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	05/07/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #2790808Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) ensure a Registered Nurse (RN) immediately assessed a resident who had fallen and complained of pain. On [DATE], Resident #3 had an unwitnessed fall. The Licensed Practical Nurse (LPN #1) responded to the fall and did not call an RN to assess the resident. The resident complained of pain and was transferred back to bed by two Certified Nursing Assistants (CNAs). On [DATE], 4 days later, the resident was transferred to the emergency room (ER) for an unrelated medical concern and was diagnosed with a right hip fracture. The facility further failed to b.) ensure that a resident (Resident #10) who experienced an acute change and decline in their medical condition was properly assessed and treated in a timely manner. This deficient practice was identified for 2 of 2 residents (Resident #3 and Resident #10) reviewed for quality of care and was evidenced by the following:Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1.) On [DATE] at 10:48 AM, during the initial tour of the facility, the surveyor observed Resident #3 in the activities room on the second floor. The resident was seated on a recliner with a mechanical lift pad beneath their back. The surveyor observed the resident's right arm to be flexed at the wrist and elbow areas and the resident's right hand rested on their right collar bone. The resident was speaking to other residents who were seated at their table. On [DATE] at 9:39 AM, the surveyor observed the resident in bed with no fall mat on either side of the bed. Their right forearm was flexed at the elbow and wrist with the resident's right hand resting on their right collar bone. The resident's feet were observed to be pointing outward. On that same date and time, the surveyor interviewed the resident who stated that they fell in the facility three times, with one fall that resulted with them hurting their right knee. The resident showed the surveyor how they grabbed the left grab bar on the bed with their left arm to pull themselves up in (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	bed, but ended up sliding to the floor on the left side of the bed, falling on their face, and hurting their right knee. The resident stated that they were alone when the incident occurred. The resident stated that CNA #2 came to check on them and called the unit nurse. The resident further stated that CNA #2 picked them up and denied that they were transferred to bed from the floor by mechanical lift. The resident stated that they were already in bed when the nurse came to take their BP (blood pressure). The resident stated that they experienced pain on the right knee including the right hamstring area when they fell. The resident stated that only one nurse came to check on the resident after the fall. The surveyor reviewed the medical record for Resident #3. A review of the admission Record (an admission summary), reflected that Resident #3 was readmitted to the facility with diagnoses which included but were not limited to the following: fracture of the right femur, suicidal ideations, and quadriplegia (paralysis of both arms and legs). A review of the most current quarterly Minimum Data Set (MDS), an assessment tool dated [DATE], reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the resident's behavioral symptoms did not reveal any rejection of care. A review of the resident's functional limitation in the range of motion reflected the resident had an upper extremity (shoulder, elbow, wrist, hand) impairment to one side. The lower extremity (hip, knee, ankle, foot) was coded 0 or no impairment. A review of the resident's functional abilities in the MDS reflected that the resident was dependent on staff for all their activities of daily living including transfers to and from bed to chair and vice versa. Being dependent on transfers means that the assistance of 2 or more helpers is required for the resident to complete the activity. A review of the resident's health conditions did not capture the resident's fall on [DATE], when the resident sustained a fracture of the right hip. A review of the individual comprehensive care plan (ICCP) included a focus area for risk of falls related to limited mobility and seizures created on [DATE]. The interventions included the following: Fall mat(s) to (Specify: Right, Left, Both) side(s) of the bed at all times when the resident is in bed initiated on [DATE]. The ICCP also specified that the resident transfers with assistance from 2 (two) staff members. A review of the Order Summary Report (OSR) active as of [DATE], revealed the following physician orders: Acetaminophen Tablet 325 mg. Give 2 tablets by mouth every 6 hours as needed for general discomfort for total dose of 650mg. Do not exceed 3 grams per 24 hours started on [DATE] and discontinued on [DATE], S/P (status post) fall documentation x (for) 72 hours every shift for s/p fall for 3 Days, shift note regarding fall, VS (vital signs) per shift, neuro checks every shift started on [DATE]. A review of the corresponding Medication Administration Record (MAR) in February 2026, revealed that the resident was maintained with zero pain level except on the following dates when acetaminophen 650 mg was administered to them: on [DATE] at 4:00 PM for pain level of 3/10, on [DATE] at 5:00 PM for pain level of 3/10, and on [DATE] at 12:27 AM for pain level of 4/10. The MAR also reflected that the resident refused their day shift medications on [DATE], prior to the fall. A review of the Progress Notes (PN) revealed on [DATE] at 2:53 PM, LPN #3 documented that the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	resident refused all their morning medications. At 3:32 PM, the nurse documented that the resident's physician was contacted because of the resident's refusal of medications and a urine output of 100 cc (cubic centimeter) on the day shift. The physician gave a telephone order to rehydrate the resident with intravenous (IV) fluid and laboratory work ups to include CBC/ CMP (Complete Blood Count [a blood test that measures the type and number of cells in the blood] / Comprehensive Metabolic Panel [a blood test that measures different substances in the liver and kidney]) and urinalysis with culture and sensitivity. A request for vascular access (a short-term access for fluid or medication through insertion of a tube in the artery or vein) was placed with [name of service redacted]. Further review of the PN revealed that on [DATE] at 3:30 PM, LPN #4 documented that the resident had an unwitnessed fall. LPN #4 checked the resident's vital signs, evaluated their skin and pain level, administered acetaminophen 650 mg by mouth for mild pain, 3/10, initiated neurological checks, placed the bed in the lowest position, placed the call bell within reach of the resident, and notified the resident's physician. LPN #4 also completed the fall risk evaluation, skin check, and pain evaluation forms in the EMR (electronic medical record). There was no documentation to indicate that an RN assessed the resident or range of motion was assessed and compared to the resident's baseline. There were no documented routine assessments for the resident's neurological status to include the level of consciousness, pupillary response, motor strength, speech pattern, facial symmetry that were assessed and performed on a scheduled basis within the PN. Further review of the PN revealed a health status note from Resident #3's physician entered on [DATE] at 9:38 AM, with a specified Date of Service on [DATE], did not include any reference to the resident's fall on [DATE]. A review of the progress notes after the resident's fall revealed that on [DATE], the resident verbalized to the staff that they were going to kill themselves if their family members would not be in the facility in 5 minutes. The resident was transferred to the hospital for further evaluation which showed an acute impacted fracture of the right hip. The resident was managed conservatively without surgical intervention since the resident was bedbound. The resident was readmitted to the facility on [DATE]. A review of a Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) on [DATE] revealed that on [DATE], the resident was transferred to the emergency room for behaviors and upon assessment was diagnosed with a right hip fracture. A review of the facility's undated investigation concluded that the resident sustained the hip fracture from the fall on [DATE], which went undetected because of the resident's comorbidities. Abuse was ruled out. A review of the facility nursing schedule on [DATE], revealed there were two RNs (RN #1, RN #2) present in the facility on the day shift at the time of the resident's fall. On [DATE] at 11:45 AM, the surveyor conducted a telephone interview with CNA #2 who stated that on [DATE], the resident threw themselves on the floor. The surveyor asked CNA #2 if they transferred the resident back to bed from the floor. CNA #2 stated that the resident was already in bed. CNA #2 told the surveyor that they wrote a statement regarding the fall. A review of the CNA #2's statement revealed that she put the resident back to bed after the nurse checked the resident's vital signs. On [DATE] at 9:18 AM, the surveyor conducted a telephone interview with Resident #3's physician (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	who stated that on [DATE], they received text messages from LPN #4 and LPN #3 regarding the resident's refusal of medications, decreased urine output and ordered IV fluids and urinalysis with culture and sensitivity tests. The physician stated they also received a message at 4:00 PM, that the resident rolled out of bed. The physician stated that it was their medical judgement not to order a radiology exam. On [DATE] at 9:31 AM, the surveyor attempted to conduct a telephone interview with LPN #3 but was unable to. On [DATE] at 12:38 PM, the surveyor interviewed RN #1 who stated that LPNs and RNs assess residents who fall in the facility. RN #1 confirmed that they did not assess Resident #3 on [DATE]. On [DATE] at 12:39 PM, the surveyor interviewed CNA #4 who stated that it was the facility protocol to call for help when a resident falls. On [DATE] at 3:31 PM, the surveyor conducted a telephone interview with LPN #4 who stated that they assessed Resident #3's vital signs, skin for redness and swelling, and for pain. The LPN also stated that they witnessed CNA #2 and CNA #3 picked up the resident from the floor. The surveyor asked LPN #4 whether they had seen the CNAs use the mechanical lift to transfer the resident. LPN #4 stated that they had not seen the CNAs use the lift to transfer the resident to bed. LPN #4 stated they did not call another nurse or an RN to assess the resident post fall. A review of LPN #4's written statement on [DATE], revealed that the resident was placed in bed by the CNAs. On [DATE] at 4:21 PM, the surveyor conducted a telephone interview with RN #2 who stated that they worked in the facility during the day shift of [DATE] on second floor. RN #2 stated that they were not called to assess Resident #'3's fall during their shift. RN #2 stated that the facility protocol was for LPNs and RNs to assess the residents who fell. On [DATE] at 10:36 AM, the surveyor interviewed the Director of Nursing (DON) who stated that LPNs can assess the residents who fall if there were no RNs in the building. When the RNs come in, then they could assess the residents at that time. A review of the facility policy revised in [DATE], titled Fall – Clinical Protocol indicated under Assessment and Recognition the following: 2) In addition, the nurse shall assess and document/ report the following: a. Vital signs; b. Recent injury, especially fracture or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc. d. Change in condition or level of consciousness; e. Neurological status; f. Pain; g. Frequency and number of falls since last physician visit; h. Precipitating factors, details on how fall occurred; i. All current medications, especially those associated with dizziness or lethargy, and j. All active diagnosis. 4) The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications associated with increased falling risk) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant). Part 2 2.) On [DATE] at 9:42 AM, Surveyor #2 reviewed the closed record of Resident #10. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the admission Record (an admission summary), revealed that the resident was admitted to the facility with diagnoses which included but were not limited to: acute respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues), heart failure, unspecified, other gram-negative sepsis (a severe, systemic infection characterized by an sudden onset of symptoms such as fever and chills, and requires prompt diagnosis and treatment), and Extended Spectrum Beta Lactamase (ESBL) Resistance (Enterobacterales (a group of bacteria that are resistant to most antibiotics), difficulty in walking, and presence of other cardiac implants and grafts. A review of the comprehensive Minimum Data Set (MDS), dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS revealed that the resident had active diagnoses which included septicemia (blood poisoning, caused by bacteria and their toxins) and Multidrug-Resistant Organism (MDRO, bacteria that are resistant to at least three families of antibiotics). A review of the resident's individual comprehensive care plan (ICCP) included a focus area with a cancelled date of [DATE], which indicated the resident was at risk for respiratory complications r/t (related to) COPD (Chronic Obstructive Pulmonary Disease, a condition involving constriction of the airways and difficulty or discomfort in breathing). The Goal included: My risk for respiratory complications and infections will be mitigated (making something bad less severe) through the review date. Interventions included: Monitor vital signs, including oxygen saturation, as ordered an/or clinically indicated. Report abnormal findings to the practitioner. Document findings and interventions. Further review of the ICCP included a focus area with a cancelled date of [DATE], which indicated the resident Required supplemental oxygen r/t COPD. Goals included: I will remain free of symptoms and complications of low oxygen levels, such as shortness of breath, dizziness, tachycardia (rapid heart rate above 100), headache through review date. Interventions included: Monitor vital signs, including pulse oximeter (a probe placed on the index finger to measure the amount of circulating oxygen levels in the blood), as ordered and clinically RN (Registered Nurse) Licensed Practical Nurse (LPN) indicated. Report abnormal findings to practitioner. Document findings and interventions. Further review of the ICCP included a focus area with a cancelled date of [DATE], which indicated the resident had an indwelling urinary catheter r/t BPH, benign prostatic hyperplasia (BPH, a condition in men related to an enlarged prostate (a gland surrounding the neck of the bladder). Interventions included: Monitor for signs and symptoms of UTI (urinary tract infection) such as .fever, chills, altered mental status, change in behavior .Report abnormal findings to Practitioner; Document findings and interventions. A review of the Order Summary Report including the following Physician's Order (PO): A PO, dated [DATE], for DNR (Do Not Resuscitate) (revive). A PO, dated [DATE], for DNI (Do Not Intubate) (a life-saving procedure to keep your airway open). A review of the electronic medical record (EMR) revealed a Health Status Note (HSN) effective on [DATE] at 00:56 AM (12:56 AM) that was written by Licensed Practical Nurse (LPN # 5) included the following: Upon doing round [sic] at 11:30pm, found resident in bed shaking very seriously, obtain vital sign bp (blood pressure) was 165/111, HR (heart rate) 111, R (respirations) 24, temp 98.7, unable to obtain oxygen saturation, slightly unconscious, not responding to verbal commands as usual, after (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	one and half hour recheck vitals with another nurse, reading obtain [sic] bp 150/79, HR 110, temp 98.7, still unable to read oxygen saturation, call placed to MD (Medical Doctor) to relayed [sic] pt condition unable to reach him, 911 call and relayed pt condition, he/she was pick up at 12:50 am will continue to follow up with pt while sent to hospital for further evaluation. Further review of the EMR revealed a Health Status Note with an effective date of [DATE] at 1:25 (AM) revealed, Doctor [name redacted] call back at 1:15 am, and ordered to send pt out to ER for evaluation. Further review of the EMR revealed a HSN with an effective date of [DATE] at 15:14 (3:14 PM) that was written by the Director of Nursing (DON) included: Pt admitted to [hospital name redacted] for sepsis. On [DATE] at 10:38 AM, the surveyor phoned LPN # 5 in the presence of the survey team and conducted an interview via speakerphone with her permission. The surveyor reviewed the HSN dated [DATE] at 12:56 AM aloud with LPN #5. LPN #5 stated that she had taken the resident's vital signs and her supervisor, was there. LPN #5 was unable to state the name of the supervisor when asked and the documentation within the resident's EMR did not indicate the presence of a nurse supervisor. LPN #5 stated that she called the MD and received no response, so we decided to call 911. LPN #5 stated that she returned to the resident's room with a Registered Nurse (RN #3), who was another nurse on the unit, and we rechecked the resident's vital signs. LPN #5 stated that the resident's hands were cold, and the pulse oximeter could not read the resident's oxygen level reading. LPN #5 stated that we called 911 and they said that they were coming. When the surveyor asked LPN #5 why she had waited one and a half hours to recheck the resident's vital signs with another nurse after she documented that at 11:30 PM, she found the resident shaking very seriously, slightly unconscious, not responding to verbal commands, unable to obtain oxygen saturation, with a blood pressure reading of 165/111, HR 111, R 24? LPN #5 stated that she could not remember the time frames. LPN #5 stated that the second time that she went to see the resident the resident had stopped shaking. When the surveyor asked LPN #5 if the resident resumed consciousness at any point she stated, Yes, the resident came around before 911 came. When the surveyor asked LPN #5 if she had ever received any education or training related to sepsis she stated, No. On [DATE] at 12:48 PM, the surveyor attempted to reach interview RN #3 via telephone, but was unable to reach her. On [DATE] at 9:32 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #2) who stated that Resident #10 should have been placed on oxygen immediately, and a code should have been called to the resident's room because the more hands to care for the resident, the better. LPN/UM #2 stated that if LPN #5 could not get a pulse oximetry reading on the resident, the resident should have been sent out via 911 and then called the physician. LPN/UM #2 stated that a nurse should have remained with the resident as the resident could have become unresponsive. LPN/UM #2 stated that the resident's first set of vital sighs were very high and she should not have waited. LPN/UM #2 stated that the blood pressure (BP) was very elevated ate 165/111, and heart rate was elevated at 111, and respirations were 24, all signs and symptoms of possible sepsis or stroke. LPN/UM #2 stated that a code should have been called and all nurses and the RN should have responded. LPN/UM #2 stated that she could not tell if a code were called or if the resident were assessed by an RN from the Progress Note that LPN #5 had written because her note just indicated that she brought another nurse in, but it did not say if it were an RN or not. LPN/UM #2 stated the facility did have a sepsis protocol and she was educated regarding the protocol upon hire. (continued on next page)

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