STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center for Rehab & Nursing Washington Township	535 Egg Harbor Road Sewell, NJ 08080

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 - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Complaint #: 2731697 Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy to ensure residents were protected after a cognitively impaired resident made an allegation of staff-to-resident physical abuse. This deficient practice was identified for 1 of 2 residents (Resident #123) reviewed for abuse. The evidence is as follows:Refer to F610 The surveyor reviewed the medical record for Resident #123. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to; insomnia, major depressive disorder, generalized anxiety disorder, and other symptoms and signs involving cognitive functions and awareness. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/15/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident did not experience hallucinations or delusions and did not have any physical or verbal behaviors directed towards others. A review of the Individual Comprehensive Care Plan (ICCP), included the following focus areas:-Cognitive loss related to a BIMS of 8 upon admission. Interventions included: Allow adequate time to respond, do not rush or supply words, approach/speak in a calm, positive/reassuring manner, and identify self when speaking with the resident.-Right to a safe, home-like environment and to be treated with dignity and respect and to be free from neglect, abuse, and discrimination. Interventions included: Staff will encourage and inform the resident of the right to be free from discrimination.-Resistive/noncompliant with treatment/care related to cognitive impairment. Interventions included: If resisting care, leave (if safe to do so) and return later. A review of the Progress Notes (PN), dated 1/20/26 through 2/3/26, did not include any allegations of abuse. On 2/3/26 at 10:00 AM, the surveyor conducted staff interviews on the 100 unit related to the facility's abuse prevention policy. On 2/3/26 at 10:11 AM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated she was in-serviced on abuse monthly and that if she heard about a resident being abused, she would immediately report it to the Supervisor, the Director of Nursing (DON), and the Licensed Nursing Home Administrator (LNHA). The CNA then stated that about a week ago, Resident #123 reported to her that a nightshift CNA punched the resident in the ribs. The CNA stated she immediately notified Licensed Practical Nurse (LPN #1), but that he told her he didn't want to get involved. When the surveyor asked CNA #1 if she reported the allegation of abuse to anyone else after receiving that response from LPN #1, the CNA stated, no. CNA #1 then stated she believed the perpetrator was CNA #2 who worked overnight shifts and had gotten in trouble in the past related to resident care. The CNA explained it was important to report allegations of abuse to keep residents safe. On 2/3/26 at 10:45 AM, the surveyor observed and interviewed Resident #123 who at first stated they were unable to recall the incident. The resident then stated, I can't honestly say, too much time has gone by, but I did get a couple punches from her. The (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resident then stated that CNA #1 probably knew who the perpetrator was and that the incident happened less than a month ago. On 2/3/26 at 10:50 AM, the surveyor interviewed CNA #6, who stated Resident #123 was confused, but had never made any false accusations towards staff. On 2/3/26 at 10:55 AM, the surveyor interviewed LPN #2, who stated Resident #123 was alert and oriented, but confused and forgetful at times. The LPN further stated the resident did not make false accusations towards staff. On 2/3/26 at 11:23 AM, the surveyor, in the presence of the survey team, interviewed the DON and the LNHA who stated that staff were supposed to report any allegations of abuse immediately to their supervisor so that an investigation could be started. The DON and the LNHA added that any staff accused of abuse should be suspended to protect the residents. At that time, the surveyor notified the DON and the LNHA of Resident #123's allegation of abuse. The DON and the LNHA stated they were unaware of the allegation and verified that CNA #1 should have reported the allegation of abuse to a supervisor. On 2/3/26 at 12:18 PM, the surveyor, accompanied by the Director of Social Services (DSS), conducted a follow-up interview with Resident #123 who stated an employee punched him/her in the side/back. The resident further stated that CNA #1 was aware, but all this time went by and nothing came of it, and, if it had been reported earlier, it would have been better. On 2/3/26 at 12:34 PM, the surveyor attempted to call LPN #1 and left a voicemail for him to call the surveyor back. On 2/3/26 at 12:35 PM, the surveyor attempted to call CNA #2 and left a voicemail for her to call the surveyor back. On 2/3/26 at 12:40 PM, the surveyor conducted a phone interview with the Licensed Practical Nurse/Supervisor (LPN/S) who stated she supervised the overnight shift. The LPN/S stated that if staff received an allegation of abuse, they should immediately report it to the DON and the LNHA to protect the resident and initiate an investigation. The LPN/S then stated she was not familiar with Resident #123, but that she had not received any allegations of abuse. On 2/3/26 at 1:00 PM, the surveyor conducted a follow-up interview with the DON and the LNHA who stated that after becoming aware of Resident #123's allegation of abuse, they immediately reported it to the New Jersey Department of Health (NJDOH) and started an investigation. A review of CNA #1's written statement, signed 2/3/26, revealed Resident #123 reported the allegation to the CNA on 1/23/26 at 9:15 AM. Further review of the statement included CNA #1 reported the allegation to LPN #1 who didn't want to get involved and she did not report the allegation to anyone else. A review of the 100 Unit Daily Assignment Sheet revealed CNA #2 worked the night of 1/22/26 into the morning of 1/23/26. A review of CNA #2's personnel file revealed a written warning, dated 11/13/25, for poor customer service, ineffective communication, providing care to resident without verbalizing what she was doing, which CNA #2 refused to sign, but signed that she received education related to the write up. On 2/4/26 at 9:00 AM, LPN #1 returned the surveyor's phone call and stated that if he received an allegation of abuse, he would report it to the supervisor to protect the residents. He further stated that reporting allegations of abuse included following the chain of command to ensure the allegation was investigated. LPN #1 denied receiving any allegations related to Resident #123 and stated Resident #123 could be difficult for the overnight staff, but had never had any behaviors of false accusations towards staff. A review of the facility's Abuse Prevention Program policy, revised January 2025, included that the residents had the right to be from abuse, neglect, misappropriation of resident property, and exploitation. The policy further included, as part of the resident abuse prevention, that the administration would do the following:1. Protect residents from abuse by anyone, including facility staff.2. Conduct employee background checks.3. Develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of residents.4. Require staff training/orientation programs that include topics such as abuse prevention and identification and reporting of abuse.5. Implement (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	measures to address factors that may lead to abusive situations.6. Identify and assess all possible incidents of abuse.7. Investigate and report any allegations of abuse within timeframes required by federal requirements.8. Protect residents during abuse investigations.9. Establish and implement a QAPI (Quality Assurance and Performance Improvement) review and analysis of abuse incidents and implement changes to prevent future occurrences of abuse.10. Involve the resident council in monitoring and evaluating the facility's abuse prevention program. NJAC 8:39-4.1(a)(5)