STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Rehabilitation and Healthcare Center	1001 Center St Little Egg Harbor Tw, NJ 08087

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ428748Based on interview, record review, and review of the facility's policy, the facility failed to ensure nurses completed narcotic mediation counts to maintain accountability for three of four residents' narcotic medications (Resident (R) 7, R8, and R9) out of 13 sampled residents. This failure had the potential for R7, R8, and R9's narcotic medications being diverted.Findings include:Review of the facility's undated policy titled, Documenting Controlled Substances revealed, I. c. Sign the appropriate area when removing from the count. II.d. Each liquid narcotic must be entered on a separate page. Description of liquid must be documented.V. Shift Count. a. Performed by an oncoming and off going [sic] nurse. b. Examine both front and back of the card and page to verify count.Review of the facility's policy titled, Controlled Substance Prescriptions, dated 11/2021 revealed, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations.Review of the facility's policy titled, Controlled Substance Storage, dated 11/2021 revealed, Policy. Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations. Procedures.B. Schedule II-V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications.C. Controlled substances that require refrigeration are stored within a locked box within the refrigerator.D. A controlled substance accountability record is prepared by the pharmacy/facility for all schedule II, III, IV, and V medications including those in the emergency supply.E. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented on the shift change form.1. Review of R8's undated admission Record, located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility in 04/2018 with diagnosis of anxiety disorder.Review of R8's Order Summary Report located in the resident's EMR under the Orders tab revealed an order dated 09/17/24 for lorazepam oral concentrate (a scheduled IV controlled substance) give 0.5 milliliters (ml) by mouth every 6 hours for anxiety.Review of R8's untitled controlled drug record provided by the facility revealed on 01/05/25 at 6:00 PM there were 10 ml on hand when one dose of lorazepam was administered leaving 9.5 ml remaining. On 01/06/25 at 12:00 AM one 0.5 ml dose was administered leaving 9.0 ml. On 01/06/25 at 6:00 AM one dose was administered leaving 8.5 ml on hand. Continued review of R8's controlled drug record revealed on 01/06/25 at 2:00 PM it was documented Count Adjusted.6.0 ml. There was no documented evidence that the medication was administered to the resident after 11/06/25 at 6:00 AM when the amount available was 8.5 ml which indicated a 2.5 ml deficit.Review of Licensed Practical Nurse (LPN)3's written statement dated 01/06/25 and located in the facility's investigation provided by the facility revealed Narcotics. When I counted the cart this A.M. with [LPN1's Name], she told me that the lorazepam for [R8's Name] was low. The book [controlled drug record] was 8.5 ml and 6.0 [ml] was in the bottle. The count was correct when I last worked on 1/3 [01/03/25] and counted out with the supervisor.Review of LPN2's written statement dated 01/06/25 and located in the facility's investigation provided by the facility revealed Ativan [lorazepam] in refrigerator was not counted during med [medication] count upon coming on shift or going off [shift]. [I] did not observe count being off during med pass. The Director of Nursing (DON) documented on the statement Spoke with [LPN2] who stated she did count with [LPN1] at 11P [11:00 PM] and [Registered Nurse (RN) 2] at 3pm [3:00 PM]. She did not count Ativan in fridge [refrigerator] but did give it at 6pm [6:00 PM] and count was correct.Review of LPN1's written statement dated 01/07/25 and located in the facility's investigation provided by the facility revealed 1/5/25 the count for the refrigerated Ativan was not counted. 1/6/25 Monday morning I realized the count was off by 2.5 ML. I reported it to the oncoming nurse and UM [unit manager]. This unfortunate incident happens to [sic] often without [sic] a discrepancy. I can only say for myself.it a time issue. This will never happen again. Review of untitled meeting documentation dated 01/07/25 at 3:00 PM and located in the facility's investigation provided by the facility revealed the meeting was with LPN1 and included the facility's Administrator and DON. Continued review revealed .When asked if she completed a count for the liquid Ativan, [LPN1] answered 'No.' When asked why not, [LPN1] said 'Because cutting corners.' and further

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #'s: NJ428767 and NJ428770Based on record review, interviews and document review, the facility failed to protect one of four residents Resident (R) #5 from an accident hazard. Specifically, Certified Nurse Aide (CNA) #1 pushed R5 in a wheelchair without leg rests causing R5's legs to become trapped underneath the wheelchair, which resulted in the fracture of R5's left femur. This failure caused unnecessary pain and resulted in R5 requiring surgery to repair the left femur fracture. Findings include:Review of R5's Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R5 was admitted to the facility in 06/2022 with diagnoses of Parkinson's Disease and Alzheimer's Disease. Review of R5's Care Plan Report initiated 07/11/2024 included under Focus: I have an ADL [Activity of Daily Living] Self Care Performance Deficit r/t [related to] Cognitive Impairment, [NAME] process, Impaired Balance. Under Goal' included I will be at reduced risk for complications of self care performance deficient and impaired mobility daily through the review date. In addition, under Interventions included: Encourage me to participate in ADLs to the fullest extent possible. AMBULATION: I am non-ambulatory. Review of R5's Progress Notes located under the Progress Note tab in the EMR dated 06/06/25 at 8:27 AM indicated, Acetaminophen Tablet 325 MG [milligrams] Give 2 tablet by mouth every 6 hours as needed for General Discomfort.pt [patient] c/o [complains of] left knee pain. Review of R5's Progress Notes dated 06/06/25 at 12:26 PM, the nurse documented, left knee noted swollen and patient c/o left knee pain vitals taken stable APN [Advanced Practice Nurse] made aware new order for xray [sic] and ultrasound. PRN [as needed] Tylenol given with good effects. Lidocaine patch applied to left. Will continue to monitor [sic]. Continued review of R5's Progress Note dated 06/06/25 at 3:21 PM, the APN documented, . new onset L [left] knee pain. Per staff, the pain started today. Nursing noted unilateral swelling to the lower extremities. The pt reports pain with movement and palpitation. No recent hx [history] of trauma to the area. Bruising suggests fx [fracture]. Review of the Radiology Note located under the Progress Note tab in the EMR dated 06/07/25 at 1:32 PM, indicated, . There is a complex comminuted fracture of the distal femur with impaction and angulation. [Name of doctor] notified via [by] phone, order received to send to ER [emergency room] for evaluation. Review of the Progress Note indicated R5 was admitted to the hospital on [DATE] with the diagnosis of left femur fracture. The Progress Note Nurses Note dated 06/07/25 at 9:02 PM and Nurses Note dated 06/12/25 at 4:00 PM indicated, .Surgery in [sic] left lower extremity. Review of the Physician Progress note dated 06/13/25 at 1:26 PM indicated, .[R5] underwent a surgical fixation on 6/9. Review of On the Spot Education - Coaching provided by the facility and dated 06/07/25 at 8:00 AM indicated under the section .Description of Issue/Education (What was observed): CNA [CNA1] pushed resident in w/c [wheelchair] [,] and legs got caught beneath w/c wheel; no leg rests utilized. Under the Correct Action section of this training indicated, Re-educated on utilizing leg rests when propelling residents who normally self-propel. Re-educated on proper transfers, if a resident's leg gets caught beneath w/c or any other type of mobility issues in which the resident says ouch, stop and inform the primary nurse immediately. This form was signed by CNA1 and Assistant Director of Nursing (ADON)1. During an interview on 11/24/25 at 6:14 PM, ADON1 stated, we thought this was an injury of unknown origin. When we interviewed [name of CNA1], she stated that she pushed [R5] into the dining room on 06/05/25, and [R5] said, Ouch. ADON1 stated CNA1 asked [R5] if they were okay, and the resident stated that they were. When asked if CNA1 had the leg rest on or off the wheelchair when she was pushing R5 into the dining room, ADON1 stated, I believe that her statement was that after [R5] said ouch [,] [CNA1] turned the wheelchair around. When asked if CNA1 should have used leg rests on the wheelchair when pushing a resident. ADON1 stated, Yes, she should have put the leg rests on the wheelchair. This resident usually is able to self-propel [themself] around the building, so that is the reason why the leg rests were not already on the wheelchair. During a phone interview on 11/25/25 at 12:34 PM, Licensed Practical Nurse (LPN) 4 stated, I don't recall ever being notified about [R5] legs getting caught underneath the wheelchair. If this happens, the CNAs are to report this to the nurse as soon as possible so that we can assess the resident. During a phone interview on 11/25/25 at 12:41 PM, CNA1 stated, I was wheeling [R5] back to the dining room [,] and I felt the resident's legs stop the wheelchair. I looked, and the resident said ouch, but they usually say that a lot. I asked [R5] if they were okay, and the resident said they were, so I wheeled the resident into the dining room. Asked if the leg rests were on or off the wheelchair when she [CNA1] was pushing the wheelchair, CNA1 replied, No, I didn't have them on the wheelchair

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Complaint #: NJ2666455Based on interview and policy review, the facility failed to provide educational materials to residents and/or resident representatives so that they could make an informed decision in regard to be administered the Coronavirus Disease (COVID-19) vaccine. This failure had the potential for all 145 residents in the facility who are the vulnerable population to be exposed to and have a greater chance of these residents contracting COVID-19.Interview with Health Department (HD)1 on 11/24/25 at 2:50 PM to discuss the COVID outbreak at the facility. HD1 confirmed during the call that the facility had kept the local Health Department (LHD) updated daily identifying which residents were positive for COVID and whether residents had received the COVID vaccine. During the conversation, it was discussed that the facility had a 9% COVID vaccination rate. HD1 did not explain during the call how this percentage was calculated.During an interview on 11/24/25 at 12:30 PM, the Infection Preventionist (IP) stated, . I haven't been able to give residents the COVID-19 vaccine because we don't have the educational materials for the year 2025-2026. The only one we have is for the previous year. The IP confirmed that no resident in the facility has been offered or given the COVID-19 vaccines. When asked if he had reached out to the facility's pharmacy or the LDH if they had the appropriate educational materials for the COVID-19 vaccine, the IP stated, No, I haven't. The Health Department (HD)1 was contacted on 11/25/25 at 10:21 AM and asked if the facility had requested educational materials to give to the residents and /or resident representatives so they could make an informed decision on whether or not to take the COVID-19 vaccine. HD1 stated, I am not aware if the facility has reached out to us about this. During an interview on 11/25/25 at 1:15 PM, the Medical Director stated that the facility has not given any COVID-19 vaccines to the residents because they do not have the appropriate educational materials to give to the residents and/or their representatives. The Medical Director stated, No, I wasn't aware of this, and it is very important for residents and/or resident representatives to have the educational materials so that they can give informed consent. During an interview on 11/25/25 at 1:45 PM, the Director of Nursing (DON) stated, I know on admission, the admitting nurse will ask if they know if they have had the COVID-19 vaccine.We will also check the state website to see which vaccine the resident has received and when. The residents have to have this [education material] so they can make an informed decision to take it or not.Review of the facility's policy Coronavirus Disease (COVID-19) - Vaccination of Residents dated August 2025 indicated, .Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. The resident or representative is provided the most current vaccine information statement (VIS) prior to the vaccine administration. Current VIS for all recommended vaccines are available at: http://www.cdc.gov/vaccines/hcp/vis/index.html .NJAC 8:39-19.4(a)