

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/30/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRYSTAL LAKE HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>395 LAKESIDE BLVD</b> <b>BAYVILLE, NJ 08721</b>		
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F 000	<p>INITIAL COMMENTS</p> <p>COMPLAINT #: NJ181767, NJ181768, NJ181846</p> <p>CENSUS: 201</p> <p>SAMPLE SIZE: 7</p> <p>THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p> <p>F600 L</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documents on 12/23/2024 and 12/30/2024, it was determined that the facility failed to a.) prevent NJ Ex Order 26.4b1 towards a resident (Resident #1) from a staff member and b.) staff members that witnessed the abuse failed to intervene and report the incident. The facility also failed to follow its policy titled "Abuse Policy and Procedure."</p> <p>During an interview on 12/23/2024 at 3:08 P.M., the Licensed Practical Nurse (LPN #1) stated she recorded a video on her cellphone of the U.S. FOIA (b) (6) Resident #1 with a NJ Ex Order 26.4 LPN #1 sent the video to a friend, and it was posted to a social media website. On NJ Ex Order 26.4B1, the local police went to the facility to investigate an abuse allegation after receiving notification that the video was circulating online.</p> <p>The Surveyors and the U.S. FOIA (b) (6)</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/22/2025

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.

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F 000	<p>Continued From page 1</p> <p><i>U.S. FOIA (b) (6)</i> reviewed a video on <i>NJ Ex Order 26, 4B1</i> at 10:41 A.M. found on a social media website, that revealed a staff member <i>NJ Ex Order 26</i> at a resident with <i>NJ Ex Order 26, 4B1</i>. Several other staff members observed the incident and did not intervene. The <i>U.S. FOIA (b) (6)</i> identified the resident in the video as Resident #1. The <i>U.S. FOIA (b) (6)</i> identified the staff member holding the <i>NJ Ex Order 26, 4B1</i> throughout the video as the <i>U.S. FOIA (b) (6)</i>. The <i>U.S. FOIA (b) (6)</i> was heard asking the staff that were present during the incident to go get another staff member. The <i>U.S. FOIA (b) (6)</i> then stated, <i>NJ Ex Order 26, 4B1</i>. The other staff members seen in the video that did not intervene when the incident occurred were identified by the <i>U.S. FOIA (b) (6)</i> as LPN #2, Certified Nursing Assistant (CNA #2), and the <i>U.S. FOIA (b) (6)</i>. The <i>U.S. FOIA (b) (6)</i> stated that according to the Facility Reportable Event (FRE) form completed by the <i>U.S. FOIA (b) (6)</i>, the incident occurred on <i>NJ Ex Order 26, 4B1</i>.</p> <p>Review of the FRE dated <i>NJ Ex Order 26, 4B1</i> revealed the <i>U.S. FOIA (b) (6)</i> conducted the investigation. The <i>U.S. FOIA (b) (6)</i> never reported the incident to the Department of Health. There was only one witness statement from staff of the incident. In addition, the incident of alleged staff to resident abuse occurred on <i>NJ Ex Order 26, 4B1</i> and the <i>U.S. FOIA (b) (6)</i> remained employed at the facility until she was suspended on <i>U.S. FOIA (b) (6)</i>.</p> <p>This placed Resident #1 and all other residents at risk for an Immediate Jeopardy (IJ) situation. The IJ began on <i>NJ Ex Order 26, 4B1</i> and was identified on 12/23/2024 at 5:40 P.M. and was reported to the <i>U.S. FOIA (b) (6)</i>. The <i>U.S. FOIA (b) (6)</i> was presented with the IJ template.</p> <p>An acceptable removal plan was electronically mailed to the surveyors on 12/26/2024 at 2:37</p>	F 000		

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F 000	<p>Continued From page 2</p> <p>P.M. indicating the action the facility will take to prevent serious harm from occurring or recurring.</p> <p>On 12/30/2024, a revisit to verify the Removal Plan was conducted. The facility implemented the Removal Plan, which included education to all staff on abuse, neglect, and exploitation. The facility also provided education on intervening and calling the police if abuse was witnessed, what to do when abuse was reported, and the process for reporting abuse. A third-party consultant company completed an audit that reviewed all incident and accident reports from <b>NJ Ex Order 26. 4B1</b> to ensure that each incident included a thorough investigation and appropriate follow-up. The third-party consultant company provided the facility with recommendations based on the audits. The staff within the video that witnessed the incident between the <b>U.S. FOIA (b)</b> and Resident #1 were no longer working at the facility. The <b>U.S. FOIA (b) (6)</b> received education from the <b>U.S. FOIA (b) (6)</b> on the proper reporting process when an abuse allegation was reported to her. CNA #1 and CNA #3 who witnessed the incident but were not in the video, continue to work at the facility and education was provided to both staff on intervening and calling the police if abuse was witnessed. The surveyors determined the IJ was removed as of 12/26/2024.</p> <p>The noncompliance remained on 12/30/2024 as a level I for actual harm that is not an IJ based on the following: The <b>U.S. FOIA (b)</b> has been suspended since <b>NJ Ex Order 26. 4B1</b> and the facility confirmed they are terminating her employment. All staff have been educated on abuse, neglect, and to intervene and call the police if abuse was witnessed.</p>	F 000			

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F 000	<p>Continued From page 3 F610 L</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documents on 12/23/2024, it was determined that the facility failed to conduct a timely and thorough investigation for an allegation of witnessed NJ Ex Order 26.4b1 toward a resident (Resident #1).</p> <p>During an interview on 12/23/2024 at 3:08 P.M., the Licensed Practical Nurse (LPN #1) stated she recorded a video on her cellphone of the U.S. FOIA (b) (6) Resident #1 with a NJ Ex Order 26. LPN #1 sent the video to a friend, and it was posted to a social media website. On NJ Ex Order 26. 4B1, the local police went to the facility to investigate an abuse allegation after receiving notification that the video was circulating online.</p> <p>The Surveyors and the U.S. FOIA (b) (6) reviewed a video on NJ Ex Order 26. 4B1 at 10:41 A.M. found on a social media website, that revealed a staff member NJ Ex Order 26 at a resident with a NJ Ex Order 26. Several other staff members observed the incident and did not intervene. The U.S. FOIA (b) (6) identified the resident in the video as Resident #1. The U.S. FOIA (b) (6) identified the staff member holding the NJ Ex Order 26.4 throughout the video as the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) was heard asking the staff that were present during the incident to go get another staff member. The U.S. FOIA (b) (6) then stated, NJ Ex Order 26. 4B1 The other staff members seen in the video that did not intervene when the incident occurred were identified by the U.S. FOIA (b) (6) as LPN #2, Certified Nursing Assistant (CNA #2), and the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) stated that according to the Facility Reportable Event (FRE) completed by the U.S. FOIA (b) (6), the incident</p>	F 000		

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F 000	<p>Continued From page 4 occurred on 06/20/2023.</p> <p>Review of the FRE dated <u>NJ Ex Order 26.4B1</u> revealed the <u>U.S. FOIA (b)</u> conducted the investigation. The <u>U.S. FOIA (b)</u> never reported the incident to the Department of Health. There was only one witness statement from staff of the incident. In addition, the incident of alleged <u>NJ Ex Order 26.4b1</u> occurred on <u>NJ Ex Order 26.4B1</u> and the <u>U.S. FOIA (b)</u> remained employed at the facility until she was suspended on <u>NJ Ex Order 26.4B1</u>.</p> <p>This placed Resident #1 and all other residents at risk for an Immediate Jeopardy (IJ) situation. The IJ began on <u>NJ Ex Order 26.4B1</u> and was identified on <u>NJ Ex Order 26.4B1</u> at 5:40 P.M. and was reported to the <u>U.S. FOIA (b) (6)</u>. The <u>U.S. FOIA (b) (6)</u> was presented with the IJ template.</p> <p>An acceptable removal plan was electronically mailed to the surveyors on 12/26/2024 at 2:37 P.M. indicating the action the facility will take to prevent serious harm from occurring or recurring.</p> <p>On 12/30/2024, a revisit to verify the Removal Plan was conducted. The facility implemented the Removal Plan, which included education to all staff on conducting a thorough investigation related to an abuse allegation. A third-party consultant company completed an independent investigation of the abuse allegation which was comprised of a documentation review, review of the resident's medical records, staff interviews, resident observations, and a review of the reportable event from <u>NJ Ex Order 26.4B1</u>. The third-party consultant company conducted an audit of all incident and accident reports from <u>NJ Ex Order 26.4B1</u> to ensure that each incident included a thorough investigation. The <u>U.S. FOIA (b) (6)</u></p>	F 000			

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F 000	Continued From page 5 <b>U.S. FOIA (b) (6)</b> implemented a daily audit to assure abuse allegations were addressed and investigated according to the facility's policy. The surveyors determined the IJ was removed as of 12/26/2024.  The noncompliance remained on 12/30/2024 as a level I for actual harm that is not an IJ based on the following: The <b>U.S. FOIA (b)</b> has been suspended since <b>NJ Ex Order 26, 4B1</b> and the facility confirmed they are terminating her employment, all facility staff were educated on conducting a thorough investigation related to an abuse allegation, and a third-party consultant company conducted an investigation of the abuse allegation.	F 000			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)  §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.  §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		12/30/24	

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F 583	<p>Continued From page 6 than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Complaint #: NJ181767, NJ181768, NJ181846</p> <p>Based on observations, interviews, and review of facility documentation, it was determined that the facility failed to ensure a resident's right to privacy and confidentiality were not violated when a video of a resident (Resident #1) being [REDACTED] with a [REDACTED] by the U.S. FOIA (b) (6) [REDACTED] was recorded by a staff member and sent to their friend who posted the video on a social media website.</p> <p>This deficient practice was identified for 1 of 1 resident (Resident #1) who was reviewed for privacy and confidentiality and was evidenced by the following:</p> <p>According to the Admission Record (AR), Resident #1 was admitted to the facility on [REDACTED] NJ Ex Order 26.4B1, with diagnoses which included but were not limited to: NJ Ex Order 26.4B1 [REDACTED].</p> <p>According to the Quarterly Minimum Data Set (MDS), an assessment tool dated [REDACTED] NJ Ex Order 26.4B1,</p>	F 583	<p>Immediate Action</p> <p>On 12/30/2024 HIPAA privacy and confidentiality education began.</p> <p>U.S. FOIA (b) (6) [REDACTED] contacted Board of Nursing on 12/30/2024 to report [REDACTED] involvement in incident, and to report the two nurses who observed, recorded video and did not intercede to help, but sent the video to a friend to post. Those nurses no longer work at facility.</p> <p>C.N.A. #1 and C.N.A. #3 were reported to Department of Health as well.</p> <p>Other residents having potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that</p>	

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F 583	<p>Continued From page 7</p> <p>Resident #1 had a Brief Interview for Mental Status (BIMS) score of <b>11</b> out of 15, which indicated the resident's cognition was <b>[redacted]</b>.</p> <p>The local police came to the facility on <b>[redacted]</b> after receiving notification that a video was circulating on a social media website of the <b>[redacted]</b> Resident #1 with a <b>[redacted]</b> while several other staff members observed the incident and did not intervene.</p> <p>During a telephone interview with the surveyor on 12/23/2024 at 3:08 P.M., the Licensed Practical Nurse (LPN #1) stated she was present when the incident occurred and recorded it on her cellphone. LPN #1 stated she sent the video of the incident to her friend who posted the video to a social media website. LPN #1 further stated she did not know how resident privacy and confidentiality worked, so she was unable to tell the surveyor whether she violated Resident #1's privacy and confidentiality when she sent the video to her friend.</p> <p>During an interview with the surveyors on 12/30/2024 at 1:25 P.M., the <b>[redacted]</b> stated that the staff were not allowed to record the residents because it was a violation of their privacy and confidentiality. The <b>[redacted]</b> stated she could not speak to why LPN #1 recorded Resident #1 on her cell phone. The <b>[redacted]</b> further stated that all staff including agency staff received training on resident privacy and confidentiality upon hire and twice yearly thereafter.</p> <p>During an interview with the surveyors on 12/30/2024 at 2:12 P.M., the <b>[redacted]</b></p>	F 583	<p>the deficient practice will not return.</p> <p>12/30/2024 Education was given to all staff on HIPAA privacy and confidentiality.</p> <p>The interim DON /designee will audit education sign in sheets to assure all staff have been educated on the HIPAA protocols. The audits will be completed weekly for four weeks and then monthly for next four months.</p> <p>Education on HIPAA confidentiality and privacy will be given monthly for six months.</p> <p>Education on HIPAA confidentiality and privacy will become part of our orientation education as well as our annual education.</p> <p>The Administrator/DON/designee will audit compliance with the education on HIPAA confidentiality and privacy and conduct 5 random staff assessment and test to assure staff have a true understanding of HIPAA confidentiality and privacy.</p> <p>How the facility plan to monitor its performance to make sure that solutions are sustained.</p> <p>The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need</p>	

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F 583	Continued From page 8  <i>U.S. FOIA (b) (6)</i> stated that staff were not allowed to record the residents on their cellphone because it violated the resident's privacy. The <i>U.S. FOIA (b) (6)</i> further stated that LPN #1 did not follow the facility policy when she recorded Resident #1 on her cell phone. The <i>U.S. FOIA (b) (6)</i> stated she was not present when the incident occurred and could not speak to why LPN #1 recorded the incident involving Resident #1.  Review of the undated facility policy titled "Personal Electronic Equipment" revealed that "The Company prohibits the use or possession in the workplace of any camera phone, cell phone camera, digital camera, video camera, or other form of image or voice recording device without the express permission of the Company and of each person whose image and or voice is recorded."	F 583	for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on February 21, 2025.		
F 600 SS=L	N.J.A.C. 8:39-4.1 (a) (18) Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		12/30/24	

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F 600	<p>Continued From page 9 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint #: NJ181767, NJ181768, NJ181846</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documents on 12/23/2024 and 12/30/2024, it was determined that the facility failed to a.) prevent NJ Ex Order 26.4b1 towards a resident (Resident #1) from a staff member and b.) staff members that witnessed the abuse failed to intervene and report the incident. The facility also failed to follow its policy titled "Abuse Policy and Procedure."</p> <p>During an interview on 12/23/2024 at 3:08 P.M., the Licensed Practical Nurse (LPN #1) stated she recorded a video on her cellphone of the U.S. FOIA (b) (6) Resident #1 with a NJ Ex Order 26.4b1 LPN #1 sent the video to a friend, and it was posted to a social media website. On NJ Ex Order 26.4B1, the local police went to the facility to investigate an abuse allegation after receiving notification that the video was circulating online.</p> <p>The Surveyors and the U.S. FOIA (b) (6) reviewed a video on NJ Ex Order 26.4B1 at 10:41 A.M. found on a social media website, that revealed a staff member NJ Ex Order 26.4b1 at a resident with a NJ Ex Order 26.4b1. Several other staff members observed the incident and did not intervene. The U.S. FOIA (b) (6) identified the resident in the video as Resident #1. The U.S. FOIA (b) (6) identified the staff member holding the NJ Ex Order 26.4b1 the video as the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) was heard asking the staff that were present during the incident to go get another staff member. The U.S. FOIA (b) (6) then stated, NJ Ex Order 26.4B1 The other staff members</p>	F 600	<p>Immediate Action</p> <p>On NJ Ex Order 26.4B1, U.S. FOIA (b) (6) was suspended pending investigation. (Terminated NJ Ex Order 26.4B1)</p> <p>Administrator/ADON/HR contacted Board of Nursing on 12/30/2024 to report U.S. FOIA (b) (6) involvement in incident, and to report the two nurses who observed, recorded video and did not intercede to help, but sent the video to a friend to post. Those nurses no longer work at facility. C.N.A. #1 and C.N.A. #3 were reported to Department of Health for not interceding to help and not reporting.</p> <p>12/24/24 Education was given to staff C.N.A. #1, and C.N.A. #3, and U.S. FOIA (b) (6) on how to follow company policy on abuse and report immediately to the abuse coordinator, intervene and call the police.</p> <p>12/24/24 Morning/clinical meeting audit process started to assure allegations of abuse and neglect and grievances are addressed and investigated within policy. Audits will be completed 3x weekly for the next 4 weeks and monthly for the next 6 months.</p> <p>Other residents having potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>CRYSTAL LAKE HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>395 LAKESIDE BLVD</b> <b>BAYVILLE, NJ 08721</b>		
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F 600	<p>Continued From page 10</p> <p>seen in the video that did not intervene when the incident occurred were identified by the <sup>U.S. FOIA (b) (6)</sup> as LPN #2, Certified Nursing Assistant (CNA #2), and the <sup>U.S. FOIA (b) (6)</sup>. The <sup>U.S. FOIA (b) (6)</sup> stated that according to the Facility Reportable Event (FRE) completed by the <sup>U.S. FOIA (b) (6)</sup>, the incident occurred on <sup>NJ Ex Order 26. 4B1</sup>.</p> <p>Review of the FRE dated <sup>NJ Ex Order 26. 4B1</sup> revealed the <sup>U.S. FOIA (b) (6)</sup> conducted the investigation. The <sup>U.S. FOIA (b) (6)</sup> never reported the incident to the Department of Health. There was only one witness statement from the staff of the incident. In addition, the incident of alleged staff to resident abuse occurred on <sup>NJ Ex Order 26. 4B1</sup> and the <sup>U.S. FOIA (b) (6)</sup> remained employed at the facility until <sup>NJ Ex Order 26. 4B1</sup> was suspended on <sup>NJ Ex Order 26. 4B1</sup>.</p> <p>This placed Resident #1 and all other residents at risk for an Immediate Jeopardy (IJ) situation. The IJ began on <sup>NJ Ex Order 26. 4B1</sup> and was identified on <sup>NJ Ex Order 26. 4B1</sup> at 5:40 P.M. and was reported to the <sup>U.S. FOIA (b) (6)</sup>. The <sup>U.S. FOIA (b) (6)</sup> was presented with the IJ template.</p> <p>An acceptable removal plan was electronically mailed to the surveyors on 12/26/2024 at 2:37 P.M. indicating the action the facility will take to prevent serious harm from occurring or recurring.</p> <p>On 12/30/2024, a revisit to verify the Removal Plan was conducted. The facility implemented the Removal Plan, which included education to all staff on abuse, neglect, and exploitation. The facility also provided education on intervening and calling the police if abuse was witnessed, what to do when abuse was reported, and the process for reporting abuse. A third-party consultant company completed an audit that reviewed all incident and</p>	F 600	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not return.</p> <p>On 12/23/24, (completed 12/25/24) the Assistant Director of Nursing/or designee immediately educated all staff on abuse, neglect and exploitation and deescalating resident behavior, and the importance of reporting all incidents to the abuse coordinator timely, calling police, and intervening.</p> <p>The Interim DON/designee will conduct this education monthly for the next six months.</p> <p>Administrator/DON/ADON/designee will audit education each month to assure all employees have had education. Audits will be conducted 3x's weekly for four weeks and then monthly for the next six months.</p> <p>The Administrator/Interim DON/designee will audit compliance with the education on abuse and conduct 5 random staff assessment and test to assure staff have a true understanding of the facilities abuse policy. Audits will be completed 3x's weekly for four weeks and then monthly for the next four months.</p> <p>The education on the facilities abuse policy and the importance of reporting all incidents to the abuse coordinator immediately, interceding in the situation and calling the police, will become part of</p>		

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F 600	<p>Continued From page 11</p> <p>accident reports from <b>NJ Ex Order 26. 4B1</b> to ensure that each incident included a thorough investigation and appropriate follow-up. The third-party consultant company provided the facility with recommendations based on the audits. The staff within the video that witnessed the incident between the <b>U.S. FOIA (b) (6)</b> and Resident #1 were no longer working at the facility. The <b>U.S. FOIA (b) (6)</b> received education from the <b>U.S. FOIA (b) (6)</b> on the proper reporting process when an abuse allegation was reported to <b>U.S. FOIA (b) (6)</b>. CNA #1 and CNA #3 who witnessed the incident but were not in the video, continue to work at the facility and education was provided to both staff on intervening and calling the police if abuse was witnessed. The surveyors determined the IJ was removed as of 12/26/2024.</p> <p>The noncompliance remained on 12/30/2024 as a level I for actual harm that is not an IJ based on the following: The <b>U.S. FOIA (b) (6)</b> has been suspended since <b>NJ Ex Order 26. 4B1</b> and the facility confirmed they were terminating her employment and reporting the <b>U.S. FOIA (b) (6)</b> to the <b>U.S. FOIA (b) (6)</b>. All staff have been educated on abuse, neglect, and to intervene and call the police if abuse was witnessed.</p> <p>This deficient practice was identified for 1 of 3 residents (Resident #1) who were reviewed for abuse and was evidenced by the following:</p> <p>According to the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents with a "date of event" of <b>NJ Ex Order 26. 4B1</b> and the <b>U.S. FOIA (b) (6)</b> identified as the "person reporting", revealed that Resident #1 attempted to <b>U.S. FOIA (b) (6)</b> LPN #1 with something that looked blue, plastic,</p>	F 600	<p>our orientation education as well as our annual education.</p> <p>12/30/2024 Ad Hoc Resident council meeting was held to educate residents on abuse and to ask that if they see something to please say something. Social services/activity director educated them on the signs hanging on units for calling the abuse coordinator, and for calling the ombudsman office.</p> <p>The resident rights were read.</p> <p>How the facility plan to monitor its performance to make sure that solutions are sustained.</p> <p>The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on February 21, 2025.</p>		

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F 600	<p>Continued From page 12</p> <p>and shiny in the resident's [redacted]. The [redacted] came to the unit and was told by LPN #1 that the resident was chasing her down the hallway. The [redacted] approached Resident #1 and he/she attempted to [redacted] at her with what appeared to be a [redacted] NJ Ex Order 26. 4B1. The [redacted] took a [redacted] and tried to [redacted] the [redacted] out of Resident #1's [redacted]. The resident could not be redirected, and the [redacted] NJ Ex Order 26. 4B1 the [redacted] from Resident #1's [redacted]. The nurse called the police. The FRE did not specify the nurse that called the police. According to the FRE, Resident #1 was sent to the [redacted] NJ Ex Order 26. 4B1.</p> <p>A review of the video footage that was found on a social media website on [redacted] NJ Ex Order 26. 4B1 revealed the [redacted] standing in front of Resident #1 holding a [redacted] NJ Ex Order 26. Resident #1 appeared to have his/her back towards the corner of the wall. The [redacted] and Resident #1 had a [redacted] between each other. Resident #1 then moved towards the [redacted] NJ Ex Order 26. 4B1, and the [redacted] NJ Ex Order 26. 4B1 the resident with the [redacted] NJ Ex Order 26. 4B1. The [redacted] NJ Ex Order 26. 4B1 asked the staff that were present during the incident to go get another staff member. The [redacted] NJ Ex Order 26. 4B1 then stated, [redacted] NJ Ex Order 26. 4B1. The video further revealed LPN #2, CNA #3, and the [redacted] NJ Ex Order 26. 4B1 that were present during the incident but did not intervene. The video did not reveal that the [redacted] NJ Ex Order 26. 4B1 a [redacted] NJ Ex Order 26. 4B1 from Resident #1's [redacted] NJ Ex Order 26. 4B1.</p> <p>According to the Admission Record (AR), Resident #1 was admitted to the facility on [redacted] NJ Ex Order 26. 4B1, with diagnoses which included but were not limited to: [redacted] NJ Ex Order 26. 4B1.</p> <p>According to the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] NJ Ex Order 26. 4B1.</p>	F 600		

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F 600	<p>Continued From page 13</p> <p>Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's cognition was [redacted]. The MDS further indicated Resident #1 had experienced [redacted] but had [redacted] towards others.</p> <p>A review of Resident #1's Care Plan (CP) initiated on [redacted] revealed that the resident could be [redacted]. "Interventions" initiated on [redacted] included: "Allow to [redacted], redirect as needed, and provide diversional activities."</p> <p>A review of Resident #1's [redacted] Progress Notes (PNs) revealed no documentation related to the incident that occurred on [redacted]. The PNs further revealed no documentation that the police were notified of the incident or that the resident was transferred to the [redacted].</p> <p>A review of the [redacted] personnel file revealed that she received training on abuse on [redacted].</p> <p>During an interview with the surveyors on 12/23/2024 at 10:41 A.M., the [redacted] stated the [redacted], and the [redacted] called her on [redacted] and made her aware that the local police were at the facility to investigate an abuse allegation involving Resident #1. The [redacted] stated she notified the NJDOH of the abuse allegation on [redacted]. The [redacted] stated she was not aware of what occurred during the incident prior to seeing the video. The [redacted] stated that according to the FRE and an investigation conducted by the [redacted], the incident on the video occurred on [redacted]. The [redacted] stated she was off the day the incident occurred. The [redacted]</p>	F 600		

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F 600	<p>Continued From page 14</p> <p>stated she was not aware that the [U.S. FOIA (b) (6)] [NJ Ex. Order 26.4B] Resident #1 with a [NJ Ex. Order 26.4B] and that the other staff members did not intervene until she watched the video. The [U.S. FOIA (b) (6)] stated the staff members who observed the incident should have not stood there but got the resident help. The [U.S. FOIA (b) (6)] stated it was not the facility's protocol to [NJ Ex. Order 26.4B] a resident with a [NJ Ex. Order 26.4B]. The [U.S. FOIA (b) (6)] stated the [U.S. FOIA (b) (6)] had been suspended since [NJ Ex. Order 26.4B] pending the outcome of the investigation being conducted by a third-party consultant company. The [U.S. FOIA (b) (6)] stated that according to the FRE from [NJ Ex. Order 26.4B], the police and the NJDOH were notified of the incident.</p> <p>The [U.S. FOIA (b) (6)] was unable to provide the surveyor evidence that the FRE was reported to the NJDOH and that the police were called on [NJ Ex. Order 26.4B].</p> <p>During an interview with the surveyors on 12/23/2024 at 11:52 A.M., the [U.S. FOIA (b) (6)] stated one of his co-workers sent him a video over the weekend of the incident involving Resident #1 and the [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated that he identified one of the staff members in the video was his former [U.S. FOIA (b) (6)] and that she had retired. The [U.S. FOIA (b) (6)] stated that no staff should let another staff member [NJ Ex. Order 26.4B] a resident with a [NJ Ex. Order 26.4B] and the other staff members should have intervened. The [U.S. FOIA (b) (6)] further stated that his former [U.S. FOIA (b) (6)] did not report the incident to him. The [U.S. FOIA (b) (6)] stated the expectation was that the [U.S. FOIA (b) (6)] should have reported what happened in the video to him immediately.</p> <p>During an interview with the surveyors on 12/23/2024 at 12:44 P.M., CNA #1 stated she had seen the video involving the incident between the</p>	F 600			

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F 600	<p>Continued From page 15</p> <p><sup>U.S. FOIA (b)</sup> and Resident #1 on social media. CNA #1 identified the person recording the video as LPN #1. CNA #1 stated she was present when the incident occurred involving the <sup>U.S. FOIA (b)</sup> and Resident #1. CNA #1 stated Resident #1 was upset about his/her clothing prior to the incident. The <sup>U.S. FOIA (b)</sup> was called to the unit due to Resident #1 having <sup>NJ Ex Order 26.4b1</sup>. CNA #1 stated the <sup>U.S. FOIA (b)</sup> came to the unit and went to Resident #1's room and the resident <sup>NJ Ex Order 26.4b1</sup> at the <sup>U.S. FOIA (b)</sup>. The <sup>U.S. FOIA (b)</sup> then ran to the nursing station where CNA #1, CNA #2, and the <sup>U.S. FOIA (b)</sup> were standing. CNA #1 stated the <sup>U.S. FOIA (b)</sup> grabbed a <sup>NJ Ex Order 26.4b1</sup> and <sup>NJ Ex Order 26.4b1</sup> Resident #1 with the <sup>NJ Ex Order 26.4b1</sup>. CNA #1 stated she did not remember Resident #1 having any items in his/her <sup>NJ Ex Order 26.4b1</sup>. CNA #1 further stated she remembered Resident #1 was <sup>NJ Ex Order 26.4b1</sup> after the <sup>U.S. FOIA (b)</sup> <sup>NJ Ex Order 26.4b1</sup> him/her with the <sup>NJ Ex Order 26.4b1</sup>. CNA #1 stated <sup>U.S. FOIA (b)</sup> did not intervene when the incident occurred because the <sup>U.S. FOIA (b)</sup> had threatened her job if she had intervened. CNA #1 further stated if the <sup>U.S. FOIA (b)</sup> had not threatened her job she would have called the police. CNA #1 stated the <sup>U.S. FOIA (b)</sup> was <sup>NJ Ex Order 26.4b1</sup> towards the residents at times.</p> <p>During an interview with the surveyors on 12/23/2024 at 2:22 P.M., the <sup>U.S. FOIA (b) (6)</sup> stated she had seen the video involving the <sup>U.S. FOIA (b)</sup> and Resident #1 that had been circulating on social media. The <sup>U.S. FOIA (b)</sup> stated she was not aware of the incident until she had seen the video on <sup>NJ Ex Order 26.4b1</sup>. The <sup>U.S. FOIA (b)</sup> stated if a resident was aggressive, the facility policy was to try to de-escalate the resident, address the resident's needs, and ensure the safety of all residents. The <sup>U.S. FOIA (b)</sup> stated it was not acceptable for a staff member to <sup>NJ Ex Order 26.4b1</sup> a resident with a <sup>NJ Ex Order 26.4b1</sup> and considered this a form of abuse. The <sup>U.S. FOIA (b)</sup> stated if</p>	F 600			

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F 600	<p>Continued From page 16</p> <p>she witnessed abuse, she would ensure the safety of the resident involved and immediately notify the <u>U.S. FOIA (b) (6)</u>, the NJDOH, and the police.</p> <p>During a telephone interview with the surveyor on 12/23/2024 at 3:08 P.M., LPN #1 stated she was present when the incident occurred and recorded it on her cellphone. LPN #1 stated she observed a walker fly past the charting room after the <u>U.S. FOIA (b) (6)</u> came to the unit. LPN #1 further stated she observed Resident #1 chasing the <u>U.S. FOIA (b) (6)</u>. LPN #1 stated she yelled out for someone to call the police, but no one called them. She further stated that the <u>U.S. FOIA (b) (6)</u> Resident #1 with a <u>NJ Ex Order 26.4b1</u> and then the resident walked away. LPN #1 stated she observed <u>U.S. FOIA (b) (6)</u> to Resident #1's <u>NJ Ex Order 26.4b1</u> and that he/she was <u>NJ Ex Order 26.4b1</u>. LPN #1 stated she reported the incident to the <u>U.S. FOIA (b) (6)</u> which resulted in her not being allowed to return to the facility since she was agency staff. LPN #1 stated she sent the video of the incident to her friend who posted the video to a social media website.</p> <p>During a telephone interview with the surveyor on 12/23/2024 at 3:20 P.M., CNA #3 stated <u>NJ Ex Order 26.4b1</u> was present when the incident occurred but could not remember the exact date. CNA #3 stated <u>NJ Ex Order 26.4b1</u> CNA #3 stated Resident #1 was <u>NJ Ex Order 26.4b1</u> at the <u>U.S. FOIA (b) (6)</u>. CNA #3 further stated Resident #1 started to go after the <u>U.S. FOIA (b) (6)</u> and the <u>U.S. FOIA (b) (6)</u> the resident with a <u>NJ Ex Order 26.4b1</u> CNA #3 stated <u>NJ Ex Order 26.4b1</u> believed the <u>U.S. FOIA (b) (6)</u> was trying to <u>NJ Ex Order 26.4b1</u> against the resident. CNA #3 stated <u>NJ Ex Order 26.4b1</u></p> <p><u>U.S. FOIA (b) (6)</u> CNA #3 stated she did not</p>	F 600		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/30/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRYSTAL LAKE HEALTHCARE AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>395 LAKESIDE BLVD</b> <b>BAYVILLE, NJ 08721</b>		
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F 600	<p>Continued From page 17</p> <p>report the incident because the [U.S. FOIA (b)] was in charge and that she had threatened the staff member's jobs. CNA #3 stated she thought someone called the police after the incident occurred.</p> <p>During a follow up telephone interview with the surveyor on 12/30/2024 at 10:21 A.M., CNA #3 stated she did not remember if the police came to the facility after the incident occurred. CNA #3 stated she did not remember if Resident #1 had anything in his/her [NJ Ex Order] when the incident occurred.</p> <p>During an interview with the surveyor on 12/23/2024 at 3:34 P.M., the [U.S. FOIA (b)] stated she was made aware of the video that was circulating on social media on [NJ Ex Order 26.4B1]. She further stated she was not aware of the incident that occurred prior to watching the video on [NJ Ex Order 26.4B1]. The [U.S. FOIA (b)] stated that no staff came to her to report the incident prior to her watching the video. The [U.S. FOIA (b)] stated that it was not the facility's protocol to [NJ Ex] a resident with a [NJ Ex Order 26.4b] The [U.S. FOIA (b)] further stated that the staff that had witnessed the event should have reported the incident immediately. The [U.S. FOIA (b)] confirmed that the [U.S. FOIA (b)] has been suspended since [NJ Ex Order 26.4B1].</p> <p>During a telephone interview with the surveyors on 12/30/2024 at 1:30 P.M., the [U.S. FOIA (b)] stated she could not remember the date the incident occurred with Resident #1. The [U.S. FOIA (b)] stated that a code was called due to Resident #1 having [NJ Ex Order 26.4b1], and she went up to the unit. The [U.S. FOIA (b)] stated when she arrived on the unit, Resident #1 was running down the hallway. Resident #1 then [NJ Ex Order 26.4b1] at the [U.S. FOIA (b)]. The [U.S. FOIA (b)] further stated she observed a</p>	F 600		

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F 600	<p>Continued From page 18</p> <p>blue object in Resident #1's [redacted]. The [redacted] stated that Resident #1 attempted to [redacted] with what was in his/her [redacted]. The [redacted] stated she got a [redacted] from the [redacted] and then told all the other staff in the area to move away. The [redacted] further stated Resident #1 started coming towards her and [redacted] him/her with the [redacted] in attempt to [redacted] what was in the resident's [redacted]. The [redacted] stated that after [redacted] the resident with the [redacted] Resident #1 walked away. The [redacted] further stated when the resident walked away, [redacted] a blue [redacted] from his/her [redacted]. The [redacted] stated, NJ Ex Order 26. 4B1 [redacted]</p> <p>The [redacted] stated she overreacted when [redacted] Resident #1 with a [redacted] because she thought the resident had a [redacted] in his/her [redacted]. The [redacted] further stated she though the local police were notified but that was the unit nurses' responsibility to call the police.</p> <p>During an interview with the surveyors on 12/30/2024 at 2:12 P.M., the [redacted] stated she was off [redacted] when the incident occurred between the [redacted] and Resident #1. The [redacted] stated the [redacted] was suspended and the Corporate Human Resources was sending the [redacted] a termination letter in the mail. The [redacted] stated that it was not acceptable to [redacted] a resident with a [redacted]. The [redacted] stated she would consider [redacted] a resident with a [redacted] a form of abuse. The [redacted] stated she was not aware at the time of the incident that Resident #1 was [redacted] with a [redacted] by the [redacted] and that other staff members watched and did not intervene. The [redacted] stated the expectation was that if staff witnessed abuse, they were to intervene and notify the local police immediately.</p>	F 600		

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F 600	Continued From page 19 The surveyors were unable to reach LPN #2, CNA#2, and the [REDACTED] for an interview regarding the incident that occurred on [REDACTED] with Resident #1.  Review of the facility policy titled "Abuse Policy and Procedure" updated 8/2014, revealed under "Policy" that "This facility requires that any allegations of abuse be addressed immediately in accordance with all federal and state regulations. All allegations will be evaluated in a prompt and thorough manner. Under "Procedure", "6. Any employee alleged to have participated in abusive activity will be removed from care of the involved resident immediately. 9. The RN supervisor will contact the Director of Nursing immediately upon suspicion or confirmation of abuse. If the Director of Nursing is unable to be contacted, the Administrator will be contacted. 10. The Administrator will be contacted regarding all cases of physical and verbal abuse. 22. Employees who have had allegations of physical abusive treatment will be removed from direct resident care."	F 600			
F 609 SS=D	N.J.A.C:8:39-4.1 (a) (5) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		12/31/24	

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F 609	<p>Continued From page 20</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ181767, NJ181768, NJ181846</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documents on 12/23/2024, it was determined that the facility failed to report an allegation of witnessed <b>NJ Ex Order 26.4b1</b> toward a resident (Resident #1) to the Department of Health and to the local</p>	F 609	<p>Immediate Action</p> <p>On <b>NJ Ex Order 26.4b1</b>, <b>U.S. FOIA (b)(7)(C)</b> was suspended pending investigation. (Terminated <b>NJ Ex Order 26.4b1</b>)</p> <p>On 12/21/24 a third-party consulting company was contracted to conduct an independent investigation of the abuse</p>		

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F 609	<p>Continued From page 21</p> <p>Police Department when the incident occurred on [redacted] NJ Ex Order 26. 4B1.</p> <p>This deficient practice was identified for 1 of 3 residents (Resident #1) who were reviewed for abuse and was evidenced by the following:</p> <p>The Surveyors and the [redacted] U.S. FOIA (b) (6) reviewed a video on [redacted] NJ Ex Order 26. 4B1 at 10:41 A.M. found on a social media website, that revealed a staff member [redacted] NJ Ex Order 26. 4B1 at a resident with a [redacted] NJ Ex Order 26. 4B1. Several other staff members observed the incident and did not intervene. The [redacted] U.S. FOIA (b) (6) identified the resident in the video as Resident #1. The [redacted] U.S. FOIA (b) (6) identified the staff member holding the [redacted] NJ Ex Order 26. 4B1 throughout the video as the [redacted] U.S. FOIA (b) (6). The [redacted] U.S. FOIA (b) (6) was heard asking the staff that were present during the incident to go get another staff member. The [redacted] U.S. FOIA (b) (6) then stated, [redacted] NJ Ex Order 26. 4B1. The other staff members seen in the video that did not intervene when the incident occurred were identified by the [redacted] U.S. FOIA (b) (6) as LPN #2, Certified Nursing Assistant (CNA #2), and the [redacted] U.S. FOIA (b) (6). The [redacted] U.S. FOIA (b) (6) stated that according to the Facility Reportable Event (FRE) form completed by the [redacted] U.S. FOIA (b) (6), the incident occurred on [redacted] U.S. FOIA (b) (6).</p> <p>The [redacted] U.S. FOIA (b) (6) presented to the surveyors a Facility Reportable Event (FRE) form, a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents dated [redacted] NJ Ex Order 26. 4B1 with an event date of [redacted] NJ Ex Order 26. 4B1. The FRE revealed that Resident #1 attempted to [redacted] NJ Ex Order 26. 4B1 LPN #1 with something that looked blue, plastic, and shiny in the resident's [redacted] U.S. FOIA (b) (6). The [redacted] U.S. FOIA (b) (6) came to the unit and was told by LPN #1 that the resident was chasing her down the hallway. The [redacted] U.S. FOIA (b) (6) approached Resident #1 and</p>	F 609	<p>allegation which comprised of review of documentation, care plans, interviews of staff, observation of resident, review of reportable information from [redacted] NJ Ex Order 26. 4B1.</p> <p>12/23/2024 (completed 12/25/24) Education began on abuse and the importance to report any allegation of abuse immediately.</p> <p>Other residents having potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not return.</p> <p>On 12/23/24 the [redacted] U.S. FOIA (b) (6) began education on abuse and the importance to report any allegation of abuse immediately to abuse coordinator, investigation starts immediately and to follow the steps of our accident incident policy to call police and to report to the Department of Health and Ombudsman.</p> <p>Education on our Accident Incident policy will be given monthly for six months. The Abuse and Accident Incident policy education will become part of our orientation education as well as our annual education.</p> <p>The Administrator/Interim DON/designee will audit compliance with the education</p>	

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F 609	<p>Continued From page 22</p> <p>he/she attempted to [redacted] at her with what appeared to be a [redacted] NJ Ex Order 26. 4B1 . The [redacted] took a [redacted] and tried to [redacted] the [redacted] out of Resident #1's [redacted]. The resident could not be redirected, and the [redacted] the [redacted] from Resident #1's [redacted]. The nurse called the police and Resident #1 was sent to the [redacted].</p> <p>The [redacted] was unable to provide the surveyor evidence that the FRE was reported to the NJDOH and that the police were called on [redacted] NJ Ex Order 26. 4B1 .</p> <p>According to the local police department's report dated [redacted] NJ Ex Order 26. 4B1 , the police were never dispatched to the facility on the date of the incident regarding Resident #1.</p> <p>A review of the video footage that was found on a social media website on [redacted] NJ Ex Order 26. 4B1 revealed the [redacted] standing in front of Resident #1 holding a [redacted] NJ Ex Order 26. 4B1 . Resident #1 appeared to have his/her back towards the corner of the wall. The [redacted] and Resident #1 had a [redacted] NJ Ex Order 26.4b1 between each other. Resident #1 then moved towards the [redacted] NJ Ex Order 26. 4B1 , and the [redacted] NJ Ex Order 26. 4B1 the resident with the [redacted] NJ Ex Order 26. 4B1 . The [redacted] asked the staff that were present during the incident to go get another staff member. The [redacted] then stated, [redacted] NJ Ex Order 26. 4B1 . The video further revealed LPN #2, CNA #3, and the [redacted] that were present during the incident but did not intervene. The video did not reveal that the [redacted] NJ Ex Order 26. 4B1 a [redacted] NJ Ex Order 26. 4B1 from Resident #1's [redacted].</p> <p>According to the Admission Record (AR), Resident #1 was admitted to the facility on [redacted] NJ Ex Order 26. 4B1 , with diagnoses which included but were not limited to: [redacted] NJ Ex Order 26. 4B1 ,</p>	F 609	<p>on Abuse and Accident Incident policy and conduct 5 random staff assessment and test to assure staff have a true understanding of the facility Accident Incident 3 times a week for the first four weeks and then monthly for four months.</p> <p>Administrator/DON/ADON/designee will audit abuse reportable events to observe and to assure the steps in the facility policy are followed such as timeliness of reporting incident, completeness of investigation and that all statements are collected and are in their original signed form, police contacted, and reported to DOH and the Ombudsman office. Audits will be conducted three times a week for one month and then monthly for four months.</p> <p>How the facility plan to monitor its performance to make sure that solutions are sustained.</p> <p>The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on February 21, 2025.</p>	

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F 609	<p>Continued From page 23</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>According to the Quarterly Minimum Data Set (MDS), an assessment tool dated <i>NJ Ex Order 26.4b1</i>, Resident #1 had a Brief Interview for Mental Status (BIMS) score of <i>NJ Ex Order 26. 4B1</i> out of 15, which indicated the resident's cognition was <i>NJ Ex Order 26. 4B1</i>. The MDS further indicated Resident #1 had experienced <i>NJ Ex Order 26. 4B1</i> but had <i>NJ Ex Order 26. 4B1</i> towards others.</p> <p>A review of Resident #1's Care Plan (CP) initiated on <i>NJ Ex Order 26.4b1</i> revealed that the resident could be <i>NJ Ex Order 26.4b1</i>. "Interventions" initiated on <i>NJ Ex Order 26.4b1</i> included: "Allow to <i>NJ Ex Order 26. 4B1</i>, redirect as needed, and provide diversional activities."</p> <p>A review of Resident #1's <i>NJ Ex Order 26.4b1</i> Progress Notes (PNs) revealed no documentation related to the incident that occurred on <i>NJ Ex Order 26. 4B1</i>. The PNs further revealed no documentation that the police were notified of the incident or that the resident was transferred to the <i>NJ Ex Order 26. 4B1</i>.</p> <p>During an interview with the surveyors on 12/23/2024 at 10:41 A.M., the <i>U.S. FOIA (b) (6)</i> stated the Receptionist, and the <i>U.S. FOIA (b) (6)</i> called her on <i>NJ Ex Order 26. 4B1</i> and made her aware that the local police were at the facility to investigate an abuse allegation involving Resident #1. The <i>U.S. FOIA (b) (6)</i> stated she notified the NJDOH of the abuse allegation on <i>NJ Ex Order 26. 4B1</i>. The <i>U.S. FOIA (b) (6)</i> stated she was not aware of what occurred during the incident prior to seeing the video. The <i>U.S. FOIA (b) (6)</i> stated that according to the FRE and an investigation conducted by the <i>U.S. FOIA (b) (6)</i>, the incident on the video occurred on <i>NJ Ex Order 26. 4B1</i>. The <i>U.S. FOIA (b) (6)</i> stated she</p>	F 609			

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F 609	<p>Continued From page 24</p> <p>was off the day the incident occurred. The [U.S. FOIA (b) (6)] stated she was not aware that the [U.S. FOIA (b) (6)] Resident #1 with a [NJ Ex Order 26.4b1] and that the other staff members did not intervene until she watched the video. The [U.S. FOIA (b) (6)] stated the staff members who observed the incident should have not stood there but got the resident help. The [U.S. FOIA (b) (6)] stated it was not the facility's protocol to [NJ Ex Order 26.4b1] a resident with a [NJ Ex Order 26.4b1]. The [U.S. FOIA (b) (6)] stated the [U.S. FOIA (b) (6)] had been suspended since [NJ Ex Order 26.4b1] pending the outcome of the investigation being conducted by a third-party consultant company. The [U.S. FOIA (b) (6)] stated that according to the FRE from [NJ Ex Order 26.4b1], the police and the NJDOH were notified of the incident.</p> <p>During an interview with the surveyors on 12/23/2024 at 12:44 P.M., CNA #1 stated she had seen the video involving the incident between the [U.S. FOIA (b) (6)] and Resident #1 on social media. CNA #1 identified the person recording the video as LPN #1. CNA #1 stated [NJ Ex Order 26.4b1] was present when the incident occurred involving the [U.S. FOIA (b) (6)] and Resident #1. The [U.S. FOIA (b) (6)] was called to the unit due to Resident #1 having [NJ Ex Order 26.4b1]. CNA #1 stated the [U.S. FOIA (b) (6)] came to the unit and went to Resident #1's room and the resident [NJ Ex Order 26.4b1] at the [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] then ran to the nursing station where CNA #1, CNA #2, and the [U.S. FOIA (b) (6)] were standing. CNA #1 stated the [U.S. FOIA (b) (6)] grabbed a [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1] Resident #1 with the [NJ Ex Order 26.4b1]. CNA #1 stated she did not remember Resident #1 having any items in his/her [NJ Ex Order 26.4b1]. CNA #1 further stated she remembered Resident #1 was bleeding after the [U.S. FOIA (b) (6)] [NJ Ex Order 26.4b1] him/her with the [NJ Ex Order 26.4b1]. CNA #1 stated she did not intervene when the incident occurred because the [U.S. FOIA (b) (6)] had threatened her job if she had intervened. CNA #1 further stated if the [U.S. FOIA (b) (6)] had not threatened her</p>	F 609		

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F 609	<p>Continued From page 25</p> <p>job she would have called the police.</p> <p>During a telephone interview with the surveyor on 12/23/2024 at 3:20 P.M., CNA #3 stated [redacted] was present when the incident occurred but could not remember the exact date. CNA #3 stated [redacted] CNA #3 stated Resident #1 was NJ Ex Order 26.4b1 [redacted] at the [redacted]. CNA #3 further stated Resident #1 started to go after the [redacted] and the [redacted] the resident with a [redacted]. CNA #3 stated she believed the [redacted] was trying to [redacted] herself against the resident. CNA #3 stated NJ Ex Order 26.4B1 [redacted]</p> <p>[redacted] CNA #3 stated she did not report the incident because the [redacted] was in charge and that she had threatened the staff member's jobs. CNA #3 stated she thought someone called the police after the incident occurred.</p> <p>During a telephone interview with the surveyors on 12/30/2024 at 1:30 P.M., the [redacted] stated she could not remember the date the incident occurred with Resident #1. The [redacted] stated that a code was called due to Resident #1 having NJ Ex Order 26.4b1, and she went up to the unit. The [redacted] stated when she arrived on the unit, Resident #1 was running down the hallway. Resident #1 then NJ Ex Order 26.4b1 [redacted] at the [redacted]. The [redacted] further stated she observed a blue object in Resident #1's [redacted]. The [redacted] stated that Resident #1 attempted to [redacted] with what was in his/her [redacted]. The [redacted] stated she got a [redacted] from the [redacted] and then told all the other staff in the area to move away. The [redacted] further stated Resident #1 started coming towards her and [redacted] him/her with the [redacted] in</p>	F 609		

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F 609	<p>Continued From page 26</p> <p>attempt to [redacted] was in the resident's [redacted]. The [redacted] stated that after [redacted] the resident with the [redacted] Resident #1 walked away. The [redacted] further stated when the resident walked away, she snatched a [redacted] from his/her [redacted]. The [redacted] further stated she thought the local police were notified but that was the unit nurses' responsibility to call the police.</p> <p>During an interview with the surveyors on 12/30/2024 at 2:12 P.M., the [redacted] stated she was off when the incident occurred between the [redacted] and Resident #1. The [redacted] stated the [redacted] was suspended and the Corporate Human Resources was sending the [redacted] a termination letter in the mail. The [redacted] stated that it was not acceptable to [redacted] a resident with a [redacted]. The [redacted] stated she would consider [redacted] a resident with a [redacted] a form of abuse. The [redacted] stated she was not aware at the time of the incident that Resident #1 was [redacted] with a [redacted] by the [redacted] and that other staff members watched and did not intervene. The [redacted] stated the expectation was that if staff witnessed abuse, they were to intervene and notify the local police immediately.</p> <p>Review of the facility policy titled "Abuse Policy and Procedure" updated 8/2014, revealed under "Policy" that "This facility requires that any allegations of abuse be addressed immediately in accordance with all federal and state regulations. All allegations will be evaluated in a prompt and thorough manner. Under "Procedure", "6. Any employee alleged to have participated in abusive activity will be removed from care of the involved resident immediately. 9. The RN supervisor will contact the Director of Nursing immediately upon suspicion or confirmation of abuse. If the Director</p>	F 609		

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F 609	Continued From page 27 of Nursing is unable to be contacted, the Administrator will be contacted. 10. The Administrator will be contacted regarding all cases of physical and verbal abuse. 22. Employees who have had allegations of physical abusive treatment will be removed from direct resident care."  Review of the facility policy titled "Investigation, Recording & Reporting of Accidents/Incidents" dated 12/22/2024 revealed under "Policy", "It is the policy of this Center to investigate all accidents and incidents." Under "Purpose", "the purpose of investigating an accident/incident is to find out what actually happened, why it happened, what needs to be done to prevent a recurrence. A comprehensive investigation of all Accidents/Incidents must be completed, and documentation must be maintained in a secure location. All accident and incidents must be investigated for possible abuse." Under "Investigation Basics," "8. Statements and an accident/incident report should be completed by the end of the shift during which the event occurred or as close to the time of the even as possible. 9. Notify the Director of Nursing and/or Administrator of any significant events. 10. Collect statements from ALL staff on the unit." Under "Responsibility Nurse," 1. "Safety is priority. Assess the situation and take the necessary steps to ensure the safety of residents, visitors, and staff. 2. Conduct and document a full head to toe assessment of all residents involved." Under "Director of Nursing/Designee," 3. If the Accident/Incident is reportable, ensure that all necessary entities have been notified. Document the date and time and name of individual notified."	F 609			

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F 609	Continued From page 28	F 609			
F 610	NJAC 8:39-9.4 (f)				
SS=L	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		12/30/24	
	<p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ181767, NJ181768, NJ181846</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documents on 12/23/2024, it was determined that the facility failed to conduct a timely and thorough investigation for an allegation of witnessed NJ Ex Order 26.4b1 toward a resident (Resident #1).</p> <p>During an interview on 12/23/2024 at 3:08 P.M., the Licensed Practical Nurse (LPN #1) stated she recorded a video on her cellphone of the U.S. FOIA (b) (6) Resident #1 with a</p>		<p>Immediate Action</p> <p>On NJ Ex Order 26.4B1, U.S. FOIA (b) was suspended pending investigation. (Terminated NJ Ex Order 26.4B1)</p> <p>On 12/21/24 a third-party consulting company was contracted to conduct an independent investigation of the abuse allegation which comprised of review of documentation, care plans, interviews of staff, observation of resident, review of reportable information from NJ Ex Order 26.4B1. Audit of all incident and accident reports</p>		

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F 610	<p>Continued From page 29</p> <p><sup>NJ Ex Order 26.4B1</sup> LPN #1 sent the video to a friend, and it was posted to a social media website.</p> <p>The Surveyors and the <sup>U.S. FOIA (b) (6)</sup> reviewed a video on <sup>NJ Ex Order 26.4B1</sup> at 10:41 A.M. found on a social media website, that revealed a staff member <sup>NJ Ex Order 26.4B1</sup> at a resident with a <sup>NJ Ex Order 26.4B1</sup>. Several other staff members observed the incident and did not intervene. The <sup>U.S. FOIA (b) (6)</sup> identified the resident in the video as Resident #1. The <sup>U.S. FOIA (b) (6)</sup> identified the staff member holding the <sup>NJ Ex Order 26.4B1</sup> throughout the video as the <sup>U.S. FOIA (b) (6)</sup>. The <sup>U.S. FOIA (b) (6)</sup> was heard asking the staff that were present during the incident to go get another staff member. The <sup>U.S. FOIA (b) (6)</sup> then stated, <sup>NJ Ex Order 26.4B1</sup> The other staff members seen in the video that did not intervene when the incident occurred were identified by the <sup>U.S. FOIA (b) (6)</sup> as LPN #2, Certified Nursing Assistant (CNA #2), and the <sup>U.S. FOIA (b) (6)</sup>. The <sup>U.S. FOIA (b) (6)</sup> stated that according to the Facility Reportable Event (FRE) form completed by the <sup>U.S. FOIA (b) (6)</sup>, the incident occurred on <sup>U.S. FOIA (b) (6)</sup>.</p> <p>On <sup>NJ Ex Order 26.4B1</sup>, the local police went to the facility to investigate an abuse allegation after receiving notification that the video was circulating online.</p> <p>Review of the FRE dated <sup>NJ Ex Order 26.4B1</sup> revealed the <sup>U.S. FOIA (b) (6)</sup> conducted the investigation. The DON never reported the incident to the Department of Health. There was only one witness statement from the staff of the incident. In addition, the incident of alleged staff to resident abuse occurred on <sup>NJ Ex Order 26.4B1</sup> and the <sup>U.S. FOIA (b) (6)</sup> remained employed at the facility until she was suspended on <sup>NJ Ex Order 26.4B1</sup>.</p> <p>This placed Resident #1 and all other residents at</p>	F 610	<p>from <sup>NJ Ex Order 26.4B1</sup> to present was conducted to ensure that each incident included a thorough investigation and appropriate follow up. Audit completed 12/26/2024.</p> <p>12/24/24 Education was given to staff C.N.A. #1, and C.N.A. #3, and <sup>U.S. FOIA (b) (6)</sup> on how to follow company policy on abuse and report immediately to the abuse coordinator, intervene and call the police.</p> <p>12/24/24 Morning/clinical meeting audit process started to assure allegations of abuse and neglect and grievances are addressed and investigated within policy. Audits will be completed 3x's weekly for the next 4 weeks and monthly for the next 6 months.</p> <p>Administrator/ADON/HR contacted Board of Nursing on 12/30/2024 to report <sup>U.S. FOIA (b) (6)</sup> involvement in incident, and to report the two nurses who observed, recorded video and did not intercede to help, but sent the video to a friend to post. Those nurses no longer work at facility.</p> <p>C.N.A. #1 and C.N.A. #3 were reported to the Department of Health for not interceding to help and not reporting.</p> <p>Other residents having potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that</p>		

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F 610	<p>Continued From page 30</p> <p>risk for an Immediate Jeopardy (IJ) situation. The IJ began on [NJ Ex Order 26.4B1] and was identified on [NJ Ex Order 26.4B1] at 5:40 P.M. and was reported to the [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] was presented with the IJ template.</p> <p>An acceptable removal plan was electronically mailed to the surveyors on 12/26/2024 at 2:37 P.M. indicating the action the facility will take to prevent serious harm from occurring or recurring.</p> <p>On 12/30/2024, a revisit to verify the Removal Plan was conducted. The facility implemented the Removal Plan, which included education to all staff on conducting a thorough investigation related to an abuse allegation. A third-party consultant company completed an independent investigation of the abuse allegation which was comprised of a documentation review, review of the resident's medical records, staff interviews, resident observations, and a review of the reportable event from [NJ Ex Order 26.4B1]. The third-party consultant company conducted an audit of all incident and accident reports from [NJ Ex Order 26.4B1] to ensure that each incident included a thorough investigation. The [U.S. FOIA (b) (6)] implemented a daily audit to assure abuse allegations were addressed and investigated according to the facility's policy. The surveyors determined the IJ was removed as of 12/26/2024.</p> <p>The noncompliance remained on 12/30/2024 as a level I for actual harm that is not an IJ based on the following: The [U.S. FOIA (b) (6)] has been suspended since [NJ Ex Order 26.4B1] and the facility confirmed they were terminating her employment and reporting the [U.S. FOIA (b) (6)] to the [NJ Ex Order 26.4b1]. All facility staff were educated on conducting a thorough</p>	F 610	<p>the deficient practice will not return.</p> <p>On 12/23/24, (completed 12/25/24)the Assistant Director of Nursing/or designee immediately educated all staff on abuse investigation protocols, importance of collecting all statements, utilizing the social worker to assist in obtaining the residents statements, assuring the original signed statements are turned into the abuse coordinator, Police are called and reporting all incidents to the abuse coordinator immediately and within 5 days turn in all findings of investigation to Administrator. The Interim DON/designee will conduct this education on abuse investigation protocols for the next six months.</p> <p>Administrfator/DON/ADON/designee will audit education each month to assure all employees have had education. Audits will be completed 3x weekly for the next 4 weeks and monthly for the next 6 months.</p> <p>The Administrator/Interim DON/designee will audit compliance with the education on abuse investigation and conduct 5 random staff assessment and test to assure staff have a true understanding of our abuse policy. Audits will be completed 3x's weekly for four weeks and then monthly for next four months.</p> <p>The education on the facility protocols on abuse investigations will become part of our orientation education as well as our annual education.</p>	

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F 610	<p>Continued From page 31</p> <p>investigation related to an abuse allegation and a third-party consultant company conducted an investigation of the abuse allegation.</p> <p>This deficient practice was identified for 1 of 3 residents (Resident #1) who were reviewed for abuse and was evidenced by the following:</p> <p>According to the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents dated [redacted] and the [redacted] identified as the "person reporting", revealed that Resident #1 attempted to [redacted] LPN #1 with something that looked blue, plastic, and shiny in the resident's [redacted]. The [redacted] came to the unit and was told by LPN #1 that the resident was chasing her down the hallway. The [redacted] approached Resident #1 and he/she attempted to [redacted] at her with what appeared to be a [redacted]. The [redacted] took a [redacted] and tried to [redacted] the [redacted] out of Resident #1's [redacted]. The resident could not be redirected, and the [redacted] the [redacted] from Resident #1's hand. The nurse called the police and Resident #1 was sent to the [redacted].</p> <p>A review of the video footage that was found on a social media website on [redacted] revealed the [redacted] standing in front of Resident #1 holding a [redacted] Resident #1 appeared to have his/her back towards the corner of the wall. The [redacted] and Resident #1 had a [redacted] between each other. Resident #1 then moved towards the [redacted], and the [redacted] the resident with the [redacted]. The [redacted] asked the staff that were present during the incident to go get another staff member. The [redacted] then stated, [redacted]. The video further revealed LPN #2, CNA</p>	F 610	<p>Administrator/Interim DON/ADON/designee will audit abuse reportable events to observe and to assure completeness of investigation and that all statements are collected and are in their original signed form, police were called, incident is reported to Department of Health and Ombudsman. Audits will be conducted three times weekly for four weeks, then monthly for the next four months.</p> <p>12/30/2024 Ad Hoc QAPI meeting was held to review the results of the third-party consulting company's independent investigation of the abuse allegation which comprised of review of documentation, care plans, interviews of staff, observation of resident, review of reportable information from [redacted]. In addition, audit of all incident and accident reports from [redacted] to present was conducted to ensure that each incident included a thorough investigation and appropriate follow up. Audit completed 12/26/2024.</p> <p>The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on February 21, 2025.</p>	

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F 610	<p>Continued From page 32</p> <p>#3, and the [U.S. FOIA (b) (6)] that were present during the incident but did not intervene. The video did not reveal that the [U.S. FOIA (b) (6)] a [NJ Ex Order 26. 4B1] from Resident #1's [NJ Ex Order 26. 4B1].</p> <p>According to the Admission Record (AR), Resident #1 was admitted to the facility on [NJ Ex Order 26. 4B1], with diagnoses which included but were not limited to: [NJ Ex Order 26. 4B1].</p> <p>According to the Quarterly Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26. 4B1] Resident #1 had a Brief Interview for Mental Status (BIMS) score of [NJ Ex Order 26. 4B1] out of 15, which indicated the resident's cognition was [NJ Ex Order 26. 4B1]. The MDS further indicated Resident #1 had experienced [NJ Ex Order 26. 4B1] but had [NJ Ex Order 26. 4B1] towards others.</p> <p>A review of Resident #1's Care Plan (CP) initiated on [NJ Ex Order 26. 4B1] revealed that the resident could be [NJ Ex Order 26. 4B1]. "Interventions" initiated on [NJ Ex Order 26. 4B1] included: "Allow to [NJ Ex Order 26. 4B1], redirect as needed, and provide diversional activities."</p> <p>A review of Resident #1's [NJ Ex Order 26. 4B1] Progress Notes (PNs) revealed no documentation related to the incident that occurred on [NJ Ex Order 26. 4B1]. The PNs further revealed no documentation that the police were notified of the incident or that the resident was transferred to the [NJ Ex Order 26. 4B1].</p> <p>During an interview with the surveyors on 12/23/2024 at 10:41 A.M., the [U.S. FOIA (b) (6)] stated the [U.S. FOIA (b) (6)], and the [U.S. FOIA (b) (6)] called her on [NJ Ex Order 26. 4B1] and made her aware that the local police were at the facility to investigate an abuse allegation</p>	F 610		

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NAME OF PROVIDER OR SUPPLIER  <b>CRYSTAL LAKE HEALTHCARE AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>395 LAKESIDE BLVD</b> <b>BAYVILLE, NJ 08721</b>		
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F 610	<p>Continued From page 33</p> <p>involving Resident #1. The [U.S. FOIA (b) (6)] stated she notified the NJDOH of the abuse allegation on [NJ Ex Order 26.4B1]. The [U.S. FOIA (b) (6)] stated she was not aware of what occurred during the incident prior to seeing the video. The [U.S. FOIA (b) (6)] stated that according to the FRE and an investigation conducted by the [U.S. FOIA (b) (6)], the incident on the video occurred on [NJ Ex Order 26.4B1]. The [U.S. FOIA (b) (6)] stated she was off the day the incident occurred. The [U.S. FOIA (b) (6)] stated she was not aware that the [U.S. FOIA (b) (6)] Resident #1 with a [NJ Ex Order 26] and that the other staff members did not intervene until she watched the video. The [U.S. FOIA (b) (6)] stated the staff members who observed the incident should have not stood there but got the resident help. The [U.S. FOIA (b) (6)] stated it was not the facility's protocol to [NJ Ex] a resident with a [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated the [U.S. FOIA (b) (6)] had been suspended since [NJ Ex Order 26.4B1] pending the outcome of the investigation being conducted by a third-party consultant company. The [U.S. FOIA (b) (6)] stated that according to the FRE from [NJ Ex Order 26.4B1], the police and the NJDOH were notified of the incident.</p> <p>According to the local police department's report dated [NJ Ex Order 26.4B1], the police were never dispatched to the facility on the date of the incident regarding Resident #1.</p> <p>During a telephone interview with the surveyors on 12/30/2024 at 1:30 P.M., the [U.S. FOIA (b) (6)] stated she could not remember the date the incident occurred with Resident #1. The [U.S. FOIA (b) (6)] stated that a code was called due to Resident #1 having [NJ Ex Order 26.4b1], and she went up to the unit. The [U.S. FOIA (b) (6)] stated when she arrived on the unit, Resident #1 was running down the hallway. Resident #1 then [NJ Ex Order 26.4b1] at the [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] further stated she observed a</p>	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/30/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRYSTAL LAKE HEALTHCARE AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>395 LAKESIDE BLVD</b> <b>BAYVILLE, NJ 08721</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	<p>Continued From page 34</p> <p>blue object in Resident #1's [redacted]. The [redacted] stated that Resident #1 attempted to [redacted] with what was in his/her [redacted]. The [redacted] stated she got a [redacted] from the [redacted] and then told all the other staff in the area to move away. The [redacted] further stated Resident #1 started coming towards her and she hit him/her with the [redacted] in attempt to [redacted] what was in the resident's [redacted]. The [redacted] stated that after [redacted] the resident with the [redacted], Resident #1 walked away. The [redacted] further stated when the resident walked away, [redacted] a [redacted] from his/her [redacted]. The [redacted] further stated [redacted] thought the local police were notified but that was the unit nurses' responsibility to call the police.</p> <p>During an interview with the surveyors on 12/30/2024 at 2:12 P.M., the [redacted] stated she was off when the incident occurred between the [redacted] and Resident #1. The [redacted] stated the [redacted] was suspended and the Corporate Human Resources was sending the [redacted] a termination letter in the mail. The [redacted] stated that it was not acceptable to hit a resident with a [redacted]. The [redacted] stated she would consider [redacted] a resident with a [redacted] a form of abuse. The [redacted] stated [redacted] was not aware at the time of the incident that Resident #1 was [redacted] with a [redacted] by the [redacted] and that other staff members watched and did not intervene. The [redacted] stated the expectation was that if staff witnessed abuse, they were to intervene and notify the local police immediately.</p> <p>Review of the facility policy titled "Abuse Policy and Procedure" updated 8/2014, revealed under "Policy" that "This facility requires that any allegations of abuse be addressed immediately in accordance with all federal and state regulations.</p>	F 610		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/30/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRYSTAL LAKE HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>395 LAKESIDE BLVD</b> <b>BAYVILLE, NJ 08721</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 610	<p>Continued From page 35</p> <p>All allegations will be evaluated in a prompt and thorough manner. Under "Procedure", "6. Any employee alleged to have participated in abusive activity will be removed from care of the involved resident immediately. 9. The RN supervisor will contact the Director of Nursing immediately upon suspicion or confirmation of abuse. If the Director of Nursing is unable to be contacted, the Administrator will be contacted. 10. The Administrator will be contacted regarding all cases of physical and verbal abuse. 22. Employees who have had allegations of physical abusive treatment will be removed from direct resident care."</p> <p>Review of the facility policy titled "Investigation, Recording &amp; Reporting of Accidents/Incidents" dated 12/22/2024 revealed under "Policy", "It is the policy of this Center to investigate all accidents and incidents." Under "Purpose", "the purpose of investigating an accident/incident is to find out what actually happened, why it happened, what needs to be done to prevent a recurrence. A comprehensive investigation of all Accidents/Incidents must be completed, and documentation must be maintained in a secure location. All accident and incidents must be investigated for possible abuse." Under "Investigation Basics," "8. Statements and an accident/incident report should be completed by the end of the shift during which the event occurred or as close to the time of the even as possible. 9. Notify the Director of Nursing and/or Administrator of any significant events. 10. Collect statements from ALL staff on the unit." Under "Responsibility Nurse," 1. "Safety is priority. Assess the situation and take the necessary steps to ensure the safety of residents, visitors, and staff. 2. Conduct and document a</p>	F 610			

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NAME OF PROVIDER OR SUPPLIER  <b>CRYSTAL LAKE HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>395 LAKESIDE BLVD</b> <b>BAYVILLE, NJ 08721</b>		
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F 610	Continued From page 36 full head to toe assessment of all residents involved." Under "Director of Nursing/Designee," 3. If the Accident/Incident is reportable, ensure that all necessary entities have been notified. Document the date and time and name of individual notified."  NJAC 8:39-4.1(a) 5	F 610			

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315125	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/30/2025	Y3
NAME OF FACILITY CRYSTAL LAKE HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 395 LAKESIDE BLVD BAYVILLE, NJ 08721		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0583	Correction	ID Prefix F0600	Correction	ID Prefix F0609	Correction
Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	12/30/2024	LSC	12/30/2024	LSC	12/31/2024
ID Prefix F0610	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/30/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		