

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2025
NAME OF PROVIDER OR SUPPLIER Barnegat Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 859 West Bay Ave Barnegat, NJ 08005	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ182922Based on interviews, medical record review, and review of other pertinent facility documents on 7/21/25, it was determined that the facility failed to implement their abuse policy by protecting Resident #4, as well as all residents from abuse, when on 1/25/25 at 8:40 PM, the Certified Nursing Aide (CNA #3) observed CNA #1 and CNA #2 physically abuse Resident #4 and CNA #3 did not report the incident until the next day, 1/26/25 at approximately 12:37 PM. This deficient practice was identified for 1 of 4 residents reviewed (Resident #4).On 1/25/25 at 8:40 PM, during the 3:00 PM to 11:00 PM shift (3-11), CNA #3 reported hearing screaming coming from Resident #4's room, and when she walked into the room, CNA #3 stated that she observed the resident sitting on their bed with CNA #1 trying to remove the resident's shirt and CNA #2 trying to put on a [NAME] coat (hospital gown). CNA #3 reported observing the resident yelling and being combative and spit at CNA #1, who appeared agitated from it and CNA #1 straddled the resident on the bed. CNA #3 reported that while resident laid on their back, CNA #2, took the resident's face and smooched it into the mattress. At that time, CNA #3 stated she told them she would take it from here, and both CNA #1 and CNA #2 stopped and walked out of the resident's room like nothing happened. CNA #3 did not report the incident immediately and CNA #1 and CNA #2 continued to work the 3-11 shift having access to Resident #4 as well as other residents. CNA #3 reported the incident the following day almost sixteen hours later on 1/26/25 at approximately 12:37 PM, during the 7:00 AM to 3:00 PM (7-3) shift. The facility's failure to ensure Resident #4, as well as all residents were protected from abuse by immediately reporting and investigating an allegation of physical abuse to Resident #4 posed the likelihood of serious physical and psychosocial harm and impairment to all residents. This resulted in an Immediate Jeopardy (IJ) situation which ran from 1/25/25 at 8:40 PM, when CNA #1 observed Resident #4 being abused, until 1/26/25 at 12:27 PM, when CNA #1 reported the incident to the Nursing Supervisor (Supervisor #1). The IJ was Past Non-Compliance (PNC).The facility's Administration was notified of the IJ on 7/21/25 at 4:58 PM. The facility submitted an acceptable Removal Plan on 7/24/25 at 1:36 PM.The facility was back in compliance when the facility addressed the situation by immediately investigating the incident; suspending CNA #1 and CNA #2 pending an investigation and later terminating; educating CNA #3 as well as all staff on the facility's abuse policy and immediately reporting allegations to the administration; Resident #4 was assessed and x-rays were taken; and contacted outsourced provider regarding training for staff on how to deal with residents with dementia and behaviors. The surveyor verified the completion of the Removal Plan was 1/30/25, during an on-site survey on 7/25/25, and determined the IJ was PNC.The evidence was as follows:A review of the undated facility policy titled Protecting Our Residents Abuse Prevention & Reporting, Dignity, Resident's Rights included each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.Definitions: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Employee Reporting Requirements: The center is required to ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source (e.g. bruise) [,] are reported immediately to the Administrator of the facility and to other officials in accordance with state law. Any employee who suspects or has had a resident or family member report abuse, must report immediately. Failure to report timely may result in disciplinary action. Suspending Pending an Investigation: Any employee whose conduct gives rise to a reasonable suspicion of resident abuse may be immediately removed from the floor, and where appropriate suspended without pay pending an investigation. In addition, if an allegation has been made against an employee, for the integrity of the investigation, the employee will be suspended pending an investigation. See something, say something. Even if you think that someone may have already reported it, still say something.A review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy dated revised September 2022, included if abuse, neglect, exploitation [,] is suspected, the suspicion must be immediately reported to the administrator and to other officials according to state law.Investigating Allegation.6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.According to the Facility Reportable Event (FRE) dated 1/27/25, reported to the New Jersey Department of Health (NJDOH), included the following:A review of the Summary revealed that on 1/26/25 at approximately 12:37 PM, a CNA (CNA #3) made the Nursing Supervisor (Supervisor #1) aware of care concern regarding a resident (Resident #4) pertaining to</p>		