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	12/19/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, it was determined that the facility failed to maintain food service and hydration station equipment in a clean and sanitary manner. This deficient practice was evidenced by the following:On 12/15/25 at 9:35 AM, during a tour of the kitchen with the Food Service Director (FSD), the surveyor observed the following:The top of the steamer was visibly soiled with food debris and splashes. The FSD acknowledged the finding and stated that, per facility policy, the steamer top should be cleaned when visibly soiled. The gas oven was observed with splashes of grease and burnt food particles on interior surfaces. The FSD acknowledged the finding and stated that, per facility policy, the oven should be cleaned when visibly soiledOn 12/16/25 at 8:56 AM, during a tour of the third-floor's hydration station, and nourishment and dining rooms with the Activities Aide (AA), the surveyor observed the following:Review of the temperature log for the nourishment room refrigerator revealed a missing temperature entry and employee initials for the evening monitoring on 12/15/25. The AA acknowledged the finding and stated that refrigerator temperatures should be checked and documented daily during both the morning (AM) and evening (PM) shifts.The hydration station water pitcher was observed to be undated and contained cloudy water. The AA acknowledged the findings and confirmed that the water pitcher should have been dated, and the water should be clear.On 12/18/25 at 9:46 AM, the surveyor interviewed the FSD who acknowledged that the steamer and oven, like other kitchen equipment, should be cleaned weekly and whenever visibly soiled and dirty, and that the staff should have cleaned the equipment. The FSD also stated that hydration station water pitchers and should cleaned, dated, and filled with fresh water daily. The FSD further stated that when the water appears cloudy, the cause is unknown, and it presents a safety hazard. On 12/18/25 at 12:12 PM, the surveyor interviewed the Regional Food Service Director (RFSD) who confirmed that kitchen equipment should be maintained in a clean sanitary manner and that the hydration station water pitchers should be dated and contain clear water. The RFSD further stated that it is important to clean the pitcher and change the water daily to prevent contamination and reduce the risk of foodborne illness.Review of the facility's Sanitization policy, dated 2001, indicated that the food service area is to be maintained in a clean and sanitary manner and that all utensils, counters, shelves, and equipment are to be kept clean and sanitized using heat or chemical sanitizing solutions.Review of the facility's undated Labeling Food and Date Marking policy indicated that labeling and dating food products helps identify what the items are, when they were prepared, and how long they can be safely stored.NJAC 8:39-17.2(g)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of pertinent facility documents it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to guide the planning and management of care for all residents. This deficient practice was identified for 1 of 19 residents (Resident #9) reviewed for MDS accuracy and was evidenced by the following:A review of the admission Record (admission summary) reflected that Resident #9 was admitted to the facility with the diagnoses which included but was not limited to; depression and schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with those of a mood disorder (depression or mania), where psychotic symptoms occur even without mood episodes)).A review of the quarterly Minimum Data Set (MDS; an assessment tool) dated 9/23/2025 indicated that the resident completed a Basic Interview for Mental Status (BIMS) with a score of 3 (three) out of 15, reflecting severe cognitive impairment. Despite the score, the MDS indicated that the resident exhibited no behaviors during this assessment reference period.On 12/15/2025 at 9:55 AM, the surveyor observed Resident #9 confused and wandering into other resident rooms. The staff were observed redirecting the resident successfully. A review of the Interdisciplinary Care Plan (ICP) indicated that the resident had behaviors such as wandering, refusing medications and physical behaviors during care.A review of the Progress Notes (PN) dated 6/5/25 at 12:11 PM, a gradual dose reduction (GDR) of the antipsychotic medication Seroquel was initiated. The resident's dosage was reduced from Seroquel 25mg one time a day to 12.5 mg once daily.A subsequent PN dated 6/26/25 at 14:16 PM (2:26 PM) authored by the Psychiatrist, indicated that resident was having increased behaviors since the GDR of Seroquel. The medication Seroquel was increased to 25 mg daily.Review of the annual MDS dated [DATE] under Section N-Medications, indicated that the resident had not undergone a GDR. However, review of the medical records confirmed that a GDR was attempted on 6/6/25, and was later determined to be contraindicated on 6/26/25, which occurred three days after the assessment reference date.Additionally, a review of the annual MDS dated [DATE] revealed a coding inaccuracy regarding whether a GDR had been attempted. The MDS indicated that a GDR was not attempted, however documentation confirmed that a GDR was attempted on 6/6/25.On 12/17/2025 at 12:09 PM, the surveyor interviewed the Licensed Practical Nurse Minimum Data Set coordinator (LPN/MDS #1) who stated that the MDS coordinator gathers information to complete the MDS by resident interview, by reviewing electronic medical records and by communication with the direct care staff. LPN/MDS #1 stated that the MDS was an assessment that helps to facilitate a resident's care and that an accurate assessment ensured that the resident received the best care possible for a quality of life.LPN/MDS #1 stated that LPN/MDS #2 completed the 6/23/25 and 9/23/25 MDS assessments and was currently on leave from the facility and therefore could not be interviewed at this time. LPN/MDS #1 further stated that the Director of Nursing (DON) signed the MDS after completion by the LPN. She stated that the DON was a Registered Nurse and signs the MDS for completion only, not for accuracy. LPN/MDS #1 stated that the LPN/MDS #2 may have been confused with the dates; however, she was unable to explain why Section N of the MDS was inaccurately coded on 6/23/25 and 9/23/25.The Resident Assessment Instrument (RAI- federally mandated framework used in long-term care facilities) section Z0400: Signature of persons Completing the Assessment indicated that the person signing the attestation must review the information to assure accuracy of information. The job description of the MDS coordinator indicated that it was the of responsibility of the MDS coordinator to inform all assessments team members of the requirements for accuracy and completion of the resident assessments (MDS).NJAC 8:39-33.2(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, interview, and record review it was determined that the facility failed to initiate an individualized care plan (ICP) for residents a.) that was incontinent of bladder and bowel and b.) identified with contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity or rigidity of joints) and limited range of motion (ROM). This deficient practice was identified for 2 (two) of 30 residents (Resident #14 and #126) reviewed for comprehensive Individual Care Planning (ICP) and implementation and was evidenced by the following: 1. On 12/15/2025 at 09:40 AM during initial tour of the facility the surveyor observed Resident # 95 in bed and they asked if surveyor # 1 could find someone to change his/her brief. A review of Resident # 95's admissions record revealed that, Resident # 14 was admitted with but not limited to fracture of the lower end of right radius, (broken wrist) and rhabdomyolysis (a condition where muscle tissue breaks down rapidly and releases its contents into the bloodstream). A review of Resident #95's admission Minimum Data Set (MDS; an assessment tool) dated 11/03/2025 revealed under section H that Resident # 95 was occasionally incontinent of bladder and frequently incontinent of bowel. A review of the current Care Plan (CP) for Resident #95 revealed no focus or intervention for incontinence or incontinence care. During an interview on 12/17/2025 at 10:427AM with surveyor #1 the Unit Manager Registered Nurse (UMRN) said that residents with any incontinence should have a focus for that on their care plan. When asked if Resident #95 should have a focus for incontinence the UMRN replied, yes, but I see that it's not here. During an interview on 12/18/2025 at 12:31 PM with surveyor # 1, the Director of Nursing (DON) replied, yes when asked if incontinence should be reflected in a care plan. The DON said it was important, so staff are aware of the care residents needed. A review of a facility provided policy titled, Care Plans, Comprehensive Person-Centered revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and function needs is developed and implemented for each resident. 2.) On 12/15/2025 at 9:51 AM, the Surveyor observed Resident #126's with left elbow maintained in a flexed position, and the fingers on the left hand were bent toward the palm. Resident #126 was not wearing orthotic device (device is applied to the body to modify or control skeletal structure or function), such as a splint or brace on the left arm or hand. When the surveyor asked the resident if they could move the left elbow or fingers of the left hand, the resident stated No. On 12/16/2025 at 9:19 AM, the surveyor again observed Resident #126 during breakfast. The resident was eating with the right hand, while the left arm remained flexed and positioned close to the body with the fingers bent toward the palm. The resident denied pain or discomfort but was unable to provide details regarding the care of the left arm. The resident appeared pleasant. The surveyor reviewed the resident's Electronic Medical Record (EMR) which revealed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Record (AD-admission summary) indicated that Resident #126 was admitted to the facility with the diagnoses which included but was not limited to; cerebral infarction (stroke), hemiplegia (paralysis) and diabetes mellitus (DM). Review of the quarterly Minimum Data Set (assessment that facilitates resident care) dated 9/25/25, reflected that Resident #126 scored a 5 out of 15 on the Basic Interview for Mental Status (BIMS) which indicated severe cognitive impairment. The MDS further identified impaired functional range of motion (ROM) of one upper extremity on one side of the body. Review of the Interdisciplinary Care Plan (ICP) revealed no documented care or goals addressing care of the resident's left elbow or left hand related to limited ROM or contracture. Review of Occupational Therapy (OT) Evaluation and Plan of Treatment dated 7/1/2024-7/28/24 indicated that Resident #126 had left sided hemiplegia affecting the non-dominant side of the body. The evaluation documented impaired limited ROM of the left shoulder, left elbow, left wrist and left hand, with functional limitations due to contracture impacting grasp and release and use of assistant device. On 12/16/2025 at 9:22 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who explained that Resident #126 required total assist with all activities of daily living (ADLs). The CNA further stated that the resident was paralyzed on the left side and required two-person assist for pivot transfers to the wheelchair (W/C). The CNA explained that the resident previously used a brace to the left arm, but the resident refused to continue wearing it and was resistant to wearing a hand roll (a rolled cloth or specialized device placed in a patient's hand to maintain finger extension, keep the thumb in opposition, and prevent painful finger curling (flexion contractures), preserving the hand's functional ability for grasping and promoting comfort). The surveyor could not locate any documentation in the EMR that verified that the resident refused to wear orthotics to the left arm or hand. The surveyor reviewed the residents ICP which did not contain a limited ROM or contracture focus with interventions or goals related to Resident #126's left arm or hand. The ICP also did not contain documentation that indicated Resident #126 refused to wear assistant devices or orthotics to the left arm or hand. On 12/16/2025 at 9:34 AM, the surveyor interviewed the Director of Rehab (DOR) who stated that Resident #126 received OT from 12/22/24 to 2/28/24 for ADLs. The DOR further added that Resident #126's initial evaluation for OT was done in 2024. He stated that on 7/1/2024 the resident was admitted to the facility with impairment/contractures to left upper extremity wrist, forearm and elbow. On 12/17/2025 at 8:30 AM, the surveyor interviewed the DOR who stated that Resident #126 was evaluated by the Occupational Therapist (OT) 12/16/25, after surveyor inquiry and the resident was ordered a splint for the left elbow and hand due to limited ROM. On 12/17/2025 at 8:39 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was familiar with Resident #126 care. The LPN stated that the resident had left sided weakness and used (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the right leg and arm. She stated that the resident was alert and informed the nurses of basic needs like pain, hunger or thirst. She stated that the resident could not provide detailed events due to confusion. The LPN stated that Resident #126 had limited ROM since admission to the facility and did not think the contractures have worsened. She explained that the resident did not use orthotics to the left elbow or hand, however, should have a ICP to address the contracture and limited ROM of the left elbow and hand. The LPN reviewed the ICP in the presence of the surveyor and confirmed that a ICP was not developed to address the contractures nor were there documented interventions or goals to prevent the contractures from getting worse. On 12/17/2025 at 9:05 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who confirmed that a ICP should have been developed with goals and interventions to address Resident #126's contracture and limited ROM of the left hand and elbow. He explained that interventions would include preventive measures to ensure that the contracture of the left elbow did not worsen or did not cause the resident discomfort. The surveyor viewed Resident #126 Medication Administration Record (MAR) which reflected that the resident did not have complaints of pain. On 12/17/2025 at 9:53 AM, the surveyor interviewed the OT who explained that Resident #126 was screened every quarter. She stated that Resident #126 was screened on the following dates: 9/24/25, 8/14/25 and 4/15/25, 4/11/25. She stated the resident's functional level did not change and there were no new contractures. OT stated that upon evaluation of 12/16/25 the residents' fingers were in a resting, curled position, however, were not contracted and were able to fully extend. She stated that the resident was admitted with the left elbow contracture. She did confirm that there should be ongoing interventions in place to prevent the contractures from deteriorating. On 12/19/2025at 9:41 AM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) both agreed on the importance of ensuring that ICPs be developed with preventative interventions and goals for residents with impaired ROM. A review of the facility policy dated 2001 and titled, Care Plans, Comprehensive Person-Centered indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39-27.1 (a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, it was determined that the facility failed to ensure that 1.) Physician-ordered treatments were administered as scheduled and 2.) proper hand hygiene and infection control practices were maintained during wound care. This deficient practice was identified for 1 of 1 resident (Resident # 22) reviewed for wound care and skin integrity.The deficient practice was evidenced by the following:A review of the Electronic Medical Record (EMR) for Resident # 22 revealed a physician's order dated 11/24/2025 for wound care to clean skin tears on bilateral arms with wound cleanser and apply xeroform and an abdominal dressing with Kling wrap daily and PRN (as needed).A review of the admission 5-Day Minimum Data Set (MDS; an assessment tool) dated 12/15/2025 revealed Resident # 22 had a diagnoses including muscle wasting and atrophy, unspecified convulsions, and anxiety disorder.A review of the individualized care plan initiated on 11/24/2025 revealed a focus of I have impaired skin integrity [related to] poor skin integrity with an intervention to Administer treatments as ordered and monitor effectiveness.On 12/15/2025 at 10:19 AM, the surveyor observed Resident # 22 in bed with dressings on both forearms dated 12/14/2025.On 12/16/2025 at 11:07 AM, the surveyor observed Resident # 22 in bed with dressings on both forearms still dated 12/14/2025, which indicated the daily treatment ordered for 12/15/2025 had not been performed.On 12/16/2025 at 11:09 AM, the surveyor observed Register Nurse (RN # 1) prepare to perform the dressing change for Resident # 22.At that time, RN # 1 brought the wound cart into the room and the surveyor observed there was no alcohol-based hand rub (ABHR) on the cart.RN # 1 donned gloves and moved the resident's bedside table but did not change his gloves or perform hand hygiene after touching the table and before initiated wound care.RN # 1 then removed the soiled dressings that were dated 12/14/2025.After removing the soiled dressings, RN # 1 removed his gloves and donned new gloves without performing hand hygiene.RN # 1 proceeded to apply xeroform and clean dressings to the wounds.After the application was complete, RN # 1 removed his gloves and did not perform hand hygiene before concluding the task.On the same date at 11:15 AM, during an interview with the surveyor, RN # 1 stated that hand hygiene should be performed before and after contact with the resident. When asked when gloves should be changed, RN # 1 stated he did not know the exact answer but changed them whenever he felt they were contaminated.On 12/18/2025 at 12:00 PM, during an interview with the surveyor, the Director of Nursing (DON) said staff should change gloves when they remove the dressing, perform hand hygiene, and reapply gloves. The DON confirmed that RN # 1 should not have brought the treatment cart into the resident's room during the treatment.A review of the facility's policy titled Wound Treatment revealed under Steps in the Procedure that staff are to Perform hand hygiene and put on clean gloves, Remove soiled dressing, and Remove gloves and perform hand hygiene before putting on clean gloves to apply the new treatment.N.J.A.C. 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) obtain physician orders for oxygen (O2) therapy before administering continuous oxygen, b.) monitor and document O2 levels while administering continuous oxygen, and c.) ensure that a resident's Interdisciplinary Care Plan (ICP) accurately reflected and guided the Resident's respiratory care needs in accordance with professional standards of nursing practice.This deficient practice was identified for 1 (one) of 6 residents (Resident #25) reviewed for Oxygen and was evidenced by the following: During the initial tour of the facility on 12/15/2025 at 10:39 AM, the surveyor observed Resident #25 lying in bed in their room. The resident was receiving O2 a rate of two liters per minute (2 LPM) via nasal cannula (NC), [tubing that delivers oxygen through the nostrils] with humidification (a process that adds moisture to the air) in use.A review of the admission Record (admission summary) dated 6/1/25 reflected that Resident #25 was admitted to the facility with diagnoses which included but were not limited to: Non-ST Elevation (NSTEMI) Myocardial Infarction (a condition that affects blood flow of the heart thereby reducing oxygen to heart) and pulmonary hypertension (high blood pressure in the lungs which causes shortness of breath). A review of the quarterly Minimum Data Set (MDS), an assessment that facilitates the management of a resident's care, dated 12/8/25, indicated that Resident #25 had a Brief Interview of Mental Status (BIMS) score of 13 out of 15, meaning the Resident's cognition was intact. The Order Summary Report (OSR), dated as of 12/16/25, did not include physician orders for O2 therapy including O2, O2 tubing, NC, or humidification. Additionally, the OSR revealed no physician orders to monitor oxygen levels, despite Resident #25 being administered O2 via NC at 2 LPM.A review of the Treatment Administration Record (TAR) for December 2025, revealed no documentation indicating that Resident #25 was receiving continuous O2 therapy. Additionally, the TAR did not reflect that the Resident's O2 levels were being monitored. Review of the Progress Notes (PN) revealed a nurse's note dated 12/12/25 at 2:03 PM revealing that Resident #25 was receiving O2 at 2 LPM via NC. This finding was supported by the Nurse Practitioner's PN dated 12/12/25 at 12:20 PM, which indicated that Resident's O2 level was 93% and confirmed that the Resident was receiving O2 at 2 LPM.A review of the O2 saturation levels (measures the percentage of oxygen in the blood), for December revealed that Resident #25's O2 level ranged from 93% to 97% on room air. No O2 measurements were documented after 12/8/25. On 12/17/25 at 9:31 AM, the surveyor interviewed the Licensed Practical Nurse (LPN)/Unit Manager (UM), who confirmed that Resident #25 was receiving O2 at 2 LPM via NC and O2 tubing with humidification without a physician's orders. The LPN/UM stated that The resident should have had physician orders for O2, O2 tubing, humidification, and monitoring O2 levels. The LPN/UM also acknowledged that the Resident's ICP should have included a problem focus with interventions to guide the Resident's care while receiving continuous O2 therapy. During the interview, the surveyor asked the LPN/UM to accompany her to Resident #25's room to assess the resident's O2 level, which was measured at 99%. The UM agreed that it was important to assess the resident's oxygen levels every shift to ensure that the O2 level is maintained within acceptable limits.On 12/17/25 at 9:40 AM, the surveyor interviewed the LPN/Infection Preventionist (IP), who confirmed that Resident #25 should have had physician orders for oxygen therapy, including weekly changes of O2 tubing and humidifier for infection prevention purposes. The LPN/IP further stated that The resident should have had a care plan in place that addressed their O2 needs and that the Resident's O2 levels should have been monitored while receiving O2 therapy.On 12/18/25 at 12:10 PM, the surveyor interviewed the Director of Nursing (DON), who acknowledged that the nurses should have obtained physician orders for O2 therapy before administering O2 including orders to monitor the Resident's O2 levels every shift. The DON also confirmed that the Resident's ICP should have been updated to reflect the O2 therapy.The DON further explained that monitoring O2 levels is essential to ensure that the Resident's O2 is maintained within recommended levels. When asked (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what nurses are expected to do if a resident does not have a physician order for O2 therapy, the DON stated, nurses are expected to contact the physician and obtain the order.The DON further explained that monitoring oxygen levels is essential to ensure that the resident's oxygen saturation is maintained within recommended levels. When asked what nurses are expected to do if a resident does not have a physician order for oxygen therapy, the DON stated, Nurses are expected to contact the physician and obtain the order.Review of the facility's policies revealed the following:1. Physician Orders policy, updated January 2025, indicated that licensed nurses will obtain, document and provide care and services in accordance with orders received from the physician. 2. Oxygen Administration policy, dated 2001, indicated that the purpose of this procedure was to provide guidelines for safe oxygen administration. The preparation outlined the following:a.) Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. b.) Review the Resident's care plan to assess for any special needs of the resident. 3. Care Plans, Comprehensive Person-Centered policy indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the Resident's physician psychosocial and functional needs is developed and implemented for each resident.N.J.A.C. 8:39-27.1(a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review it was determined that the facility failed to ensure a pain management regimen was followed in accordance with physician orders. This deficient practice was identified in 1 of 2 residents reviewed for pain (Resident #12).This deficient practice was evidenced by the following:On 12/15/25 at 11:22 AM, during the initial tour of the facility Resident #12 was observed in the room and said they feel good.On 12/16/2025 at 1:06 PM, Resident #12 was observed in the room and told the surveyor that he/she felt good, that they receive pain medication and said that their pain was controlled.A review of Resident #12's admission Record (an admission summary) reflected that Resident #12 was admitted to the facility with diagnoses which included but were not limited to arthritis and low back pain.A review of the Annual Minimum Data Set (MDS), an annual summary, dated 12/02/2025 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 11 out of 15, which indicated the resident was moderately cognitively impaired. Review of Section J, titled Health Conditions, revealed that the resident had a pain assessment completed. It reflected that the resident received routine pain medication.The surveyor reviewed Resident #12's physician orders which reflected, on 05/26/2025, an order for Hydrocodone-Acetaminophen Tablet 5-325 milligrams [MG] (a narcotic pain reliever), one tablet every four hours as needed for moderate pain related to presence of a left artificial knee joint (four to six on the one to ten numeric pain scale), Tramadol HCl Oral Tablet 50 MG (narcotic pain reliever) one tablet every six hours as needed for mild pain related to presence of left artificial knee joint (one to three on the one to ten numeric pain scale) and Acetaminophen 325mg (pain reliever), give two tablets by mouth every six hours as needed for pain. A review of the Medication Administration Record (MAR) for November and December 2025 reflected that Resident #12 received tramadol 50mg on 11/25/2025 at 1:20 PM for a pain level of four, on 12/4/2025 at 9:05 PM for a pain level of four, and on 12/14/2025 at 8:27 PM for a pain level of five. Resident #12 received acetaminophen 325mg two tablets on 11/4/2025 at 7:08 PM for a pain level of four, 11/26/2025 at 05:29 PM for a pain level of five and on 12/02/2025 at 8:46 PM for a pain level of five. The November and December MAR reflected that Resident # 12 did not receive the Hydrocodone-Acetaminophen Tablet 5-325 MG according to the physician order.On 12/16/2025 at 9:53 AM, the surveyor interviewed the Registered Nurse (RN) who cared for Resident #12 regarding the pain regime. The RN stated that the facility used a numeric pain scale of one to ten. The surveyor and the RN reviewed the pain medication orders for Resident #12. The RN acknowledged that Resident #12 received pain medication outside of the physician ordered parameters. On 12/17/2025 at 12:17 PM, the surveyor interviewed the LPN Unit Manager regarding pain scale. The LPN stated they used a numeric scale, one to three for mild pain, four to six for moderate pain and seven to ten for severe pain. The Unit Manager reviewed the November and December 2025 MAR for Resident #12 and acknowledged the tramadol and acetaminophen were given outside of the parameters ordered by the physician. The surveyor reviewed the facility provided policy titled, Pain Assessment and Management dated April 2025, reflected that the purposes of this procedure are to help the staff identify pain in the resident, develop interventions consistent with the resident goals and needs, and address the underlying causes of pain. The surveyor reviewed the facility policy titled, Administering Medications with a reviewed date of April 2019. The policy stated that medications are administered in accordance with prescriber orders and validate physician ordered parameters prior to medication administration. NJAC-8:39-27.1 (a)

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	315218	A. Building B. Wing	12/19/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, it was determined that the facility failed to ensure that medications were administered in accordance with prescriber orders by failing to administer an intravenous (IV) antibiotic within the required timeframe. This deficient practice was identified for 1 of 1 resident (Resident # 3) review for medication administration.The deficient practice was evidenced by the following:A review of Resident # 3's diagnoses revealed but were not limited to, acute osteomyelitis (a sudden and painful infection of the bone) of the left ankle and foot, bacteremia (the presence of harmful bacteria in the bloodstream), and a Methicillin-resistant Staphylococcus aureus (MRSA) infection (a type of staph bacteria that is very difficult to treat because it is resistant to many common antibiotics).A review of a physician's orders located in the Electronic Medical Record dated 12/2/2025 revealed an order for Daptomycin (an antibiotic) Intravenous Solution Reconstituted 430 milligram to be administered intravenously one time a day at 18:00 (6:00 PM) for osteomyelitis.A review of the facility's Medication Audit Report revealed that the Daptomycin IV was administered outside of the facility's designated one-hour window on the following dates:On 12/2/2025, the 18:00 dose was administered at 20:26 (8:26 PM).On 12/5/2025, the 18:00 dose was administered at 20:01 (8:21 PM).On 12/10/2025, the 18:00 dose was administered at 19:51 (7:51 PM).On 12/12/2025, the 18:00 dose was administered at 21:14 (9:14 PM).On 12/18/2025 at 9:44 AM, during an interview with the surveyor, the Interim Unit Manager Registered Nurse (UMRN) stated that the antibiotic should be administered at six, with a window of one hour before and one hour after the scheduled time.The UMRN further stated that if a medication is going to be late on more than one occasion, the nurse should notify the doctor and Infectious Disease (doctors who specialize in treating illness caused by germs like bacteria and viruses) to ask for a schedule change.The UMRN confirmed that there was no indication in the progress notes that the nurse had contacted the physician regarding the late administrations.On 12/18/2025 at 12:00 PM, during an interview with the surveyor, the Director of Nursing (DON) stated that medications should be given within their administration times, which is defined as one hour before and one hour after the scheduled time.A review of the facility's policy titled, Administering Medications revealed that Medications are administered in accordance with prescriber orders, including any required time frame. The policy further indicated that Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.N.J.A.C. 8:39-29.4(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications and medical supplied were stored safely, securely, and in accordance with professional standards. The facility failed to ensure that a resident did not self-administer medications without a physician's order, evaluation, and care plan, and failed to store medications in a locked area. Additionally, the facility failed to ensure medical supplies were maintained for use by having expired supplies in 1 of 2 medication storage rooms inspected under the Medication Storage task. The deficient practice was identified for 1 of 1 residents (Resident # 38) reviewed for medication storage and 1 of 2 medication storage rooms inspected. The deficient practice was evidenced by the following: A review of Resident # 38's diagnoses revealed a fracture of unspecified part of neck of left femur (a break in the upper part of the thigh bone), chronic obstructive pulmonary disease (a group of lung diseases that make it hard to breathe), and acute respiratory failure with hypoxia (a sudden condition where the lungs cannot get enough oxygen into the blood). A review of physician's orders for Resident # 38 revealed an order for Albuterol Sulfate HFA inhalation Aerosol Solution, 2 puffs inhaled orally every 6 hours as needed for wheezing. A review of Resident # 38's individualized care plan initiated on 11/16/2025 revealed a goal to mitigate the risk for respiratory complications and infections. A review of Resident's # 38 Electronic Medical Record revealed there was no physician's order for the self-administration of medications and no care plan for self-administration. On 12/15/2025 at 10:12 AM, the surveyor observed an inhaler and a nasal spray on Resident # 38's bedside table. At that time, Resident # 38 told the surveyor that she [NAME] the medications from home and was allowed to have them. On 12/16/2025 at 9:43 AM, during an interview with the surveyor, the Interim Unit Manager Registered Nurse (UMRN) stated that the facility keeps a record of which residents can self-administer medications in the physician's orders, care plan, and Minimum Data Set (MDS). The UMRN further stated that the process for a resident to self-administer medication requires speaking with the physician, obtaining a physician's order, an evaluation for self-administration, and an updated care plan. The UMRN confirmed that medications considered for self-administration, such as nasal sprays and rescue inhalers, should be stored at the bedside only if properly labeled and was unsure if they could remain at the bedside. On 12/18/2025 at 12:00 PM, during an interview with the surveyor, the Director of Nursing (DON) stated that inhalers or nasal sprays should not be left at a resident's bedside. The DON further stated that if a resident is able to self-administer, the medical record must contain a (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order, and evaluation, and a care plan. The DON confirmed that even if a resident is cleared to self-administer, the medications should be stored in a locked drawer in the bedroom. A review of the facility's policy titled Medication Storage revealed that the administrator will provide an appropriate and safe medication storage area for the storage of medications that are not self-administered by the resident. A review of the facility's policy titled Administering Medications revealed that residents may self -administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determining that they have the decision-making capacity to do so safely. N.J.A.C. 8:39-29.4(h) On 12/15/2025 at 12:29 PM the surveyor in the presence of a Licensed Practical Nurse (LPN)# 2, observed 3 Hypodermoclysis kits with an expiration date on 10/01/2025 in the third-floor medication storage room. LPN # 2 said we don't use them much, but no, expired ones should not be in here, and she removed them from the medication room to dispose of them. During an interview on 12/18/2025 at 12:31 PM with the surveyor the Director of Nursing (DON) said there should not be any expired items in the medication rooms because you don't want to give residents expired medications. Facility failed to provide a policy. N.J.A.C 8:39-29.4 (g)

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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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on record review, interview, and review of facility documentation, it was determined that the facility failed to ensure that 1 of 24 Registered Nurses (RN # 1) maintained a valid license or multistate privilege to practice in the State of New Jersey in accordance with the Nurse Licensure Compact (NLC) 60-day residency rule. The deficient practice was evidenced by the following: A review of the employee file for RN # 1 revealed that she was hired on 8/14/2025.The file included a New Jersey Driver's License issued on 01/17/2025, which listed a primary residential address in New Jersey.A review of RN # 1's employment application, signed on July 21, 2025, also listed a primary residential address in New Jersey.The licensure documentation in the file consisted of a multistate Registered Nurse license from the State of Florida, issued on 4/21/2025, with an expiration date of 4/30/2027. The address listed on the license revealed another New Jersey residential address that was different than the one on her New Jersey Driver's License. A review of Nurse Licensure Compact (NLC) rule 402.2 revealed that a multistate licensee who changes their primary state of residence to another party state shall apply for a multistate license in the new party state within 60 days.As RN # 1 had established primary residency in New Jersey as of 01/17/2025 but continued to practice under a Florida multistate license past the 60-day requirement, she was not properly licensed to practice in New Jersey.On 12/18/2025 at 11:03 AM, during an interview with the surveyor, the Human Resources (HR) Manager stated that RN # 1 was a per-diem employee and that there was no knowledge of any address change for her.The HR Manager confirmed that RN # 1's residential address on file was in New Jersey and that no Florida address could be found in the employee's paper file.On 12/18/2025 at 11:40 AM, during an interview with the surveyor, the Director of Nursing (DON) confirmed that RN # 1 was an active employee and was scheduled to work in the facility.A review of the facility policy titled Licensure, Certification, and Registration of Personnel revealed that the facility conducts license verification in accordance with current federal and state laws.N.J.A.C. 8:39-5.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility staff failed to ensure that respiratory equipment was stored in a manner that prevented contamination, in accordance with infection prevention and control standards for 1 of 6 residents reviewed for oxygen. (Resident # 57). The deficient practice was evidenced by the following: On 12/16/2025 at 09:32 AM during the initial tour the surveyor observed Resident # 57's continuous positive airway pressure (CPAP) machine (a machine that gently blows air throw a hose and mask to help a person breath while they sleep) mask laying on the night stand open to air.A review of Resident # 57's admission Record revealed the resident was admitted to the facility with but not limited to Chronic Respiratory Failure with Hypoxia (low levels of oxygen in your body), Chronic Obstructive Pulmonary Disease (a group of lung conditions that cause breathing difficulties), and Obstructive Sleep Apnea. (a sleep disorder where a person stops breathing repeatedly during sleep.)A review of Resident #57's Medication Administration Record (MAR) revealed a physician's order to provide new patient bedside bag weekly for CPAP.During an interview on 12/17/2025 at 10:21 AM with the surveyor, the Licensed Practical Nurse (LPN) #1 said that all respiratory equipment should be stored in a labeled plastic bag when not in use for proper infection control. During an interview on 12/17/2025 at 11:42 AM with surveyors, the infection preventionist (IP) said that tubing and masks should be stored in a bag when not in use. The IP also said tubing, bag and masks should be changed weekly and should not be stored open to air on top of the nightstand.A review of a facility provided policy titled Cleaning and Disinfection of BiPAP/CPAP devices Between Residents revealed, Store clean BiPAP/CPAP device in an area where there is low risk of contamination between uses. NJAC 8:39-19.4 (k)