STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315364	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jersey Shore Center	3 Industrial Way East Eatontown, NJ 07724

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273 Based on observation, interview, record review, and policies, the facility failed to protect the resident's right to be free from sexual abuse by a resident for one of 28 sample residents (Resident (R) 89). Failure to identify risk factors and intervene to prevent an incident involving inappropriate sexual contact directly increased the risk R89 and other residents could experience abuse. Findings include: R89's "Admission Record" located in the electronic medical record (EMR) under the Profile tab documented R89 was admitted to the facility on [DATE] with a diagnosis of dementia. The quarterly "Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/01/24 was located under the MDS tab in EMR. The MDS documented R89 had severely impaired cognition and scored three out of 15 on the "Brief Interview for Mental Status (BIMS). The MDS noted R89 needed maximum assistance with transfers and was able to navigate a wheelchair in the environment. On 03/11/25 at 10:05 AM, R89 was observed seated in the dining room at a table. When greeted R89 was responded engaged in simple conversation. R89 was confused but responded appropriately, presenting a calm and pleasant demeaner. When asked about the incident that occurred on 04/14/24, R89 had no recall. R174's "Admission Record," found in the EMR under the Profile tab, documented an admitted [DATE] with multiple diagnoses including schizophrenia and anxiety. A quarterly MDS assessment, found under the MDS tab in EMR, with an ARD date of 02/27/24 documented R174 scored a 15 out of 15 on the BIMS, indicating intact cognition. The MDS documented R174 was independent with most activities of daily living (ADLs), including transfers and mobility, and identified the resident displayed verbally abusive behaviors directed toward others. The facility investigation, dated 04/17/24, documented R174 was in the dining room on 04/14/24 at 11:00 AM. The report indicated an activities staff saw witnessed R174 with his hand between R89's thighs. The investigation identified it was an incident of inappropriate touching. When R174's actions were observed in the dining room on 04/14/24, by an activities staff, they intervened separated the resident R89 and R174. R174 was moved to another unit the same day. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/25 at 1:00 PM, the Administrator stated R174 no longer resided in the facility and explained he had been sent to psychiatric hospital for evaluation after attempting to strike a staff member. R174 was transferred on 07/25/24, and the Administrator explained an alternate placement was found. The Administrator stated R174 had a history of aggressiveness with the staff in the past, but he was not aware of any other instances or altercations involving other residents, and acknowledged the incident occurred. The Administrator stated the staff intervened when they noticed the inappropriate touching, but the resident had not displayed similar behavior in the past. The facility policy "Abuse Prohibition," revised 10/24/22, indicated the facility would prohibit abuse . through prevention of occurrences ." Sexual abuse was defined as ". non-consensual sexual contact of any type with a patient." Under subheading five (5.) the policy identified actions to prevent abuse, included identifying, correcting, and intervening in situations in which abuse . is more likely to occur; and evaluating a patient's capacity to consent to sexual activity ." NJAC 8:39-4.1(a) NJAC 8:39-9.4(f) NJAC 8:39-33.2(c)12

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273 Based on observation, interview, record review, and policy review, the facility failed to ensure an abuse investigation of inappropriate touching was documented for one of 28 sample residents (Resident (R) 89). Failure to ensure a thorough investigation of the incident increased the risk that other residents may have experienced a similar incident, or the incident had a negative impact on their sense of well-being. Findings include: R89's "Admission Record," located in the electronic medical record (EMR) under the Profile tab, documented R89 was admitted to the facility on [DATE] with a diagnosis of dementia. The most recent annual "Minimum Data Set (MDS)" assessment with an Assessment Reference Date (ARD) of 01/23/25 was located under the MDS tab in EMR. The MDS documented R89 had severely impaired cognition and scored two out of 15 on the "Brief Interview for Mental Status (BIMS). On 03/11/25 at 10:05 AM, R89 was observed seated in the dining room at a table. When greeted R89 was responded engaged in simple conversation. R89 was confused but responded appropriately, presenting a calm and pleasant demeaner. When asked about the incident that occurred on 04/14/24, R89 had no recall. R174's "Admission Record," found in the EMR under the Profile tab documented an admitted [DATE] with multiple diagnoses including schizophrenia and anxiety. A quarterly MDS, located in the EMR under the MDS tab, with an ARD date of 02/27/24, documented R174 scored a 15 out of 15 on the BIMS, indicating intact cognition. The MDS documented R174 was independent with most activities of daily living (ADLs) including transfers and mobility, and identified the resident displayed verbally abusive behaviors directed toward others. The MDS data revealed R174 was discharged from the facility on 07/25/24 and did not return. Review of the facility investigation dated 04/14/24 revealed, on 04/14/24 at 11:00 AM, R174 was observed by staff with his hand between R89's thighs. The incident occurred in the dining room, a common area. The staff intervened and separated the residents. R174 was moved to another unit. The incident was reported to the state agency and local police as required and implemented an investigation. The facility investigation included a "Reportable Event Record/Report" sent to the Department of Health dated 04/17/24. A summary statement dated 04/17/24, signed by Director of Nursing (DON), stated they documented a thorough investigation, which included interviews of both residents, and interviews with other residents on the Ocean Unit. The facility concluded R174 had inappropriately touch R89. The investigation file did not include any documentation of the interviews with R174 and/or R89 or other residents on the Ocean Unit to see if anyone had a similar experience or if they observed the incident if it affected their psycho-social wellbeing. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/25 at 11:00 AM, the Administrator was asked if interviews with residents were documented, he stated the Social Workers would usually complete them, and he would try to find them. The Administrator returned to the conference room at 3:30 PM and reported they were unable to find documents related to the resident interviews. NJAC 8:39-9.4(f)