STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Subacute Rehabilitation Center at Sewell	685 Salina Road Sewell, NJ 08080

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Complaint # 430386Based on interviews, medical record review, and review of the facility's policy, the facility failed to protect Resident (R)5's right to be free from physical abuse by a staff member. This deficient practice was identified for R5, 1 of 3 residents reviewed for staff-to-resident abuse. Review of R5's undated admission Record in the resident's electronic medical record (EMR) revealed that the resident was admitted to the facility on [DATE]. R5 had diagnoses which included dementia without behavioral disturbances.Review of R5's quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) of 2 out of 15, which indicated the resident was severely cognitively impaired.Review of the Facility Investigation Form (FRI) provided by the facility and dated [DATE] revealed Licensed Practical Nurse (LPN) 1 was observed by Activity Aide (AA) 1 on [DATE] around 10:10 AM, to continue to attempt to give R5's medication despite R5's refusal. When R5 threw juice at LPN1, the LPN grasped R5's wheelchair's armrest and pushed the wheelchair forward, causing it to move towards another chair positioned in front of the resident. Video surveillance of the incident revealed LPN1 grabbed R5's left arm and roughly pushed R5 into another wheelchair. LPN1 provided a written statement on [DATE] at 2:07 PM denying any allegations of abuse to R5.After the incident, LPN1 clocked out and did not return to the facility. However, the AA did not immediately notify the Director of Nursing (DON) or the Nursing Supervisor of the incident; the AA wrote a statement and left it for the DON, which was not found by the DON until [DATE].Record review revealed on [DATE], a skin assessment, located in the EMR under the Assessments tab, was completed on R5 with no injuries noted.During an interview on [DATE] at 10:30 AM, the Business Office Manager (BOM) stated LPN1 clocked in at 7:00 AM on [DATE] and clocked out at 10:36 AM. The BOM also confirmed that LPN1's license was current at the time of the incident and expired on [DATE].During an interview on [DATE] at 2:00 PM, the DON stated LPN1 did not return to the facility after [DATE] and was terminated on [DATE]. The DON said R5 did not show any signs of increased behaviors following the incident or since. The DON stated LPN1 provided a written statement on [DATE] at 2:07 PM, denying any allegations of abuse to R5. The DON also said that LPN1 had no prior incidents of inappropriate interactions with residents. The criminal background check completed on hire revealed no concerns. The DON further stated the facility investigation substantiated an allegation of abuse from LPN1 to R5.According to the DON, no other residents on the Memory Care unit were affected by the incident. The DON also stated that the facility completed an all-staff Abuse and Neglect in-service the week of [DATE].In addition, the DON stated that AA1 had an in-service on [DATE] specifically regarding who and when to report allegations of resident abuse. The DON and Registered Nurse (RN1) conducted specific in-services on dementia residents and approaches to use for medication refusals. The DON further stated that monitoring for effectiveness was completed by observations on the unit with staff.During an interview on [DATE] at 2:30 PM, RN1 stated LPN1 notified RN1 at approximately 10:30 AM on [DATE] that LPN1 was leaving (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	and stated .I have too much going on at home . RN1 was not made aware of the incident between LPN1 and R5 when LPN1 left.Review of the facility's policy title, Abuse Prevention, revised 10/25, revealed .physical abuse includes hitting, slapping, punching and kicking, it also includes controlled behavior through corporal punishment. NJAC 8:39-4.1(a)5

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint# 430386 and 2595402Based on interviews, record review, and facility policy review, the facility failed to ensure allegations of staff-to-resident abuse were reported timely, and in accordance with federal reporting requirements, to the State Survey Agency (SSA) for two of two sampled residents (Resident (R) 3 and R5) reviewed for allegations of abuse. The facility's failure to promptly report allegations of abuse limited regulatory oversight and had the potential to delay protective interventions for residents. Findings include:1. Review of a complaint intake dated 08/20/25 for R3 revealed R3 made an allegation of sexual abuse against a former facility staff employee, Maintenance Worker (MW) 1, to his/her therapist on 06/29/25, after discharge from the facility. Review of R3's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] for a respite stay. R3 had diagnoses of a traumatic brain injury (TBI) and anxiety. R3 was discharged home on [DATE]. Review of R3's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/25 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. During an interview on 01/29/26 at 10:00 AM, the Administrator stated that R3 did not voice any allegations regarding sexual abuse during R3's stay. The Administrator stated the facility was made aware of the allegations when local law enforcement contacted the facility on 07/08/25. According to the Administrator, MW1 was not scheduled for work on 07/08/25 or 07/09/25. On 07/10/25, MW1 reported for work at approximately 7:00 AM and was suspended by the Administrator prior to clocking in and beginning work. MW1 did not return to the facility and submitted his/her resignation on 07/13/25. The Administrator further stated the facility did not report R3's allegations to the SSA, as R3 no longer resided at the facility. Review of the investigative file revealed documented evidence that MW1 did not work at the facility on 07/08/25 or 07/09/25 and was suspended on 07/10/25 prior to the shift beginning. MW submitted his/her resignation on 07/13/25. 2. Review of R5's undated admission Record, located in the resident's EMR under the Profile tab revealed that R5 was admitted to the facility on [DATE]. R5 had a diagnosis of dementia without behavioral disturbances. Review of R5's quarterly MDS with an ARD of 08/11/25, located under the MDS tab of the EMR, revealed a BIMS score of 2 out of 15, which indicated the resident was severely cognitively impaired. Review of the facility's Investigation Form provided by the facility and dated 06/10/25 revealed that on 06/08/25 around 10:10 AM, Licensed Practical Nurse (LPN) 1 was observed by Activity Aide (AA) 1, and on video surveillance, to continue to attempt to give R5's medication despite R5's refusal. When R5 threw juice at LPN1, LPN1 grasped R5's left arm and roughly pushed R5 into another wheelchair. Continued review revealed AA1 did not inform the Director of Nursing (DON) or the Nursing Supervisor of the incident. AA1 left a written statement for the DON on 06/09/25 of her observations of LPN1 and R5. Review of the Facility Reported Event (FRE) revealed the facility notified the SSA on 06/09/25 at 3:30 PM of the allegation. During an interview on 01/29/26 at 2:00 PM, the DON stated the facility was unaware of the incident until 06/09/25 when the DON found the statement from AA1. The DON also confirmed the initial notification to the SSA did not occur until 06/09/25. The DON stated the facility completed an all staff Abuse and Neglect in-service the week of 06/09/25. The DON further stated that AA1 had an in-service on 06/10/25, specifically regarding who and when to report allegations of resident abuse. The DON and Registered Nurse (RN1) conducted specific in-services regarding dementia residents and approaches to utilize with medication refusals. The DON stated that monitoring for effectiveness was completed by observations on the unit with staff. Review of the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy titled, Abuse Prevention, revised 10/25, revealed . Each covered individual [employee] shall report immediately, but not later than two hours after forming the suspicion . NJAC 8:39-9.4(f)