STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315312	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Ridge Healthcare and Rehabilitation	94 Stevens Road Toms River, NJ 08755

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2723157Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to report an allegation of sexual abuse to the New Jersey Department of Health (NJDOH) as mandated for 1 of 1 resident (Resident #21) reviewed for abuse and was evidenced by the following:On [DATE] at 9:33 AM, the surveyor observed Resident #21, awake in bed. When the surveyor began speaking to the resident, the resident indicated to the surveyor that they were hard of hearing.On [DATE] at 11:22 AM, the surveyor together with another surveyor observed Resident #21, awake and alert in bed. The resident was calm with no sign of distress. The resident was asked by the surveyors through written questions that the resident was able to read and understand, whether they prefer a male or female aide (CNA) (Certified Nursing Assistant) to give them care. The resident stated that they only prefer female aides to give them care. The resident was asked if they previously had a problem with a male aide. The resident narrated that a few months ago, they had a male aide who gave them a shower with the name that sounded like [name redacted] who touched them inappropriately in the groin area. The resident stated that they told one of the people that changed them or the administrator on the day or the next day when the incident happened. A review of the electronic medical record (EMR) for Resident #21 revealed the following:A review of the admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to the following: Dementia, Depression, and Mixed Anxiety Disorder.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [DATE], reflected that Resident #21 had severely impaired cognition. The MDS also revealed that the resident was dependent on staff for their activities of daily living that included toileting hygiene, shower, and lower body dressing.A review of the individualized person-centered care plan revised on [DATE], included a focus of impaired functional status related to impaired mobility due to fall at home resulting in fracture of the right shoulder. One of the interventions included no male CNAs created on [DATE].A review of the Point-of-Care (POC) documentation (care staff documentation of care activities in the EMR) in [DATE] revealed the resident was given shower on [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 10:10 AM, the Director of Nursing (DON) identified to the surveyor the male aide who gave the showers on the above dates as CNA #2.A review of the facility-initiated investigation file about Resident #21's allegation included the following: a summary of events with conclusion by the Licensed Nursing Home Administrator (LNHA) dated [DATE]; a list of female residents under the care of CNA #2 who were interviewed by LPN/ UM dated [DATE]; undated statement from CNA #2; statements from other CNAs and 2 nurses with varied dates from [DATE] to [DATE]; facility-wide re-education about Abuse, Neglect and Resident Rights from [DATE] to [DATE]; a completed background screening form of CNA #2; and Abuse and Neglect Policy and Procedure dated February 2025. The investigation concluded that there was no evidence to support the allegation of sexual abuse. CNA #2 was placed on administrative leave on [DATE] and was reinstated back to work on [DATE]. The investigation file did not include any documentation that the New Jersey Department of (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Health (NJDOH) was notified.On [DATE] at 9:42 AM, during an interview with the surveyor, the DON stated that when an allegation of abuse is reported, they interview the resident, check for pain and do skin assessment, do incident report, notify the family, physician, and police. The DON further stated that with the administrator already aware, investigation would be started and if the event is reportable, they report to the NJDOH. The DON stated that they report to the NJDOH within 2 hours if there's an injury and if not within 24 hours. On [DATE] at 12:58 PM, during an interview with the survey team, the Licensed Nursing Home Administrator (LNHA) stated that they should have reported the allegation to the NJDOH and that they were wrong in not doing so. The LNHA confirmed to the survey team that there was no evidence to support the allegation and that CNA #2 does not work in the facility anymore since their certification expired last [DATE].A review of the facility-provided policy revised in February 2025, titled Resident Abuse/ Neglect Policy and Procedure included under Investigative and Reporting Procedure: The Department of Health and Senior Services, and the Office of the Ombudsman if the resident is 60 or over, will be notified immediately (as soon as possible but not to exceed 2 hours) of the incident, followed by a written report within 5 days of the incident and if the alleged violation is verified, the facility shall take corrective action. N.J.A.C. 8:39-27.1(a)