STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Atlantic Coast Rehab & Health		STREET ADDRESS, CITY, STATE, ZIP CODE 485 River Ave Lakewood, NJ 08701	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews, record reviews and a review of pertinent facility documentation, it was determined that the facility failed to a) ensure that a resident was protected from alleged abuse by a Certified Nursing Assistant (CNA) #1, and b) failed to implement facility's abuse policy when they became aware of an allegation that CNA #1 pushed the resident knocking them to the floor on 12/11/25. According to an undated document titled reference 12/11/25, which the facility provided to the surveyor, on 12/12/25, the facility administration reviewed video footage and statements from CNA #1 and LPN #1; and after the review, the Interdisciplinary Team (IDT) agreed to obtain formal statements about the incident from both Residents #1 and #2. The document stated that LPN #1 was alerted by the noise coming from Resident #2's room and went to the room, where she saw Resident #1 grabbing CNA #1. The document further stated that when LPN #1 could not de-escalate the situation, she left the room; upon her return, she found CNA #1 still in the room; and that she saw Resident #1 getting up off the floor. The document stated that the resident called 911 to be transported to the hospital for documentation of injuries they received post assault by CNA #1. The document further stated that the facility was aware of the resident's mental health history and that there is no merit to Resident #1's accusatory statement toward CNA #1, and that they asked the CNA to return to her scheduled shift. On 3/3/26, the facility provided the surveyor with email communications dated between 12/15/25 and 1/29/26 that Resident #1 sent to the Director of Social Services and to LNHA, in which the resident complained about the 12/11/25 incident. The email communications included, but were not limited to, the following: -12/15/25 at 8:30 AM, Resident #1 wrote CNA #1 assaulted me in Resident #2's room.-1/10/26 at 10:22 AM, . Resident #1 wrote Nothing about CNA #1's assault on me on 12/11 .that is so disrespectful and cruel .I need your help to exit this .facility .because you don't want residents that hold you accountably [accountable] .-1/29/26 . Resident #1 wrote, I was assaulted by [CNA #1], you took the word of the 'assailant over mine . These email communications showed that on 12/15/25, the resident informed the facility of an alleged abuse by CNA #1. The facility did not obtain statements from other staff members besides the alleged perpetrator, LPN #1, and the Nursing Supervisor. The facility did not interview or obtain statements from other residents on CNA #1's assignment. The facility allowed CNA #1 to continue working and had access to other residents before a full investigation was conducted. The facility also allowed CNA #1 to return Resident #1's unit despite the resident's repeated verbalization of angry feelings when they saw the CNA on their unit. The facility's failure to protect Resident #1 from alleged abuse posed a likelihood that serious injury, harm, impairment, or death could occur to residents and resulted in immediate jeopardy (IJ). The IJ began on 12/15/25 at 8:30 AM, when the facility failed to remove CNA #1 from all residents' care after Resident #1 notified both LNHA and the Director of Social Services that CNA #1 assaulted them. The facility was notified of the IJ on 3/5/26 at 2:15 PM. The facility submitted an acceptable Removal Plan (RP) on 3/10/26 at 11:21 AM. The survey team verified the implementation of the RP during the onsite survey and determined that the IJ was removed as of 3/11/26 at 3:32 PM. The evidence was as follows: The facility's policy titled Resident Abuse/Neglect Policy and Procedure indicated that the facility will not condone the abuse (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	and neglect of any resident by anyone, including but not limited to, staff members. It further revealed under the heading of Protection, investigating and Reporting that Employees of the facility who are under investigation will be temporarily suspended until the Administrator has reviewed the results of the investigation.A review of the admission Record (AR) revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to Bipolar Disorder, Anxiety Disorder, and Major Depressive Disorder.According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 2/6/26, the resident has a Brief Interview Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was cognitively intact.A review of Behavior Note written by the Licensed Practical Nurse (LPN) #1 dated 12/11/25 at 6:45 PM, revealed that LPN #1 observed Resident #1 enter Resident #2's room and shortly after, the LPN heard yelling in Resident #2's room. The note stated that when LPN #1 went into Resident #2's room to see what was going on, she saw Resident #1 yelling and grabbing onto CNA #1's left upper arm. The Behavior Note stated that LPN #1 then asked Resident #1 to leave CNA #1 alone, but the resident continued to shout at the CNA up close to the CNA's face. LPN #1 further stated that she left Resident #2's room, notified the Nursing Supervisor, and called 911.A review of the emergency department's after visit summary dated 12/11/25 indicated that the reason for the resident's visit was battery and the diagnosis was abrasion of left upper extremity.On 3/3/26, the surveyor requested all investigation documents and witness statements related to the incident.According to the employee statement from CNA #1, she stated that the resident grabbed her in an aggressive manner to cause physical harm, but that she did not assault the resident.A review of LPN #1's statement dated 12/11/25 stated that she heard yelling in resident #2's room, she went into the room and witnessed Resident #1 grabbing CNA#1's left upper arm, and that she told the resident to stop; and that she exited the room to call 911 and to notify the nursing supervisor.The facility did not provide documented evidence that they had interviewed other residents who were usually on CNA #1's assignment until after the surveyor's inquiry on 3/3/26. The facility also did not obtain statements from other staff members besides the alleged perpetrator, LPN #1, and the Nursing Supervisor.The facility allowed CNA #1 to continue working with other residents, which allowed her access to other residents before a thorough investigation of the incident was completed.A review of CNA #1's assignment dated 12/11/25 revealed that CNA #1 continued to care for other residents before the facility conducted an investigation of the abuse allegation. CNA #1 also continues to work on Resident #1's unit despite the facility's admission; the resident still expresses anger when they see CNA #1 on their unit.A review of CNA #1's assignment revealed the following:On 12/11/25, evening shift on the Behavior Unit (Resident #1's unit).On 12/12/25, evening shift on the Long-Term Care Unit.On 12/15/25, evening shift on the Behavior Unit (Resident #1's unit).On 12/17/25, evening shift on the Behavior Unit (Resident #1's unit).On 12/18/25, evening shift on the Behavior Unit (Resident #1's unit).A review of the payroll documentation for CNA#1 revealed the following:12/11/25 arrived at 3:10 PM and departed at 11:03 PM.12/12/25 arrived at 2:54 PM and departed at 11:00 PM.12/15/25 arrived at 3:07 PM and departed at 10:56 PM.12/16/25 arrived at 2:54 PM and departed at 10:58 PM.12/17/25 arrived at 2:52PM and departed at 11:16PM.12/18/25 arrived at 2:56 PM and departed at 6:56 AM.On 3/3/26 at 10:40 AM, the surveyor interviewed Resident #1, who stated that they heard their friend (Resident #2) yelling out and crying and went to rescue them. Resident #1 further stated that as soon as they entered Resident #2's room, CNA #1 stated: what are you doing here? and that the CNA then grabbed both their arms and pushed them back and knocked them down. The resident told the surveyor that after they (the resident) got off the floor, they called 911, and that 2 police officers came to the facility. The resident further stated that they get upset when they see CNA #1 on the unit.On 3/3/26 at 1:43 PM, the surveyor attempted to interview Resident #2, but the resident could not remember any information about the 12/11/25 incident.On 3/3/26 at 11:18 AM during the interview, the Director of Social Services (DSS) stated that she interviewed Resident #1 regarding the incident and that there was something about the 12/11/26 incident that left [the resident] accusatory and volatile. The DSS further stated that the resident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	once told her that seeing CNA #1 gets them angry. When asked if the facility considered moving CNA #1 permanently to a different unit to accommodate Resident #1's feelings of anger, the DSS stated that if the facility moved staff out based on Resident #1's accusations, there would be no one left.On 3/3/26 at 11:00 AM, during an interview with the Licensed Nursing Home Administrator (LNHA), he stated that Resident #1 would not stop talking about the 12/11/26 incident. When the surveyor asked why CNA #1 continues to work on the unit where Resident #1 resides, despite the resident's continued feeling of anger when they see CNA #1 on the unit, the LNHA stated that they gave CNA #1 the option of returning to the same unit, and that the CNA has rights too.On 3/3/26 at 2:50 PM, the surveyor interviewed the ADON, who revealed that the resident had aggressive behavior and that Resident #1 is explosive. She further stated that CNA #1 was transferred off Resident 1#'s unit but not from the facility. She further stated that Resident #1 had a history of behaviors attacking staff. When asked why the facility did not follow their abuse allegation policy, the ADON stated that if the incident was with another resident, the process of investigation would have been different.On 3/3/26 at 4:39PM, the surveyor interviewed the Regional Nurse, who stated for an incident of abuse, we follow the abuse policy.However, the facility did not provide an explanation for why they did not implement their abuse policy when they became aware of the resident's allegation of abuse.An acceptable Removal plan (RP) was received on 3/10/26 at 11:21 AM, indicating the action the facility will take to prevent serious harm from occurring and recurring. The facility implemented a corrective action plan to remediate the deficient practice, to include: Resident #1, who appears to have no ill effect from this alleged incident; Resident #1 had a follow up consultation on 12/15/25 with the Statewide Clinical Outreach Program for the Elderly (S-COPE); ADON conducted Abuse policy re-education post incident for nursing staff on 12/15/25. On 3/5/26, the Administrator and the ADON were re-educated on the Abuse Policy and Procedure and Federal deficiency F600 (free from abuse and neglect) by the [NAME] President of Clinical Services. On 3/5/26, the ADON and the Regional Nurse Consultant provided 1:1 re-education on Abuse Policy to the Registered Nurse Supervisor involved in the 12/11/25 incident. On 3/5/26, ADON began facility-wide education for all staff on Abuse Policy, to protect all residents from abuse. On 3/5/26, unit managers and Nursing Supervisors were re-educated by ADON on Abuse Policy and the requirement to report. On 3/9/26, the Social Worker conducted additional interviews on the two units assigned to the CNA; no new findings were identified.The surveyor verified the implementation of the RP on site and determined that the immediacy was removed as of 3/11/26 at 3:32 PM.

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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. Based on interviews, medical record reviews, and review of pertinent facility documents on 3/5/26 and 3/11/26, it was determined that the facility failed to report to the New Jersey Department of Health an allegation of physical abuse that occurred on 12/11/25, after the resident notified staff that a Certified Nursing Assistant pushed them and knocked them down. This deficient practice was identified for 1 of 4 residents reviewed (Resident #1). Findings Include:According to the admission Record (AR), Resident #1 was admitted to the facility with diagnose that included but were not limited to Bipolar Disorder, Anxiety Disorder, and Major Depressive Disorder. According to the comprehensive Minimum Data Set (MDS), an assessment tool, dated 2/6/26, Resident #1 had a Brief Interview Mental Status score of 15 out of 15, indicated that the resident was cognitively intact. A Behavior Note dated 12/11/25 at 6:45 PM included that a Licensed Practical Nurse (LPN) #1 heard yelling and shouting in Resident #2's room, where CNA #1 was providing care to Resident #2. The note further stated that when LPN #1 went into the room, she witnessed Resident #1 grabbing Certified Nursing Assistant (CNA) #1's arm; and that the LPN exited the room to call 911 and to notify the nursing supervisor. A review of a summary of the event document titled Reference 12/11/25, which was provided by the facility, revealed that Resident #1 called 911 and asked to be transported to the hospital to document the injuries they sustained after being physically assaulted . by CNA #1. The Emergency department After Visit Summary showed that the resident was treated for an abrasion of the left upper arm and received an injection of the Tetanus, Diphtheria, Pertussis vaccine (Tdap). A review of the Nursing Supervisor's witness statement dated 12/12/25 revealed that she was made aware of an incident that occurred between Resident #1 and CNA #1. Review of a document titled One - One Inservice dated 12/12/25, revealed that the facility provided in-service for staff on Abuse and Neglect policies and procedures training following the 12/11/25 incident, but there is no evidence that the facility notified NJDOH of the abuse allegation. A review of the facility's in-service for staff dated 12/15/25, titled As per [Facility Name] resident abuse/neglect policy and procedure, revealed that nursing staff were educated on the facility's abuse policy, but there is no evidence that the facility reported it to the New Jersey Department of Health. On 3/3/26 at 2:50 PM surveyor interviewed the Assistant Director of Nursing (ADON), who stated that the facility would notify Department of Health for alleged abuse, major injury, staff to resident abuse, the ADON further stated that she was not involved in the investigation of the 12/11/25 incident between Resident #1 and CNA #1; and that she believed the incident was considered a resident to staff incident, and not considered a staff - to - resident allegation. NJAC 8:39-9.4(f)