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 02/11/2026

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 Complaint #: 2732687 Survey Dates: 2/11/26 Survey Census: 104 Sample Size: 7 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		02/26/2026
F0838 SS = D	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive	F0838	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by alleged deficient practice. How has the facility identified other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents residing at center have potential to be affected by alleged deficient practice. Facility reviewed and updated Facility Assessment. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice did not occur? Director of Operations provided education to U.S. FOIA (b) (6), U.S. FOIA (b) (6), and Interdisciplinary Team regarding completion of Facility Assessment, when updates are needed, and Policy and Procedure. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Administrator or designee will complete review of	03/03/2026

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

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 02/11/2026

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F0838 SS = D	Continued from page 1 disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure:	F0838	Continued from page 1 Facility Assessment monthly at QAPI meeting x 6 months to ensure Facility Assessment is accurate and current. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent with substantial compliance has been met.	03/03/2026

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F0838 SS = D	Continued from page 2 § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of facility documents, it was determined that the facility failed	F0838		03/03/2026

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F0838 SS = D	Continued from page 3 to develop and maintain a comprehensive facility assessment that accurately identified the mental and behavioral health needs of its resident population and the resources necessary to provide appropriate care. On 2/11/26 at 11:54 AM, the surveyor requested a copy of the Facility Assessment (FA). On 2/11/26 at 1:25 PM, the surveyor reviewed the FA dated [redacted] The FA under "Purpose Statement:" The purpose of this assessment is to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. The FA under, "Scope" identified: The facility's resident population, including but not limited to: the number of residents and the facility's resident capacity. The care required by the resident population using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments. The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. The FA under, "Scope" identified: The facility's resources, including but not limited to: Services provided such as physical therapy, pharmacy, behavioral health and specific rehabilitation therapies; All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/ or training and any competencies related to resident care. The FA under, "Diseases/Conditions & Physical/Cognitive Disabilities for Which We Provide Care": Psychiatric/Mood Disorders listed schizophrenia, depression, anxiety. The FA under, "Resident Acuity Affecting Licensed Nurses (include facility specifics not already listed here)": Behavioral/Mental Health listed vendor retained to provide services psych and psychological. The FA under, "SERVICES AND CARE WE OFFER	F0838		03/03/2026

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F0838 SS = D	Continued from page 4 BASED ON OUR RESIDENT'S NEEDS": Behavioral and Mental Health listed psychological psychiatric, and pess [Psychiatric Emergency Screening Services] unit. The FA under, "INFORMATION ABOUT OUR STAFF": Social Services listed Mental Health Professional as "contracted". The contracted party was not identified. The FA under, "INFORMATION ABOUT OUR STAFF": Behavioral/Mental Health Providers listed "Psychiatrists, Psychologists, Licensed Counselors". None of the providers were identified and the areas to identify the behavioral and mental health providers were left blank. The FA under, "INFORMATION ABOUT OUR STAFFING PATTERNS": Behavioral Health Services listed staffing is adequate for caring for residents with dementia, mental health conditions, or history of trauma as evidenced by: . No evidence was listed. The FA under, "Reassessment": This assessment will be reviewed and updated, as necessary, and at least annually. Whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment, the Administrator will ensure that all relevant elements of the assessment is reviewed and updated. Additionally, the facility will consider specific staffing needs for each shift… and for each resident unit in the facility based on changes to the resident population. Any changes to this assessment will be documented, along with a revision history. On 2/11/26 at 1:31 PM, the surveyor conducted an interview with the U. S. FOIA (b) (2) [redacted]. The surveyor gave the copy of the FA that was received for review and requested that staff point out the areas of the FA that covered psychiatric and behavioral issues. The [redacted] pointed out that the FA included under "SERVICES AND CARE WE OFFER BASED ON OUR RESIDENT'S NEEDS": Behavioral and Mental Health listed psychological psychiatric, and pess unit. She also stated that under "INFORMATION ABOUT OUR STAFF": Social Services listed Mental Health Professional as "contracted". The [redacted] then stated that information for mental health providers was not available. She also acknowledged that no evidence was listed under "INFORMATION ABOUT OUR STAFFING PATTERNS": Behavioral Health Services.	F0838		03/03/2026

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F0838 SS = D	Continued from page 5 On 2/11/26 at 1:41 PM, the surveyor asked if the FA that was reviewed would be a fully complete FA. The [redacted] stated no. The surveyor then asked if the facility has a large population of residents who have mental health, behavioral and psychiatric issues. The [redacted] stated yes. The surveyor then reiterated the missing components that were reviewed by the [redacted] and received acknowledgement from the U. S. FOIA (b) (2) that several components necessary for the FA were missing. The [redacted] stated she did try to review the FA but did not have a chance to. A review of the facility's policy titled "Facility Assessment", with a last revised date of 12/12/24, included the following information under "Guideline": this facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents competently during both day-to-day operation (including nights and weekends) and emergencies. The purpose of this policy is to establish responsibilities and procedures for the facility assessment process. Under, Explanation and Compliance Guidelines: 1. The facility assessment will, at a minimum, address or include: a. The facility's resident population, including but not limited to: i. Number of residents and the facility's capacity; ii. The care required by the resident population, using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments; iii. The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; b. The facility's resources, including but not limited to; iii. Services provided, such as physical therapy, pharmacy, behavioral health and specific rehabilitation therapies; iv. All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and	F0838		03/03/2026

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F0838 SS = D	Continued from page 6 volunteers, as well as their education and/or training and any competencies related to resident care; 3. The facility will use the facility assessment to: b. Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. 4. The Administrator is responsible for ensuring the completion of the facility assessment and maintaining all documents that pertain to the assessment. The Administrator serves as the leader of the facility assessment process, or may designate someone to lead the process. 5. The completed facility assessment will be organized according to resident population, staffing, physical resources, and risk assessments. 8. Based on the assessment of resident characteristics, the facility will determine what care/services, staff competencies, and staffing needs are required to meet the needs of our residents. This will be compared to the specific care/services, including by contract, and training that we provide. Action plans will be implemented as necessary. 10. The facility assessment will be reviewed and updated as necessary and at least annually, whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment. Additionally, the facility will consider specific staffing needs for each shift (e.g., day, evening, night, weekend shifts) and for each resident unit in the facility based on changes to resident population. Any changes to the assessment will be documented, along with a revision history. NJAC 8:39-5.1(a)	F0838		03/03/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 3.4.26 in relation to the 2.11.26 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		03/04/2026

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.

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