed
LSC	12/28/2024	LSC	12/28/2024	LSC	12/28/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
10/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061501 Y1	A. Building B. Wing Y2	1/30/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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 S0560	Correction	ID Prefix S1680	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed	Reg. #	Completed
LSC	12/28/2024	LSC	12/28/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/29/2024	☐ YES ☐ NO