STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST , MANAHAWKIN, New Jersey, 08050

(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
F0000	INITIAL COMMENTS CENSUS: 109 SAMPLE SIZE: 4 COMPLAINT #: 2564823 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.	F0000		09/29/2025
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F0584	Temperature checks of shower rooms and elevators have been added to maintenance inspections. All residents have the potential to be affected by this deficient practice. Maintenance staff have been educated by the Administrator on the required temperature range of 71 to 81 degrees Fahrenheit by 8/26/2025. A temperature log was created to monitor and record the temperatures of the four shower rooms and the elevators. Maintenance will conduct temperature checks of the shower rooms and elevators daily, Monday through Friday, for 4 weeks, then every Monday, Wednesday, and Friday for 4 weeks, then weekly for 4 weeks. These logs will be submitted to the Administrator weekly starting on 8/29/2025. The Maintenance Director will submit a monthly report to the facility's monthly QAPI committee meeting for 4 months. Date of completion: 9/15/2025	09/15/2025

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 reverse for further 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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F0584 SS = D	Continued from page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Complaint # 2564823 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain a safe and comfortable room temperature levels in residents' shower rooms and in the facility elevator. This deficient practice was identified in 2 of 4 resident shower rooms and in 1 of 1 facility elevator (elevator car 1). This deficient practice was evidenced by the following: On 07/18/2025 at 10:23 A.M., the surveyor checked temperatures in different locations throughout the facility in the presence of the U.S. FOIA (b) (6)) and the following were obtained: The second-floor East shower room has room temperature of 84.4 degrees Fahrenheit (F). which is above the required temperature range of 71 to 81°F. There were no residents present at this time. The second-floor West shower room had room temperature of 84.4 degrees F in the shower stall and 84.2 degrees F outside of the stall. No residents were present in the shower room. In the Elevator car 1, the air temperature was 84.6 degrees F. No residents present in the elevator. After the temperature checks, the surveyor observed	F0584		

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F0584 SS = D	Continued from page 2 residents, visitors, and staff using the elevator Car 1throughout the day. On 07/18/2025 at 3:06 P.M., the surveyor interviewed the facility U.S. FOIA (b) (6) . The U.S. FO stated that the air conditioning had been working properly since the power was restored after a brief outage on 07/16/2025. The U.S. FO further stated that he was not aware of any work orders related to room temperatures. On 07/18/2025 at 4:36 P.M., the surveyor interviewed the U.S. FOIA (b) (6)), who confirmed that the facility had a power outage on 07/16/2025. The U.S. FOIA (stated that the facility's generator switched on and functioned properly. The U.S. FOIA (further stated that the facility did not have an interruption in air conditioning during the power outage. The U.S. FOIA (also stated that as far as she knew, the air conditioning system was functioning properly. NJAC 8:39 -31.6(p)4	F0584		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in	F0585	Resident #3 has been discharged from the facility since NJ Ex Order 26.4(All residents have the potential to be affected by this deficient practice. Department heads have been educated on the grievance policy by the Administrator by 8/29/2025. All staff have been educated on the grievance policy by the Staff Educator by 9/1/2025. An audit tool was created to track all grievances as they proceed through the grievance process. Social Services will utilize the audit tool daily, Monday through Friday, making updates as appropriate and reporting at the daily stand-up meeting for 4 weeks, then Monday, Wednesday, and Friday for 4 weeks, then weekly for 4 weeks. A copy of the audit will be provided to the Administrator weekly starting on 8/29/2025. The Social Service Director will submit a monthly report to the facility's monthly QAPI committee meeting for 4 months. Date of completion: 9/15/2025	09/15/2025

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F0585 SS = D	Continued from page 3 this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F0585		

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F0585 SS = D	Continued from page 4 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure a family member's concern regarding missing clothing and personal items were filed as a grievance and investigated for one of nine sample residents (Resident (R) 3) reviewed for grievances. This had the potential for residents' rights not being supported, to have their lost belongings searched for, and/or reimbursed. Review of the facility's policy titled, "Grievance Guideline," revised on 05/31/23, revealed "Purpose: To provide a process to voice grievances (such as those about treatment, care, management of funds, lost clothing, or violation of rights) and respond with prompt efforts to resolve while keeping the resident and/or resident representative appropriately apprised of progress toward resolution…Grievance Official: Our facility Grievance Official is the Administrator and/or Designee appointed by the Administrator…A grievance or concern may be expressed orally or in writing to the Grievance Official or facility staff… RESOLUTION: The Grievance Official and/or designee will complete a response within 5 days of receipt to the resident and/or resident representative." Review of R3's "Admission Record" located in the electronic medical record (EMR) under the "Admission" tab revealed the resident was admitted to the facility on [redacted] with a diagnosis of [redacted]. The resident was discharged to the hospital in [redacted] and did not return to the facility. Review of R3's "Progress Note," dated [redacted], located in the EMR under the "Progress Note" tab, revealed the resident's family was in for a visit and had concerns because the resident's lock was off [redacted] closet. The nurse told the family member they would look into it.	F0585		

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F0585 SS = D	Continued from page 5 Review of the facility's "Grievances" for [NJ Ex Order 26.4(b)(1)] and provided by the facility revealed no evidence of grievance being filed by the facility on behalf of R3's family. During an interview on 07/30/25 at 1:00 PM, the Licensed Practical Nurse (LPN) 2/ Unit Manager (UM) revealed back in [NJ Ex Order 26.4(b)(1)], R3's family member said the facility could cut the lock off the resident's closet so staff could get into the closet and get the resident a change of clothes. LPN2/UM was not aware of the family reporting there was missing clothing and personal items from the closet. During an interview on 07/31/25 at 2:20 PM, the [U.S. FOIA (b) (6)] confirmed R3's family did have concerns that the resident was missing clothing and personal items from [NJ Ex] closet back in [NJ Ex Order 26.4(b)(1)] when the lock was removed. She confirmed she did send an email to the family on [NJ Ex Order 26.4] stating that she would submit a request for reimbursement in the amount of [NJ Ex Order 26.] to cover the missing clothing and personal items. She stated, however, that the facility had not sent R3's family [NJ Ex Order 26.4] or followed up with the family. The [U.S. FOIA (b) (6)] confirmed she did not complete a formal grievance or look into the concern. She confirmed a grievance should have been filed in order to complete a thorough investigation, so a resolution could be presented to the family of R3.	F0585		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Complaint # 2564823 Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 07/18/2025, it was determined that the facility failed to administer medications according to the acceptable standards of nursing practice. This deficient practice was identified for 1 of 3 residents reviewed (Resident #3).	F0658	Resident #3 had no adverse effects from Nurse #1 not watching them take their medications. The medications were removed from the room. The physician was notified. All residents have the potential to be affected by this deficient practice. Nurse #1 had a medication pass observation completed by the Staff Educator on 7/22/2025. All nurses were educated on medication safety by the Staff Educator by 7/25/2025. The Unit Managers will audit behind the nurses during medication pass daily, Monday through Friday, for 4 weeks, then Monday, Wednesday, and Friday for 4 weeks, then weekly for 4 weeks, for medications left at bedside. They will report the findings to the Director of Nursing starting 8/29/2025. Nurses will have a medication pass observation completed by 9/3/2025.	09/15/2025

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F0658 SS = D	Continued from page 6 This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions " b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem. According to the Admission Record (AR), Resident #3 was admitted to the facility with diagnoses that included but not limited to: NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), reflected that Resident #3 had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1) During an interview with Resident #3 on 07/18/2025 at 9:55 A.M., the surveyor observed the resident in bed with their head under the covers. The surveyor observed multiple pills of varying shapes, sizes and colors in a medicine cup on top of Resident # 3's overbed table. When interviewed, Resident #3 stated that the nurse handed the medication to them, and that they placed the cup of medication on the table and forgot about them. At that time, the surveyor called the U.S. FOIA (b) (6) and showed her the medications left at Resident #3's bedside. The U.S. FO removed the medication cup with the pills from Resident #3's bedside. On 07/18/2025 at 1:54 P.M., the surveyor interviewed	F0658	Continued from page 6 The Director of Nursing will submit a monthly report to the facility's monthly QAPI committee meeting for 4 months. Date of completion: 9/15/2025	

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F0658 SS = D	Continued from page 7 the Registered Nurse (RN #1), who stated that she was the nurse caring for Resident #3 and confirmed that that during the morning medication administration, she handed a cup containing the resident's morning medications to the resident and left the room without waiting for the resident to take the medications. RN #1 stated that the usual process was to watch the resident take their medications before leaving the room. RN #1 further stated that she was in a rush that morning and did not wait for Resident #3 to take their medications. RN #1 stated that the medications she left with Resident #3 were NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) along with the resident's other morning medications. RN #1 further stated that it was important for safety to watch residents take their medication in order to prevent accidents and medication diversion. A review of the resident's Medication Administration Record (MAR) revealed that RN #1 prepared for administration to Resident #3 the following medications: NJ Ex Order 26.4(b)(1) tablet NJ Ex Order 26.4(b)(1) tablet NJ Ex Order 26.4(b)(1) tablet NJ Ex Order 26.4(b)(1) tablet NJ Ex Order 26.4(b)(1)) tablet NJ Ex Order 26.4(b)(1) tablet NJ Ex Order 26.4(b)(1) tablet (NJ Ex Order 26.4(b)(1)) An interview was conducted with the U.S. FC on 07/18/2025 at 2:30 P.M. The U.S. FC stated that that the expectation was for the nurses to watch the residents take their medications to ensure the medication was taken and that it was tolerated well. The U.S. FC stated the if the resident was not observed taking their medication, they may not receive the prescribed treatment, or another resident could take the medication. The U.S. FC further	F0658		

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F0658 SS = D	Continued from page 8 stated that the administering nurse was responsible to watch the resident take their medications. An interview was conducted with the U.S. FOIA (b) (6)) on 07/18/2025 at 4:45 P.M. The U.S. FOIA stated the expectation was that nurses observed the residents take their medications. The U.S. FOIA stated that leaving pills at the bedside did not comply with the facility's policy or his expectations for medication administration. The U.S. FOIA further stated that watching residents take their medications was important to in order to ensure that the resident got their ordered medications and that another resident did not get them. A review of the undated facility policy titled, "Medication Administration," revealed under "Policy," "Medications are administered by licensed nurses […] as ordered by the physician and in accordance with professional standards of practice…" Under "Policy Explanation and Compliance Guidelines:" the policy revealed, "18. Observe resident consumption of medication." NJAC 8:39-29.2(d)	F0658		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of hospital records, interview, and review of facility policy, the facility failed to ensure ordered treatments were completed for NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) for one of three residents (Resident (R) 2) reviewed for NJ Ex Order 26.4(b)(1) out of a total sample of nine residents. This had the potential for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to worsen and a potential for NJ Ex Order 26.4(	F0684	Resident #2 has been discharged from the facility since NJ Ex Order 26.4(b All residents have the potential to be affected by this deficient practice. All residents with wounds were audited by the Director of Nursing for proper treatments and care plans by 8/1/2025. The Director of Nursing or designee will audit residents with wounds twice weekly to ensure orders are correct, treatments are on the treatment administration record, care plans are appropriate, and weekly wound evaluations are documented for 12 weeks. The Director of Nursing will submit a copy of the audit to the Administrator weekly starting 8/29/2025. The Director of Nursing will submit a monthly report to the facility's monthly QAPI committee meeting for 4 months.	09/15/2025

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F0684 SS = D	Continued from page 9 Review of the facility's policy titled, "Skin Integrity-Incontinence Associated Dermatitis (IAD)" with a date implemented 02/14/23, revealed "Residents who are incontinent will receive appropriate treatment and services for the prevention and management of IAD…e. For residents with fungal skin infection, apply antifungal products as ordered by the physician." Review of R2's "Admission Record" located in the electronic medical record (EMR) under the "Admission Record" tab revealed R2 was admitted to the facility on NJ Ex Orde with diagnoses including NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) The resident was discharged from the facility in NJ Ex Order Review of R2's "Hospital Record" located in the EMR under the "Evaluation" tab, dated NJ Ex Order 26.4(b) revealed the resident was being discharged to the facility with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . Review of R2's "Care Plan" located in the EMR under the "Care Plan" tab with an initiated date NJ Ex Order 26.4 , revealed the resident had NJ Ex Order 26.4(b)(1) related to NJ Ex Ord The goal was for the resident to have NJ Ex Order 26.4(b) . Intervention included complete treatments as ordered. Review of R2's 'NJ Ex Order 26.4(b)(1) Chart Details," dated NJ Ex Order 26.4 located in the EMR under the "Evaluation" tab and completed by the U.S. FOIA (b) (6)), revealed R2's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) were assessed and treated with the Licensed Practical Nurse (LPN) 3/Unit Manager (UM) at the bedside. The resident's following NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with treatment orders included the following: NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1)), with an order to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)) daily. The treatment was completed by the U.S. FOIA (b) (6) , and subsequent treatments were to be completed by the staff of the facility. NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) with an order to NJ Ex Order 26.4(b)(1) ,	F0684	Continued from page 9 Date of completion: 9/15/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST , MANAHAWKIN, New Jersey, 08050

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F0684 SS = D	Continued from page 10 and NJ Ex Order 26.4(b)(1) daily. The treatment was completed by the U.S. FOIA (b) (6), and subsequent treatments were to be completed by the staff of the facility. NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) with an order to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The treatment was completed by the U.S. FOIA (b) (6), and subsequent treatments were to be completed by the staff of the facility. NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) with an order to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) The treatment was completed by the U.S. FOIA (b) (6), and subsequent treatments were to be completed by the staff of the facility. NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) and between NJ Ex Order 26.4(b)(1) with an order to NJ Ex Orde and NJ Ex Ord and NJ Ex Order 26.4(b)(1). The treatment was completed by the U.S. FOIA (b) (6) and subsequent treatments were to be completed by the staff of the facility. NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1)) with an order to NJ Ex Order 26.4(b)(1) with soap and water with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) , to be completed twice a day. The treatment was completed by the U.S. FOIA (b) (6), and subsequent treatments were to be completed by the staff of the facility. NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1)) with an order to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) , to be completed twice a day. The treatment was completed by the U.S. FOIA (b) (6) and subsequent treatments were to be completed by the staff of the facility. NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1)) with an order to NJ Ex Order 26.4(b)(1) with soap and water with NJ Ex Order 26.4(b)(1) to be completed twice a day. The treatment	F0684		

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F0684 SS = D	Continued from page 11 was completed by the U.S. FOIA (b) (6), and subsequent treatments were to be completed by the staff of the facility. Review of R2's "Treatment Administration Record (TAR)" for NJ Ex Order 26.4(b) located in the EMR under the "Orders" tab, revealed no evidence the treatments ordered by the U.S. FOIA (b) (6) for R2's three areas of NJ Ex Order 26.4(b)(1) were on the "TAR" to be completed on NJ Ex Order 26.4(b) Review of R2's "TAR" for NJ Ex Order 26.4(b)(located in the EMR under the "Orders" tab, revealed only one combined entry for all of R2's NJ Ex Order 26.4(b)(1), the treatment for all of R2's NJ Ex Order 26.4(b)(1) were to NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1). This was documented as completed from NJ Ex Order 26.4(through NJ Ex Order 26.4(b) However, the treatment documented as completed was not the specific orders that were ordered by the U.S. FOIA (b) (6) on NJ Ex Order 26.4 for the NJ Ex Order 26.4(b)(1). The "TAR" for NJ Ex Order 26.4(b)(further revealed the specific orders received by the U.S. FOIA (b) (6) on NJ Ex Order 26.4 for R2's NJ Ex Order 26.4(b)(1) were not started until NJ Ex Order 26.4. There was no evidence that any treatments were completed on the resident's NJ Ex Order 2 [redacted] on NJ Ex Order 26.4 and NJ Ex Order 26.4(b) Further review of R2's "TAR" for NJ Ex Order 26.4(b)(located in the EMR under the "Orders" tab, revealed the treatments to the residents NJ Ex Order 26.4(b)(1) that were ordered on NJ Ex Order 26.4(b) to be completed twice a day were not started until NJ Ex Order 26.4 and were only completed once a day. Review of the weekly NJ Ex Order 26.4(b)(1) Chart Details," dated NJ Ex Order 26.4 NJ Ex Order 26.4(b) NJ Ex Order 26.4, and NJ Ex Order 26.4(b) located in the EMR under the "Assessment" tab, revealed the U.S. FOIA (b) (6) completed the treatments to R2's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) once a week, and completed assessments. The status of the resident's NJ Ex Order 26.4(b)(1) remained unchanged. The status of the NJ Ex Order 26.4(b)(1) [redacted] had NJ Ex Order 26.4(b) The status of the resident's NJ Ex Order 26.4(b)(1) [redacted]. During an interview on 07/31/25 at 9:30 AM, the U.S. FOIA (b) (6) confirmed the documentation of R2's NJ Ex Order 26.4(b)(1) completed by the facility from NJ Ex Order 26.4 to NJ Ex Order 26.4(were not according to the specific orders received by the U.S. FOIA (b) (6) on NJ Ex Order 26.4(b). He confirmed there was no evidence treatments were completed on NJ Ex Order 26.4 and NJ Ex Order 26.4. The U.S. FOIA confirmed the only time R2's NJ Ex Order 26.4(b)(1) treatments were completed per order was when the U.S. FOIA (b) (6) came to the facility once a week NJ Ex Order 26.4(b) NJ Ex Order 26.4 and NJ Ex Order 26.4) and completed them as well as assessed the NJ Ex Order 26.4(b)(1). He further	F0684		

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F0684 SS = D	Continued from page 12 confirmed there was no evidence that R2's NJ Ex Order [redacted] treatment orders were completed by the facility until NJ Ex Order 26.4 and they were only completed once a day, however, were ordered to be completed twice a day. During a telephone interview on 07/31/25 at 10:15 AM the LPN3/UM of the unit R2 resided on, revealed she did not know why the treatments to R2's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) were not completed as ordered by the U.S. FOIA (b) (6).	F0684		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of hospital records, interview, and review of facility policy, the facility failed to ensure ordered treatments were completed for NJ Ex Order 26.4(b)(1) for one of three residents (Resident (R) 2) reviewed for NJ Ex Order 26.4(b)(1) out of a total sample of nine residents. This had the potential for the NJ Ex Order 26.4(b)(1) and a potential for NJ Ex Order 26.4(Review of the facility's policy titled, "Pressure Injury Prevention and Management" with a date implemented 02/14/23, revealed "This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcers/ injuries…2. The facility shall establish and utilize a systematic approach for	F0686	Resident #2 has been discharged from the facility since NJ Ex Order 26.4(All residents have the potential to be affected by this deficient practice. The Director of Nursing audited all residents with wounds to ensure that the treatments recorded on the treatment order record matched the physician's treatment orders by 8/1/2025. The Director of Nursing or designee will audit the residents with wound treatment administration records daily, Monday through Friday, for 4 weeks, then every Monday, Wednesday, and Friday for 4 weeks, then weekly for 4 weeks. These logs will be submitted to the Administrator weekly starting on 8/29/2025. The Director of Nursing will submit a monthly report to the facility's monthly QAPI committee meeting for 4 months. Date of completion: 9/15/2025	09/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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F0686 SS = D	Continued from page 13 pressure injury prevention and management, including prompt assessment and treatment." Review of R2's "Admission Record" located in the electronic medical record (EMR) under the "Admission Record" tab revealed R2 was admitted to the facility on [redacted] with diagnoses including [redacted] and [redacted] The resident was discharged from the facility in [redacted] Review of R2's "Hospital Record" located in the EMR under the "Evaluation" tab, dated [redacted] revealed the resident was being discharged to the facility with [redacted], [redacted]), [redacted], [redacted], and [redacted]. Review of R2's "Care Plan" located in the EMR under the "Care Plan" tab with an initiated date [redacted], revealed the resident had [redacted] related to [redacted] Intervention included complete treatments to the [redacted] as ordered. Review of R2's '[redacted] Chart Details," dated [redacted] located in the EMR under the "Evaluation" tab and completed by the [redacted]) revealed R2's [redacted] were assessed and treated with the Licensed Practical Nurse (LPN) 3/ Unit Manager (UM) at the bedside. The resident's following [redacted] with treatment orders included the following: [redacted] of the [redacted] with an order to [redacted] The treatment was completed by the [redacted], and subsequent treatments were to be completed by the staff of the facility. [redacted] of the [redacted]. The order revealed to [redacted] The treatment was completed by the [redacted], and subsequent treatments were to be completed by the staff of the facility. Review of R2's "Treatment Administration Record (TAR)" for [redacted] located in the EMR under the "Orders" tab, revealed only one combined entry for all of R2's [redacted] the treatment for all of R2's [redacted] were to	F0686		

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F0686 SS = D	Continued from page 14 NJ Ex Order 26.4(b)(1) with NJ Ex Order 2 . This was documented as completed from NJ Ex Order 26.4(b) through NJ Ex Order 26.4. However, the treatment documented as completed was not the specific orders that were ordered by the U.S. FOIA (b) (6) on NJ Ex Order 26.4. The "TAR" for NJ Ex Order 26.4(b)(revealed the orders received by the NJ Ex Order 26.4(b) on NJ Ex Order 26.4 were not started until NJ Ex Order 26.4. There was no evidence that any treatments were completed on the resident's NJ Ex Order 26.4 on NJ Ex Order 26.4 and NJ Ex Order 26.4(b) Review of the weekly "Multi NJ Exec Orde Chart Details," dated NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b) located in the EMR under the "Assessment" tab, revealed the U.S. FOIA (b) (6) completed the treatments once a week and assessed the residents NJ Ex Order 26.4(b)(1). The status of the above NJ Ex Order 26.4(b)(1) remained unchanged. During an interview on 07/31/25 at 9:30 AM, the U.S. FOIA (b) (6)) confirmed the documentation of R2's NJ Ex Order 26.4(b)(1) completed by the facility from NJ Ex Order 26.4(b)(1) were not according to the orders received by the U.S. FOIA (b) (6) or NJ Ex Order 26.4(b) He confirmed there was no evidence treatments were completed at all on NJ Ex Order 26.4(b)(1) The U.S. FOIA confirmed the only time R2's NJ Ex Order 26.4(b)(1) treatments were completed per order was when the U.S. FOIA (b) (6) came to the facility once a week NJ Ex Order 26.4(b)(1)) and completed them as well as assessed the NJ Ex Order 26.4(b)(1). During a telephone interview on 07/31/25 at 10:15 AM, the LPN3/UM of the unit R2 resided on revealed she did not know why the treatments to R2's NJ Ex Order 26.4(b)(1) were not completed as ordered by the U.S. FOIA (b) (6)	F0686		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F0812	Refrigerator/freezer temperatures are being checked daily. Food temperatures are being checked for each meal. The rolls were removed and discarded on 7/18/2025. The expired rolls were removed and discarded on 7/18/2025. The wall by the walk-in refrigerator was cleaned and sanitized on 7/28/2025. All residents have the potential to be affected by this deficient practice. The U.S. FOIA (b) (6) was educated by the Administrator regarding refrigerator temps, food temps and checking food for expiration dates and/or mold by 8/29/2025. Dietary staff educated by the Food Service Manager on temperatures and proper food storage by 8/6/2025.	09/15/2025

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F0812 SS = F	Continued from page 15 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Complaint: 2564823 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain refrigerated potentially hazardous foods at appropriate temperatures to prevent potential microbial growth, b.) discard foods that were past their date of expiration and showed signs of spoilage, c.) maintain the kitchen in a sanitary manner, e.) accurately record appropriate cooking and holding temperatures, and f.) accurately record refrigeration temperatures. This deficient practice was evidenced by the following: 1.) On 07/18/2025 at 9:30 A.M., the surveyor and the U.S. FOIA toured the kitchen and observed the needle of the dial type external thermometer on the chest refrigerator was resting in the lowest possible position (below -40 degrees Fahrenheit (F)). The thermometer did not appear to be functioning. The internal thermometer read 50 degrees F. There was cloudy liquid pooled at the bottom of the chest refrigerator. During a follow up tour and interview on 07/18/2025 at 12:00 P.M., the U.S. FOIA (b) (6)) confirmed that the exterior thermometer of the chest refrigerator was not functioning, and that the internal thermometer read 50 degrees F. The U.S. FOI confirmed the presence of cloudy liquid at the bottom of the chest refrigerator. The U.S. FOI attempted to calibrate two digital probe thermometers which belonged to the facility, but was unsuccessful. The surveyor calibrated a digital probe thermometer in an ice bath to 32 degrees F and obtained the following temperatures from products that were held in the chest refrigerator: A single serving carton of fat free milk was 44.2	F0812	Continued from page 15 The Food Service Manager or designee will audit temperature logs and food temperatures daily for 12 weeks. The audits will be submitted to the Administrator weekly starting 8/29/2025. The Food Service Director will submit a monthly report to the facility's monthly QAPI committee meeting for 4 months. Date of completion: 9/15/2025	

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F0812 SS = F	Continued from page 16 degrees F. A single serving carton of whole milk was 48.5 degrees F. The following temperatures were obtained from food items stored inside of the double-door reach-in refrigerator: A peach flavored yogurt cup was 41.9 degrees F. A butterscotch pudding was 43.3 degrees F. 2.) On 07/18/2025 at 9:44 A.M., the surveyor and the [U.S. FOIA] toured the kitchen and observed on the shelving unit directly outside of the [U.S. FOIA (] office door, a cardboard box containing bags of long rolls. The rolls were dotted with circles of a blue-green fuzzy substance. The cook stated, “that is mold.” The cook removed the two bags of rolls containing the blue/green fuzzy substance from the cardboard box. During a follow up tour and interview on 07/18/2025 at 12:19 P.M., the surveyor returned to the shelving unit outside of the [U.S. FOIA (] office with the [U.S. FOI] The [U.S. FOI] looked in the cardboard box and confirmed the presence of a blue/green fuzzy substance on an additional six packs of long rolls. The [U.S. FOI] stated that the substance was "mold." The [U.S. FOI] confirmed that the expiration date of the rolls was 07/15/2025. The [U.S. FOI] stated that they should have been discarded on that date. 3.) On 07/28/2025 at 9:15 A.M., the surveyor and the [U.S. FOI] toured the kitchen. The surveyor observed on the wall next to the walk-in refrigerator and walk-in freezer, multiple spots of a black fuzzy substance extending approximately two feet up the metal wall. The floors outside of the walk-in refrigerator and walk-in freezer had standing cloudy water with small, black items in it. The [U.S. FOI] stated that the standing water could have been rain from outside or water left over from power-washing that occurred two or three days prior. The [U.S. FOI] further stated that the black substance on the wall may have been "mold" and the black items in the water on the floor may have been fruit flies. During the kitchen tour on 07/28/2025 at 9:15 A.M., the [U.S. FOI] stated that cleaning was done according to a cleaning matrix. The [U.S. FOI] stated that cleaning tasks	F0812		

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F0812 SS = F	Continued from page 17 were documented on a sanitation checklist by the person who completed the task. The U.S. FOI stated that completed sanitation checklists were kept in a binder in the kitchen. The U.S. FOI was unable to provide a completed sanitation checklist for the previous week. 4.) On 07/28/2025 at 8:15 A.M., the surveyor and the facility's U.S. FOIA (b) (6)) entered the kitchen, and the U.S. FOIA informed the U.S. FOIA that the surveyor intended to check food temperatures. The U.S. FOIA informed the surveyor that he did not have a thermometer, and that the facility's steam table was not working. The remaining breakfast food were disposed of by the U.S. FOIA at that time. During an interview on 07/28/2025 at 9:10 A.M., the U.S. FOI stated that the facility's process for checking food temperatures was to take the temperatures food was finished cooking on the stove or in the oven. The U.S. FOI stated when the food was then transferred to the steam table for serving, the temperatures were checked again. The U.S. FOI acknowledged that temperatures should have been checked with a thermometer prior to service. During a follow-up interview on 07/28/2025 at 11:04 A.M., the U.S. FOI stated that food temperatures were recorded on a log that was kept in a binder in the kitchen. A review of the "SERVICE LINE CHECKLIST" (SLC)document with "7/28," written at the top was reviewed with the U.S. FOIA The document revealed the following under, "BREAKFAST": Milk 38 degrees F, coffee 150 degrees F, [orange juice]/cereal 38 degrees F, oatmeal 160 degrees F, oatmeal 160 degrees F, bacon 175 degrees F, sausage 175 degrees F, sausage 175 degrees F, and French toast 170 degrees F. The U.S. FOI stated that food temperatures were not taken for the breakfast meal on 07/28/2025, and he filled in the SLC for the breakfast meal that day. The U.S. FOI further stated that the temperatures that were entered on the SLC for breakfast that day were based on average temperatures and not the temperatures of the food items for that day. The U.S. FOI confirmed that prior to 07/28/2025, that last entry in the SLC was made on 07/21/2025.	F0812		

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(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
F0812 SS = F	Continued from page 18 On 07/28/2025 at 11:20 A.M., in the presence of the U.S. FOIA (b) (6), the U.S. FOIA confirmed that the temperatures in the breakfast column of the SLC for 07/28/2025, were not taken by him and were entered by the NJ Ex Of around 9:30 A.M., when breakfast service was complete, and no food was present. 5.) On 07/28/2025 at 3:17 P.M., the surveyor reviewed the following documents with, “July 2025” written at the top with the U.S. FOIA “REFRIGERATOR TEMPERATURE RECORD” with the unit description, “2 Door,” written at the top; “REFRIGERATOR TEMPERATURE RECORD” with the unit description, “Milk Box,” written at the top; “REFRIGERATOR TEMPERATURE RECORD” with the unit description, “Walk-In,” written at the top; and “FREEZER TEMPERATURE RECORD. The surveyor obtained these logs from the kitchen during an 8:15 A.M. tour on 07/28/2025, prior to the U.S. FOIA (arrival to the facility. The U.S. FOI confirmed that the last temperature entered for the refrigerator described as “2 Door,” was the P.M. temperature on 07/24/2025. The U.S. FOI confirmed that the last temperature entered for the refrigerator described as “Milk Box,” was the A.M. temperature on 07/25/2025. The U.S. FOI confirmed that the last temperature entered for the refrigerator described as “Walk-In,” was the P.M. temperature on 07/26/2025. The U.S. FOI confirmed that the last temperature entered for the freezer was the P.M. temperature on 07/26/2025. The U.S. FOI confirmed that his initials appeared next to the entries for the walk-in refrigerator and freezer for 07/26/2025. The U.S. FOI stated that he did not work on that date or on 07/27/2025. The U.S. FOI further stated that he was unsure how his initials got onto the temperature logs. A review of the undated facility's "Food Storage," policy included “POLICY,” “Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination.” Under, “PROCEDURE,” the policy revealed, “16. Refrigerator temperatures: a. Temperature for refrigerators should be 41 degrees F and below. They must be recorded daily.” The policy further revealed, “17. Freezer Temperatures: Temperatures for freezer should be 0 degrees or below and must be recorded daily...” A review of the facility's "Record of Food	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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F0812 SS = F	Continued from page 19 Temperatures" guideline with a reviewed/revised date of 03/26/2025, included “It is the guideline of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled.” Under, “Explanation and Compliance Guidelines:” the guideline revealed, “1. Food temperatures will be checked on all items prepared in the dietary department. 2. Hot foods will be held at 135 degrees Fahrenheit or greater […] 4. Potentially hazardous cold food temperatures will be kept at or below41 degrees Fahrenheit […] 6. Measure and record the temperatures for each food product and milk at all meals. Record the temperature on the temperature log. 7. When holding hot foods for service, food temperature should be measured when placing it on the steam table […] 14. Food temperatures will be verified using a thermometer which is both clean, sanitized and calibrated to ensure accuracy.” A review of the facility's “Cook” job description included “Overview:” the job description revealed, “…prepare food in accordance with current applicable federal, state, and local standards, guidelines and regulations, with our established policies and procedures […] to assure that quality food service is provided at all times.” Under, “Essential Functions:” the job description revealed, “Perform administrative requirements such as completing necessary forms, reports, etc., and submit to the Director of Food Services. […] Ensure that all food procedures are followed in accordance with established policies and procedures.” A review of the facility's “Food Service Manager,” job description included “Overview:” the job description revealed, “…assist the Dietitian in planning, organizing, developing and directing the overall operation of the Food Service Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility […] to assure that quality nutritional services are provided on a daily basis and that the Food Services Department is maintained in a clean, safe, and sanitary manner.” Under, “Essential Functions:” the job description revealed, “Interpret the department’s policies and procedures to employees […] Perform administrative duties such as completing necessary forms, reports, evaluations, studies, etc., to assure control of equipment and supplies. […] Inspect food storage rooms, utility/janitorial closets, etc., for upkeep and supply control.”	F0812		

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F0812 SS = F	Continued from page 20 NJAC 8:39-17.2(g)	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061520	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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S0000	Initial Comments CENSUS:109 SAMPLE SIZE: 4 COMPLAINT #: 2564823 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S0000		08/15/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 2564823 Based on review of facility documents, it was determined that the facility failed to ensure staffing ratios were met for 65 of 77 day shifts and 2 of 14 overnight shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum	S0560	Staffing was reviewed for the referenced dates/shifts. Sign-on bonuses and referral bonuses are being offered to attract more applicants to apply to the facility. All residents have the potential to be affected by this deficient practice. Education on minimum staffing requirements to be completed for Staffing Coordinator, Director of Nursing, Unit Managers, and Human Resources by 8/29/2025. Daily review of staffing by the Director of Nursing or designee to ensure compliance with NJSA 30:13-18 minimum staffing requirements for nursing homes for all shifts. Call-out policy reviewed. A staffing agency will be used as needed. An employee referral bonus is being offered to encourage peers to work at the facility. Weekly staffing meetings will be held to include the Director of Nursing or designee and the Staffing Coordinator to determine upcoming schedules	09/15/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061520	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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S0560	Continued from page 1 staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1.For the week of Complaint staffing from 12/15/2024 to 12/21/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -12/15/2024 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -12/16/2024 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/17/2024 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/18/2024 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/20/2024 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -12/21/2024 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. 2.For the four weeks of Complaint staffing from 02/02/2025 to 03/01/2025, the facility was deficient in CNA staffing for residents on 19 of 28 day shifts as follows: -02/03/2025 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/05/2025 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs.	S0560	Continued from page 1 and anticipate staffing needs. The Director of Nursing will report findings to the Administrator weekly for 4 weeks, then monthly for 3 months. The Director of Nursing will submit a monthly report to the facility's monthly QAPI committee meeting for 4 months. Date of completion: 9/15/2025	

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S0560	Continued from page 2 -02/06/2025 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/07/2025 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/08/2025 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/09/2025 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/10/2025 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/11/2025 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -02/12/2025 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -02/15/2025 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/16/2025 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/17/2025 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/19/2025 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/22/2025 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/23/2025 had 7 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/24/2025 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/25/2025 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -02/28/2025 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -03/01/2025 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. 3. For the week of Complaint staffing from 03/30/2025	S0560		

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S0560	Continued from page 3 to 04/05/2025, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -03/30/2025 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/31/2025 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/01/2025 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/03/2025 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/04/2025 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/05/2025 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. 4.For the week of Complaint staffing from 06/08/2025 to 06/14/2025, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -06/09/2025 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -06/10/2025 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -06/11/2025 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -06/12/2025 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -06/13/2025 had 12 CNAs for 113 residents on the day shift, required at least 14 CNAs. -06/14/2025 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. 5. For the two weeks of Complaint staffing from 06/29/2025 to 07/12/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows: On 06/29/2025 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs.	S0560		

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S0560	Continued from page 4 On 06/30/2025 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. On 07/01/2025 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. On 07/02/2025 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. On 07/03/2025 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. On 07/04/2025 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 07/05/2025 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 07/05/2025 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff. On 07/06/2025 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 07/06/2025 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff. On 07/07/2025 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 07/08/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 07/09/2025 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 07/10/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs.	S0560		

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S0560	Continued from page 5 On 07/11/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 07/12/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs 6.For the two weeks of Complaint staffing from 07/13/2025 to 07/26/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -07/14/2025 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -07/15/2025 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. -07/16/2025 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/17/2025 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/18/2025 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/19/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/20/2025 had 8 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/21/2025 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/22/2025 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/23/2205 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/24/2025 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/25/2025 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/26/2025 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. For the two weeks of staffing prior to complaint survey	S0560		

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S0560	Continued from page 6 from 06/29/2025 to 07/12/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows: On 06/29/2025 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs. On 06/30/2025 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. On 07/01/2025 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. On 07/02/2025 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. On 07/03/2025 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. On 07/04/2025 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 07/05/2025 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 07/05/2025 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff. On 07/06/2025 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 07/06/2025 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff. On 07/07/2025 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 07/08/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs.	S0560		

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S0560	Continued from page 7 On 07/09/2025 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 07/10/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 07/11/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 07/12/2025 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs	S0560		
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day	S1680	AAS-12 form is utilized to calculate the minimum staffing required for the next day to ensure the facility is properly staffed. All residents have the potential to be affected by this deficient practice. Corporate representative to educate the Administrator, DON, Unit Managers, Staff Educator and Staffing Coordinator on how to calculate minimum staffing levels. The Director of Nursing or designee willcalculate the minimum staffing level for the upcoming day before the facility's morning meeting and report the need at the meeting. Weekend needs will be reported at the Friday meeting. The Staffing Coordinator will utilize the provided information to ensure proper staffing is scheduled for the upcoming day. The Staffing Coordinator and DON will meet daily, Monday through Friday, to discuss whether staffing requirements are being met. The Director of Nursing will report findings to the Administrator weekly for 4 weeks, then monthly for 3 months, with results reported at the monthly QAPI meeting for 4months .Date of completion: 9/15/2025	09/15/2025

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MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST , MANAHAWKIN, New Jersey, 08050

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S1680	Continued from page 8 Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint: 2564823 Based on review of the Nurse Staffing Reports for 06/29/2025 to 07/12/2025 and 07/13/2025 to 07/26/2025, it was determined that the facility failed to provide at least minimum staffing levels for 7 of 28 days. 2. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. · For the 2 weeks of AAS-12 staffing from 07/13/2025 to 07/26/2025, the facility was deficient in staffing for required resident services for 4 of 14 days as follows: For the week of 07/13/25 Required Staffing Hours: 298 -07/13/25 had 272 actual staffing hours, for a difference of -26 hours. -07/17/25 had 296 actual staffing hours, for a difference of -2 hours. -07/19/25 had 288 actual staffing hours, for a difference of -10 hours.	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061520	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1680	Continued from page 9 For the week of 07/20/25 Required Staffing Hours: 291.50 -07/20/25 had 256 actual staffing hours, for a difference of -35.50 hours. . 1. The required staffing hours and actual staffing hours are as follows: 1.For the week of 06/29/2025 Required staffing hours: 285.5. On 06/29/2025 had 280 actual staffing hours, for a difference of -5.5 hours. On 07/05/2025 had 264 actual staffing hours, for a difference of -21.5 hours. For the week of 07/06/2025 Required staffing hours: 285.5. On 07/06/25 had 272 actual staffing hours, for a difference of -13.5 hours.	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST , MANAHAWKIN, New Jersey, 08050**

(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
F0000	INITIAL COMMENTS Corrected	F0000		

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 reverse for further 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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061520	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments corrected	S0000		

Office of Primary Care and Health Systems Management

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