STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 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
F 000	INITIAL COMMENTS Complaint #: NJ00175433, NJ00178356 Survey Dates: 10/31/24 Census: 106 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and policy reviews on 10/31/2024, the facility failed to notify the Physician of laboratory results for 1 of 3 Resident (Resident #3.) reviewed for laboratory services. Specifically, the facility failed to notify the Physician of Resident#3 of the [redacted]	F 773	Resident #3 physician was aware of the [redacted] on [redacted] and gave an order for [redacted] No [redacted] were noted. All residents have the potential to be	11/18/24

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

Electronically Signed | 11/15/2024

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

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F 773	Continued From page 1 NJ Exec Order 26.4b1 results. The Surveyor reviewed the Electronic Medical Record (EMR) was as follows: According to the Admission Face Sheet Resident #3 was admitted to the facility with diagnoses which included but not limited to: NJ Exec Order 26.4b1 A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 showed a Brief Interview for Mental Status score of NJ Exec This indicated that resident #3's NJ Exec Order 26.4b1 was NJ Exec Order On 10/31/2024 at 10:20 AM, the Surveyor interviewed US FOIA (b)(6)) who informed the Surveyor that NJ Exec Order 26.4b1 for Resident #3 was collected on NJ Exec Order 26.4b1, The results were received by the facility on NJ Exec Order 26.4b1. Resident #3 was started on NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1. US FOIA stated the lab report was faxed to the front desk and secretary gives the labs slip to the nurses. Once the nurses' receive the lab slip results, the Physician should be notified on the same day and documented in the progress notes. At that time, the US FOIA acknowledged that there was no documented evidence in Resident #3's EMR that the Physician was made aware of the NJ Exec Order 26.4b1 result on NJ Exec Order 26.4b1. On 10/31/2024 at 1:44 PM, The surveyor interviewed and reviewed medical records with The US FOIA (b)(6)) who confirmed that a NJ Exec Order 26.4b1 was collected for Resident #3 on NJ Exec Order 26.4b1 with results received by the facility	F 773	affected by this deficient practice. The facility will move from one generic lab access to personal lab access for each nurse by 11/12/2024. Nurses will be educated by the Staff Development or designee regarding physician Lab notification by 11/18/2024. The Director of Nursing or designee will print the order log from the laboratory site daily Monday through Friday and provide a copy of the log to the units. Nursing staff will utilize the order log to ensure lab results are obtained and will notify physicians of the results. Unit Managers will audit the previous day order logs checking for lab results, documentation of physician notification and physician response daily Monday through Friday for 2 weeks then twice weekly for two weeks then weekly. These audits will be submitted to the Director of Nursing upon completion starting 11/12/2024. The Director of Nursing will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months	

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	315206	A. BUILDING _____ B. WING _____	C 10/31/2024

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

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F 773	Continued From page 2 on [NJ Exec Order 26.4b1] Lab was not reviewed or reported to the physician. The Surveyor reviewed the progress notes with the [US FOIA (b)] who confirmed there is no documented evidence staff reported lab result for Resident #3 to Physician on. During an interview on 11/4/2024 at 1:45 PM, the Physician stated that he ordered a [NJ Exec Order 26.4b1] for Resident on [NJ Exec Order 26.4b1]. The Physician confirmed that the staff had not notified him of the results. The Physician was reviewing labs slips on [NJ Exec Order 26.4b1] and found that Resident #3 had [NJ Exec Order 26.4b1] results. The Physician notified the [US FOIA (b)(6)] that same day and provided an order for [NJ Exec Order 26.4b1] The Physician stated that the protocol was for the nurse on duty at the facility to call him with any [NJ Exec Order 26.4b1] lab results promptly , and then he would provide an order. Review of the facility's policy titled, "Physician, Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Lab Notification," revised October,2022, revealed, ". . . It is the policy of this facility to timely notify the physician, physician assistant, nurse practitioner or clinical nurse specialist of lab results. Definitions: "Promptly" means that results shall be relayed with little or no delay to the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist. NJAC 8:39-13.1(d)	F 773		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 10/31/2024

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

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 16 day shifts and 1 night shift. The deficient practice was evidenced by the following: 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	S 560	Staffing was reviewed for the referenced dates/shifts. No residents were negatively affected. All residents have the potential to be affected Daily review of staffing by the Director of Nursing or designee to ensure compliance with NJSA 30:13-18 minimum staffing requirements for nursing homes for all shifts. Call out policy reviewed. A staffing agency will be engaged as needed. Employee referral bonus program put in place for employees to encourage peers	11/18/24

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

Electronically Signed | 11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 10/31/2024

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 07/07/2024 to 07/13/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 day shifts as follows: -07/07/24 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/08/24 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/09/24 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/10/24 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/11/24 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/12/24 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/12/24 had 7 total staff for 112 residents on the overnight shift, required at least 8 total staff. -07/13/24 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs.	S 560	to work at the facility. In-service training on minimum staffing requirements to be completed for Staffing Coordinator, Director of nursing, unit Managers and Human Resources by 11/13/2024. Weekly staffing meetings to include the Director of Nursing or designee and the Staffing Coordinator to be held to determine upcoming schedules to anticipate staffing needs. The Director of Nursing will report findings to the Administrator weekly for 4 weeks then monthly for 3 months with results reported at the monthly QAPI meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 10/31/2024

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S 560	Continued From page 2 2. For the 3 weeks of staffing prior to survey from 10/06/2024 to 10/26/2024, the facility was deficient in CNA staffing for residents on 20 of 21 day shifts, deficient in total staff for residents on 2 of 21 evening shifts, and deficient in total staff for residents on 1 of 21 overnight shifts as follows: -10/06/24 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -10/07/24 had 7 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/08/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/09/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/10/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/11/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/11/24 had 10 total staff for 107 residents on the evening shift, required at least 11 total staff. -10/12/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/13/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/14/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/15/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/16/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/17/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/18/24 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/19/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/20/24 had 9 CNAs for 107 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 day shift, required at least 13 CNAs. -10/20/24 had 9 total staff for 107 residents on the evening shift, required at least 11 total staff. -10/21/24 had 6 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/22/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/23/24 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/25/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/26/24 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -10/26/24 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315206 Y1	A. Building B. Wing Y2	11/15/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0773	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.50(a)(2)(i)(ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/31/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061520 Y1	A. Building B. Wing Y2	11/15/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO