STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315105	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Harbor Rehabilitation and Healthcare Center	2050 Sixth Ave Neptune City, NJ 07753

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint NJ #: 177087, 178121 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain a homelike environment by ensuring resident bathroom doors were in good repair. This deficient practice was observed in 1 of 2 nursing units and was evidenced by the following: On 1/6/25 at 12:27 PM, during initial tour of the facility, the surveyor observed the bathroom door of Resident room [ROOM NUMBER] to be deformed with a bow causing the top corner and the bottom corner of the handle side to be bowed out from the frame when the door was completely closed. Only the latch was able to fully be seated in the door frame with the top and bottom corners pulled away allowing the surveyor to see into the bathroom with the door closed. The door also had at least eight approximately half inch sized holes drilled into the door on the inside running half the length of the door from the top down. The door handle appeared to be coming off/loose from the door on the inside. On 1/9/25 at 12:08 PM, the surveyor interviewed the Director of Maintenance (DM), who stated that the facility utilized a system called TELS that all staff had access to put in work orders and inform the Maintenance Department of repairs that needed to be addressed. The DM acknowledged having knowledge of the bathroom door of Resident room [ROOM NUMBER] being in disrepair, but stated that the facility had not yet developed a plan to address it. The DM was unsure of how long it had been in its current state. The DM further stated that the facility was aware that some doors need to be replaced, specifically on the second floor, but stated we don't have anything in place for door orders. The DM acknowledged that the facility had a responsibility to ensure the building was in good repair and to look and function as good as it should in order to maintain a homelike environment for residents. On 1/9/25 at 12:52 PM, in the presence of the survey team, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who confirmed that all staff had access and knew how to use the TELS repair order system and that the Maintenance Department as well as the Regional Administration did monthly rounds of the facility to ensure all repairs were addressed. On 1/10/25 at 10:22 AM, in the presence of the survey team, the LNHA provided the surveyor with photos of the bathroom door for Resident room [ROOM NUMBER] and acknowledged it was in disrepair and he informed the surveyor that the door was replaced after surveyor inquiry. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Harbor Rehabilitation and Healthcare Center	2050 Sixth Ave Neptune City, NJ 07753

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Homelike Environment policy with revised February 2021, included .Residents are provided with a safe, clean, comfortable and homelike environments and encouraged to use their personal belongings to the extent possible .the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary, and orderly environment . A review of the facility's Maintenance Service policy revised December 2009, included .the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . NJAC 8:39-31.4(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Complaint NJ #: 177087 Based on observations, interviews, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to report an allegation of abuse within two hours to the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 1 residents reviewed for abuse (Resident #145), and was evidenced by the following: On 1/6/25 at 1:00 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) all reportable events, grievances, accidents, and incident reports for Resident #145. On 1/7/25 at 1:15 PM, the LNHA provided the surveyor with the requested documentation for Resident #145. This documentation included the following: An internal compliance hotline call from the resident dated 7/27/24. A fall accident report and investigation dated 9/26/24. A fall accident report and investigation dated 10/14/24. At that time, the surveyor asked the LNHA if that was all the reports for Resident #145, and the LNHA replied as far as she was aware, it was. On 1/9/25 at 9:04 AM, the LNHA and the Director of Nursing (DON) informed the surveyor that after the surveyor's multiple inquiries for reportable events, accidents, incidents, and grievances regarding Resident #145, they began to ask facility staff if they were aware of any other incidents that were not provided to the surveyor. The LNHA stated that the Social Worker (SW) looked through her emails and found two emails, both dated 8/7/24, one was from Resident #145 and the second from the Resident's Representative (RR). The emails both included grievances and an accusation of verbal abuse from an unnamed nurse at the facility towards the resident. The LNHA stated that the email was just found in the SW's spam/junk folder after surveyor inquiry. The LNHA acknowledged that the allegation was absolutely considered verbal abuse, and stated that the facility started an investigation into the matter which included attempting to reach out to the resident who no longer resided at the facility. On 1/9/25 at 9:58 AM, the surveyor reviewed Resident #145's medical record. A review of the resident's Transfer/Discharge Report indicated the resident was admitted to the facility with diagnoses which included but were not limited to; chronic obstructive pulmonary disease (COPD), need for assistance with personal care, and chronic pain. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 7/31/24, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 11:46 AM, the surveyor interviewed the LNHA, who stated that normally when an allegation of abuse or grievance was reported to the facility by a resident or the resident's representative, it was brought to the attention of the administration team. The LNHA continued if a particular person or staff member was named, then that staff member was suspended pending an investigation, and the facility reported the allegation to the NJDOH, the office of the Ombudsman, and if necessary to local law enforcement. The LNHA stated that investigations should be completed and closed out in five days or sooner. The LNHA stated she was unsure as to why or how Resident #145's emailed grievance/allegation of abuse was sent to the spam/junk folder and the facility's information technology (IT) department had to investigate it. The LNHA further acknowledged that it was the facility's responsibility to ensure all allegations of abuse and grievances were received timely and addressed including reported immediately. The LNHA stated that the abuse allegation was reported to the NJ DOH on 1/8/25. On 1/9/25 at 1:01 PM, the Regional Director of Operations (RDO), in the presence of the survey team, acknowledged the delay in investigating the accusation of abuse and stated, we agree that the system inhibited the ability to respond to the complaint/allegation. On 1/10/25 at 10:22 AM, the LNHA acknowledged to the surveyor, in the presence of the survey team, that the allegation of abuse which was sent on 8/7/24, was just being investigated and followed up with/reported after surveyor inquiry. A review of the facility provided policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated revised September 2022, included the following:All reports of resident abuse .are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management .Reporting Allegations to the Administrator and Authorities 1. If resident abuse is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility .3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. NJAC 8:39-5.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. NJ Complaint NJ #: 177087 Based on interview and review of pertinent facility documents, it was determined that the facility failed to investigate allegations of verbal abuse emailed to the facility on 8/7/24, by both a resident (Resident #145) and their representative, that an unidentified nurse verbally abused the resident and it was not investigated until surveyor inquiry. This deficient practice was identified for 1 of 1 residents reviewed for abuse (Resident #145), and was evidenced by the following: On 1/6/25 at 1:00 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) all reportable events, grievances, accidents, and incident reports for Resident #145. On 1/7/25 at 1:15 PM, the LNHA provided the surveyor with the requested documents for Resident #145. The documentation included the following: An internal compliance hotline call from the resident dated 7/27/24. A fall accident report and investigation dated 9/26/24. A fall accident report and investigation dated 10/14/24. At that time, the surveyor asked the LNHA if those were all the reports for Resident #145 that the facility investigated, and the LNHA replied yes, as far as she was aware. On 1/9/25 at 9:04 AM, the LNHA and the Director of Nursing (DON) informed the surveyor that after the surveyor's multiple inquiries for reportable events, accidents, incidents, and grievances regarding Resident #145, they began to ask facility staff if they were aware of any other incidents that were not provided to the surveyor. The LNHA stated that the Social Worker (SW) looked through her emails and found two emails, both dated 8/7/24, one was from Resident #145 and the second from the Resident's Representative (RR). The emails both included grievances and an accusation of verbal abuse from an unnamed nurse at the facility towards the resident. The LNHA stated that the email was just found in the SW's spam/junk folder after surveyor inquiry. The LNHA acknowledged that the allegation was absolutely considered verbal abuse, and stated that the facility started an investigation into the matter which included attempting to reach out to the resident who no longer resided at the facility. On 1/9/25 at 9:58 AM, the surveyor reviewed Resident #145's medical record. A review of the resident's Transfer/Discharge Report indicated that the resident was admitted to the facility with diagnoses which included but were not limited to; chronic obstructive pulmonary disease (COPD), need for assistance with personal care, and chronic pain. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 7/31/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the resident was cognitively intact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 11:46 AM, the surveyor interviewed the LNHA, who stated when an allegation of abuse or grievance was reported to the facility by a resident or their representative, it was brought to the attention of the administration team. The LNHA continued if a particular person or staff member was named, then that staff member was suspended pending investigation. The LNHA stated that investigations should be completed and closed out in five days or sooner. The LNHA stated she was unsure as to why or how the emailed grievance/allegation was sent to the spam/junk folder and the facility's information technology (IT) department needed to investigate it. On 1/9/25 at 1:01 PM, the Regional Director of Operations (RDO), in the presence of the survey team, acknowledged the delay in investigating this accusation of abuse and stated, we agree that the system inhibited the ability to respond to the complaint/allegation. On 1/10/25 at 10:22 AM, the LNHA acknowledged to the surveyor, in the presence of the survey team, that the allegation of abuse that was emailed on 8/7/24, was just being investigated and followed up with now after surveyor inquiry. A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy dated revised April 2021, included .Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to; freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse and physical or chemical restraint not required to treat the resident's symptoms .the facility would .develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents .identify and investigate all possible incidents of abuse, neglect, mistreatment or misappropriation of resident property . NJAC 8:39-4.1(a)5

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint NJ #: 173483 Based on interview, medical record review, and review of other pertinent facility documentation, it was determined that the facility failed to obtain admission diet orders for a resident identified as a nutritional risk. This deficient practice was identified for 1 of 19 residents reviewed for physician's orders (Resident #146), and was evidenced by the following: A review of the admission Record face sheet (an admission summary) indicated that Resident #146 was admitted to the facility with the diagnoses which included but was not limited to; malignant neoplasm of the urethra (cancer of the tube that carries urine out of the body), absence of the left upper arm limb (left upper arm (LUA) amputation), and right left below the knee amputation (BKA). A review of the admission Screener (AS) dated 4/24/24, reflected that Resident #146 required assistance with activities of daily living (ADLs) and was confined to the wheelchair. The AS also reflected that the resident had a pressure ulcer located on the coccyx area. A review of the Minimum Data Set (MDS), an assessment tool, was not required to be completed for the resident. The resident resided in the facility for eight days in 2024. A review of the Physician's Order Report (POR) revealed that Resident #146 did not have a diet order. A review of the admission Nutritional Risk Assessment (ANRA) dated 4/26/24 at 10:31 AM, reflected that the Registered Dietitian (RD) assessed Resident #146 as new admission to facility after a hospitalization related to percutaneous endoscopic gastrostomy (PEG; an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall) removal, a wound infection of the left foot, right BKA and LUE amputation at elbow, and stage two pressure ulcer of the coccyx (tailbone). The ANRA reflected that Resident #146 was at risk for malnutrition related to altered skin integrity, underweight body mass index (BMI; calculation of weight to height), multiple amputations, with need for a therapeutic diet and supplementation. The ARNA dated 4/26/24, indicated that Resident #146 had a pressure injury noted to coccyx on admission (stage II per hospital records) and diet was to include double protein with meals. Recommendations included to: provide diet as ordered of regular, regular textures, thin liquids, double portions; provide Ensure Plus eight ounces (8 oz) every day and monitor future tolerance/acceptance; monitor future wound reports, update to resident skin integrity; monitor resident intake, weight trends, signs and symptoms of aspiration, gastrointestinal regularity, and glycemic control; monitor resident fluid/hydration status, updated lab values, updated food preferences; provide additional assistance with meals and supplements as needed. The ANRA revealed a discrepancy related to whether the resident was to have double protein diet or a double portion diet and a diet was not prescribed by a physician on admission to the facility. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #146's individualized comprehensive care plan (ICCP) initiated on 4/26/24, reflected that the resident had the potential for nutritional problems related to hypertension, pancreatitis, PEG removal and amputations and had a need for a therapeutic diet with supplementation. Interventions included to provide a regular diet, regular textures, thin liquids with double protein. This diet was not ordered when the resident was admitted to the facility. On 1/9/25 at 9:06 AM, the surveyor interviewed the RD, who stated that she had been working in the facility for approximately five months and did not know the resident. At that time, the RD reviewed Resident #146's electronic medical record (EMR) and confirmed that a diet was not ordered for Resident #146 at the time the resident was admitted to the facility. The RD stated that the nursing department was responsible to obtain the physician's order for Resident #146's diet on admission and explained that the importance of obtaining a physician's order was so the resident received a food tray in accordance with their diet orders from the hospital records. The RD also stated that it was important to have admission diet orders to assure that the resident received a therapeutic diet with the right texture and consistency to ensure safety. The RD reviewed the ANRA dated 4/26/24, and confirmed that the resident should have received double portions of protein for wound healing, however the recommendation documented on the nutritional risk assessment dated [DATE], indicated Resident #146 was to receive double portions of the entire meal. The RD stated that the previous dietician must have made an error in documentation and that according to the resident's tray ticket, Resident #146 was provided with the correct double protein diet. The surveyor reviewed Resident #146's food tray ticket dated 4/24/24, which indicated that the resident received a double meat diet, however a diet was not prescribed for the resident on admission to the facility. On 1/9/25 at 10:37 AM, the surveyor interviewed the Licensed Practical/Nurse Unit Manager (LPN/UM), who explained the admission process to the surveyor and stated that admission orders were to include diagnoses, the correct diet with consistencies of diet, texture of diet or if the resident was on a therapeutic diet, allergies, medications, labs, and treatments. At that time, the LPN/UM reviewed Resident #146's admission orders and confirmed that a diet was not ordered for the resident on admission. On 1/9/25 at 10:50 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated that admission orders included: weights, medications, treatments, diet, skin checks, bath, and shower orders. The ADON stated that it was important to put a diet order from the physician in the EMR to ensure the resident received the correct therapeutic diet with proper texture and consistency to ensure that the resident was safe. The ADON stated that when the diet was ordered, the nurse completed a diet slip and gave it to the kitchen but must have forgotten to write the diet in the physician's orders. The ADON stated that the kitchen had a different computer system and they inputted the diet into their system so that the resident received the tray with the correct diet even though there was not a physician's order for the resident's diet. The ADON confirmed that the staff did not obtain a diet order for Resident #146 on admission to the facility. On 1/10/25 at 10:30 AM, the surveyor interviewed the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) who both confirmed that residents' diet orders were required at the time of admission. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review the facility's undated Diet Order Policy included that upon admission, the resident's diet will be updated by the nursing staff based on hospital recommendations .the dietician and speech pathologist may review the recommended diet order upon admission to ensure that it is appropriate and if adjustments were to be made, the physician would be notified to approve or disapprove of the recommendations and changes to the diet would be made to the diet order following documentation in the electronic medical record (EMR) . NJAC 8:39-11.2 (a), 27.1(a)