STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 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

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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50919 Complaint # NJ178530 Based on interviews, medical record review, and review of other pertinent facility documentation on 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 physical abuse for a resident (Resident #1), b) used a physical hold restraint for a resident (Resident #1) with a known history of physically aggressive behaviors towards others and diagnoses of Traumatic Brain Injury, Impulse Disorder, and Schizoaffective Disorder. On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 on the floor in the hallway with CNA #2 and the Smoking Monitor (SM) hitting 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 a loud bang and yelling in the hallway. LPN #1 responded to the hallway and saw Resident #1 laying on the floor in the hallway yelling please stop, get them off of me. LPN #1 stated she observed CNA #2 kicking Resident #1 and the SM hitting Resident #1 with his fist. LPN #1 told both staff members (CNA #2 and SM) to stop and to get off the resident. LPN#1 stated CNA #2 and the SM did not immediately stop and get off the resident. She had to repeat the request. LPN#1 stated the SM said, Its ok we are told to do this. LPN #1 stated she assisted Resident #1 off the floor to the nursing station and immediately reported the incident to the Assistant Director of Nursing (ADON). CNA #2 and the SM went down to the other side of the hallway and passed the lunch trays. The Social Worker (SW#1) stated the ADON got her to come to the unit. SW #1 stated Resident #1 was yelling They just beat the [profanity] out of me. SW#1 stated while at the nursing station, she observed the resident's back when Resident #1 lifted his/her tee shirt. SW #1 reported the observation to the ADON. 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 back pain. During an interview with SW#1, she stated while Resident #1 stated oh my back while attempting to pick up food from off the floor. The ADON stated Resident #1 told her that he/she fell , and an order was obtained from the Medical Director to send Resident #1 to the hospital for a fall. On 10/14/2024, Resident #1 was admitted to the hospital with diagnoses of splenic laceration, subcapsular hematoma, and an active bleed. (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: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Lakeside Blvd Bayville, NJ 08721	

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	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 Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and ADON. The LNHA, DON, and ADON were presented with the IJ template. The IJ began on 10/14/2024 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 SW 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 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 no longer at the facility, CNA #2 and the SM no longer work at the facility, and all facility staff have been re-educated on 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 with a report date of 10/15/2024, Resident #1 was upset while in his/her room and threw an overbed tray table at a staff member outside of Resident #1's room on 10/14/2024. While throwing the overbed tray table, Resident #1 lost balance and fell to the floor. While on the floor, Resident #1 continued to be a danger to the staff and others. Staff attempted to subdue Resident #1 by using gentle resistance while on the floor. 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 beaten up by two staff members. The police department notified the facility on 10/15/2024 of Resident #1's allegation. According to the FRE, a full investigation was initiated on 10/15/2024. Both staff members were suspended pending an investigation on 10/15/2024. According to the facility's document titled Summary of Investigation with a date reported of 10/15/2024 under Summary, Resident #1 sustained injuries when he/she fell on top of the overbed tray table while trying to continue an attack on the staff member. Resident #1 had a history of aggression towards others and staff were protecting residents and themselves while trying to keep Resident #1 from continuing aggression. The staff were concerned for everyone's safety and tried to keep Resident #1 down on the floor to avoid Resident #1 from hurting others. They were too aggressive while trying to keep Resident #1 down to prevent further aggression from Resident #1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [DATE], with diagnoses which included but were not limited to: Traumatic Brain Injury (a head injury causing damage to the brain), Impulse Disorder (an inability to control impulses and behaviors), and Schizoaffective Disorder (a chronic mental health condition that combines symptoms of psychosis with symptoms of mood disorders). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 395 Lakeside Blvd Bayville, NJ 08721	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the Admission Minimum Data Set (MDS), an assessment tool dated 08/09/2024, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. The MDS further indicated Resident #1 was on antipsychotic medications and had no behaviors that were exhibited towards others. According to the Discharge MDS dated [DATE], Section A, a discharge assessment indicated return anticipated. Section E revealed that Resident #1 had physical and behavioral symptoms directed toward others. A review of Resident #1's Care Plan (CP) initiated on 8/25/2024 revealed under Focus: Resident #1 is the aggressor in a physical altercation with peer related to poor impulse control. The Goal included Resident #1 will not harm others through the review date. Interventions initiated on 8/25/2024 included: When Resident #1 becomes agitated, intervene before agitation escalates. Guide away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. A review of Resident #1's Progress notes (PNs) dated 10/14/2024 at 2:24 PM written by the ADON revealed Resident #1 became upset while in the room and threw an overbed table at a staff member outside the room door. During the throwing of the overbed tray table, Resident #1 lost his/her balance and fell to the floor. While on the floor, Resident #1 continued to be a danger to the staff. Staff attempted to subdue Resident #1 using gentle resistance while on the floor. Resident #1 was given time to calm down before being assisted to a standing position. Resident #1 was taken off the unit with Social Services (SS) to further calm down. The Physician was informed of Resident #1's behaviors. An order was secured to send Resident #1 to the hospital for a behavioral evaluation and x-ray of the right hip and ribs. 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 transport via stretcher and taken to the emergency room (ER). A review of CNA#2 and the SM's personnel files revealed that both staff had training on abuse and how to deal with aggressive residents. During an interview with the surveyors on 10/22/2024 at 1:04 PM, CNA #1 stated that on 10/14/2024 at 11:58 AM, she walked out of the dayroom, heard a commotion, and observed Resident #1 on the floor in the hallway between Resident #1's room and the dayroom on his/her back. She observed CNA#2 and the SM hitting resident with their fists. 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 SM 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 aggressive at times but re-directable with a calm approach. CNA #1 stated she heard both CNA #2 and the SM tell LPN #1 that Resident #1 got upset because resident was told to wait to go out to smoke. (continued on next page)

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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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(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	During an interview with the surveyors on 10/22/2024 at 1:27 PM, LPN #1 stated she worked on 10/14/2024 and was assigned Resident #1. LPN #1 stated she was in the charting room speaking with the Speech therapist (ST) and heard a loud bang and yelling. LPN #1 stated the ST 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 the yelling was coming from and observed Resident #1 laying in the hallway in front of his/her room. LPN #1 stated she heard Resident #1 yelling please stop, get them off of me. LPN #1 further stated that the ST was behind her and stated, Oh my God, what are they doing to him? LPN #1 stated she observed CNA #2 kicking Resident #1 and the SM punching Resident #1. LPN #1 stated Resident #1 was laying on his/her side. LPN #1 stated she told CNA #2 and the SM to stop and get off the resident. CNA #2 and the SM did not immediately stop. She had to repeat the request to CNA#2 and the SM to stop hitting the resident. CNA #2 and the SM then stopped hitting the resident. LPN #1 further stated that the SM said, its ok, we are told to do this. LPN #1 did not state who told the SM that it was okay to hit and punch the resident. LPN #1 stated she assisted the resident off the floor to the nursing station and immediately reported the incident to the ADON. She stated that CNA #2 and the SM 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 SM were moved off the floor to the other units. LPN #1 stated SW#1 and the ADON 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 ADON went. LPN #1 further stated Resident #1 complained of pain all over and asked her to call the police because he/she wanted to press charges. LPN #1 stated SW#1 lifted Resident #1's tee shirt, and they both observed red marks on the resident's back. She stated that SW#1 told the ADON that the resident had red marks on their back. LPN #1 stated she asked the ADON 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 SM 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 SM left the unit after the overhead page. LPN #1 stated she received a call from the DON 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 DON's office. Upon her return to the unit, she received a phone call from the ADON stating that Resident #1 was going to the hospital. LPN#1 further stated that the ADON told her that Resident #1 and their roommate (Resident #4) were being moved to the seventh-floor unit. Resident #1 was not moved to the seventh 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 ADON. She took Resident #1's chart and the UTF to the seventh-floor unit and observed CNA #2 on that unit. LPN #1 stated she did not observe Resident #1 on the seventh-floor unit. She stated CNA #2 came to work on 10/15/2024, but the SM had called out. LPN #1 further stated that CNA #2 did not work on her unit on 10/15/2024. 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 12:00 PM on 10/14/2024 when she heard a commotion in the hallway. She came out from the dayroom and observed Resident #1 on the floor laying on his/her side. CNA #3 stated she observed the SM pinning down the resident on the floor and CNA #2 was standing there. CNA #3 further stated SW#1 and the ADON 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 SM passed out the lunch trays. CNA #3 stated she did not see CNA #2 and the SM on the unit after lunch but saw CNA #2 and the SM 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 10/15/2024 she saw CNA #2 on the fifth floor. (continued on next page)

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	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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(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	During an interview with the surveyors on 10/22/2024 at 4:06 PM, SW #1 stated she met the ADON by the elevators on 10/14/2024, and the ADON told her that Resident #1 was upset 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 yelling they just beat the [profanity] out of me. SW #1 stated Resident #1 pulled his/her tee shirt up and she observed red marks to the resident's back. She told the ADON about the red marks on the resident's back. 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 anxious, had excessive speech, and was agitated. SW #1 stated while Resident #1 was eating he/she dropped a piece of mashed potato on the floor, the resident attempted to pick up the mashed potato and stated, oh my back. She stated the resident was still in her office for approximately 45 minutes when she texted the LNHA to let her know the resident was still in her office. During an interview with the surveyors on 10/22/2024 at 4:47 PM, the ADON stated on 10/14/2024, I was told that Resident #1 was having some behaviors and took the over bed table and tried to hit the CNA. The ADON stated she did not know where the resident got the overbed tray table 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 throw the overbed tray table at the aide and the resident and the overbed table went down. The surveyor asked the ADON if LPN#1 made her aware of the abuse allegation and she stated, LPN#1 did not say anything else. The ADON stated that when she got to the unit, she did not see anyone on the floor but saw the overbed tray table broken in half. The ADON further stated she saw Resident #1 and he appeared angry, and she tried to get the resident somewhere quiet. She asked Resident #1 what happened with the overbed tray table, and the resident stated he/she fell . According to the ADON the resident refused an assessment. The ADON called the doctor and got an order to send Resident #1 to the hospital because the resident was on the floor. The ADON stated the reason for Resident #1's transfer to the hospital was because the resident complained of right leg pain, had agitation, and an x-ray was requested. The ADON was unsure of what time Resident #1 went to the hospital. During an interview with the surveyors on 10/22/2024 at 5:01 PM, the DON stated that LPN #1 told her Resident #1 was acting out. The DON stated that when she came to work on 10/15/2024 there were two police officers and a detective at the facility. The DON stated she was asked if she knew what happened to the resident. The DON stated she was asked by the police if she had heard that Resident #1 had been beaten up the day before and the DON stated she told them No. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Lakeside Blvd Bayville, NJ 08721	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/22/2024 at 5:03 PM, the LNHA stated on 10/15/2024 the police asked her if she knew Resident #1 had been beaten up. The LNHA stated she knew that the resident had thrown an overbed tray table, the overbed tray table got broken, and the resident had a fall. The LNHA stated she did not call the police because she thought it was a resident to staff incident. The LNHA further stated she normally would have called the police for a resident to resident, staff to resident, and resident to staff incident but did not for this incident. The LNHA further stated she would have called the police if the resident hit the staff or if the resident was a harm to self and others. The LNHA stated she would have considered a resident throwing an overbed tray table a danger to a resident's self and others. The LNHA stated the police should have been notified. The LNHA stated the police came to the facility on [DATE] and talked to the staff and were trying to determine if abuse had occurred. The LNHA further stated she reviewed the camera surveillance on 10/15/2024 in the presence of the police and observed the overbed tray table come out of the resident's room. She also observed CNA#2 and the SM holding Resident #1 on the floor. When asked by the surveyor if the camera surveillance was reviewed on 10/14/2024, the LNHA stated no, I was told the resident threw an overbed tray table and had a fall. I didn't think to review the camera because it was reported as a regular fall. The LNHA stated after reviewing the camera surveillance with the police, she was informed by them that they were taking CNA #2. The LNHA further stated the SM was not at the facility on 10/15/2024. The LNHA determined through the investigation CNA #2 and the SM were trying to hold Resident #1 after the resident threw the overbed tray table. The LNHA stated a physical hold was not a part of how to deal with aggressive residents and a physical hold would be considered a restraint. The LNHA stated the facility did not have a policy on restraints. The surveyors requested a copy of surveillance footage from the LNHA throughout the complaint survey. During exit conference on 10/29/2024 at 3:24 PM, the LNHA stated that the facility was not able to access the footage because 14 days had passed since the incident occurred on 10/14/2024. During a post survey telephone interview with the surveyors on 10/30/2024 at 2:52 PM, the ST stated she was on the third-floor unit to use the bathroom and did not witness the incident with Resident #1 that occurred on 10/14/2024. 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 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. N.J.A.C:8:39-4.1(a)(5)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50919 Complaint # NJ178530 Based on interviews, medical record review, and review of other pertinent facility documentation on 10/22/2024, 10/23/2024, 10/24/2024, and 10/29/2024, it was determined that the facility failed to conduct a timely and thorough investigation for an allegation of witnessed and reported staff to resident physical abuse 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 on the floor in the hallway with CNA #2 and the Smoking Monitor (SM) hitting 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 a loud bang and yelling in the hallway. LPN #1 responded to the hallway and saw Resident #1 laying on the floor in the hallway yelling please stop, get them off of me. LPN #1 stated she observed CNA #2 kicking Resident #1 and the SM hitting Resident #1 with his fist. LPN #1 told both staff members (CNA #2 and SM) to stop and to get off the resident. LPN#1 stated CNA #2 and the SM did not immediately stop and get off the resident. She had to repeat the request. LPN#1 stated the SM said, Its ok we are told to do this. LPN #1 stated she assisted Resident #1 off the floor to the nursing station and immediately reported the incident to the Assistant Director of Nursing (ADON). CNA #2 and the SM went down to the other side of the hallway and passed the lunch trays. The Social Worker (SW#1) stated the ADON got her to come to the unit. SW#1 stated Resident #1 was yelling They just beat the [profanity] out of me. SW#1 stated while at the nursing station, she observed the resident's back when Resident #1 lifted his/her tee shirt. SW#1 reported the observation to the ADON. 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 back pain. During an interview with SW#1, she stated Resident #1 stated oh my back when he/she attempted to pick food up off the floor. The ADON stated Resident #1 told her that he/she fell , and an order was obtained from the Medical Doctor to send Resident #1 to the hospital for a fall. On 10/14/2024, Resident #1 was admitted to the hospital with diagnoses of splenic laceration, subcapsular hematoma, and an active bleed. 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 Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and ADON. The LNHA, DON, and ADON were presented with the IJ template. The IJ began on 10/14/2024 and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan. (continued on next page)

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	10/29/2024

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 SM 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 (NJDOH) document used by healthcare facilities to report incidents dated 10/15/2024, Resident #1 was upset while in his/her room and threw an overbed tray table at a staff member outside Resident #1's room on 10/14/2024. While throwing the overbed tray table, Resident #1 lost balance and fell to the floor. While on the floor, Resident #1 continued to be a danger to the staff and others. Staff attempted to subdue Resident #1 by using gentle resistance while on the floor. 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 beaten up by two staff members. The police department notified the facility on 10/15/2024 of Resident #1's allegation. According to the FRE, a full investigation was initiated on 10/15/2024. Both staff members were suspended pending an investigation on 10/15/2024. According to the facility's document titled Summary of Investigation with a date reported of 10/15/2024 under Summary, Resident #1 sustained injuries when he/she fell on top of the overbed tray table while trying to continue an attack on the staff member. Resident #1 had a history of aggression towards others and staff were protecting residents and themselves while trying to keep Resident #1 from continuing aggression. The staff were concerned for everyone's safety and tried to keep Resident #1 down on the floor to avoid Resident #1 from hurting others. They were too aggressive while trying to keep Resident #1 down to prevent further aggression from Resident #1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [DATE], with diagnoses which included but were not limited to: Traumatic Brain Injury (a head injury causing damage to the brain), Impulse Disorder (an inability to control impulses and behaviors), and Schizoaffective Disorder (a chronic mental health condition that combines symptoms of psychosis with symptoms of mood disorders). According to the Admission Minimum Data Set (MDS), an assessment tool dated 08/09/2024, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. The MDS further indicated Resident #1 was on antipsychotic medications and had no behaviors that were exhibited towards others. (continued on next page)

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	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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the Discharge MDS dated [DATE], Section A, a discharge assessment indicated return anticipated. The MDS further indicated that Resident #1 had physical and behavioral symptoms directed towards others. A review of Resident #1's Care Plan (CP) initiated on 08/25/2024 revealed under Focus: Resident #1 is the aggressor in a physically altercation with peer related to poor impulse control. The Goal included Resident #1 will not harm others through the review date. Interventions initiated on 08/25/2024 included: When Resident #1 becomes agitated, intervene before agitation escalates. Guide away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. A review of Resident #1's Progress notes (PNs) dated 10/14/2024 at 2:24 PM written by the ADON revealed Resident #1 became upset while in the room and threw an overbed tray table at a staff member outside the room door. During the throwing of the overbed tray table, Resident #1 lost his/her balance and fell to the floor. While on the floor, Resident #1 continued to be a danger to the staff. Staff attempted to subdue Resident #1 using gentle resistance while on the floor. Resident #1 was given time to calm down before being assisted to a standing position. Resident #1 was taken off the unit with Social Services (SS) to further calm down. The physician was informed of Resident #1's behaviors. An order was secured to send Resident #1 to the hospital for a behavioral evaluation and x-ray of the right hip and ribs. 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 transport via stretcher to the emergency room (ER). A review of CNA #2 and the SM's personnel files revealed that both staff had training on abuse and how to deal with aggressive residents. During an interview with the surveyors on 10/22/2024 at 1:04 PM, CNA #1 stated that on 10/14/2024 at 11:58 AM, she walked out of the dayroom, she heard a commotion and observed Resident #1 on the floor in the hallway between Resident #1's room and the dayroom on his/her back with CNA#2 and the SM hitting resident with their fists. 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 SM 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 aggressive at times but re-directable with a calm approach. CNA #1 stated she heard both CNA #2 and the SM tell LPN #1 that Resident #1 got upset because resident was told to wait to go out to smoke. During a subsequent interview with the surveyors on 10/23/2024 at 3:23 PM, CNA #1 stated I wrote my statement on 10/14/2024 and gave the original copy to LPN#1. (continued on next page)

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Crystal Lake Healthcare and Rehabilitation	395 Lakeside Blvd Bayville, NJ 08721

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/22/2024 at 1:27 PM, LPN #1 stated she worked on 10/14/2024 and was assigned Resident #1. LPN #1 stated she was in the charting room speaking with the Speech therapist (ST) and heard a loud bang and yelling. LPN #1 stated the ST 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 the yelling was coming from and observed Resident #1 laying in the hallway in front of his/her room. LPN #1 stated she heard Resident #1 yelling please stop, get them off of me. LPN #1 further stated that the ST was behind her and stated, Oh my God, what are they doing to him? LPN #1 stated she observed CNA #2 kicking Resident #1 and the SM punching Resident #1. LPN #1 stated Resident #1 was laying on his/her side. LPN #1 stated she told CNA #2 and the SM to stop and get off the resident. CNA #2 and the SM did not immediately stop. She had to repeat the request. CNA#2 and the SM stopped hitting the resident. LPN #1 further stated that the SM said, its ok, we are told to do this. LPN#1 was unsure of who told both staff they could hit and punch the resident. LPN #1 stated she assisted the resident off the floor to the nursing station and immediately reported the incident to the ADON. She stated that CNA #2 and the SM 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 SM were moved off the floor to the other units. LPN #1 stated Social Worker (SW#1) and the ADON 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 ADON went. LPN #1 further stated Resident #1 complained of pain all over and asked her to call the police because he/she wanted to press charges. LPN #1 stated SW#1 lifted Resident #1's tee shirt, and they both observed red marks on the resident's back. She stated that SW#1 told the ADON that the resident had red marks on his/her back. LPN #1 stated she asked the ADON 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 SM 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 SM left the unit after the overhead page. LPN #1 stated she received a call from the DON 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 DON's office. Upon her return to the unit, LPN #1 received a phone call from the ADON stating that Resident #1 was going to the hospital. LPN#1 further stated that the ADON told her that Resident #1 and their roommate (Resident #4) were being moved to the seventh-floor unit. Resident #1 was not moved to the seventh-floor unit and was transported to the hospital. She stated she received Resident #1's universal transfer form (UTF) already completed by the ADON. She took Resident #1's chart and the UTF to the seventh-floor unit and observed CNA #2 on that unit. LPN #1 stated she did not observe Resident #1 on the seventh-floor unit. She stated CNA #2 came to work on 10/15/2024, but the SM had called out. LPN #1 further stated that CNA #2 did not work on her unit on 10/15/2024. 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 10/14/2024. 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). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/22/2024 at 3:22 PM, the DON stated when an incident occurs the nurse assigned the resident is responsible for completing an incident report. The DON stated, I guess that day it was not filled out. The DON confirmed that no incident report was completed for Resident #1 on 10/14/2024. The DON stated the expectation was that the charge nurse should have filled out an incident report and gathered witness statements after the incident occurred. The DON further stated the next day either the ADON or herself would review the incident report and were responsible to ensure there was an incident report with witness statements. The DON further stated, We did not ask the nurse why an incident report was not completed. The DON confirmed there was no incident report or witness statements regarding 10/14/2024 incident involving Resident #1. The DON 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 ADON 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 ADON by the elevators on 10/14/2024, and the ADON told her that Resident #1 was upset 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 pulled his/her tee shirt up and she observed red marks to the resident's back. She told the ADON about the red marks on the resident's back. 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 appeared anxious, had excessive speech, and was agitated. SW #1 stated while Resident #1 was eating he/she dropped a piece of mashed potato on the floor, the resident attempted to pick up the mashed potato and stated, oh my back. She stated the resident was still in her office for approximately 45 minutes when she texted the LNHA to let her know the resident was still in her office. SW #1 stated she came to work the next day and the police were at the facility. SW#1 stated she did not speak with the police. SW #1 stated she did not recall why the police 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 were detained, and a resident was in the hospital in critical condition. 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 abuse allegation occurred, it was to be reported to the LNHA who was the abuse coordinator. SW #1 stated that if the LNHA was not there she would report the allegation to the DON or ADON. SW #1 further stated that she would await instruction from the LNHA. SW #1 stated the LNHA would tell her to interview the resident. SW #1 stated she would report the abuse allegation and then await further instruction from the LNHA. SW #1 stated she did not ask Resident #1 who beat him/her up. SW #1 stated that Resident #1 pointed to the two staff members in the hallway after the incident occurred and the resident stated, they just beat the [profanity] out of me. SW #1 stated she assumed the two staff members were CNA #2 and the SM 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 SM's assignments. SW#1 stated the LNHA did not ask her to speak to any of the residents cared for on 10/14/2024 by CNA #2 and the SM as of 10/22/2024. SW#1 stated she did not speak to Resident #1 about the incident. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/22/2024 at 5:01 PM, the DON stated that LPN #1 told her Resident #1 was acting out. The DON stated that when she came to work on 10/15/2024 there were two police officers and a detective at the facility. The DON stated she was asked if she knew what happened to the resident. The DON stated she was asked by the police if she had heard that Resident #1 had been beaten up the day before and the DON stated she told them No. During an interview with the surveyors on 10/22/2024 at 5:03 PM, the LNHA stated on 10/15/2024 the police asked her if she knew Resident #1 had been beaten up on 10/14/2024. The LNHA stated she knew that the resident had thrown an overbed tray table, the overbed tray table got broken, and the resident had a fall. The LNHA stated she did not call the police because she thought it was a resident to staff incident. The LNHA further stated she normally would have called the police for a resident to resident, staff to resident, and resident to staff incident but did not for this incident. The LNHA further stated she would have called the police if the resident hit the staff or if the resident was a harm to self and others. The LNHA stated she would have considered a resident throwing an overbed tray table, a danger to resident's self and others. The LNHA stated the police should have been notified. The LNHA stated the police came to the facility on [DATE] and talked to the staff and were trying to determine if abuse had occurred. The LNHA stated she reviewed the camera surveillance on 10/15/2024 in the presence of the police and observed the overbed tray table come out of the resident's room. She also observed CNA#2 and the SM holding Resident #1 on the floor. When asked by the surveyor if the camera surveillance was reviewed on 10/14/2024, the LNHA stated no, I was told the resident threw an overbed tray table and had a fall. I didn't think to review the camera because it was reported as a regular fall. The LNHA further stated an incident report should have been completed for the fall and the incident that occurred on 10/14/2024. During an interview with the surveyors on 10/23/2024 at 12:48 PM, the LNHA stated she was the abuse coordinator. The LNHA stated once an abuse allegation was made, the staff was to report it to the SW and herself and they would start the investigation. She stated the nurse on the floor would collect the witness statements and the SW would interview and gather statements from the resident(s) involved. The LNHA stated there were no instances where the SW would not have collected resident statements when an abuse allegation occurred. She further stated, I cannot speak to why there were no statements gathered for the other residents for the incident on 10/14/2024. The LNHA stated, I know the SW talked to the other residents after the incident. The LNHA further stated the expectation was that the SW should have talked to Resident #1 and other residents on CNA #2 and the SM's assignments after the incident occurred. The LNHA stated that she agreed that some of the steps of the abuse and investigation policies were not followed for the incident on 10/14/2024. The LNHA confirmed that SW#1 should have started an investigation and reported the incident to her on 10/14/2024. The LNHA stated I was not made aware of the marks seen by SW#1 and the ADON on 10/14/2024. All I knew was the resident fell . The LNHA stated the witness statements were written and collected on 10/15/2024. During a third interview with the surveyors on 10/23/2024 at 3:05 PM, the LNHA stated she was told the employees' written statements were left in the DON's mailbox. The LNHA stated I think the employees have the original statements and left the copies in the DON's mailbox. The LNHA stated the nurse would collect the statements and put them in the mailbox. The LNHA stated The DON would be the first person to collect and look at the statements if they are put in her mailbox. The LNHA further stated, Yes, for the 10/14/2024 incident the witness statements were all put in the DON's mailbox. During an interview with the surveyors on 10/23/2024 at 3:23 PM, CNA #1 stated I wrote my statement on 10/14/2024 and gave the original copy to LPN #1. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/23/2024 at 3:27 PM, the DON stated copies of the written statements were in her mailbox on 10/15/2024. The DON further stated, I don't remember off the top of my head, who the statements were from. The DON stated she does not review the witness statements and the final investigation. The DON stated she has not reviewed the witness statements for the incident that occurred on 10/14/2024. The DON confirmed she took the witness statements regarding the 10/14/2024 incident out of her mailbox on 10/15/2024. The DON stated, I don't know who would read the witness statements. The facility was unable to provide written statements from CNA #2 and the SM. The surveyors requested a copy of the surveillance footage from the LNHA throughout the complaint survey. During exit conference on 10/29/2024 at 3:24 PM, the LNHA stated that the facility was not able to access the footage because 14 days had passed since the incident occurred on 10/14/2024. 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, 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 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

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F 0644 Level of Harm - Actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50919 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 [DATE], with diagnoses which included but were not limited to: Traumatic Brain Injury (a head injury causing damage to the brain), Impulse Disorder (an inability to control impulses and behaviors), and Schizoaffective Disorder (a chronic mental health condition that combines symptoms of psychosis with symptoms of mood disorders). According to the Admission Minimum Data Set (MDS), an assessment tool dated 08/09/2024, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. The MDS further indicated Resident #1 was on antipsychotic medications and had no behaviors 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 5/23/2024 revealed that Resident #1 had mental health treatment needs that could be met in a nursing facility. According to the notification, the recommendations made for the resident included the following: 1. Psychiatric consult upon admission to the nursing facility. 2. Routine follow up visits with the Primary Care Physician and Psychiatrist. 3. Medication Monitoring 4. Supportive Counseling 5. Routine Laboratory Testing 6. Formulate and implement a behavioral modification plan to address any behavioral disturbances. 7. Provide education to the client and family on mental illness and medication. 8. Develop a Crisis Intervention/Safety Plan with the client. (continued on next page)

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F 0644 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #1's medical record revealed an initial assessment from the psychologist titled with a date of service of 08/27/2024 (25 days after resident's admission into the facility). Resident #1's medical record did not reveal any visits from the psychiatrist 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 (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 psychiatric consult was already a part of the admission process for a resident. SW #1 stated I think the psychiatric consults were scheduled when the psychiatrist comes to the building. SW #1 further stated she had seen the psychiatrist 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 March and ended in May. 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 Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) stated Resident #1's PASARR recommendations were not followed because the resident was never seen by a psychiatrist since being admitted to the facility. The DON stated she could not speak to why Resident #1 was not seen by a psychiatrist. During an interview with the surveyors on 10/24/2024 at 3:37 PM in the presence of the DON, the LNHA stated the SW was responsible for putting the PASARR in the resident's electronic medical record. The LNHA stated the resident's care plan was updated based on the PASARR recommendations. The LNHA 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 LNHA further stated she could not speak to why Resident #1 was not seen by a psychiatrist. The surveyors requested a facility policy on PASARR recommendations, and the facility was unable to provide a policy. NJAC 8:39-27.1 (a)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50919 Complaint #: NJ178530 Based on interviews, medical record review, and review of other pertinent facility documentation on 10/22/2024, 10/23/2024, 10/24/2024, and 10/29/2024, it was determined that the facility failed to a.) implement care plan (CP) interventions for a resident (Resident #1) with a known history of physically aggressive behaviors towards others and diagnoses of Traumatic Brain Injury (a head injury causing damage to the brain), Impulse Disorder (an inability to control impulses and behaviors), and Schizoaffective Disorder (a chronic mental health condition that combines symptoms of psychosis with symptoms of mood disorders). On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 on the floor in the hallway with CNA #2 and the Smoking Monitor (SM) hitting 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 a loud bang and yelling in the hallway. LPN #1 responded to the hallway and saw Resident #1 laying on the floor in the hallway yelling please stop, get them off of me. LPN #1 stated she observed CNA #2 kicking Resident #1 and the SM hitting Resident #1 with his fist. LPN #1 told both staff members (CNA #2 and SM) to stop and to get off the resident. LPN#1 stated CNA #2 and the SM did not immediately stop and get off the resident. She had to repeat the request. LPN#1 stated the SM said, Its ok we are told to do this. LPN #1 stated she assisted Resident #1 off the floor to the nursing station and immediately reported the incident to the Assistant Director of Nursing (ADON). CNA #2 and the SM went down to the other side of the hallway and passed the lunch trays. The Social Worker (SW#1) stated the ADON got her to come to the unit. SW #1 stated Resident #1 was yelling They just beat the [profanity] out of me. SW#1 stated while at the nursing station, she observed the resident's back when Resident #1 lifted his/her tee shirt. SW #1 reported the observation to the ADON. 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 back pain. During an interview with the SW, the SW stated while Resident #1 stated oh my back while attempting to pick up food from off the floor. The ADON stated Resident #1 told her that he/she fell and an order was obtained from the Medical Director to send Resident #1 to the hospital for a fall. On 10/14/2024, Resident #1 was admitted to the hospital with diagnoses of splenic laceration, subcapsular hematoma, and an active bleed. 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 Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and ADON. The LNHA, DON, and ADON were presented with the IJ template. The IJ began on 10/14/2024 and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 395 Lakeside Blvd Bayville, NJ 08721	

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 10/15/2024, Resident #1 was upset while in his/her room and threw an overbed tray table at a staff member outside of Resident #1's room on 10/14/2024. While throwing the overbed tray table, Resident #1 lost balance and fell to the floor. While on the floor, Resident #1 continued to be a danger to the staff and others. Staff attempted to subdue Resident #1 by using gentle resistance while on the floor. 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 beaten up by two staff members. The police department notified the facility on 10/15/2024 of Resident #1's allegation. According to the FRE, a full investigation was initiated on 10/15/2024. Both staff members were suspended pending an investigation on 10/15/2024. According to the facility's document titled Summary of Investigation with a date reported of 10/15/2024 under Summary, Resident #1 sustained injuries when he/she fell on top of the overbed tray table while trying to continue an attack on the staff member. Resident #1 had a history of aggression towards others and staff were protecting residents and themselves while trying to keep Resident #1 from continuing aggression. The staff were concerned for everyone's safety and tried to keep Resident #1 down on the floor to avoid Resident #1 from hurting others. They were too aggressive while trying to keep Resident #1 down to prevent further aggression from Resident #1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [DATE], with diagnoses which included but were not limited to: Traumatic Brain Injury, Impulse Disorder, and Schizoaffective Disorder. According to the Admission Minimum Data Set (MDS), an assessment tool dated 08/09/2024, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. The MDS further indicated Resident #1 was on antipsychotic medications and had no behaviors that were exhibited towards others. According to the Discharge MDS dated [DATE], Section A, a discharge assessment indicated return anticipated. Section E revealed that Resident #1 had physical and behavioral symptoms directed toward others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 395 Lakeside Blvd Bayville, NJ 08721	

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #1's CP initiated on 8/25/2024 revealed under Focus: Resident #1 is the aggressor in a physically altercation with peer related to poor impulse control. Under Goal revealed Resident #1 will not harm others through the review date. Under Interventions initiated on 8/25/2024 revealed the following: When Resident #1 becomes agitated, intervene before agitation escalates. Guide away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. Resident #1 was sent to ER for behavioral evaluation. A review of Resident #1's Progress notes (PNs) dated 10/14/2024 at 2:24 PM written by the ADON revealed Resident #1 became upset while in the room and threw an overbed table at a staff member outside the room door. During the throwing of the overbed table, Resident #1 lost their balance and fell to the floor. While on the floor, Resident #1 continued to be a danger to the staff. Staff attempted to subdue Resident #1 using gentle resistance while on the floor. Resident #1 was given time to calm down before being assisted to a standing position. Resident #1 was taken off the unit with Social Services (SS) to further calm down. The Physician was informed of Resident #1's behaviors. An order was secured to send Resident #1 to the hospital for a behavioral evaluation and x-ray of the right hip and ribs. 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 transport via stretcher to the ER. During an interview with the surveyors on 10/22/2024 at 5:01 PM, the DON stated the expectation was that the staff should follow a resident's CP. The DON further stated that a resident could be in danger if the CP was not followed. The DON confirmed that Resident #1's CP was not followed for the incident that occurred on 10/14/2024. During an interview with the surveyors on 10/22/2024 at 5:03 PM, the LNHA stated she was told by the staff that Resident #1 was on the floor and CNA#3 and the SM held Resident #1 down to prevent any further aggression. The LNHA further stated the expectation was to remove either the aggressor or other people from the situation which ever was safer. The LNHA agreed that Resident #1's CP intervention was not followed for the incident that occurred on 10/14/2024. During an interview with the surveyors on 10/24/2024 at 3:11 PM, the ADON stated the importance of the CPs were for staff to know how to care for the residents. The ADON stated the expectation was that CP interventions should be implemented by the staff. The ADON further stated if the care plan interventions were not implemented, it could cause harm to the resident. The ADON 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)

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NAME OF PROVIDER OR SUPPLIER: Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 395 Lakeside Blvd Bayville, NJ 08721	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45622 Complaint #: NJ178766, NJ178770 Based on interviews, medical record review, and review of other pertinent facility documents on 10/22/2024, 10/23/2024, and 10/24/2024, 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 abuse 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 10/18/2024, with an event date of 10/17/2024 and a time of event of 12:30 P.M., pertaining to Resident #3: Local authorities came to the facility stating they were investigating an anonymous call stating, the resident was being abused by staff. An investigation was immediately started in the presence of the local authorities. A body check was completed with the local authorities present in the facility with skin alterations observed on the right side of the resident's body post a fall in the shower on Monday. According to the FRE dated 10/18/2024, with an event date of 10/17/2024 and a time of event of 12:30 P.M., pertaining to Resident #4: Local authorities came to the facility stating they were investigating an anonymous call stating the resident was being abused by staff. An investigation is immediately started in the presence of the local authorities. A body check is completed with the local authorities present in the facility with no skin alterations observed. Review of the Electronic Medical Records (EMRs) was as follows: 1.The surveyor reviewed Resident #3's medical record on 10/24/2024. The Admission Record (AR) reflected Resident #3 was admitted to the facility with medical diagnosis which included but not limited to; Hyperlipidemia (too many lipids in the blood), Insomnia (persistent problems falling asleep), and Hypertension (when the pressure in your blood vessels is high). According to the Minimal Data Set (MDS) an assessment tool dated 07/09/2024, Resident #3 had severe cognitive impairment. The resident's CP initiated on 08/17/2023 with a Focus of Resident #3 makes false allegations about staff and or peers. 2. The surveyor reviewed Resident #4's medical record on 10/24/2024. According to the AR Resident #4 was admitted to the facility with medical diagnosis which included but was not limited to; Schizophrenia (a serious mental health condition that affects how people think, feel and behave), Type Two Diabetes Mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy), and Gastro-Esophageal Reflux Disease (a condition is which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). According to the MDS dated [DATE], the resident had a severe cognitive impairment. The resident's CP initiated on 08/17/2023 with a Focus of Resident #4 makes false allegations about staff and or peers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER: Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 395 Lakeside Blvd Bayville, NJ 08721	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's and #4's CP included no new updates with interventions for making false allegations about staff and peers for the FRE dated 10/18/2024, with an event date of 10/17/2024 and a time of event of 12:30 P.M., During an interview on 10/24/2024 with the Assistant Director of Nursing (ADON), she stated the importance of the CP is how everyone is 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 abuse allegation made by Resident #3 and #4 on 10/17/2024 was a significant event, the ADON said Yes, the CP should had been updated with new interventions. The ADON acknowledged the CP for Resident #3 and #4 was not updated and revised with new interventions after the 10/17/2024 abuse allegation. 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. N.[NAME].C.: 8:39-11.2(d)(2)

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NAME OF PROVIDER OR SUPPLIER Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Lakeside Blvd Bayville, NJ 08721	

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50919 Complaint # NJ178530 Based on interviews, medical record review, and review of other pertinent facility documentation on 10/22/2024, 10/23/2024, 10/24/2024, and 10/29/2024, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to: a.) provide services necessary to prevent physical abuse for a resident (Resident #1), b.) follow the facility's abuse policy by allowing staff members to continue to work with other residents after an abuse allegation occurred, c.) conduct a timely and thorough investigation for a reported witnessed allegation of staff to resident physical abuse, 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 a known history of physically aggressive behaviors towards others and diagnoses of Traumatic Brain Injury, Impulse Disorder, and Schizoaffective Disorder. On 10/14/2024 at approximately 11:58 AM, the Certified Nursing Assistant (CNA#1) stated she observed Resident #1 on the floor in the hallway with CNA #2 and the Smoking Monitor (SM) hitting 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 a loud bang and yelling in the hallway. LPN #1 responded to the hallway and saw Resident #1 laying on the floor in the hallway yelling please stop, get them off of me. LPN #1 stated she observed CNA #2 kicking Resident #1 and the SM hitting Resident #1 with his fist. LPN #1 told both staff members (CNA #2 and SM) to stop and to get off the resident. LPN#1 stated CNA #2 and the SM did not immediately stop and get off the resident. She had to repeat the request. LPN#1 stated the SM said, Its ok we are told to do this. LPN #1 stated she assisted Resident #1 off the floor to the nursing station and immediately reported the incident to the Assistant Director of Nursing (ADON). CNA #2 and the SM went down to the other side of the hallway and passed the lunch trays. The Social Worker (SW#1) stated the ADON got her to come to the unit. SW#1 stated Resident #1 was yelling They just beat the [profanity] out of me. SW#1 stated while at the nursing station, she observed the resident's back when Resident #1 lifted his/her tee shirt. SW #1 reported the observation to the ADON. 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 back pain. During an interview with the SW#1, she stated Resident #1 stated oh my back while attempting to pick up food from off the floor. The ADON stated Resident #1 told her that he/she fell , and an order was obtained from the Medical Director to send Resident #1 to the hospital for a fall. On 10/14/2024, Resident #1 was admitted to the hospital with diagnoses of splenic laceration, subcapsular hematoma, and an active bleed. The facility also failed to follow its job description titled Administrator. 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 Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the ADON. The LNHA, DON, and the ADON were presented with the IJ template. The IJ began on 10/14/2024 and continued through 10/29/2024 when the facility submitted an acceptable Removal Plan. (continued on next page)

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	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 SM) 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 10/14/2024 and did not report it to the Abuse Coordinator. 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 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 SM 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 10/15/2024, Resident #1 was upset while in his/her room and threw an overbed tray table at a staff member outside of Resident #1's room on 10/14/2024. While throwing of the overbed tray table, Resident #1 lost balance and fell to the floor. While on the floor, Resident #1 continued to be a danger to the staff and others. Staff attempted to subdue Resident #1 by using gentle resistance while on the floor. 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 beaten up by two staff members. The police department notified the facility on 10/15/2024 of Resident #1's allegations. According to the FRE, a full investigation was initiated on 10/15/2024. Both staff members were suspended pending an investigation on 10/15/2024. (continued on next page)

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	315125	A. Building B. Wing	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the facility's document titled Summary of Investigation with a date reported of 10/15/2024 under Summary, Resident #1 sustained injuries when he/she fell on top of the overbed tray table while trying to continue an attack on the staff member. Resident #1 had a history of aggression towards others and staff were protecting residents and themselves while trying to keep Resident #1 from continuing aggression. The staff were concerned for everyone's safety and tried to keep Resident #1 down on the floor to avoid Resident #1 from hurting others. They were too aggressive while trying to keep Resident #1 down to prevent further aggression 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: Traumatic Brain Injury (a head injury causing damage to the brain), Impulse Disorder (an inability to control impulses and behaviors), and Schizoaffective Disorder (a chronic mental health condition that combines symptoms of psychosis with symptoms of mood disorders). According to the Admission Minimum Data Set (MDS), an assessment tool dated 08/09/2024, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. The MDS further indicated Resident #1 was on antipsychotic medications and had no behaviors that were exhibited towards others. According to the Discharge MDS dated [DATE], Section A, a discharge assessment indicated return anticipated. Section E revealed that Resident #1 had physical and behavioral symptoms directed toward others. A review of Resident #1's Care Plan (CP) initiated on 8/25/2024 revealed under Focus: Resident #1 is the aggressor in a physical altercation with peer related to poor impulse control. Under Goal revealed Resident #1 will not harm others through the review date. Under Interventions initiated on 8/25/2024 revealed the following: When Resident #1 becomes agitated, intervene before agitation escalates. Guide away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. A review of Resident #1's Progress notes (PNs) dated 10/14/2024 at 2:24 PM written by the ADON revealed Resident #1 became upset while in the room and threw an overbed tray table at a staff member outside the room door. During the throwing of the overbed tray table, Resident #1 lost his/her balance and fell to the floor. While on the floor, Resident #1 continued to be a danger to the staff. Staff attempted to subdue Resident #1 using gentle resistance while on the floor. Resident #1 was given time to calm down before being assisted to a standing position. Resident #1 was taken off the unit with Social Services (SS) to further calm down. The Physician was informed of Resident #1's behaviors. An order was secured to send Resident #1 to the hospital for a behavioral evaluation and x-ray of the right hip and ribs. 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 transport via stretcher and taken to the emergency room (ER). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/22/2024 at 1:04 PM, CNA #1 stated that on 10/14/2024 at 11:58 AM, she walked out of the dayroom, heard a commotion, and observed Resident #1 on the floor in the hallway between Resident #1's room and the dayroom on his/her back. She observed CNA#2 and the SM hitting resident with their fists. 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 SM 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 aggressive at times but re-directable with a calm approach. CNA #1 stated she heard both CNA #2 and the SM tell LPN #1 that Resident #1 got upset because resident was told to wait to go out to smoke. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/22/2024 at 1:27 PM, LPN #1 stated she worked on 10/14/2024 and was assigned Resident #1. LPN #1 stated she was in the charting room speaking with the Speech Therapist (ST) and heard a loud bang and yelling. LPN #1 stated the ST 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 the yelling was coming from and observed Resident #1 laying in the hallway in front of his/her room. LPN #1 stated she heard Resident #1 yelling please stop, get them off of me. LPN #1 further stated that the ST was behind her and stated, Oh my God, what are they doing to him? LPN #1 stated she observed CNA #2 kicking Resident #1 and the SM punching Resident #1. LPN #1 stated Resident #1 was laying on his/her. LPN #1 stated she told CNA #2 and the SM to stop and get off the resident. CNA #2 and the SM did not immediately stop. She had to repeat the request. CNA #2 and the SM then stopped hitting the resident. LPN #1 further stated that the SM said, its ok, we are told to do this. When asked by the surveyor if the SM said who told him to this, the LPN said, No, he did not say who told him to do this. LPN #1 stated she assisted the resident off the floor to the nursing station and immediately reported the incident to the ADON. She stated that CNA #2 and the SM 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 SM were moved off the floor to the other units. LPN #1 stated Social Worker (SW#1) and the ADON 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 ADON went. LPN #1 further stated Resident #1 complained of pain all over and asked her to call the police because he/she wanted to press charges. LPN #1 stated SW#1 lifted Resident #1's tee shirt, and they both observed red marks on the resident's back. She stated that SW#1 told the ADON that the resident had red marks on their back. LPN #1 stated she asked the ADON 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 SM 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 SM left the unit after the overhead page. LPN#1 stated she received a call from the DON 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 DON's office. Upon her return to the unit, she received a phone call from the ADON stating that Resident #1 was going to the hospital. LPN#1 further stated that the ADON told her that Resident #1 and his/her roommate (Resident #4) were being moved to the seventh-floor unit. Resident #1 was not moved the seventh-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 ADON. She took Resident #1's chart and the UTF to the seventh-floor unit and observed CNA #2 on that unit. LPN #1 stated she did not observe Resident #1 on the seventh-floor unit. She stated CNA #2 came to work on 10/15/2024, but the SM had called out. LPN #1 further stated that CNA #2 did not work on her unit on 10/15/2024. 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]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 12:00 PM on 10/14/2024 when she heard a commotion in the hallway. She came out from the dayroom and observed Resident #1 on the floor laying on his/her side. CNA #3 stated she observed the SM pinning down the resident on the floor and CNA #2 was standing there. CNA #3 further stated SW#1 and the ADON 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 SM passed out the lunch trays. CNA #3 stated she did not see CNA #2 and the SM on the unit after lunch but however, she saw CNA #2 and the SM 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 10/15/2024 she saw CNA #2 on the fifth-floor unit. During an interview with the surveyors on 10/22/2024 at 3:22 PM, the DON stated when an incident occurs the nurse assigned the resident is responsible for completing an incident report. The DON stated, I guess that day it was not filled out. The DON confirmed that no incident report was completed for Resident #1 on 10/14/2024. The DON stated the expectation was that the charge nurse should have filled out an incident report and gathered witness statements after the incident occurred. The DON further stated the next day either the ADON or herself would review the incident report and were responsible to ensure there was an incident report with witness statements. The DON further stated, We did not ask the nurse why an incident report was not completed. The DON confirmed there was no incident report or witness statements regarding 10/14/2024 incident involving Resident #1. The DON 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 ADON stated as a team, we go over the incident reports in morning meeting. This has not happened in this case with Resident #1. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/22/2024 at 4:06 PM, SW #1 stated she met the ADON by the elevators on 10/14/2024, and the ADON told her that Resident #1 was upset 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 yelling they just beat the [profanity] out of me. SW #1 stated Resident #1 pulled his/her tee shirt up and she observed red marks to the resident's back. She told the ADON about the red marks on the resident's back. 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 anxious, had excessive speech, and was agitated. SW #1 stated while Resident #1 was eating he/she dropped a piece of mashed potato on the floor, the resident attempted to pick up the mashed potato and stated, oh my back. She stated the resident was still in her office for approximately 45 minutes when she texted the LNHA to let her know the resident was still in her office. SW #1 stated she came to work the next day and the police were at the facility. SW#1 stated she did not speak with the police. SW #1 stated she did not recall why police 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 were detained, and a resident was in the hospital in critical condition. 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 abuse allegation occurred, it was to be reported to the LNHA who was the Abuse Coordinator. SW #1 stated that if the LNHA was not there she would report the allegation to the DON or ADON. SW #1 further stated that she would await instruction from the LNHA. SW #1 stated the LNHA would have told her to interview the resident. SW #1 stated she would report the abuse allegation and then await further instruction from the LNHA. SW #1 stated she did not ask Resident #1 who beat him/her up. SW #1 further stated she had not spoken to any residents on CNA #2 and the SM's assignments. SW#1 stated the LNHA did not ask her to speak to any of the residents cared for on 10/14/2024 by CNA #2 and the SM 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 4:47 PM, the ADON stated on 10/14/2024 that I was told that Resident #1 was having some behaviors and took the over bed tray table and tried to hit the CNA. The ADON stated she did not know where the resident got the overbed tray table 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 throw the overbed tray table at the aide, the resident and the overbed tray table went down. The surveyor asked the ADON if LPN#1 made her aware of the abuse allegation and she stated, LPN#1 did not say anything else. The ADON stated that when she got to the unit, she did not see anyone on the floor but saw the overbed table broken in half. The ADON further stated she saw Resident #1 and he appeared angry and tried to get the resident somewhere quiet. The ADON stated she asked Resident #1 what happened with the overbed tray table, and the resident stated they fell . The ADON stated the resident refused an assessment. The ADON stated she called the doctor and got an order to send Resident #1 to the hospital because resident was on the floor. The ADON stated the reason for Resident #1's transfer to the hospital was because resident complained of right leg pain, had agitation, and an x-ray was requested. The ADON stated she was unsure of what time Resident #1 went to the hospital. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/22/2024 at 5:01 PM, the DON stated that LPN #1 told her Resident #1 was acting out. The DON stated that when she came to work on 10/15/2024 there were two police officers and a detective at the facility. The DON stated she was asked if she knew what happened to the resident. The DON stated she was asked by the police if she had heard that Resident #1 had been beaten up the day before and the DON stated she told them No. The DON further stated the expectation was that staff should follow a resident's care plan. The DON further stated that a resident could be in danger if the care plan was not followed. The DON confirmed that Resident #1's care plan was not followed during the incident that occurred on 10/14/2024. During an interview with the surveyors on 10/22/2024 at 5:03 PM, the LNHA stated on 10/15/2024 police asked her if she knew Resident #1 had been beaten up. The LNHA stated she knew that the resident had thrown an overbed tray table, the overbed tray table got broken, and the resident had a fall. The LNHA stated she did not call the police because she thought it was a resident to staff incident. The LNHA further stated she normally called the police for a resident to resident, staff to resident, and resident to staff incident but did not for this incident. The LNHA further stated she would have called the police if the resident hit the staff or if the resident was a harm to self and others. The LNHA stated she would have considered a resident throwing an overbed tray table, a danger to resident's self and others. The LNHA stated the police should have been notified. The LNHA stated the police came to the facility on [DATE] and talked to the staff and were trying to determine if abuse had occurred. The LNHA stated she reviewed the camera surveillance on 10/15/2024 in the presence of the police and observed the overbed tray table come out of the resident's room. She also observed CNA#2 and the SM holding Resident #1 on the floor. When asked by the surveyor if the camera surveillance was reviewed on 10/14/2024, the LNHA stated no, I was told the resident threw an overbed tray table and had a fall. I didn't think to review the camera because it was reported as a regular fall. The LNHA stated after reviewing the camera surveillance, with the police, she was informed by them that they were arresting CNA #2. The LNHA further stated the SM was not at the facility on 10/15/2024. The LNHA stated she finalized her investigation, and that CNA #2 and the SM were trying to hold Resident #1 after he/she threw the overbed tray table. She stated a physical hold was not a part of how to deal with aggressive residents. The LNHA stated she would consider a physical hold as a restraint. The LNHA stated the facility did not have a policy on restraints. The LNHA further stated an incident report should have been completed for the fall and the incident. The LNHA stated she was told by staff that Resident #1 was on the floor and CNA#3 and the SM held Resident #1 down to prevent any further aggression. The LNHA further stated the expectation was to remove either the aggressor or other people from the situation whatever was safer. The LNHA agreed that Resident #1's care plan intervention was not followed for this incident. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the surveyors on 10/23/2024 at 12:48 PM, the LNHA stated she was the Abuse Coordinator. The LNHA stated once an abuse allegation was made, the staff was to report it to the SW and herself and they would start the investigation. She stated the nurse on the floor would collect the witness statements and the SW would interview and gather statements from the resident(s) involved. The LNHA stated there were no instances where the SW would not have collected resident statements when an abuse allegation occurred. She further stated, I cannot speak to why there were no statements gathered for the other residents for the incident on 10/14/2024. The LNHA stated, I know the SW talked to other residents after the incident. The LNHA further stated the expectation was that the SW should have talked to Resident #1 and other residents on CNA #2 and SM's assignments after the incident occurred. The LNHA stated that she agreed that some of the steps of the abuse and investigation policies were not followed the incident on 10/14/2024. The LNHA confirmed that SW#1 should have started an investigation and reported the incident to her on 10/14/2024. The LNHA stated I was not made aware of the marks seen by SW#1 and the ADON on 10/14/2024. All I knew was the resident fell . The LNHA stated the witness statements were written and collected on 10/15/2024. 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 hit on Resident #1 while resident was on the floor. 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 LNHA stated she was told the employees' written statements were left in the DON's mailbox. The LNHA stated I think the employees have the original statements and left the copies in the DON's mailbox. The LNHA stated the nurse would collect the statements and would put them in the mailbox. The LNHA stated The DON would be the first person to collect and look at the statements if they are put in her mailbox. The LNHA further stated, Yes, for the 10/14/2024 incident the witness statements were all put in the DON's mailbox. During an interview with the surveyors on 10/23/2024 at 3:23 PM, CNA #1 stated I wrote my statement on 10/14/2024 and gave the original copy to LPN#1. 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 DON. 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 DON stated copies of written statements were in her mailbox on 10/15/2024. The DON further stated, I don't remember off the top of my head, who the statements were from. The DON stated she does not review the witness statements and the final investigation. The DON stated she has not reviewed the witness statements for the incident that occurred on 10/14/2024. The DON confirmed she took the witness statements regarding 10/14/2024 incident out of her mailbox on 10/15/2024. The DON 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. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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)