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 03/25/2026

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 #: 2806068, 2789654, 2789700, 2794269, 2679147, 2639889, 2588899, 2806341 Census: 107 Sample Size: 21 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 SURVEY. A complaint survey was conducted at Manahawkin Health and Rehabilitation Center on 03/05/2025 through 03/25/2026, to determine compliance with 42 CFR Part 483 requirements for Long-Term Care Facilities. A. During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.25(d)(2) F 689, as the facility failed to provide a safe environment for its residents, failed to investigate and develop interventions to prevent smoking related accidents, and failed to ensure that residents did not have smoking materials in their possession or smoke in the facility. A resident (Resident #9) who had NJ Exec Order 26.4b1 on NJ Exec Order 26.4b, used a wheelchair for NJ Exec Order 26 was NJ Exec Order 26.4b1 on staff to get out of bed, and was observed with NJ Exec Order 26.4b1 in their clothing had documented NJ Exec Order 26 incidents inside the facility on NJ Exec Order 26.4b1, and again on NJ Exec Order 26.4b1 when NJ Exec Order was being used by their roommate (Resident #16) because of NJ Exec Order 26 Resident #9 was allowed to retain their NJ Exec Order 26 materials and received no additional supervision. Resident #8 was observed NJ Exec Order 26 an NJ Exec Order 26.4b1 indoors on NJ Exec Order 26.4b1 and no removal of the NJ Exec Order 26 materials, investigation, or interventions were implemented. During an interview on 03/10/2026 at 1:19 PM, the U.S. FOIA (b)(6) stated that there were no updated Care Plan interventions after the five NJ Exec Order 26 incidents by	F0000		04/17/2026

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

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F0000	Continued from page 1 Resident #9. During an interview on 03/10/2026 at 4:41 PM, U.S. FOIA (b)(6) stated that even without piped-in NJ Exec Order improper NJ Exec Order 26 could cause the whole facility to NJ Exec Order 26 The U.S. FOIA (b) further stated that NJ Exec Order 26.4b1 were just as NJ Exec Order 26.4b1 as regular NJ Exec Order 26.4b1 The U.S. FOIA (b) was notified of the F 689 IJ and was provided the IJ Template on 03/09/2026 at 5:41PM. An acceptable Removal Plan (RP) was received on 03/23/2026 at 3:37 PM, indicating the actions the facility would take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: a facility-wide NJ Exec Order 26 evaluation audit was done for residents who were NJ Exec Order 26 on 03/10/2026; residents who were NJ Exec Order 26 were re-evaluated using the facility-approved NJ Exec Order 26 assessment tool and appropriate supervision level was assigned; resident care plans were updated to reflect NJ Exec Order 26 status and safety interventions; residents identified as unsafe to NJ Exec Order 26.4b1 were placed on supervised NJ Exec Order 26 status; staff was provided written guidance on completing the facility smoking evaluation and the required follow-up; residents who are found with NJ Exec Order 26.4b1 in their rooms will be placed on 1:1 monitoring until the NJ Exec Order 26 materials are given to staff; and staff received re-education. The surveyor verified implementation of the RP plan on-site on 03/25/2026 and determined that the immediacy was removed as of 03/20/2026 at 7:00PM. B. During the survey, findings which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.15(c) F 627, as the facility failed to ensure a NJ Exec Order 26.4b1 resident who lived NJ Exec Ord was safely discharged from the facility to the community with all the required services to meet the resident's needs. Resident #18, who had a history of NJ Exec Order 26.4b1 use and was admitted to the facility with NJ Exec Order 26.4b1, was discharged from the facility with their NJ Exec Order 26.4b1 in place. The NJ Exec Or is NJ Exec O NJ Exec Order NJ Exec Order 26.4b1 into a NJ Exec Order 26.4b1 and guided to the NJ Exec Order 26.4b near the NJ Exec Ord Resident #18 had documented complications of up to NJ Exec Order 26.4b1 for their NJ Exec Order 26.4b During an interview on 3/10/26,	F0000		04/17/2026

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F0000	Continued from page 2 with the U.S. FOIA (b)(6)), the U.S. FOIA NJ Exec Order confirmed that a resident with a history of discharged with a NJ Exec Order 26.4b in place had the potential to NJ Exec During an interview on 3/10/26 with the U.S. FOIA (b)(6)), the U.S. FOIA (b) confirmed that Resident #18's discharge was not safe. The Administration was informed of the F 627 IJ, and was provided with the IJ template on 3/10/26 at 5:44 P.M. An acceptable RP was received on 03/23/2026 at 3:37 PM, indicating the actions the facility would take to prevent serious harm from occurring or recurring. The facility implemented corrective action plans to remediate the deficient practices including: a facility-wide audit that was conducted on 3/18/26 for all discharged residents with a NJ Exec Or or NJ Exec Order 26.4b as well as residents who were pending discharge; no residents will be discharged with NJ Exec Order 26.4b1 unless a physician is notified and document their approval, there is a physician order addressing the resident's NJ Exec Order 26.4b1, nursing clinical assessments are to be completed and safe discharge plan is documented; residents who refuse NJ Exec Order 26 removal will have physicians notified immediately, the risks vs benefits will be explained and documented, Against Medical Advice (AMA)/refusal documentation will be completed, and a supervisor will be notified and involved prior to discharge; mandatory in-service education for all nursing staff began 3/18/26 which included discharge safety requirements, physician notification, NJ Exec Order 26.4b1 and removal protocol, documentation requirements and refusal/AMA process. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 3/25/26 and determined that the immediacy was removed as of 03/20/2026 at 7:00PM.	F0000		04/17/2026
F0689 SS = SQC-L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F0689	Corrective Action: On 3/19/26, the Director of Nursing and/or licensed designee reevaluated Resident #9 using the facility-approved NJ Exec Order 26 assessment tool and assigned resident an appropriate NJ Exec Order 26.4b1 level and updated their plan of care. On 3/19/26, the Director of Nursing and/or licensed designee reevaluated Resident #8 using the facility-approved NJ Exec Order 26 assessment tool and assigned resident an appropriate NJ Exec Order 26.4b1 level and	04/17/2026

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F0689 SS = SQC-L	Continued from page 3 accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 03/05/2026, 03/09/2026, and 03/10/2026, it was determined that the facility failed to provide a safe environment for its residents. The facility failed to ensure that a resident (Resident #9) who had NJ Exec Order 26.4b1 the facility against facility policy on four previous occasions since NJ Exec Order 26.4b1 did not have NJ Exec Order 26 materials in their possession or NJ Exec Order in the facility and in the presence of a resident (Resident #16) who was receiving NJ Exec Order 2 therapy on NJ Exec Order 26.4b1. The facility failed to provide adequate NJ Exec Order 26.4b1 to prevent NJ Exec Order 26 in the resident's room on NJ Exec Order 26.4b1 when the resident NJ Exec Order 2 to surrender their NJ Exec Order 26 materials; and on NJ Exec Order 26.4b1 when Resident #9 was discovered NJ Exec Order 26 indoors, in the presence of a roommate who was receiving NJ Exec Order 26.4b1 and NJ Exec Order 2 to surrender their NJ Exec Order 26 materials. The facility also failed to investigate and implement interventions to prevent NJ Exec Order 26 against policy when Resident #9 was found NJ Exec Order 26 on NJ Exec Order 26.4b1 ; and when Resident #8 was observed NJ Exec Order 26 an NJ Exec Order 26.4b NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. This deficient practice was identified for 2 of 3 residents (Resident #8 and Resident #9) reviewed for NJ Exec Order 26. On 03/05/2026, the surveyor observed Resident #9 NJ Exec Order 26 in the facility NJ Exec Order 26 area. On 03/05/2026, the surveyor observed what appeared to be NJ Exec O in the NJ Exec Order 2 of a NJ Exec O and NJ Exec Order 26.4b1 worn by Resident #9. Review of the Progress Notes (PN) revealed that Resident #9 was found NJ Exec Order 26 in their room on the following dates: NJ Exec Order 26.4b1 . Further review of the PNs revealed that Resident #9 NJ Exec Order 2 to NJ Exec Order 26.4b their NJ Exec Order 26 materials after they were observed Exec Order 26 inside on NJ Exec Order 26.4b1 An interview was conducted with Resident #9 on 03/05/2026 at 1:30PM. Resident #9 stated that when they NJ Exec Order 26 in their room in NJ Exec Order 26 their roommate (Resident #16) was using NJ Exec Order but NJ Exec Order 26.4b1 so that the resident could NJ Exec Orde in the bathroom. During a follow up interview on 03/09/2026, Resident #9 stated in reference to the	F0689	Continued from page 3 updated their plan of care. Resident #16 no longer resides at the facility. On 3/19/26, the Director of Nursing and/or licensed designee completed smoking evaluations for all identified smokers utilizing the facility- approved smoking assessment tool and assigned appropriate supervision levels and updated care plans to reflect smoking status and safety interventions. On 3/19/26, the Administrator, Director of Nursing and Interdisciplinary Team members conducted an immediate facility wide facility and resident room audit to identify unauthorized and remove smoking material and potential weapons or hazardous items. On 3/13/26, Facility RN confiscated medication resident had kept from recent hospital stay and called NJ Exec for Resident #19 and #20 (resident NJ Exec Order 2 transfer). On 3/13/26, the Nurse Supervisor, under Director of Nursing directive, contacted the NJ Exec Orde regarding incident that occurred with resident #19 and #20. On 3/13/26 the Director of Nursing provided education to resident #19 and #20 on the importance of only consuming medications that are prescribed by a physician and administered by a licensed nurse. On 4/9/2026, the Facility Educator initiated re-education for facility staff on the reportable event policy and process, environment and resident room search policy and reporting allegations of abuse and neglect and completion of resident inventory sheet upon a resident's admission and re-admission. On 4/1/2026, the Administrator contracted with a security company who provides on-site services and will assist staff with deescalation efforts, environmental safety and room/package search per policy. Services initiated on 4/6/2026. Identification of other residents or areas having the potential to be affected due to the nature of the	04/17/2026

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F0689 SS = SQC-L	Continued from page 4 NJ Exec Order 26.4b1 incident, that they had NJ Exec Order 26 but NJ Exec Order 2 to give them up and that they were not placed under any additional NJ Exec Order 26.4b1 by the facility that day. On 03/10/2026 at 9:15 AM, the facility NJ Exec Order 26.4b1 sounded, and the alarm panel indicated that the source was on the NJ Exec Order 26.4b1. The surveyor reported to the unit and determined that the alarm was from Resident #8's room. Upon arrival to Resident #8's room there was no odor of NJ Exec Orde but the room smelled of NJ Exec Order 26.4b1. There was no NJ Exec Order 26.4b1 observed but a NJ Exec Order 26.4b1 was noted resting on the NJ Exec Order The residents denied NJ Exec Order 26 in the room. The PNs for Resident #8 were reviewed. The PN revealed that on NJ Exec Order 26.4b1 Resident #8 was observed NJ Exec Order 26 an NJ Exec Order 26.4b1 at the nurse's station. The PN did not reveal that the resident's NJ Exec Order 26.4b1 was removed and stored per facility policy or that the resident received additional NJ Exec Order 26.4b1 An interview was conducted with the U.S. FOIA (b)(6) on 03/10/2026 at 4:41 PM. The U.S. FOIA (b) stated that even without NJ Exec Order 26.4b1 could cause the whole facility to NJ Exec Order 2. The U.S. FOIA (b) further stated that NJ Exec Order 26.4b1 were just as NJ Exec Order 26.4b1 as regular NJ Exec Order 26.4b1 The facility's failure to a.) ensure that Resident #9, who had NJ Exec Order 26.4b1 inside the facility did not have NJ Exec Order 26 materials in their possession or NJ Exec Orde in the facility in the presence of NJ Exec Order 2 and b.) ensure that Resident #8 had their NJ Exec Order 26.4b1 properly secured after they were observed NJ Exec Order 26 at the nurses station placed all residents at risk for serious harm, injury, or death from accidental explosion or fire from unsafe NJ Exec Order 26.4 This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Exec Order 26.4b1, after Resident #9 was observed NJ Exec Ord... in their room. The facility was notified of the IJ on 03/09/2026 at 5:41 PM. The facility submitted an acceptable Removal Plan (RP) on 03/23/2026 at 3:37PM. The surveyor verified the implementation of the RP during the on-site survey on 03/25/2026 and determined that the immediacy	F0689	Continued from page 4 deficiency: All residents have the potential to be affected by this deficient practice. Measures Put into Place: On 3/20/2026 the Facility Administrator and Facility Director of Nursing implemented a reviewed smoking evaluation process to include assessing residents' cognitive status, vision assessment, dexterity/physical ability, safe smoking ability and oxygen use. On 3/20/2026 the Facility Educator reeducated initiated for Licensed Nurses, Unit Managers and U.S. FOIA (b)(6) that the nurse completing the smoking evaluation is responsible for immediately implementing the determined supervision level, updating the resident's care plan, and communicating the resident's smoking status to nursing management / interdisciplinary team members. In addition, staff were educated that residents who are found with smoking paraphernalia to be placed on 1:1 monitoring until the smoking materials are obtained and secured by staff. On 3/20/2026, the Facility Director of Nursing and Facility Administrator updated the smoking process to ensure that smoking evaluations are completed on a resident's admission, quarterly (with the MDS), with any change in status and after any smoking related incident. On 3/20/2026 the Facility Educator initiated reeducation for facility staff a resident who is identified to smoke is evaluated to require supervision, smoking materials must be maintained by the smoking monitor/activity department or nursing staff designee and staff supervision is required during all smoking activities. On 04/06/2026 the Facility Educator initiated reeducation for licensed nursing staff on the incident reporting policy and process inclusive of the investigation of findings, completing a review of contributing factors and administration notification expectations.	04/17/2026

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F0689 SS = SQC-L	Continued from page 5 was removed as of 03/20/2026 at 7:00 PM. The facility further failed to c.) provide adequate supervision to prevent medication misuse by a resident with NJ Exec Order 26.4b1 who had a history of NJ Exec Order 26.4b1 (Resident #20), who brought NJ Exec Order 26.4b1 into the facility, and NJ Exec Order 26.4b1 and [redacted] it together with another resident who had a history of NJ Exec Order 26.4b1 (Resident # 19). Complaint #: 2806068, 2789654, 2789700, 2794269, 2679147, 2639889, 2588899, 2806341 The facility policy "Resident Smoking" with a revised date of 03/01/2025 was reviewed. Under "Explanation and Compliance Guidelines," the policy revealed that smoking was prohibited in all areas expect the designated smoking area; all residents and family members would be notified of the policy as part of the admission process and as needed; and e-cigarettes can catch fire or explode if not handled and stored safely, use e-cigarettes in designated smoking area only. This section of the facility policy revealed, "12. A resident does not have the right to put others at risk within or on grounds of the facility […] 15. If a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures and may include a Smoking Contract." This section of the facility policy further revealed that the Activities Director and Nursing Supervisor were jointly responsible for ensuring compliance with the Resident Smoking policy; all staff must immediately report residents smoking in rooms or non-designated areas; and incident reports will be completed and reviewed by administration. Part A The facility policy "Incidents and Accidents" with a revised date of 07/01/2024 was reviewed. Under "Guideline,' the facility policy revealed that staff were to use the electronic medical record (EMR) to report, investigate, and review any accidents or incidents that occurred on facility property and involved residents. The facility policy defined accidents as an unintentional incident which results in or may result in injury or illness to a resident. The policy defined incident as an occurrence or situation that is not consistent with routine care of a resident or routine operation of the organization. Under	F0689	Continued from page 5 On 3/20/2026, the Administrator implemented a room search policy and procedure and package search policy to discover and contain contraband, smoking materials and hazardous items. On 3/26/2026 a Resident Smoking Binder was initiated for Smoking Aides to better identify residents who smoke and current privileges and individualized interventions they may have. Starting 3/20/2026 the Facility Director of Nursing and/or designee will audit daily x7 days, weekly x4 weeks then monthly x 3 months, 20% of resident's identified as a person who smokes, to ensure that smoking evaluations are completed, care plans are updated, and interdisciplinary team has been notified. Starting 3/20/2026 the Facility Director of Nursing and/or designee will audit all resident hospital returns/new admissions weekly x 3 months to verify smoking evaluation completion and proper staff follow up occurred, as well as a physical inventory check of all belongings completed. How Will These Actions Be Measured: The results of the daily, weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. A Quality Assurance and Process Improvement Committee Meeting was held on 4/6/2026. Completion Date: 4/17/2026	04/17/2026

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F0689 SS = SQC-L	Continued from page 6 "Explanation," the policy revealed that the purpose of incident reporting included assuring that appropriate and immediate interventions were implemented and corrective actions were taken to improve resident care and prevent recurrences. This section of the facility policy further revealed that the purpose of incident reporting also included conducting a root cause analysis to determine causative and contributing factors. Under "Compliance Guidelines," the facility policy revealed that licensed staff should use the EMR to report incident and accidents and to assist with completion of investigative information to identify the root cause; documentation should include date, time, and nature of the incident, initial findings, immediate interventions, and notifications, orders, and follow-up interventions. This section of the policy further revealed that if the accident or incident was witnessed by other people written documentation of the event should be obtained from those people and submitted to the Director of Nursing (DON) or LNHA. No incident/accident reports, investigation findings, or statements related to the [redacted] incidents by Resident #9 on NJ Exec Order 26.4b1 [redacted]; or the for the [redacted] incident by Resident #8 on [redacted] were provided. According to the Admission Record (AR), Resident #8 was admitted to the facility with diagnoses that included but were not limited to: [redacted] A review of Resident #8's quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] 5, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted] Review of a PN dated [redacted] at 2:33 AM, revealed that staff observed Resident #8 [redacted] their [redacted] while standing at the nurse's station and that the resident was educated on facility policy and designated [redacted] area. No incident report, investigation findings, or root	F0689		04/17/2026

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F0689 SS = SQC-L	Continued from page 7 cause analysis were provided related to this incident. Review of the Care Plan (CP) for Resident #8 revealed that no [NJ Exec Order 26.4b1] related foci, goals, or interventions were included in the resident's CP after the resident [NJ Exec Order 26.4b1] the facility on [NJ Exec Order 26.4b1]. On 03/05/2026 at 10:22 AM, the surveyor observed Resident #9 [NJ Exec Order 26.4b1] in the facility [NJ Exec Order 26.4b1] area. On the same day at 10:57 AM, the surveyor observed what appeared to be [NJ Exec Order 26.4b1] in the [NJ Exec Order 26.4b1] of the resident's [NJ Exec Order 26.4b1]. According to the AR, Resident #9 was admitted to the facility with diagnoses which included but were not limited to: [NJ Exec Order 26.4b1]. A review of Resident #9's comprehensive MDS dated [NJ Exec Order 26.4b1] revealed that the resident had a BIMS score of [NJ Exec Order 26.4b1] out of 15, which indicated that the resident's [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b1]. Further review of the MDS revealed that Resident #9 had [NJ Exec Order 26.4b1] to their [NJ Exec Order 26.4b1] on both [NJ Exec Order 26.4b1] used a [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1] wheelchair, and required the [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1] or more [NJ Exec Order 26.4b1] to [NJ Exec Order 26.4b1] from bed to a chair. A review of the PNs for Resident #9 revealed that the resident was found [NJ Exec Order 26.4b1] in the facility as follows: On [NJ Exec Order 26.4b1] at 10:40 AM, found [NJ Exec Order 26.4b1] in their room with a "cup full of [NJ Exec Order 26.4b1] by their bedside. On [NJ Exec Order 26.4b1] at 10:40 PM, the room was, "filled with [NJ Exec Order 26.4b1] and "a cup full of used [NJ Exec Order 26.4b1] was observed. On [NJ Exec Order 26.4b1] at 6:26 AM, the resident was observed [NJ Exec Order 26.4b1] in their room and was educated that they were endangering themself and everyone in the building. The resident expressed that they	F0689		04/17/2026

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F0689 SS = SQC-L	Continued from page 8 wanted to continue [NJ Exec Order 26] in the room. Facility staff informed the resident that communication with management was the responsibility of all staff. On [NJ Exec Order 26.4b1] at 7:21 AM, resident was received in bed. [NJ Exec Order 26.4b1] with the [NJ Exec Order 26] policy and [NJ Exec Order 2] to stop [NJ Exec Order 26] or [NJ Exec Order 26.4] their [NJ Exec Order 26] materials. On [NJ Exec Order 26.4b1] at 5:26 AM, the resident was found [NJ Exec Order 26] in their bedroom and [NJ Exec Order 2] to [NJ Exec Order 26.4b] their [NJ Exec Order 26] materials. There was no facility documentation provided to indicate that the facility Administration was notified of any of the incidents prior to [NJ Exec Order 26.4b1]. Review of the Care Plan (CP) for Resident #9 revealed a "Focus," related to [NJ Exec Order 26] initiated on [NJ Exec Order 26.4b1] The "Goal" was for the resident to remain compliant with the facility [NJ Exec Order 26] procedure and restrictions. "Interventions" included completing [NJ Exec Order 26] assessments of the resident, and notifying the resident, family, and physician of the results; informing the resident and/or their responsible party of facility [NJ Exec Order 26] policy; and maintaining and or monitoring all [NJ Exec Order 26] materials in the designated [NJ Exec Order 26] area; and completing periodic [NJ Exec Order 26] evaluation/assessment per policy, or as needed for change in condition. The focus, goals, and interventions were created on [NJ Exec Order 26.4b1]. No interventions were added or adjusted after the five documented [NJ Exec Order 26] episodes in the facility after [NJ Exec Order 26.4b1] On 03/05/2026 at 1:30 PM, an interview was conducted with Resident #9. Resident #9 confirmed that they had [NJ Exec Order 2] in their room in [NJ Exec Order 26] The resident further stated that their roommate at the time (Resident #16) was receiving [NJ Exec Order] but had [NJ Exec Order 26.4b1] when resident #9 informed them that they were going to [NJ Exec Orde] in the bathroom. On 03/09/2026 at 10:50 AM, a follow-up interview was conducted with Resident #9. The resident confirmed that they had [NJ Exec Order 2] in their bathroom on [NJ Exec Order 26.4b1] and on that date they had [NJ Exec Order 26] in their [NJ Exec Order 26.4b1] which they [NJ Exec Order 2] to [NJ Exec Order 26.4b] to facility staff. The resident stated that they did not have extra [NJ Exec Order 26.4b1] by facility staff while they	F0689		04/17/2026

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 03/25/2026

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F0689 SS = SQC-L	Continued from page 9 remained in [redacted] of the [redacted] Resident #9 further confirmed that the [redacted] in their [redacted] were [redacted] that resulted from [redacted] while [redacted] a [redacted] in the facility [redacted] area. Resident #16 was no longer in the facility; a closed record review was conducted. A review of the AR for Resident #16 revealed that the resident was admitted with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]. A review of Resident #16's admission MDS dated [redacted], revealed that the resident had a BIMS score of [redacted] out of 15 which indicated that the resident's [redacted] was [redacted] A review of the PNs for Resident #16 revealed the following: On [redacted] at 11:05 PM, the resident arrived at 8:46 PM, and the resident had [redacted] in place via a [redacted] at a rate of [redacted] per [redacted] On [redacted] at 12:06 PM, the resident was receiving NJ Exec Order 26.4b1 at a rate of [redacted]. An interview was conducted with the Certified Nursing Assistant (CNA #1) on 03/05/2026 at 10:31AM. CNA #1 stated that residents [redacted] in their rooms all of the time. CNA #1 stated that if she saw or suspected resident [redacted] in the facility, she would notify the U.S. FOIA (b)(6) An interview was conducted with Registered Nurse (RN) #1 on 03/05/2026 at 1:15 PM. RN #1 stated that if a resident was found [redacted] she would try to stop them and report the incident to the [redacted] RN #1 further stated that [redacted] incidents should be included on that resident's CP. An interview was conducted with the [redacted]	F0689		04/17/2026

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F0689 SS = SQC-L	Continued from page 10 U.S. FOIA (b)(6) on 03/05/2026 at 2:01 PM. The U.S. FO stated that she was aware that residents NJ Exec Order 2 inside the facility. The U.S. FO stated that the facility NJ Exec Order 26 policy has been revised twice but residents did not take it seriously, break the NJ Exec Order 26 policy, and NJ Exec Order 26.4b1. The U.S. FO stated that she was informed that an Activities Aide (AA#1) buys NJ Exec Order 2 products and gives them directly to residents. The U.S. FO further stated that she reported this concern to the facility's former LNHA (FLNHA #1) and nothing was done. The U.S. FO further stated that she reported the concern to FLNHA #2 as well and she was not sure what was done, but AA #1 was still working at the facility. A call was placed to AA #1 on 3/9/2026 at 11:54 AM. Unable to speak with as phone was not in service. An interview was conducted with UM #2 on 03/09/2026 at 2:04 PM. UM #2 stated that residents in NJ Exec Order 26.4b1 of NJ Exec Order 26 materials would create a big safety issue for the whole building due to possible presence of NJ Exec Order 26.4b1 UM #2 stated that it was her expectation that if staff observed a resident NJ Exec Order 26 in the facility, they would stop the resident from NJ Exec Order 26 and report the incident to a UM. The UM would then be expected to collect the resident's NJ Exec Order 26 materials and escalate the issue to the U.S. FOIA (b)(6) UM #2 stated that it was her expectation that an incident report was completed after each NJ Exec Order 26 incident and there should be a discussion with the Interdisciplinary Team (IDT) to determine interventions geared toward resident and facility safety. UM #2 stated that the interventions should then be documented in the incident report and on the resident's CP. During the same interview UM #2 confirmed that there were no incident reports, no investigations, and no CP updates related to the aforementioned NJ Exec Order 26 incidents involving Resident #8 and Resident #9. An interview was conducted with the U.S. FOIA (b)(6)) on 03/10/2026 at 9:50 AM. The U.S. FOIA had responded to the facility because a NJ Exec Or... alarm was triggered in Resident #8's room that morning. The U.S. FOI stated that she was aware of residents NJ Exec Order 26 inside the facility and that NJ Exec Order 26 around	F0689		04/17/2026

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F0689 SS = SQC-L	Continued from page 11 NJ Exec Order and NJ Exec Order 26.4b1 could cause an NJ Exec Order 26.4b and NJ Exec Order 26.4b1 residents may not be able to get out of the facility. The U.S. FOIA further stated "This place has the potential for mass loss of life." An interview was conducted with the U.S. FOIA on 03/10/2026 at 1:19 PM. The U.S. FOIA stated that 107 people (the facility census) could be put at risk by NJ Exec Order 26 inside the facility. The U.S. FOIA stated that residents should NJ Exec Orde only in the designated outdoor area, not inside the facility. The U.S. FOIA stated that if a resident was found NJ Exec Order 26 inside, they should be educated on the policy, and staff should try to get the resident to surrender their NJ Exec Order 26 materials. Staff should notify the supervisor, U.S. FOIA (b) and U.S. FOIA (b). The U.S. FOIA stated that residents who NJ Exec Order 2 to NJ Exec Order 26.4b the NJ Exec Order 26 materials should be put on a NJ Exec Order 26 contract, and the physician should be contacted per the NJ Exec Order 26 policy. The U.S. FOIA further stated that it was her expectation that an incident report be completed so that everyone was made aware of the incident and it could be discussed in morning meetings. The U.S. FOIA stated that CP should be updated with what happened and education, and interventions could be established with the goal of preventing NJ Exec Order 26 inside. The U.S. FOIA stated that she did not know if any investigation was done after the resident's NJ Exec Order 26.4b1 incident and that the lack of investigations after resident NJ Exec Order 26 incidents did not meet her expectations. During the same interview the CP for Resident #9 was reviewed with the U.S. FOIA (b) The U.S. FOIA stated that there were no updates to the CP interventions after the aforementioned five NJ Exec Order 26 incidents, only the goals section was revised on NJ Exec Order 26.4b1 An interview was conducted with the U.S. FOIA (b) on 03/10/2026 at 4:41 PM. The U.S. FOIA (b) stated that even without NJ Exec Order 26.4b1 could cause the whole facility to NJ Exec Order 2 . The U.S. FOIA (b) further stated that NJ Exec Order 26.4b1) were just as NJ Exec Order 26.4b1 as regular NJ Exec Order 26.4b1 An acceptable RP was received on 03/23/2026 at 3:37 PM, indicating the actions the facility would take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: a facility-wide NJ Exec Order 26 evaluation audit was done for residents who were NJ Exec Order 26 on	F0689		04/17/2026

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F0689 SS = SQC-L	Continued from page 12 NJ Exec Order 26.4b1; residents who were NJ Exec Order 26 were re-evaluated using the facility-approved NJ Exec Order 26 assessment tool and appropriate NJ Exec Order 26.4b1 level was assigned; resident care plans were updated to reflect NJ Exec Order 26 status and safety interventions; residents identified as unsafe to NJ Exec Orde were placed on NJ Exec Order 26.4b1 status; staff was provided written guidance on completing the facility NJ Exec Order 26 evaluation and the required follow-up; residents who are found with NJ Exec Order 26.4b1 in their rooms will be placed on 1:1 monitoring until the NJ Exec Order 26 materials are given to staff; and staff received re-education. The surveyor verified implementation of the RP on-site on 03/25/2026 and determined that the immediacy was removed as of 03/20/2026 at 7:00PM. Part B A Facility Reportable Event (FRE), a form used by facilities to report events to the New Jersey Department of Health, dated NJ Exec Order 26.4b1 was reviewed. The FRE, submitted by the facility's U.S. FOIA (b)(6) revealed that Resident #19 was observed by a U.S. FOIA (b)(6)) in Resident #20's room with a NJ Exec Order 26.4b1 into a NJ Exec Order 26 Resident #19 was observed NJ Exec Order 26 a NJ Exec Order 26.4b1 up their NJ Exec Ord According to the AR, Resident #19 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 A review of the comprehensive MDS dated NJ Exec Order 26.4b1 revealed that Resident #19 had a BIMS score of NJ Ex out of 15 which indicated that the resident's NJ Exec Order 26.4 was NJ Exec Ord A review of the CP for Resident #19 revealed a "Focus," that the resident was at risk for NJ Exec Order 26.4b to current or historical NJ Exec Order 26. The focus was initiated on NJ Exec Order 26.4b1 Interventions	F0689		04/17/2026

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F0689 SS = SQC-L	Continued from page 13 related to this focus included but were not limited to: contacting emergency services for signs of [redacted] educating the resident on [redacted] skills; and physician notification of NJ Exec Order 26.4b1 [redacted] The interventions were initiated on [redacted]. A facility incident report with Resident #19's name at the top dated [redacted] at 6:30 PM, was reviewed. The incident report revealed under, "Incident Description," that Resident #19 was observed in Resident #20's room and a [redacted] was observed on the bedside table. The incident report further revealed that Resident #20 was [redacted] medication with Resident #19. A PN dated [redacted] at 11:57 PM, revealed that Resident #19 was observed with [redacted] and [redacted]. The resident also had [redacted] Resident #20 [redacted] to go to the hospital for evaluation. According to the AR, Resident #20 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] A review of the MDS dated [redacted] revealed that Resident #20 had a BIMS score of [redacted] out of 15 which indicated that the resident had NJ Exec Order 26.4b1 [redacted] A review of the CP for Resident #20 revealed no foci, goals, or interventions addressing their history of [redacted] prior to the [redacted] incident. The PNs for Resident #20 were reviewed. A PN dated [redacted] at 9:22 PM revealed that Resident #20 was observed in their room attempting to [redacted] a NJ Exec Order 26.4b1 with another resident. The PN revealed that the [redacted] was [redacted] and it was determined to be medication that the resident NJ Exec Order 26.4b1 that had not been reported to facility nursing staff upon readmission. The PN further revealed that the [redacted] were contacted.	F0689		04/17/2026

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F0689 SS = SQC-L	Continued from page 14 A [redacted] Investigation Report (IR) dated [redacted] at 7:53 PM was reviewed. The IR revealed that Resident #19 had [redacted] provided to them by the hospital back to the facility and was [redacted] for further personal use. The IR further revealed that Resident #19 admitted to [redacted] the [redacted] prescribed to them and [redacted] them. An interview was conducted with Resident #20 on 03/18/2026 at 9:36 AM. Regarding the [redacted] incident of [redacted] a [redacted], the resident stated that they were opening their [redacted] and [redacted] them. The resident further stated that the [redacted] were from the hospital, and they brought the [redacted] into the facility when they were readmitted [redacted] earlier. Resident #20 stated that Resident #19 was their [redacted] and was in the room to keep them [redacted] An interview was conducted with Resident #19 on 03/18/2026 at 10:45 AM. Resident #19 stated that Resident #20 was their [redacted] Resident #19 stated that they were aware that Resident #20 [redacted] for [redacted]. Resident #19 [redacted] being present in Resident #20's room on [redacted] and [redacted] medication. An interview was conducted with the [redacted] on 03/28/2026 at 1:40 PM. The [redacted] stated that when Resident #19 and Resident #20 were observed with the [redacted], Resident #20 handed [redacted] to the nurse that were wrapped in a [redacted] The [redacted] stated that she identified the [redacted] using an online resource and determined that they were not medications that were provided to the resident in the facility. The [redacted] stated that only Resident #19 was observed [redacted] the [redacted] During the same interview the [redacted] stated that no residents in the facility were allowed to [redacted] medications. The [redacted] stated that in order to [redacted] medication, an assessment should be completed, and a resident's medication would need to be locked away in order to keep it out of access to other residents. The [redacted] further stated that when residents were admitted to the facility, their possessions were inventoried. Documentation of a personal item inventory for Resident #20's recent re-admission was requested by the surveyor.	F0689		04/17/2026

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F0689 SS = SQC-L	Continued from page 15 During exit conference on 03/18/2026, the U.S. FOIA stated that there was no documentation that the Resident #20's possessions were inventoried when the resident returned from the hospital. The facility policy, "Resident Personal Belongings," with a review/revised date of 07/01/2025 was reviewed. Under, "Explanation and Compliance Guidelines:" the policy revealed that all resident personal items would be inventoried by social services or a designee on admission and documentation would be maintained in the medical record. This section of the facility policy further revealed, "5. The facility may refuse to allow a resident to retain his or her personal possession(s) due to the following reasons: […] b. As protection of health and safety." N.J.A.C. 8:39-27.1(a), 31.6(e)	F0689		04/17/2026
F0627 SS = J	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or	F0627	Corrective Action: Resident #18 no longer resides at the facility. On 3/18/26, an audit was completed for all residents who have NJ Exec Order 26.4b1 and are pending discharge to ensure appropriate discharge plan has been implemented. No additional residents were identified as being discharged with NJ Exec Order 26.4b1 access without physician oversight. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice. On 3/18/26, the Director of Nursing reviewed all current residents and there were no other residents identified to have PICC lines or IV access. Measures Put into Place: On 3/10/26, the facility Administrator and facility Director of Nursing implemented the following	04/17/2026

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F0627 SS = J	Continued from page 16 after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	F0627	Continued from page 16 practice: no resident will be discharged with PICC lines or IV access unless ALL the following are completed: Physician notified and documents approved Physician order addressing IV/PICC status Nursing clinical assessment completed Safe discharge plan documented. On 3/18/26 education initiated for all licensed nursing staff and admission/discharge team members by the Facility Educator on the discharge process should a resident refuse to have their PICC line or IV access line removed prior to discharge. Education was also done on, discharge safety requirements, physician notification expectations, PICC lines or IV access risks, PICC lines or IV access removal protocols, documentation requirements and refusal/AMA process. On 4/6/2026, the Facility Administrator incorporated into the morning meeting process a section to review upcoming discharges scheduled for that week which is inclusive of ensuring a safe discharge plan is in place for residents that have PICC lines or IV access. Starting 3/20/26, the Director of Nursing and/or designee will audit weekly x4 weeks then monthly x 3 months all resident discharges to ensure that physician notification is documented, orders are present prior to discharge, PICC lines or IV access status is addressed, and a safe discharge plan is documented. How Will These Actions Be Measured: The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. A Quality Assurance and Process Improvement Committee Meeting was held on	04/17/2026

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F0627 SS = J	Continued from page 17 §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning	F0627	Continued from page 17 4/6/2026. Completion Date: 4/17/2026	04/17/2026

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F0627 SS = J	Continued from page 18 process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure	F0627		04/17/2026

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F0627 SS = J	Continued from page 19 that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, review of the medical records, and review of other pertinent facility documents, it was determined that the facility failed to ensure a safe discharge for a resident. This deficient practice was identified for 1 of 18 residents reviewed (Resident #18). Resident #18, who had a history of [redacted] and was admitted to the facility with [redacted] to receive [redacted], was discharged from the facility with their [redacted] in place. The [redacted] into a [redacted] and [redacted]. Resident #18 had documented complications of up to [redacted] of their [redacted]. During an interview on 3/10/26, with the [redacted], the [redacted] confirmed that a resident with a history of [redacted] discharged with a [redacted] in place had the potential for harm or death. During an interview	F0627		04/17/2026

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F0627 SS = J	Continued from page 20 on 3/10/26 with the U.S. FOIA (b)(6) [redacted] the [redacted] confirmed that Resident #18's discharge was not safe. The facility's failure to ensure Resident #18 was safely discharged from the facility placed Resident #18, as well as all residents being discharged from the facility, at risk for an unsafe discharge. This posed the likelihood of serious harm, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation. The IJ began [redacted] at 4:05 P.M., when Resident #18 was discharged from the facility. The facility was notified of the IJ on 3/10/26 at 5:44 P.M. The facility submitted an acceptable Removal Plan (RP) on 3/23/26 at 3:37 P.M. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 3/25/26 and determined that the immediacy was removed as of 03/20/2026 at 7:00PM. Complaint #: 2806068, 2789654, 2789700, 2794269, 2679147, 2639889, 2588899, 2806341 The deficient practice was evidenced by the following: A review of the facility's policy titled "Discharge Planning Process" with a date reviewed/revised of 5/12/2025, included "It is the guideline of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions." Under "Procedure": 4. In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care: a. Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs	F0627		04/17/2026

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F0627 SS = J	Continued from page 21 and attempt to ascertain why the resident is choosing that location. b. Offer other, more suitable, options of locations that are equipped to meet the needs of the resident. Document any discussion related to the options presented. c. Document refusals of other options that could meet the resident's needs. d. At time of discharge, follow policies regarding discharges Against Medical Advice, and refer to Adult Protective Services (or other state entity charged with investigating abuse and neglect), as necessary. 5. If discharge to community is a goal, an active discharge care plan will be implemented and will involve the interdisciplinary team, including the resident and/or resident representative. The plan shall be documented on (list facility-specific form, comprehensive care plan, etc). 6. An active individualized discharge care plan will address, at a minimum: a. Discharge destination, with assurances the destination meets the resident's health/safety needs and preferences. b. Identified needs, such as medical, nursing, equipment, educational, or psychological needs. c. Caregiver/support person availability and the resident's or caregiver's/support person's capacity and capability to perform required care. d. Resident's goals of care and treatment preferences. 7. The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications. 8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community.	F0627		04/17/2026

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F0627 SS = J	Continued from page 22 9. The facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. The surveyor reviewed the closed medical record for Resident #18. According to the Admission Record (AR), Resident #18 was admitted to the facility with diagnoses which included but were not limited to: [redacted]. According to the discharge Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #18 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted]. While not included under Resident #18's AR, Resident #18 also had diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] hese diagnoses were in the discharge paperwork provided to the facility by the [redacted] from which Resident #18 was transferred. A review of the Electronic Medical Record (EMR) revealed the following: Resident #18's Care Plan (CP) included the following: Under "Focus" date initiated [redacted] "The resident is on NJ Exec Order 26.4b1 related to (r/t) NJ Exec Order 26.4b1 Under "Goal": "The resident will be free of any [redacted] or NJ Exec Order 26.4b1 of [redacted] therapy through the review date." Under "Interventions": "Administer [redacted] medications as ordered by physician" and "Monitor/document/report PRN (as needed) [redacted]	F0627		04/17/2026

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F0627 SS = J	Continued from page 23 NJ Exec Order 26.4b1" Under "Focus" date initiated NJ Exec Order "The resident is on NJ Exec Order 26.4b1 medication therapy (SPECIFY medication) r/t.". Under "Goal": "The resident will be free of any NJ Exec Order 26.4b or NJ Exec Order 26.4b1 effects from NJ Exec O medication through the review date." Under "Focus" date initiated NJ Exec Orde: "[Resident #18] has NJ Exec Order 26.4b1 and is on NJ Exec Order 26.4b1 daily til NJ Exec Order 26.4b1 and requires NJ Exec Order 26.4b1 r/t NJ Exec Order 26.4b1." Under "Goal:" "The resident will be free from complications related to NJ Exec Order 26 through the review date." Under "Interventions:" "Administer NJ Exec Order 26 as per MD (medical Doctor) orders" and "Monitor/document/report to MD s/sx (signs and symptoms) of NJ Exec Order 26 NJ Exec Order 26.4b1 NJ Exec Order Wide variation in NJ Exec Order 26.4b1 throughout the day, NJ Exec Order 26.4b1 , Periods of NJ Exec Order 26 NJ Exec Order 26.4b1 and NJ Exec Order 26.4 NJ Exec Order 26.4b1." Under "Focus" date initiated NJ Exec Order : "The resident has infection of the (SPECIFY)" Under "Goal:" "The resident will be free from complications related to NJ Exec Order 26 through the review date." Under "Interventions: "Follow facility policy and procedures for line listing, summarizing and reporting infections." Under "Focus" date initiated NJ Exec Order 26: "Resident at risk for NJ Exec O r/t NJ Exec Order 26.4b1." Under "Goal:" "Resident will notify nursing of any changes in condition of NJ Exec Order 26.4b1." Under "Interventions:" "Monitor site NJ E -shift [every shift] for s/s (signs and symptoms) of NJ Exec Order 26 and NJ Exec Order 26.4b1 Resident #18's CP did not include any focus, goals, or interventions for Resident #18's discharge or discharge planning. A review of Resident #18's Progress Notes (PN) showed that Resident #18's NJ Exec O had documented complications of up to NJ Exec Order 26.4b1 on the following dates: NJ Exec Order 26.4b1	F0627		04/17/2026

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F0627 SS = J	Continued from page 24 A review of Resident #18's PN dated [NJ Exec Order 26.4] created at 3:46 PM by the [U.S. FOIA (b)(6)] that discharged Resident #18 [NJ Exec Ord] stated that Resident #18 had "met all goals for discharge [NJ Exec Orde] A review of Resident #18's PN dated [NJ Exec Order 26.] created at 4:11 PM by the Director of Nursing (DON) #3 at the time revealed that Resident #18 was discharged from the facility with their [NJ Exec Order 26.4b] after Resident #18 [NJ Exec Order 2] to allow the facility to remove the [NJ Exec O] due to concerns for possible excess [NJ Exec Order 26.4] The PN created by DON #3 was the last PN for Resident #18 and there was no documentation that the facility notified the MD related to Resident #18 leaving the facility with a [NJ Exec Order 26.4b] or further efforts to ensure Resident #18's safety after discharge. There were no PNs by the [U.S. FOIA (b)(6)]) related to Resident #18's discharge from the facility. A review of Resident #18's "Discharge Instructions and Review of Systems for Resident" (DIRSR) under "Discharge Location" indicated that Resident #18 was being discharged home. The DIRSR under "Current Physical Status (Therapy/Nsg [Nursing])" stated that Resident #18 required '[NJ Exec Order 26.4b1]' for [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4] It also stated that Resident #18 was [NJ Exec Order 26.4b1] when it came to [NJ Exec Order 26.4b1]. Resident #18's [NJ Exec Orde] bearing status was [NJ Exec Order 2] but no equipment was ordered for discharge. The DIRSR under "Follow-Up Physician Care (Nsg)" revealed that Resident #18 had no follow up appointments. The DIRSR under "Person Receiving Instructions (Nsg)" revealed that Resident #18's [NJ Exec Order 26.4] was the one receiving instructions for discharge. On 3/9/26 at 2:45 PM, the surveyors interviewed the [U.S. FOIA (b)(6)] of the second floor. UM #2 stated that if a resident has a [NJ Exec Order 26.4b1], typically	F0627		04/17/2026

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F0627 SS = J	Continued from page 25 the [NJ Exec Or] is removed before discharge. She stated that if a resident was being discharged home and refused to have their [NJ Exec Or] line removed she would reach out to the MD and notify them of the refusal. She further stated she would inform her [U.S. FOIA] as well and escalate the situation because it would be an [NJ Exec Order 26] and safety concern for the resident. On 3/9/26 at 3:02 PM, the surveyors interviewed UM #1 who stated that she had not heard of a resident being discharged with a [NJ Exec Order 26.4b1] and stated it would be a concern because a [NJ Exec Or] is a [NJ Exec Order 26.4b] [redacted] On 3/10/26 at 10:30 AM, the surveyors interviewed the U.S. FOIA (b)(6) regarding what the typical process is for discharging a resident from the facility. The [U.S. FO] responded that she does the discharge summary, and discussions are held regarding resident therapy, equipment, and scripts with staff. The [U.S. FO] could not recall participating in an Interdisciplinary Team (IDT) meeting related to Resident #18's [NJ Exec Or] dislodgements and admitted an IDT should have been held. The [U.S. FO] also stated that as a [U.S. FO] if a resident was being discharged with NJ Exec Order 26.4b1 that was to continue out of the facility, she would have set up home care services. The [U.S. FO] confirmed she did not set up home care services for Resident #18. She then stated that when she informs the nurses that a resident with a [NJ Exec Or] is being discharged, the nurses call the doctors and the [NJ Exec Order 26.4b] is typically removed before discharge. On 3/10/26 at 1:19 PM, the surveyors interviewed DON #2 who stated that discharge planning starts when a resident enters the facility. She stated that discharge should be a part of a resident's CP. DON #2 was handed Resident #18's CP and reviewed it. She confirmed that Resident #18's CP did not include discharge planning and that there was no documentation to confirm that the MD had been notified that Resident #18 left the facility with a [NJ Exec Or] [redacted] On 3/10/26 at 2:10 PM, the surveyors asked DON #2 why a resident with a history of [NJ Exec Order 26] should not leave a facility with a [NJ Exec Or] She replied that the resident could leave the facility and q [NJ Exec Order 26.4] [redacted]. She	F0627		04/17/2026

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F0627 SS = J	Continued from page 26 further stated that the facility would not want to be responsible for [NJ Exec Ord] let alone an [NJ Exec Order 26.4] Referring to Resident #18, DON #2 stated if [NJ Exec Order 26.4B] [NJ Exec Order 26.4bT] were completed there was no need for and that it was an inappropriate discharge. On 3/10/26 at 4:41 PM, the surveyors interviewed [U.S. FOIA (b)] regarding discharging residents. The [U.S. FOIA (b)] stated that a discharge must be safe for residents. When asked if Resident #18's discharge was safe she stated, "No, it is not a safe discharge. In the same interview with the [U.S. FOIA (b)] the surveyors requested the [U.S. FOIA (b)] review the Order Summary Report (OSR) for Resident #18. After reviewing, the [U.S. FOIA (b)] confirmed there was no discharge order for Resident #18 and that there should have been because discharge documentation starts from the day of admission. NJAC 8:39-5.4(c); 39.1	F0627		04/17/2026
F0755 SS = H	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F0755	Corrective action ON 4/14/26 a comprehensive clinical evaluation completed by a licensed nurse for Resident #9 Resident #10 Resident #15 focusing on [NJ Exec Order 26.4] s/s of [NJ Exec Ord] withdrawal, vital signs and mental status Resident #18 no longer resides at the facility On 4/15/2026 attending physicians for resident #9 resident #10 resident #15 were consulted regarding residents [NJ Exec O] updated orders were obtained as appropriate and confirmation received of [NJ Exec Order 26.4b1] availability per physician order On 4/14/26 the Facility Director of Nursing and / or licensed nurse designee audited in-house residents who have orders for [NJ Exec Order 26.4b1] to ensure that their [NJ Exec Order 26.4b1] was available at the facility for proper administration Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice.	04/17/2026

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F0755 SS = H	Continued from page 27 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Complaints: 2794269, 2679147, 2588899, 2639889, 2789654, 2789700 Based on interviews, review of medical records, and review of pertinent facility documents on 03/05/2026, 03/09/2026 and 03/10/2026, it was determined that the facility failed to a.) ensure that physician ordered medication was obtained and available to be administered and b.) maintain records of, receipt, accountability, and removal from inventory of NJ Exec Order 26.4b1, for 4 out of 5 residents (Resident #9, Resident #10, Resident #15, and Resident #18) reviewed for NJ Exec Order 26.4b1 [redacted] The deficient practice was evidenced by the following: A. According to the Admission Record (AR), Resident #9 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]. A review of Resident #9's quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted] A review of Resident #9's physician orders (POs) revealed the following: An order for NJ Exec Order 26.4b1	F0755	Continued from page 27 Measures put in Into Place On 4/3/26 the facility developed and implemented a Methadone Calendar which delineates which staff member is designated to pick up the resident Methadone and on what dates which is reviewed daily in Morning Meeting. On 4/6/2026 the facility implemented a process that residents with orders for Methadone are reviewed in both Morning Meeting and Clinical Start-Up to ensure availability and administration of medication On 4/16/2026 the Facility Educator initiated education to all licensed clinical staff on: Safe administration and regulatory requirements for controlled substances, including methadone. Identification and management of opioid withdrawal symptoms. Facility policy on missed/omitted medications and notification requirements, proper documentation and escalation procedures when medication is not available. Starting 4/14/2026 the Facility Director of Nursing and or designee will audit all residents with orders for Methadone to ensure availability of medication and that administration per physician order weekly x 4 weeks then monthly x 6 months. How these actions will be Measured: The results of the weekly and month audits will be submitted to the Quality Assurance and Process Improvement Committee meeting monthly. Based on the results of these audit's decisions will be made regarding the need for continued submission and reporting A Quality assurance and process improvement committee meeting was held on 4/6/2026 Completion Date 4/17/2026	04/17/2026

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 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0755 SS = H	Continued from page 28 NJ Exec Order 26.4b1), give NJ Exec Order 26.4b1 mouth daily in the morning for NJ Exec Order 26.4b1. The order start date was NJ Exec Order 26.4b1 The order end date was NJ Exec Order 26.4b1. An order for NJ Exec Order 26.4b1 daily in the morning for NJ Exec Orde . The order start date was NJ Exec Order 26.4b1 The order end date was NJ Exec Order 26.4b1. A review of the Care Plan (CP) for Resident #9 revealed a "Focus," that the resident was, "on NJ Exec Order 26.4b1)." Goals related to this focus included administering medication as ordered by the physician and monitoring for side effects. Review of the Medication Administration Record (MAR) for Resident #9 revealed that the code " NJ E was used for NJ Exec Order 26.4b1 by mouth daily in the morning on the following dates: NJ Exec Order 26.4b1 Review of the "Chart Codes/Follow Up Codes," section of the MAR revealed that the code " NJ E " meant "Other/See Nurses Note". Review of the Progress Notes (PNs) for Resident #9 revealed the following related to the resident's NJ Exec Order 26.4b1 doses: A PN dated NJ Exec Order 26.4b1 at 1:44 PM, revealed, "medication unavailable". A PN dated NJ Exec Order 26.4b1 at 9:53 AM, revealed, "being delivered later." A PN dated NJ Exec Order 26.4b1 at 12:01PM revealed "awaiting delivery". The MARs and PNs for Resident #9 revealed no documentation that NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 doses were administered. B. According to the AR, Resident #10 was admitted	F0755		04/17/2026

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F0755 SS = H	Continued from page 29 to the facility with diagnoses which included but not limited to NJ Exec Order 26.4b1 [redacted]. A review of the MDS for Resident #10 revealed that the resident had a BIMS score of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted]. A review of Resident #10's POs revealed the following: An order for NJ Exec Order 26.4b1 [redacted] by mouth daily in the morning for history of NJ Exec Order 26.4b1. The order start date was [redacted]. The order end date was [redacted]. An order for NJ Exec Order 26.4b1, give two tablets by mouth every 4 hours as needed for [redacted] to NJ Exec Order 26.4b1 [redacted]. The order start date was [redacted]. A review of the CP for Resident #10 revealed a "Focus," that the resident was, "on [redacted]. Goals related to this focus included administering medication as ordered by the physician and monitoring for side effects. A review of the MAR for Resident #10 revealed that the code [redacted] was used for NJ Exec Order 26.4b1 [redacted], give [redacted] by mouth daily in the morning on the following dates: NJ Exec Order 26.4b1 [redacted]. Further review of the MAR revealed that Resident #10 received [redacted] for [redacted] on the days that they did not receive their [redacted] as follows: On [redacted] at 10:13 AM for a NJ Exec Order 26.4b1 [redacted]. On [redacted] at 5:32 PM, for a NJ Exec Order 26.4b1	F0755		04/17/2026

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F0755 SS = H	Continued from page 30 [redacted] Review of the PNs for Resident #10 revealed the following related to the resident's [redacted] doses: A PN dated [redacted] at 10:10 AM, revealed, "on order". A PN dated [redacted] at 9:56 AM, revealed, "Awaiting delivery". A PN dated [redacted] at 10:30 AM, revealed, "Awaiting delivery." A PN dated [redacted] at 11:13 AM, revealed, "none on hand." A PN dated [redacted] at 9:55 AM, revealed, "on order". A PN dated [redacted] at 10:13 AM, revealed, "Awaiting delivery". A PN dated [redacted] at 10:41 AM, revealed, "Awaiting delivery". A PN dated [redacted] at 10:07 AM, revealed, "awaiting delivery." The MARs and PNs for Resident #10 revealed no documentation that the [redacted] doses were administered. C. According to the AR, Resident #15 was admitted to the facility with diagnoses including but not limited to: [redacted]	F0755		04/17/2026

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F0755 SS = H	Continued from page 31 NJ Exec Order 26.4b1 . According to the quarterly MDS, dated NJ Exec Order 26, Resident #15's BIMS score was NJ E out of 15, which indicated that the resident's NJ Exec Order 26.4 was NJ Exec Ord A review of Resident #15's POs revealed the following: An order for NJ Exec Order 26.4b1 by mouth one time a day for NJ Exec Order 26.4b1. The order start date was NJ Exec Order 26.4b1 An order for NJ Exec Order 26.4b1 , give two tablets by mouth every four hours as needed for NJ Exec O The order start date was NJ Exec Order 26.4b1 A review of the CP for Resident #15 revealed no foci, goals or interventions related to the resident's history of NJ Exec Order 26.4b1. A review of the MAR for Resident #15 revealed that the code "NJ E" was used for NJ Exec Order 26.4b1 by mouth one time a day for NJ Exec Order 26.4b1 order on the following dates: NJ Exec Order 26.4b1 . Further review of the MAR revealed that Resident #15 received NJ Exec Order 26.4b1 for NJ Exec on the days that they did not receive their NJ Exec Order 26.4b1 as follows: On NJ Exec Order 26.4b1 at 1:26 PM, for a NJ Exec Order 26.4b1 Review of the PNs for Resident #15 revealed the following related to the resident's NJ Exec Order 26.4b1 doses: A PN dated NJ Exec Order 26.4b1 at 1:02 PM, revealed, "Not on hand."	F0755		04/17/2026

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F0755 SS = H	Continued from page 32 A PN dated NJ Exec Order 26.4b1 8:28 AM, revealed, "out of medication." A PN dated NJ Exec Order 26.4b1 at 10:52 AM, revealed no documentation of the reason the medication was not given. The MARs and PNs for Resident #15 revealed no documentation that the NJ Exec Order 26.4b1 doses were administered. D. Resident #18 was no longer at the facility. A closed record review was conducted. According to the AR, Resident #18 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 According to PNs from the transferring hospital but not included on Resident 18's AR was the resident's history of NJ Exec Order 26.4b1. According to the discharge MDS dated NJ Exec Order 26.4b1 Resident #18 had BIMS score of NJ E out of 15, which indicated that the resident's NJ Exec Order 26.4 was NJ Exec Orc A review of Resident #18's POs revealed the following: An order for NJ Exec Order 26.4b1 by mouth one time a day for NJ Exec Order 26.4b1. The order start date was NJ Exec Order 26.4b1 The order end date was NJ Exec Order 26.4b1 An order for NJ Exec Order 26.4b1 by mouth one time a day for NJ Exec Order 26.4b1 disorder. The order start date was NJ Exec Order 26.4b1. The order end date was NJ Exec Order 26.4b1 A letter dated NJ Exec Order 26.4b1, provided by the facility and signed by Resident #18 was reviewed. The letter revealed that Resident #18 wanted the facility to pick up and administer their NJ Exec Order 26.4b1 during the	F0755		04/17/2026

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F0755 SS = H	Continued from page 33 resident's stay at the facility. Review of the MARs for Resident #18 revealed the code, "[NJ E]" was used for methadone [NJ Exec Order 26.4b1] by mouth one time a day on the following dates: [NJ Exec Order 26.4b1] Review of the PNs for Resident #18 revealed the following related to the resident's [NJ Exec Order 26.4b1] doses: A PN dated [NJ Exec Order 26.4b1] at 10:19 AM, revealed, "Awaiting delivery". A PN dated [NJ Exec Order 26.4b1] at 10:09 AM, revealed, "On order". A PN dated [NJ Exec Order 26.4b1] at 9:33 AM, revealed, "Awaiting delivery". A PN dated [NJ Exec Order 26.4b1] at 9:30 AM, revealed, "Awaiting delivery". The MARs and PNs for Resident #18 revealed no documentation that the [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] doses were administered. Further review of the PNs for Resident #9, Resident #10, Resident #15, and Resident #18 revealed no documentation indicating the residents' physicians were notified of the aforementioned unavailable [NJ Exec Order 26.4b1] doses. An interview was conducted with Resident #10 on 03/05/2025 at 10:05 AM. Resident #10 stated that recently they went three days without their [NJ Exec Order 26.4b1] which caused the resident to have hot [NJ Exec Order 26.4b1]. The resident stated that they were given [NJ Exec Order2] but it did not help. Resident #10 further stated that Unit Manager (UM) #2 was responsible for picking up the [NJ Exec Order 26.4b1] from the clinic. An interview was conducted with Resident #9 on	F0755		04/17/2026

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F0755 SS = H	Continued from page 34 [redacted] at 10:57 AM. Resident #9 stated that approximately [redacted] prior they had missed their NJ Exec Order 26.4b1. Resident #9 stated that they had [redacted] and were in [redacted] Resident #9 further stated that not receiving their [redacted] affected their [redacted], made them consider using [redacted] and did not make them [redacted] at the facility. An interview was conducted with Resident #15 on 03/09/2026 at 10:40 AM. Resident #15 stated they remembered missing [redacted] doses around the [redacted]. The resident stated that they [redacted] had [redacted] and had [redacted] when the [redacted] doses were missed. Resident #15 stated that their doses were late because the facility failed to pick them up from the [redacted] clinic on time. An interview was conducted with UM #2 on 03/05/2025 at 12:22 PM. UM #2 stated that around the [redacted] Resident #9 and Resident #10 did not receive their [redacted] UM #2 stated that the residents did not receive their [redacted] because she did not pick it up. UM #2 stated that she thought the residents would have enough medication to carry them through, but they did not. UM #2 stated, "that was my mistake." UM #2 stated that either she or the facility U.S. FOIA (b)(6) pick up the [redacted] for the residents. UM #2 further stated that there was not a system in place to ensure that the [redacted] was picked up if she or the [redacted] were not available. During the same interview UM #2 stated that she was not aware that Resident #18 wanted the facility to pick up and administer their [redacted] UM #2 further stated that she could not produce documentation of declining counts for [redacted] for Resident #18. An interview was conducted with the facility's U.S. FOIA (b)(6) on 03/09/2026 at 12:46 PM. The [redacted] stated that he would be involved in ensuring that there was a facility process in place related to [redacted] The [redacted] stated that he was not aware that residents had missed doses of [redacted] The [redacted] further stated that declining counts should be kept by the facility for any NJ Exec Order 26.4b1 [redacted]) in order to maintain chain of custody and to allow the facility to look into any concerns.	F0755		04/17/2026

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F0755 SS = H	Continued from page 35 An interview was conducted with Licensed Practical Nurse (LPN) #3 on 03/18/2026 at 12:13 PM. LPN #3 stated that the process for giving [NJ Exec Order 26.4b1] included both the nurse and the resident signing the declining count sheet at the time of administration. LPN #3 stated that he was aware of times that Resident #10 did not receive their [NJ Exec Order 26.4b1] LPN #3 stated that Resident #10 experienced [NJ Exec O] and he medicated the resident with [NJ Exec Order 2] NJAC 8:39- 29.7 (c)	F0755		04/17/2026
F0656 SS = F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F0656	Corrective Action: On 3/21/2026 Resident #8's care plan was updated by the Unit Manager to include foci, goals and interventions related to [NJ Exec Order 26] and any additional occurrences. On 3/13/2026 Resident #9's care plan was updated by the Unit Manager to include foci, goals and interventions behaviors related to [NJ Exec Order 26] in their room. On 4/15/2026 Resident #15's care plan was updated by the Unit Manager to include safe administration of and use of [NJ Exec Order 26.4b1] safe monitoring and [NJ Exec Order] use. Resident #18 was discharged from the facility. On 4/15/2026 Resident #20's care plan was updated by the Unit Manger to include foci, goals and interventions related to resident's history of [NJ Exec Ord]. On 4/15/2026, the Unit Managers and Director of Nursing initiated an audit of all resident care plans to ensure each care plan includes foci, goals and interventions that are resident specific. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:	04/17/2026

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F0656 SS = F	Continued from page 36 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Complaint: 2639889 Based on interviews, medical record reviews and reviews of other pertinent facility documentation on 3/5/26, 3/9/26, 3/10/26, and 3/18/26, it was determined that the facility failed to develop and implement a comprehensive, person-centered Care Plan (CP) for residents: with a NJ Exec Order 26.4b1 [redacted]. The CPs lacked foci, goals and interventions addressing NJ Exec Order 26.4b1 monitoring NJ Exec Order 26.4b1 safe administration of NJ Exec Order 26.4b1 safe utilization of NJ Exec Order 2 NJ Exec Order 26 addressing residents who were found [redacted] in their rooms, and for residents with history of NJ Exec Order 26.4b1. This failure resulted in the residents experiencing NJ Exec Order 26.4b1 [redacted] without clear staff directions for response, placing the residents at risk for improper handling and monitoring which could have led to potential harm. This deficient practice was identified for 5 of 20 residents reviewed for resident records (Resident #8, Resident #9, Resident #15, Resident #18 and Resident #20), and was evidenced by the following: Complaint #: 2806068, 2789654, 2789700, 2794269, 2679147, 2639889, 2588899, 2806341 1. During the survey, the surveyor reviewed Resident #18's CP which did not address Resident #18's documented complications of up to NJ Exec Order 26.4b1 for their NJ Exec Or nor had interventions in place for clear staff direction to respond. According to the Admission Record (AR), Resident #18 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1	F0656	Continued from page 36 All residents have the potential to be affected by this deficient practice. Measures Put into Place: The Facility Educator initiated education on 4/14/2026 for all interdisciplinary team members inclusive of licensed nursing staff, social work, activities director, dietitian and therapy on the policy for Baseline Care Plan process. The Facility Director of Nursing reviewed the clinical/ morning meeting process on 4/6/2026. The Director of Nursing on 4/6/2026 revised the process to ensure that during the clinical/ morning meeting it will include review of 24-hour report, and that incident reports are completed, and the process of updating resident care plans is completed. Starting 4/15/2026, the Facility Director of Nursing and/or designee will audit weekly x 4 weeks then monthly x 3 months 20% of resident care plans on each unit to ensure that each care plan contains foci, goals and interventions as well as are updated based on resident occurrences and/or changes in status. How Will These Actions Be Measured: The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. A Quality Assurance and Process Improvement Committee Meeting was held on 4/6/2026. Completion Date: 4/17/2026	04/17/2026

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F0656 SS = F	Continued from page 37	F0656		04/17/2026

NJ Exec Order 26.4b1

According to the discharge Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4 Resident #18 had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated the resident's NJ Exec Order 26.4 was NJ Exec Or

While not included under Resident #18's AR, Resident #18 also had diagnoses which included but were not limited to: NJ Exec Order 26.4b1 These diagnoses were in the discharge paperwork provided to the facility by the hospital that Resident #18 was transferred from.

Resident #18's CP included the following:

Under "Focus" date initiated NJ Exec Orde: "The resident is on NJ Exec Order 26.4b1 related r/t (related to) NJ Exec Order 26.4b1 Under "Goal:" "The resident will be free of any NJ Exec Order 26.4b or NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 through the review date." Under "Interventions:" "Administer NJ Exec Order 26.4b1 medications as ordered by physician" and "Monitor/document/report PRN (as needed) NJ Exec Order 26 "

Under "Focus" date initiated NJ Exec Ord: "The resident is on NJ Exec Order 26.4b1 medication therapy (SPECIFY MEDICATION) r/t.". Under "Goal:" "The resident will be free of any NJ Exec Order 26.4b or NJ Exec Order 26.4b1 effects from NJ Exec O medication through the review date."

Under "Focus" date initiated NJ Exec Orde: "[Resident #18] has NJ Exec Order 26.4b1 and is on NJ Exec Order 26.4b1 and requires NJ Exec Order 26.4b1 " Under "Goal:" "The resident will be free from complications related to NJ Exec Order 26 through the review date." Under "Interventions:" "Administer NJ Exec Order 26. as per MD (Medical Doctor) orders" and "Monitor/document/report to MD s/sx (signs and symptoms) of NJ Exec Order 26 NJ Exec Order 26.4b1, NJ Exec Order s, wide variation in NJ Exec Order 26.4b1 throughout the day, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 periods of NJ Exec Order 26. NJ Exec Order 26.4b1 and NJ Exec Order 26.4 NJ Exec Order 26.4b1 ."

Under "Focus" date initiated NJ Exec Order : "The resident

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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
F0656 SS = F	Continued from page 38 has [redacted] of the (SPECIFY)" Under "Goal:" "The resident will be free from complications related to infection through the review date." Under "Interventions:" "Follow facility policy and procedures for [redacted] listing, summarizing and reporting infections." Under "Focus" date initiated [redacted]: "Resident at risk for injury r/t NJ Exec Order 26.4b1." Under "Goal:" "Resident will notify nursing of any changes in condition of [redacted]." Under "Interventions:" "Monitor site [redacted]-shift [every shift] for s/s (signs and symptoms) of [redacted] and [redacted] Resident #18's CP did not include proper foci, goals, or interventions for Resident #18's [redacted] or monitoring for [redacted] of their [redacted] The facility did not specify which infection Resident #18 had. 2. During the survey, the surveyor reviewed Resident # 15 and Resident #18's CP for safe administration and use of [redacted] According to the AR face sheet, Resident #15 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] According to the MDS, dated [redacted], Resident #15's BIMS was a score of [redacted] out of 15, which indicated the resident was [redacted]. Resident #15's CP did not address the resident's administration of or use of [redacted] Resident #18's CP did not address the resident's administration of or use of [redacted] 3. During the survey the surveyor reviewed Resident #15's and Resident 18's CP for safe monitoring and utilization of [redacted] Resident #15's CP did not address the resident's safe monitoring and utilization of [redacted]	F0656		04/17/2026

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F0656 SS = F	Continued from page 39 Resident #18's CP did not address the resident's safe monitoring and utilization of [redacted] 4. During the survey, the surveyor reviewed, Resident #8 and Resident #9's CPs which did not address the residents who were found [redacted] in their rooms. According to the AR face sheet, Resident #8 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] According to the MDS, dated [redacted], Resident #8's BIMS had a score of [redacted] out of 15, which indicated the resident was [redacted]. Resident #8's CP did not include any foci, goals, or interventions for Resident #8's [redacted] or addressing the documented occurrences of Resident #8 being caught [redacted] in their room on [redacted] According to the AR face sheet, Resident #9 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] According to the MDS, dated [redacted], Resident #9's BIMS had a score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] Resident #9's CP included the following:	F0656		04/17/2026

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F0656 SS = F	Continued from page 40 Under "Focus" date initiated [redacted]: [redacted] Under "Goal:" "Resident #9 will remain compliant with facility [redacted] procedure and [redacted] restrictions." Under "Interventions:" "Inform [Resident name] and/or responsible party of facility [redacted] policy and document accordingly," "Nursing to maintain/monitor all [redacted] materials in designated [redacted] area," and "Report Resident #9's non-compliance with facility [redacted] policy or unsafe [redacted] practices to supervisor as indicated." Resident #9's CP did not include proper foci, goals, or interventions for any of Resident #9's five documented occurrences of being caught [redacted] in their room on NJ Exec Order 26.4b1 [redacted]. 5. During the survey, the surveyor reviewed Resident # 20's care plan According to the AR face sheet, Resident #20 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] According to the MDS, dated [redacted], Resident #20's BIMS had a score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] Resident #20's CP did not include any foci, goals, or interventions for Resident #20's history of [redacted] On 3/9/26 at 1:32 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), LPN #2 stated that residents with a [redacted] should have a CP for it. LPN #2 further stated that if issues occur with a resident's [redacted] she would document the issue, and then take the proper steps to fix it and then go over the process with the U.S. FOIA (b)(6)) to see if anything else needed to be done. On 3/9/26 at 2:45 PM, the surveyor interviewed the U.S. FOIA (b)(6) of the 1st floor who stated that the UM is responsible for updating the CP for residents with [redacted]	F0656		04/17/2026

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F0656 SS = F	Continued from page 41 On 3/9/26 at 3:43 PM, the surveyor interviewed the U.S. FO of the 2nd floor who stated that residents should have care plans specific to methadone if they are taking NJ Exec Order 26.4b1 She agreed that care plans are the plan of care for residents. On 3/9/26 at 5:29 PM, the surveyor interviewed the U.S. FO of the 1st floor who stated if residents are on NJ Exec Order they should have a CP for it. She also stated that if residents are on NJ Exec Order 26.4b1 they should also have a CP for it. On 3/10/26 at 1:19 PM, the surveyor interviewed the U.S. FOIA (b DON #2 stated that the CP should be revised for safety measures for residents who NJ Exec Orde and are caught NJ Exec Order 26 in their rooms. DON #2 further stated that she expects the CP to list interventions and anything pertaining to NJ Exec Order 26 such as education if the NJ Exec Order 26 policy is not followed. She stated that interventions are put in place so that staff and residents are aware of their own CP. DON #2 also said that if residents have a physician order for NJ Exec Order or NJ Exec Order 26.4b1 they should also have a CP for it. On 3/10/26 at 4:41 PM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated that CP for all residents should be kept updated. The U.S. FOIA (b also stated that a CP could be generalized but must be inclusive to the resident's orders and plan of care. A review of the facility's policy titled "Baseline Care Plan" with a revision date of 5/12/25, included the following information under "Guideline:" "The facility will develop and implement a baseline care plan for each resident that include the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care". Under "Explanation and Compliance Guidelines:" 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including but not limited to: i. Initial goals based on admission orders.	F0656		04/17/2026

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F0656 SS = F	Continued from page 42 ii. Physician orders. 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified need for supervision, behavioral interventions, and assistance with activities of daily living. iii. Any special needs such as for IV therapy, dialysis or wound care. A review of the facility's policy titled "Comprehensive Care Plans" with a revision date of 5/12/25, included the following information under "Guideline": "It is the guideline of this facility to develop and implement a comprehensive person-centered care plan for reach resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality". Under, "Explanation and Compliance Guidelines": 3. The comprehensive care plan will describe, at minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished,	F0656		04/17/2026

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F0656 SS = F	Continued from page 43 but are not provided due to the resident's exercise of his or her right to refuse treatment. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity… NJAC 8:39-11.2 (e)	F0656		04/17/2026
F0842 SS = E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F0842	Corrective Action: Resident #14 no longer resides at the facility. On 4/15/2026 the Director of Nursing and/or Nursing Designee reviewed the [NJ Exec Order 2] counts for in house residents on [NJ Exec Order 26.4b1] to ensure there were no discrepancies in administration, inclusive of Resident #9 Resident #10 and #15 Resident #18 no longer resides at the facility On 4/15/2026 the Facility Director of Nursing and or Nursing Designee reviewed level of [NJ Exec Order 26.4b1] necessary for Resident #3 and Resident #4 and current need for [NJ Exe] documentation. On 4/17/2026 the Facility Resident Care coordinator completed a personal inventory sheet for Resident #20 to reconcile their current belongings at the facility. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency All residents have the potential to be affected by this deficien practice. Measures Put into Place On 4/15/2026/ the Director of Nursing and/0r Nursing Designee audtied in house residents with orders for Methadone to ensure medication was available at the facility and declining inventory sheets in place. On 4/15/2026 the Director of Nursing and or Nursing Designee audited in house for residents with orders	04/17/2026

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F0842 SS = E	Continued from page 44 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, medical record reviews and reviews of other pertinent facility documentation on 3/5/26, 3/9/26, 3/10/26, and 3/18/26, it was determined the facility failed to ensure residents medical records were complete, accurate and readily accessible as evidenced by: a.) the facility not being	F0842	Continued from page 44 for 1:1 supervision and implemented 1:1 monitoring sheets for any residents assessed for needed 1:1 monitoring On 4/16/2026 the Resident Care Coordinator / or Designee initiated audit to ensure that in-house residents have completed personal inventory sheet and completed a personal inventory sheet for residents identified without sheet on file as resident allowed. On 4/14/2026 the Director of Nursing and/or Designee audited to ensure that in house residents have ADL task in electronic medical record activated. On 4/16/2026 the facility educator-initiated reeducation to licensed nurses cna's and applicable staff on: Documentation requirements for ADL's, 1:1 monitoring, personal inventory sheet completion, controlled substance documentation requirements, Methadone declining inventory logs, as well as the expectations for real-time accurate, and complete documentation. Starting 4/14/2026 , the Director of Nursing and /or Nursing Designee wil audit weekly x4weeks then monthly x 6months a 20% sample on each resident unit of resident documentation to ensure: ADL logs are present and completed, declining inventory sheets for residents that are prescribed Methadone are present and complete, residents who have orders for 1:1 supervision have 1:1 sheets that re completed . Inventory logs are present and completed. How will these actions be measured: The results of weekly and monthly audits will be submitted to the quality Assurance and Process Improvement Committee Meeting monthly. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. A Quality Assurance and Process Improvement Committee Meeting was held on 4/6/2026 Completion Date 4/17/2026	04/17/2026

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F0842 SS = E	Continued from page 45 able to provide surveyors with Activities of Daily Living (ADL) logs, b.) the facility not being able to provide surveyors with declining sheets for residents on [redacted] c.) the facility not being able to provide surveyors with complete and correctly documented 1:1 logs, and d.) the facility not being able to provide surveyors with a personal belongings log for a resident that was being admitted to the facility. This deficient practice resulted in incomplete and unavailable clinical records, which had the potential to impact the facility's ability to ensure appropriate care, monitor resident conditions, ensure accountability of services provided, and protect residents. This deficient practice was identified for 8 of 21 residents (Resident #3, Resident #4, Resident #9, Resident #10, Resident #14, Resident #15, Resident #18, and Resident #20) and was evidenced by the following: Complaint #: 2806068, 2789700, 2679147, 2639889 The facility was unable to provide ADL documentation to reflect the care and services delivered to Resident #14. According to the Admission Record (AR) face sheet, Resident #14 was admitted to the facility with diagnoses which included but were not limited to: [redacted]. A review of Resident #14's quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted]. During the survey, surveyors requested a copy of Resident #14's ADL logs and the facility was unable to provide them. The facility was unable to provide declining sheets or monitoring documentation for residents receiving methadone until [redacted] of [redacted] to demonstrate ongoing assessment and response to the medication regimen. According to the AR, Resident #9 was admitted to the facility with diagnoses which included but were not limited to: [redacted]	F0842		04/17/2026

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F0842 SS = E	Continued from page 46 According to the MDS, dated [redacted], revealed that the resident had a BIMS score of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted] According to the AR Resident #10 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]. According to the MDS, dated [redacted], it revealed that the resident had a BIMS score of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted] According to the AR, Resident #15 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] According to the MDS, dated [redacted], Resident #15's BIMS was a score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] According to the AR, Resident #18 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] According to the MDS, dated [redacted] Resident #18 had a BIMS score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] During the survey the surveyors requested declination sheets for these residents who were on [redacted] and were informed that declination sheets were unable to be provided prior to the end of [redacted] of [redacted] The facility was unable to provide complete and accurately documented [redacted] records for residents (Resident #3 and Resident #4), including missing or incomplete entries necessary to verify continuous monitoring. According to the AR, Resident #3 was admitted to	F0842		04/17/2026

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F0842 SS = E	Continued from page 47 the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 According to the MDS, dated [redacted], Resident #3 had a BIMS score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] According to the AR, Resident #4 was admitted to the facility with diagnoses which included: NJ Exec Order 26.4b1 [redacted]. According to the MDS, dated [redacted], Resident #4 had a BIMS score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] During the survey the surveyors requested the 1:1 observation records for Resident #3 and Resident #4 and the facility was unable to provide complete and accurately documented records and records that matched their policy such as both the residents' Electronic Medical record (EMR) Electronic Treatment Administration Record/Electronic Medication Administration Record (eTAR/eMAR). The facility was unable to provide a personal belongings inventory for a resident upon admission, to account for resident property (Resident #20). According to the AR face sheet, Resident #20 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] According to the MDS, dated [redacted], Resident #20 had a BIMS score of [redacted] out of 15, which indicated the resident's [redacted] was NJ Exec Order 26.4b1. During the survey the surveyors requested a personal belongings inventory for Resident #20 when they were re-admitted into the facility on [redacted] which the facility was unable to provide. Surveyors requested this inventory as Resident #20 was [redacted] to have brought [redacted] back from the hospital that they were NJ Exec Order 26.4b1. This was observed by staff and reported to the Department of Health (DOH).	F0842		04/17/2026

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F0842 SS = E	Continued from page 48 On 3/5/26 at 12:22 PM, the surveyors interviewed the U.S. FOIA (b)(6)) on the second floor regarding the declining sheets for [NJ Exec Order 26.4b1] UM #2 stated that she did not keep records of the residents who were on [NJ Exec Order 26.4b1] until the end of [NJ Exec Order 2] of [NJ Exec Or] On 3/9/26 at 10:40 AM, the surveyor interviewed Resident #15 who reported that they do not receive their [NJ Exec Order 26.4b1] on time and that caused them to feel [NJ Exec O] On 3/9/26 at 10:50 AM, the surveyor interviewed Resident #9 who reported missing [NJ Exec Order 26.4b1] doses and having an inadequate supply of [NJ Exec Order 26.4b1] On 3/9/26 at 1:01 PM, the surveyors interviewed Certified Nursing Assistant (CNA) #2 who confirmed that the care that he provides for residents he documents in the Point of Care (POC) for the facility and that the POC should be completed by the end of his shift. CNA #2 also confirmed that there should not be blanks on [NJ Exe] record as that would indicate that the CNA filling out the [NJ Exe] record is not paying attention to their documentation. On 3/9/26 at 1:32 PM, the surveyors interviewed Licensed Practical Nurse (LPN) #2 who stated that documentation for residents should be complete and accurate so that all personnel would be able to know what care is being provided for a resident. LPN#2 was shown the [NJ Exe] record for Resident #3 and Resident #4 and stated that the forms were filled out incorrectly because there were blanks. When asked why there should be no blanks on the [NJ Exe] record, the LPN stated because the observer is not doing their job correctly if there are blanks. On 3/9/26 at 2:14 PM, the surveyors interviewed UM #2 who stated that Resident #3 and Resident #4's [NJ Exe] record were not filled out per facility policy or her expectations for her staff. UM #2 also stated that the [NJ Exe] log should be able to be provided to surveyors and up to date because it informs all personnel that the facility is properly implementing their own interventions related to [NJ Exe] observation. On 3/10/26 at 2:10 PM, the surveyors interviewed the Director of Nursing (DON) #2 who stated that documentation is what properly allows the facility to care for residents. She further stated that documentation is the driving force for residents, their family, and the facility as it allows everyone to be aware of the care being provided for the residents.	F0842		04/17/2026

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 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0842 SS = E	Continued from page 49 On 3/10/26 at 4:41 PM, the surveyors interviewed the [U.S. FOIA (b)(6)]) who confirmed there were errors on the [NJ Exec] logs and that they were not done correctly. . The [U.S. FOIA (b)] also confirmed that the facility could not produce declination sheets for [NJ Exec Order 26.4b1] On 3/18/26 at 1:40 PM, DON #2 was interviewed and stated that when residents are admitted to the facility an inventory of their belongings is completed. When asked why inventorying a resident's belonging was important [U.S. FOIA] #2 stated to know what a resident has when they come in and so that belongings don't get misplaced. She also stated that that typically she does not check a resident's pockets or performs a body check when performing an inventory of a resident's belongings. Surveyor requested Resident #20's inventory of belongings from re-admission in [NJ Exec Order 26.4b1] On 3/18/26 at 2:14 PM, DON #2 stated she was unable to provide surveyors with the inventory log for Resident #2. A review of the facility's policy titled "Documentation in Medical Record" with a revision date of 5/12/25 included the following information under "Guideline": Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Under, "Explanation and Compliance Guidelines": Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Documentation may be performed manually or as per the facility's specific electronic medical record software program. A review of the facility's policy titled "One to One Supervision" with a revision date of 12/11/25 included the following information under "Purpose":	F0842		04/17/2026

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F0842 SS = E	Continued from page 50 One-to-one observation/supervision is implemented when a resident's clinical assessment indicated a one on one necessary based on an increased safety necessity. Implementation of one-to-one supervision is reserved for extreme situations where they may be a significant risk to the safety and well-being of a resident or other residents. Under, "Procedure": 1. One-to-one supervision requires that a resident is always never out of sight of the assigned staff member. a. The resident is always accompanied by the designated staff member (including bathing, showering, shaving, and toileting), unless care plan indicates otherwise. 5. Residents on a one-to-one status will be evaluated at least every shift by a Licensed Nurse. a. In addition, the Interdisciplinary Team (IDT) will reassess the resident every 24 hours or as needed to ensure that one-to-one staff supervision continues to be necessary. b. One-on-one will be added to the EMR (eTAR/eMAR), and the nurse assigned to ethe resident will sign off each shift, verifying supervision is in place and current. c. The patient will be on Alert/Shift-to shift charting every shift for the duration of one-to-one supervision to document the patients activities and both effective and ineffective interventions utilized. d. The designated staff member who is providing one-to-one supervision will utilize the Safety Check Log & Data Collection (One-to-One) form to document resident activity throughout the observation period. A review of the facility's policy titled "Resident Personal Belongings" with a revision date of 7/12/25 included the following information under "Guideline": It is the guideline of this facility to protect the resident's right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. The facility will ensure that personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative, in the event of the resident's death or discharge from the facility.	F0842		04/17/2026

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F0842 SS = E	Continued from page 51 Under, “Explanation and Compliance Guidelines”: 3. All resident personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the medical record. 5. The facility may refuse to allow a resident to retain his or her personal possession(s) due to the following reasons: b. As protection of health and safety. c. The facility determines through observation that a resident may have access to illegal substances that they have brough into the facility or secured from an outside source. The facility does not act as an arm of law enforcement. Rather, in accordance with state laws, the facility will determine if a referral to local law enforcement is warranted. The facility may choose to provide additional monitoring and supervision determined on a case by case basis. If facility staff identify items or substances that pose risks to residents’ health and safety and are in plain view, they may confiscate them. d. To maintain and prevent the infringement of other resident rights. N.J.A.C. 8:39-35.2	F0842		04/17/2026

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 03/25/2026

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S0000	Initial Comments Complaint #: 2806068, 2789654, 2789700, 2794269, 2679147, 2639889, 2588899, 2806341 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		04/17/2026
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: Based on interviews and review of facility documents on 02/15/2026-02/28/2026, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. 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	S0560	Corrective Action: Staffing coordinator was educated by the facility Administrator on New Jersey state staffing ratio requirements on 4/14/2026. Efforts to hire facility staff will continue until there is adequate staff to meet the minimum staff to resident ratios. Until that time, the facility will use staffing agencies and offer additional shifts to current staff with bonuses as required. Facility Administrator will continue to work with Human resources to secure additional staffing agency contracts. Interdisciplinary team met on 4/14/2026 to discuss recruitment and retention interventions which included scheduling a job fair to be held May 2026. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice.	04/17/2026

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

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S0560	Continued from page 1 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 staffing prior to survey from 02/15/2026-02/28/2026, , the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -2/15/26 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/16/26 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/17/26 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/18/26 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/19/26 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/20/26 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/21/26 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/22/26 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/23/26 had 5 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/24/26 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/25/26 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/26/26 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/27/26 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -2/28/26 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. The facility is deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows:	S0560	Continued from page 1 Measures Put into Place: Weekly recruitment, retention and employee appreciation meeting was initiated on 4/16/2026 and will be led by the Director of Human Resources and/or designee. Hiring and recruitment efforts including pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives. The facility administrator/designee will continue to track and document all recruitment and retention efforts weekly x 3 months The administrator/designee will review staffing schedules weekly x 4 weeks then monthly x 3 months to ensure adequate staffing for all shifts. How Will These Actions Be Measured: The results of the weekly and monthly recruitment and retention audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. A Quality Assurance and Process Improvement Committee Meeting was held on 4/6/2026. Completion Date: 4/17/2026	04/17/2026

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S0560	Continued from page 2 -2/22/26 had 6 total staff for 103 residents on the overnight shift, required at least 7 total staff. -2/16/26 had 6 CNAs for 103 residents on the overnight shift, required at least 7 total staff. -2/23/26 had 8 total staff for 103 residents on the evening shift, required at least 10 total staff.	S0560		04/17/2026
S0890	Mandatory Administration CFR(s): 8:39-9.4(f) The facility shall notify the State Long-Term Care Ombudsman at (800) 792-8820 immediately of any suspected or reported resident abuse, neglect, or exploitation of residents aged 60 or older, pursuant to P.L. 1983 c. 43 (N.J.S.A. 52:27G-7.1), and shall notify the Department immediately at 1-800 792-9770 with respect to residents under the age of 60. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and review of facility policies and procedures on 3/5/26, 3/9/26, 3/10/26, and 3/18/26, it was determined that the facility failed to ensure [redacted] or suspicions of potential [redacted] were reported timely and in accordance with facility policy for 6 out of 21 residents (Resident #3, Resident #4, Resident #8, Resident #9, Resident #10 and Resident #12) reviewed. Specifically, the facility failed to report incidents involving residents who were found [redacted] in their rooms and to report when [redacted] were conducted at the facility and residents were found to have items identified as possible [redacted] These incidents had the potential to place the residents, and others at risk for serious harm, including fire hazards and physical injury with N.J.A.C. 8:39-9.4 (f). Complaint #: 2789654, 2789700 Record review showed that the facility called in an incident to the New Jersey Department of Health (NJDOH) that concerned Resident #3 and Resident #4 and mentioned during [redacted] that Resident #4 was found to have a [redacted] and a [redacted] that was made into a [redacted] in their room in relation to Resident #4 [redacted] to [redacted] Resident #3. Record reviews showed that the facility called in an incident to the NJDOH between two other residents	S0890	Corrective Action: AAS-45 submitted on 2/25/2026 for incident involving resident #4 [redacted] resident #3. On 4/14/2026 the Administrator and DIRECTOR OF NURSING, immediately called in reportable events to the New Jersey Department of Health for identified incidents related to resident #4 [redacted] #8 ([redacted] in room per 2567, no documentation at facility of [redacted] in room), resident was [redacted] an [redacted] near the nursing station, which was taken from residents' possession, the C.N.A. noting resident [redacted] in room), #10 ([redacted]) and #12 [redacted]). On 4/1/2026, the Administrator, DIRECTOR OF NURSING and Unit Managers conducted an immediate facility wide safety assessment for Residents #4, #8, #9, #10 and #12 to ensure no injury or ongoing risk, which included implemented care plan interventions related to identified risk, enhanced supervision or monitoring, removal of hazardous items, smoking safety evaluation and supervision plan. On 3/19/26, the Administrator, DIRECTOR OF NURSING and Unit Managers conducted an immediate facility wide facility and resident room audit to identify unauthorized smoking material and potential weapons or hazardous items. On 4/9/2026, the Facility Educator re-educated all staff on the reportable event policy and process, environment and resident room search policy and reporting allegations of abuse and neglect. On 4/1/2026, the Administrator contracted with a	04/17/2026

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S0890	Continued from page 3 which led to a facility wide room search. During the room search, Resident #10 was found to have a [NJ Exec O] [redacted] in their room and Resident #12 was found to have a [NJ Exec Order 26.4b] [NJ Exec Order 26.] [redacted] in their room. Both of these possible were not reported to the NJDOH. Record review of Progress Notes (PNs) showed that Resident #8 and Resident #9 were documented to have been caught [NJ Exec Order 26] [redacted] in their rooms During interviews on 3/5/26, 3/9/26, 3/10/26, and 3/18/26, multiple staff members confirmed awareness of the incidents and acknowledged that the events were not reported, and no formal investigation was conducted. Staff members confirmed that facility procedures were not followed, as well as proper documentation for the incidents above. Some staff members admitted that they were not sure of policies and procedures related to what needed to be reported to the NJDOH. Despite facility policy requiring reporting and investigation of events that pose a risk to resident health and safety, the policy was not followed. A review of the facility's policy titled "Environment and Resident Room Search" with a revision date of 7/12/25 included the following information under "Purpose": This guideline is to establish guidelines and protocols for selected staff members of the facility to safely conduct searches of resident rooms. The goal of these searches is to ensure the safety and well-being of all residents and maintain a safe environment within the facility. Under, "Compliance Guidelines": 1. Staff Responsibility b. Staff members must consider relevant laws, regulations, and ethical guidelines when conducting searches with the goal of immediate safety of the residents and staff within the facility. A review of the facility's policy titled "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation" with a revision date of 7/12/25 included the following information under "Guideline": It is the guideline of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are	S0890	Continued from page 3 security company who is on-site daily, 24/7. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice Measures Put into Place: Effective 4/6/2026, all incident and accident reports are reviewed in morning meeting by the Administrator, DIRECTOR OF NURSING and Interdisciplinary team to assess/review for reportable determination, resident care interventions and environmental/systemic concerns. No incident is closed without a completed summary and conclusion that includes determination of reportability to DOH and assessment to rule out abuse and neglect. On 4/2/2026, the Administrator implemented a room search policy and procedure and package search policy to assess for contraband, smoking materials and hazardous items. The Administrator and/or designee will audit weekly x 4 weeks then monthly x 3 months all incident and accident reports, to ensure all incidents that meet the criteria of reporting to the Department of Health have been reported timely, per regulatory requirement. How Will These Actions Be Measured: The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. A Quality Assurance and Process Improvement Committee Meeting was held on 4/6/2026. Completion Date: 4/17/2026	04/17/2026

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S0890	Continued from page 4 reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. Under, “Compliance Guidelines”: The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. 2. Training: New employees will be educated by the department manager, or designee, on issues related to abuse prohibition practices and abuse reporting requirements during initial orientation. Annual education and training will be provided to all existing employees. Front line supervisors will provide education as situations arise. 3. Prevention: The facility will provide resident, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution, and will provide feedback regarding the concerns that have been expressed. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. 5. Alleged violation: A situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property 6. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response as described below. 7. Protection: The facility will protect residents from harm during an investigation. 8. Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation. The	S0890		04/17/2026

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S0890	Continued from page 5 facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences Under, “Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation”: Any owner, operator, employee, manager, agent, or contractor of the facility can report an allegation of abuse/neglect/exploitation to the abuse agency hotline without fear of retaliation. When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated (facilities may develop written facility specific protocols based on guidelines): Guideline The Licensed Nurse will: a. Respond to the needs of the resident and protect him/her from further incident. b. Remove the accused employee from resident care areas. c. Notify the Administrator or designee d. Notify the attending physician, resident's family/legal representative, and Medical Director. e. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. f. Document actions taken in the medical record. g. Complete an incident report is [sic] indicated. h. Revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. 2. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion b. Obtain statements from direct care staff.	S0890		04/17/2026

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 03/25/2026

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
S0890	Continued from page 6 c. Suspend the accused employee pending completion of the investigation. d. Follow up with appropriate agencies, during business hours, to confirm the report was received. e. Report to the state nurse aide registry or nursing board any knowledge of any actions which would indicate an employee is unfit for service. f. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified. Employee Training: New employees should be educated by the department manager on alleged violations and reporting requirements during initial orientation. Annual education and training is provided to all existing employees. Front line supervisors can provide education as situations arise. The facility failed to maintain compliance with N.J.A.C. 8:39-9.4(f) by not reporting the above incidents and implementing their policies. This deficient practice resulted in a failure to ensure appropriate oversight and response to significant safety risks, placing residents at risk of serious harm, including fire-related injury and physical harm. N.J.A.C. 8:39-9.4(f)	S0890		04/17/2026
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	S1680	Mandatory Nursing Staffing Corrective action: On 4/14/2026 the staffing coordinator was educated by the facility Administrator on the minimum staffing levels required by NJAC 8:39-25:1(a) Identification of other residents or areas having the potential to be affected due to the nature of these deficiency All residents have the potential to be affected by this deficient practice Measures Put into Place	04/17/2026

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S1680	Continued from page 7 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 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: Based on review of the Nurse Staffing Reports for the weeks of 02/15/2026 and 02/22/2026, it was determined that the facility failed to provide at least minimum staffing levels for 6 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 02/15/26 Required Staffing Hours: 268.25 -02/15/26 had 264.00 actual staffing hours, for a difference of -4.25 hours. -02/16/26 had 264.00 actual staffing hours, for a difference of -4.25 hours. -02/21/26 had 264 actual staffing hours, for a difference of -4.25 hours. For the week of 02/22/26 Required Staffing Hours: 268.25 -02/22/26 had 232 actual staffing hours, for a difference of -36.25 hours.	S1680	Continued from page 7 The administrator designee will review staffing schedules weekly x4 weeks then monthly x6months to ensure adequate staffing for all shifts. How will these actions be monitored The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting Monthly Based on the results of these audits a decision will be made regarding the need for continued submission and reporting. A quality Assurance and Process Improvement Committee Meeting was held on 4/6/2026. Completion Date 4/17/26	04/17/2026

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 03/25/2026

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S1680	Continued from page 8 -02/23/26 had 184.00 actual staffing hours, for a difference of -84.25 hours. -02/24/26 had 256.00 actual staffing hours, for a difference of -12.25 hours.	S1680		04/17/2026

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 04/30/2026

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

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F0000	INITIAL COMMENTS An on-site revisit for the facility's Plan of Correction was conducted on 04/30/2026 in relation to the 03/25/2026 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	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 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 04/30/2026

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

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S0000	Initial Comments An on-site revisit for the facility's Plan of Correction was conducted on 04/30/2026 in relation to the 03/25/2026 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		

Office of Primary Care and Health Systems Management

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