STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute at Seashore Gardens	22 West Jimmie Leeds Road Galloway Township, NJ 08205

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to ensure one of three residents (Resident (R) 102) reviewed for choices and food preferences were honored, Specifically, 27 out of 28 residents residing in the secure dementia unit were not offered choices of food, beverages, and condiments at meals. This failure could lead to dissatisfaction with meals, weight loss, or malnutrition. Findings include:Review of R102's admission Record located under the Profile tab in his electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] and had diagnoses including dementia, mood disorder, chronic kidney disease, and anemia.Review of R102's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/07/25 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of one out of 15 which indicated R102 had severely impaired cognition. The resident did not exhibit any mood or behavioral problems. The resident received a mechanically altered, therapeutic diet.During an interview on 07/21/25 at 11:54 AM, R102's Family Member (F1) stated the residents on the secure dementia unit were not offered choices of food or beverages at meals. F1 stated she provided information on the resident likes and dislikes, but added, I know they give him/her things he/she doesn't like, like today's tuna casserole. He/she doesn't like fish. I told them that. Review of R102's Care Plan dated 02/11/25 and located under the Care Plan tab of the EMR revealed, [R102] is at risk for malnutrition r/t [related to] Hx [history of] significant weight change, inadequate caloric intake with need of supplementation, need of therapeutic/mechanically altered diet, [and] PMHx: [past medical history of] Afib [atrial fibrillation], CKD [chronic kidney disease], Anemia, Dementia, HTN [hypertension], [and] HLD [high cholesterol]. The approaches included, Encourage H2O [water] intake at and between meals for hydration . [and] Honor food and fluid preferences to optimize PO [oral] intake, update PRN [as needed]. -Dislikes: fish, mushrooms.Review of R102's Dietary Assessment and Documentation dated 11/03/24 and located under the Assessments tab of the EMR revealed, Food preferences were reviewed and updated with the kitchen. Dislikes fish, mushrooms. Review of R102's meal tray card provided on paper from the kitchen revealed the dislikes of fish and mushrooms were included on the card. During observation of lunch in the secure dementia unit on 07/21/25 beginning at 11:58 AM, all residents but one (who received a grilled cheese sandwich) were served tuna casserole, tater tots, and green beans. There were no condiments, such as salt, pepper, or ketchup, available or offered to the residents. All residents received a glass of lemonade; there were no other beverages available or offered, though one resident requested and received a cup of coffee. No water was served with the meal. R102 was served tuna casserole, tater tots, green beans, and a glass of lemonade. The resident did not receive water with their meal as directed on the Care Plan. The resident was observed to only eat bites of their meal while being assisted by F1.During observation of lunch in the secure dementia unit on 07/24/25 beginning at 11:50 AM, all residents but one (who received a veggie burger) were served pasta and sauce, meatballs, and spinach. All residents were served a glass of strawberry-kiwi juice, there were no other beverages available or offered. Additionally, no condiments were available or offered. During an interview on 07/24/25 at 11:57 AM, Certified Nure Aide (CNA) 2 stated the kitchen typically sent one type of juice with each meal. She stated the residents were only given the juice that was sent, they were not offered a choice of beverage. During an interview on 07/24/25 at 12:04 PM, CNA7 stated the kitchen typically sent the main meal for all residents; their orders were not taken, and they were not offered choices at meals.During an interview on 07/24/25 at 12:05 PM, CNA1 stated all residents were served the main meal; however, they could ask for something different and it would be requested from the kitchen.During an interview on 07/24/25 at 1:26 PM, the Dietary Manager (DM) stated that since the residents in the secure dementia unit were cognitively impaired, the weekly menus were left out at the front desk for the family members to fill out with resident preferences. She stated there was no system in place to offer residents a choice of meals unless the family members were in the facility to fill out the menus each week. The DM stated residents' likes and dislikes were assessed upon admission, and the kitchen should serve something different if a food is listed as a dislike. The DM stated R102 did not like fish, so he/she should have received a substitute for the tuna casserole. The DM explained that in the facility's main dining room, there was a menu provided, and servers assisted the residents to choose their preferences at the beginning of each meal. The DM stated the staff should be offering a choice of beverages. She stated in the main dining room, different types of juice, different types of soda, water

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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** Based on interview, record review, and policy review, the facility failed to ensure timely reporting of an injury of unknown origin for one out of five residents reviewed for abuse (Resident (R) 97). This failure had the potential to contribute to further abuse or injury, which could result in mental anguish, physical harm, or fear. Findings include: Review of R97's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, depression, and anxiety. Review of R97's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/12/25 and located under the MDS tab of the EMR revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS) and was assessed with severely impaired cognition. The resident had short and long-term memory problems and exhibited physical behaviors toward others almost daily and other behavioral symptoms and rejection of care occasionally. Review of R97's Care Plan initiated on 03/23/24 updated 06/05/24 and located under the Care Plan tab of the EMR revealed, I am at risk for misappropriation, neglect, abuse and/or exploitation r/t [related to] Dementia. The goal was, I will not experience any form of abuse, neglect, misappropriation and/or exploitation through review date. The approaches included, Assess me for s/s [signs/symptoms] of abuse and/or neglect (ex. bruises, wt [weight] loss, behavior, psychosocial status) and report to appropriate resources . Investigate all allegations of abuse & [and] neglect promptly . [and] provide support and ensure I am free from abuse.Review of R97's Nurse's Note written on 06/02/24 at 11:36 AM and located under the Progress Notes tab of the EMR revealed, Nurse was notified by CNA [Certified Nurse Aide] that resident presented with new bruises all over bilateral lower extremities, chest, abdomen, hip into coccyx area. Resident also has swelling on abdominal area. Review of R97's Reportable Event Record/Report dated 06/03/25, in the investigation packet, revealed bruising was noted to R97's sternal area, along the lateral aspects following the seams of the bra line, right posterior hip, and coccyx. R97 was unable to explain the bruising and staff was unaware of the cause of the bruising. The report documented R97's injury of unknown origin was found on 06/02/24 at 11:36 AM, and the initial report was called in to the State Survey Agency (SSA) on 06/02/24 at 5:31 PM, almost six hours after the injury was discovered.During an interview on 07/24/25 at 6:11 PM, the Director of Nursing (DON) stated she was unsure when she was alerted to R97's unexplained injuries, but the injury was discovered on 06/02/24 at 11:36 AM and should have been reported to her immediately. She stated with an injury of unknown origin, there was a two-hour reporting window, and it should have been reported to the SSA within two hours of discovery.Review of the facility's policy titled, Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, dated September 2022 revealed, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: . The state licensing/certification agency responsible for surveying/licensing the facility . 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury . NJAC 8:39-9.4(f)