STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315332	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN OCEAN CENTER	1361 ROUTE 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 Complaints: NJ # 426049; 2582034; 426167; 426150 Survey Date: 9/8/2025 Census: 129 Sample Size: 26 + 3 Closed Records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		10/21/2025
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to implement their [redacted] policies and procedures by ensuring a resident (Resident #104) was free from [redacted].	F0600	The housekeeper that had been [redacted] to have been [redacted] the resident was immediately placed on administrative leave and then [redacted] once the [redacted] was substantiated All residents have the potential to be affected by the deficient practice. Education was provided to all staff on abuse prohibition with a highlight on verbal abuse. The social services director or designee will randomly interview 5 residents in regards to care and ensure that there are no concerns for abuse. The interviews will be conducted weekly times 2 followed by monthly times 4. The results of the interviews will be reviewed monthly by the QAPI committee with corrections needed or taken during the course of the audits.	10/21/2025

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

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

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F0600 SS = D	Continued from page 1 This deficient practice was identified for 1 of 1 resident reviewed for [redacted] (Resident #104) and was evidenced by the following: A review of the Admission Record (admission summary) indicated that Resident # 104 was admitted to the facility with the diagnoses which included but was not limited to [redacted], [redacted], [redacted] and [redacted]). The annual Minimum Data Set (MDS), an assessment tool used to facilitate a resident's care dated [redacted] indicated that Resident #104 scored a [redacted]/15 on the Basic Interview for Mental Status (BIMS) which indicated that the resident had [redacted]. The MDS also reflected that the resident did not exhibit any [redacted] A review of the form AAS-45 (Facility Reportable Event) dated [redacted], indicated that on [redacted] a housekeeper told Resident #104 to [redacted]" when the housekeeper had to clean up [redacted] from the resident's [redacted] A review of a [redacted] untimed statement dated [redacted], indicated that as the [redacted] was attempting to take Resident #104 for [redacted], the resident refused [redacted] and was [redacted] because the resident reported that a staff member [redacted] them. The resident reported that a staff member had to clean the resident's [redacted] too often because the resident was [redacted] often. A review of Resident #104's untimed statement taken [redacted], revealed that on [redacted] a [redacted] was cleaning, and the resident overheard the [redacted] saying that she had to "[redacted] the floor and from [redacted]. I [redacted] this morning and now I have to do it again." A review of the emailed statement dated 8/8/25 at 12:35 PM, from the [redacted] reflected that the [redacted] admitted that an aide had told her that Resident #104 [redacted] the [redacted] and it [redacted] and [redacted]. The [redacted] stated, "I said to [Resident #104] to [redacted] how [redacted] and this [redacted] can't you [redacted]" The facility provided the surveyor with the full investigation and conclusion and summary related that the incident.	F0600		

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F0600 SS = D	Continued from page 2 A review of the Summary and Conclusion dated [NJ Ex Order], indicated that the facility immediately provided the resident with NJ Ex Order 26.4(b)(1) and the U.S. FOIA (b) (6) was placed on administrative leave and was not permitted to return to work pending the outcome of an internal investigation. During the investigation the facility contacted the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) admitted to making the comments aloud in the hall and then entered the resident's room and told the resident that he/she needed to learn how to [NJ Ex Order 26.4(b)(1)] As a result, the U.S. FOIA (b) (6) was immediately terminated, and the facility proceeded to interview other residents in the area where Resident #104 resided. No other residents had complaints regarding any mistreatment from the U.S. FOIA (b) (6) On 9/03/2025 at 10:54 AM, the surveyor interviewed Resident #104 who stated that he/she felt that the facility did [NJ Ex Order 26.4(b)(1)] and fired the U.S. FOIA (b) (6) that [NJ Ex Order 26.4(b)(1)] him/her. The resident stated that they had been [NJ Ex Order 26.4(b)(1)]" and stated that they [NJ Ex Order 26.4(b)(1)] in the facility. During the interview the resident's U.S. FOIA (b) (6) entered the resident's room for a session with the resident. On 9/04/2025 at 11:02 AM the surveyor interviewed the U.S. FOIA (b) (6)) who stated that when Resident #104 reported that a U.S. FOIA (b) (6) NJ Ex Order 26.4(b)(1) him/her, the U.S. FOIA (b) (6) was immediately terminated. The [U.S. FOIA (b) (6)] stated that the facility reported the incident to the Department of Health and investigated. He confirmed that the [NJ Ex Order] was verified because the U.S. FOIA (b) (6) admitted that she made NJ Ex Order 26.4(b)(1) the resident about learning NJ Ex Order 26.4(b)(1) by not NJ Ex Order 26.4(b)(1) or [NJ Ex Order 26.4(b)(1)]. He stated that the facility provided the resident with [NJ Ex Order 26.4(b)(1)] and the resident was being followed by a U.S. FOIA (b) (6) . The [U.S. FOIA (b) (6)] continued to explain that during the investigative process, the resident was interviewed, and statements were obtained from staff and other residents. He stated that he interviewed other residents that were [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] and who were exposed to the U.S. FOIA (b) (6) He stated that was very important to interview other residents to ensure that it was not happening to them and to know as to what extent this was happening. The [U.S. FOIA (b) (6)] provide the surveyor with typed list of other residents interviewed in the immediate area of Resident #104 and according to the list, no other residents were affected.	F0600		

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F0600 SS = D	Continued from page 3 On 9/04/2025 at 11:18 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that she had reported the event to the New Jersey Department of Health (NJDOH) the same day the resident reported the incident on NJ Ex Order. She stated that she remembered that the U.S. FO conducted interviews with other residents on the unit or exposed to the U.S. FOIA (b) (6) The U.S. FOIA (b) stated that interviews with other residents would be important to ensure that any NJ Ex Order was not happening to others and if it was, as to what extent it was occurring and to provide support and help to others that may have been affected. On 9/04/2025 at 11:31 AM, the surveyor interviewed the PT who stated that he was not sure what date Resident #104 reported that a U.S. FOIA (b) (6) was NJ Ex Order 26.4(b)(1) to him/her but that no other resident reported any occurrence of NJ Ex Order to him that day. He stated that he immediately reported the residents' concerns to the administration. He stated that Resident #104 did not want to attend NJ Ex Order 26 because NJ Ex Order 26.4(b)(1) by U.S. FOIA (b) (6) who made NJ Ex Order 26.4(b)(1) about NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). On 9/04/2025 at 11:42 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who was also the U.S. FOIA (b) (6) for the facility who stated that the NJ Ex Order 26.4(b)(1) was substantiated when the housekeeper admitted that she was NJ Ex Order 26 with the resident. He stated that the facility takes all NJ Ex Order 26.4(b)(1) seriously and the U.S. FOIA (b) (6) was NJ Exec Order 26.4(b) immediately. The U.S. FOIA (stated that the U.S. FO was responsible to interview other residents on the units that the U.S. FOIA (b) (6) was working on to make sure other residents were not affected. He stated that resident interview revealed that no other residents were affected by the U.S. FOIA (b) (6) The U.S. FOIA (provided the surveyor with education that was conducted for all other employees in the facility from NJ Ex Order 26. until NJ Ex Order 26 regarding identification of types of NJ Ex Order and on how to report NJ Ex Order which contained employee signatures. On 9/05/2025 at 10:23 AM, the facility provided the surveyor with additional information and documentation that 6 (six) NJ Ex Or and NJ Ex Order 26. residents were interviewed by the U.S. FO regarding any NJ Ex Order with staff or U.S. FOIA (b) (6) while residing at the facility and each resident denied any NJ Ex Order 26.4(b)(1). The surveyor interviewed the unsampled residents and all stated that they had not experienced any mistreatment by any staff member while in the facility. The surveyor also reviewed the U.S. FOIA (b) (6) file which indicated that the	F0600		

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F0600 SS = D	Continued from page 4 facility conducted a background check prior to hire in NJ Ex Ord and that the U.S. FOIA (b) (6) had training on the facilities abuse policy and procedures while an employee. A review of the facility policy dated 10/24/22 and titled, “Abuse Prohibition” indicated that the center prohibits abuse, mistreatment, neglect, misappropriation of resident/patient property and exploitation for all residents. The policy specified that verbal abuse is any use of oral, written or gestured language that willfully included disparaging and derogatory terms to patients or their families or within hearing distance, regardless of their age, ability to comprehend, or disability. NJAC 8:39-4.1(a)(5)	F0600		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days	F0640	A NJ Ex Orde MDS was completed and transmitted on NJ Ex Order 26.4(d All residents have the potential to be affected by the deficient practice. Inservice education was provided to facility MDS coordinators by the regional MDS lead. The education included review of the RAI manual section regarding setting ARDs for resident end of stay/ deaths. The facility MDS coordinator or designee will complete audits on all residents discharged from ceasing to breathe at the facility to ensure a MDS is completed within the 7 day period and transmitted within 14 days. The audits will be completed weekly by 4 followed by monthly x2. The results of the audits will be reviewed monthly at QAPI with corrections needed or taken during the course of the audits.	10/21/2025

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F0640 SS = D	Continued from page 5 after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set death in facility tracking record in accordance with federal guidelines. This deficient practice was identified for 1 of 1 resident reviewed for resident assessment (Resident #17). This deficient practice was evidenced by: On 09/04/2025, at 9:47 AM the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The surveyor reviewed Resident #17's electronic medical record. The record revealed that the resident NJ Ex Order 2 on NJ Ex Order 26.4(b)(1) The electronic health record reflected that there was NJ Ex Order 26.4 in facility tracking record completed for the resident's NJ Ex Orde date of NJ Ex Order 26.4(b)(1) On 09/04/2025 at 12:30 PM, the surveyor interviewed the	F0640		

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F0640 SS = D	Continued from page 6 U.S. FOIA (b) (6). The U.S. FOIA (b) (6) confirmed that the NJ Ex Orde in facility tracking record was not completed or transmitted for Resident #17. She stated it should have been completed and transmitted by NJ Ex Order 26:4(b)(1). A MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. NJAC 8:39-11.2	F0640		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: This deficient practice was evidenced by the following: On 09/03/2025, from 08:47 AM to 09:39 AM, during the kitchen tour, the surveyor, accompanied by the U.S. FOIA (b) [redacted], observed three gallons of unopened whole	F0812	The 3 gallons of milk found in the refrigerator were immediately discarded. All residents have the potential to be affected by the deficient practice. All dietary staff were educated by the regional dietary manager on ensuring that all food products on hand in the kitchen are within the recommended sell by date. The contents of the kitchen refrigerator will be audited weekly x4 followed by monthly x2, by the dietary director or designee to ensure that all food products are within the recommended sell by date. The findings of these audits will be reviewed monthly at the facility QAPI meeting with corrections needed or taken during the course of the audits .	10/21/2025

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F0812 SS = F	Continued from page 7 milk in the walk-in refrigerator. The manufacturer's expiration date on the milk was 08/27/2025. On 09/03/2025 at 8:47 AM, during an interview with the surveyor, the U.S. FOIA (b) (6)) stated that the expired milk would be discarded, and that expired milk could cause illness. A review of the undated facility policy titled, "Use By Dating Guidelines", revealed that "."The manufactures' expiration date, when available, is the "use by" for unopened items". N.J.A.C 8:39-17.2 (g)	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	NPE/RN #1, LPN #1 and RN/UM were given on the spot education on the need to don protective eye wear when entering the room of residents on NJ Ex Order 26.4(b)(1). LPN #2 was given on the spot education on the need to don a protective gown when providing NJ Ex Order 26.4(b)(1) including NJ Ex Order 26.4(b)(1). HSK #1 was given on the spot education on preventing clean linens from touching the floor, despite being in a bag. Alcohol based hand wipes were placed in the main dining room for distribution to residents to provide hand hygiene prior to consuming meals. All residents have the potential to be affected by the deficient practices. Inservice education was provided to all staff by the Infection Preventionist (IP) on Isolation precautions and proper PPE including droplet and enhanced barrier precautions. All housekeeping staff was educated on preventing bags of clean linens from touching the ground. All staff was educated on the need to use alcohol based hand cleaning agents for residents when sanitizing hands before meals Random audits of 5 staff will be performed by the IP or designee of staff donning PPE prior to entering rooms of residents on isolation precautions, enhanced barrier and droplet when applicable. 5 Random audits of housekeeping carts will be conducted to ensure that no attached clean linen bags are dragging on the floor. The main dining room will be audited to ensure that the	10/21/2025

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F0880 SS = E	Continued from page 8 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of medical records, and other pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices during a NJ Ex Order 26.4(b)(1), specifically the a.) use of Personal Protective Equipment (PPE) for 2 unsampled residents (Resident #46 and Resident #105) and 1 resident	F0880	Continued from page 8 hand wipes provided to the residents contain alcohol for sanitization. All audits will be performed weekly times 4 followed by monthly times 2. The results of the audits will be presented monthly to the QAPI committee with corrections needed or taken during the course of the audits.	

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F0880 SS = E	Continued from page 9 (Resident #3) reviewed for NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1), b.) handling of clean linen during transport in the nursing unit on NJ Ex Order 26.4(b)(1), and c.) hand hygiene for residents in the dining room, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was evidenced by the following: Reference: “As SARS-CoV-2 transmission in the community increases, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during patient care encounters as described… Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters.” https://www.cdc.gov/covid/hcp/infection-control/index.html Reference: “Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).” https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html Reference: “When patients and visitors should clean their hands: Before preparing or eating food…How to clean hands: With an alcohol-based hand sanitizer…With soap and water… https://www.cdc.gov/clean-hands/about/hand-hygiene-for-healthcare.html A.1.) On 9/3/2025 at 8:57 AM, Surveyor #1 observed Nurse Practice Educator/ Registered Nurse #1 (NPE/ RN #1) wearing NJ Ex Order 26.4(b) and eyeglasses, sanitize their hands and don yellow disposable gown and gloves outside the room of Resident #105. The eyeglasses did not have covers on the side. The surveyor observed a signage for NJ Ex Order 26.4(b)(1) along the doorway which indicated that staff had to wear gown, gloves, NJ Ex Order 26.4(b), eye protection or face shield. The signage also indicated that staff was required to keep the door closed. The surveyor observed NPE/ RN #1 leave the door open and	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315332	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/08/2025

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F0880 SS = E	Continued from page 10 NJ Ex Orde Resident #105 to the wheelchair. A review of the Resident #105's electronic medical record (EMR) revealed the following: A review of the Admission Record reflected the resident had diagnoses that included but not limited to NJ Ex Order 26.4(b)(, NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b) A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4 revealed that the resident had a Brief Interview for Mental status (BIMS) of N which indicated NJ Ex Order 26.4(b)(1) . The MDS also indicated that the resident required NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(A review of the clinical physician orders active as of NJ Ex Order 26.4(b) revealed an order for NJ Ex Order 26.4(b)(1). A review of Resident #105's most current comprehensive care plan initiated on NJ Ex Order 26.4(b)(reflected a focus for NJ Ex Order 26.4(b)(1) with interventions which included NJ Ex Order 26.4(b)(1). On 9/4/2025 at 10:30 AM, during an interview with the surveyor, the U.S. FOIA (b) (6)) stated that the facility was on NJ Ex Order 26.4(b)(1) which started last NJ Ex Order 26.4(b). The surveyor asked the U.S. what PPE staff is expected to wear inside residents with NJ Ex Order 26.4(b)(1). The U.S. stated that inside the rooms of residents with NJ Ex Order 26.4(b)(1), the staff are expected to observe NJ Ex Order 26.4(b)(1) which meant they must wear NJ Ex Order 26.4(b)(, gown, gloves, and protective eye gear like face shield and goggles. The U.S. also stated that eyeglasses need to have side cover for protection. On 9/5/2025 at 11:37 AM, during an interview with the survey team, the U.S. FOIA (b) (6)) stated that staff should be wearing gown, NJ Ex Order 26.4(b), gloves, and face shield inside the room of a NJ Ex Order 26.4(b)(1) resident. The U.S. FOIA also stated that staff should not be using eyeglasses for eye protection because eyeglasses have open sides and that the sides should be closed. A review of the facility-provided policy revised on 5/1/2025 titled "Transmission Based Precautions" included under droplet Precautions the following: 10.6 Based upon the pathogen or clinical syndrome, if there is a risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn.	F0880		

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F0880 SS = E	Continued from page 11 2.) On 9/3/2025 at 9:00 AM, Surveyor #1 observed Licensed Practical Nurse (LPN) #1 enter the room of Resident #46 wearing yellow gown, gloves, NJ Ex Order 26.4(b) and brown eyeglasses. The eyeglasses did not have covers on the side. The room had a signage along the doorway for NJ Ex Order 26.4(b)(1). The surveyor observed LPN #1 close the door. On 9/3/2025 at 9:03 AM, Surveyor #1 observed LPN #1 leave Resident #46's room wearing the brown eyeglasses. LPN #1 continued to wear the brown eyeglasses while doing medication administration in the nursing unit. On 9/3/2025 at 12:35 PM, Surveyor #1 observed U.S. FOIA (b) (6)) enter Resident #46's room wearing N95 mask, yellow gown, and gloves. U.S. FOIA (b) (6) was not wearing eye protection. A review of the Resident #46's electronic medical record (EMR) revealed the following: A review of the Admission Record reflected the resident had diagnoses that included but not limited to NJ Ex Order 26.4(b), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) . A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b) revealed that the resident was on NJ Ex Order 26.4(b)(1) for an NJ Ex Order 26.4(b)(1) under section NJ E A review of the clinical physician orders active as of NJ Ex Order 26.4(b) revealed an order for NJ Ex Order 26.4(b)(1). A review of Resident #46's most current comprehensive care plan revised on NJ Ex Order 26.4 reflected a focus for NJ Ex Order 26.4(b)(1) . On 9/4/2025 at 10:30 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) stated that the facility was on NJ Ex Order 26.4(b)(1) which started last NJ Ex Order 26.4(b)(The surveyor asked the U.S. what PPE staff is expected to wear inside residents with NJ Ex Order 26.4(b)(1). The U.S. stated that inside the rooms of residents with NJ Ex Order 26.4(b)(1), the staff are expected to observe NJ Ex Order 26.4(b)(1) which meant they must wea NJ Ex Order 26.4(b)(, gown, gloves, and protective eye gear like face shield and goggles. The U.S. also stated that eyeglasses need to have side cover for	F0880		

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F0880 SS = E	Continued from page 12 protection. On 9/5/2025 at 11:37 AM, during an interview with the survey team, the U.S. FOIA (b) (6)) stated that staff should be wearing gown, N95 mask, gloves, and face shield inside the room of a NJ Ex Order 26.4(b)(1) resident. The U.S. FOIA also stated that staff should not be using eyeglasses for eye protection because eyeglasses have open sides and that the sides should be closed. A review of the facility-provided policy revised on 5/1/2025 titled “Transmission Based Precautions” included under droplet Precautions the following: 10.6 Based upon the pathogen or clinical syndrome, if there is a risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn. 3.) On 9/3/2025 at 12:24 PM, Surveyor #1 observed Licensed Practical Nurse (LPN) #2 administer NJ Ex Ord and a NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) of NJ Ex Order 26.4(b)(1) to Resident #3 who was sitting in a wheelchair. LPN #2 was wearing NJ Ex Order 26.4(b) and gloves. LPN #2 was not wearing protective gown. On the doorway of the resident’s room, there was a signage for NJ Ex Order 26.4(b)) NJ Ex Order 26.4(b)(1)). The signage indicated staff to wear gown and gloves when providing NJ Exec Order 26.4b1 care for residents. The examples given in the signage for NJ Exec Order 26.4b1 care included NJ Ex Order care or use like NJ Ex Order 26.4(b)(1). A review of the Resident #3’s electronic medical record (EMR) revealed the following: A review of the Admission Record reflected the resident had diagnoses that included but not limited to NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.). A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4 revealed that the resident was NJ Ex Order 26.4(b)(1). A review of the clinical physician orders active as of NJ Ex Order 26.4(b) revealed an order for NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1).	F0880		

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F0880 SS = E	Continued from page 13 A review of Resident #3's most current comprehensive care plan revised on [redacted] reflected a focus for [redacted] with interventions which included [redacted]. On 9/4/2025 at 10:30 AM, during an interview with the surveyor, the [redacted] stated that the facility was on [redacted] which started last [redacted]. The surveyor asked the [redacted] what PPE staff should be wearing for residents on [redacted] The [redacted] that staff should be wearing gown and gloves during high-contact activities such as [redacted] On 9/5/2025 at 11:37 AM, during an interview with the survey team, the [redacted]) stated that staff should be wearing gown and gloves for residents on [redacted] during high-contact activities that included [redacted] A review of the facility-provided policy revised on 12/16/2024 titled "Enhanced Barrier Precautions" indicated under Process 4. Use EBP when patient status included wound or indwelling medical device without secretions or excretions that are unable to be covered or contained and not known to be infected or colonized with any MDRO (multi-drug-resistant organisms). B.) On 9/3/2025 at 11:51 AM, Surveyor #1 observed a yellow housekeeping cart outside a resident's room with a big plastic bag tied on the handle. The plastic bag contained clean-looking multi-colored washcloths touching the floor in the hallway. The surveyor also observed Housekeeper (HSK) #1 mop the floor of the resident's room nearest the cart. The surveyor asked HSK #1 to identify the content of the plastic bag which they identified as clean rugs. HSK#1 was observed wheeling the cart in the hallway dragging the plastic bag along with it. On 9/4/2025 at 10:30 AM, during an interview with the surveyor, the [redacted] stated that clean linen should not touch the floor. On 9/5/2025 at 11:37 AM, during an interview with the survey team, the [redacted] stated that clean rugs in plastic bag should not touch the floor for infection control. A review of facility-provided policy revised on 5/1/2024, titled "Linen Handling" included under Policy: All linen will be handled, stored, transported, and processed to contain and minimize exposure to waste	F0880		

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F0880 SS = E	Continued from page 14 products. Under Definitions: “Linen” includes sheets, blankets…. washcloths, and similar items from departments such as …environmental services. C.) On 09/03/2025 at 11:40 AM, Surveyor #2 observed dining for lunch in the 1st floor dining room. The U.S. provided the residents in the dining room with moist towelettes for hand hygiene. The moist towelettes were alcohol free. During an interview with Surveyor #2 on 09/03/2025 at 11:55 AM, the U.S. stated that residents receive towelettes for hand hygiene prior to meals. She added that she was not sure whether the towelettes contain alcohol and that they should suffice and are good enough. During an interview with Surveyor #1 on 09/05/2025 at 11:37 AM, the U.S. FOIA E stated that staff should ensure residents use alcohol-based hand sanitizer before meals to help prevent the spread of germs. He clarified that the wipes are intended for cleaning residents’ hands and faces after consuming messy foods, such as ribs, to remove visible sauce or residue. A review of a facility policy dated 05/01/2025 titled, “Hand Hygiene”, revealed that, "Per the Centers for Disease Control and Prevention (CDC), when hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for hand hygiene.” N.J.A.C. § 8:39-19.4(a)(1)(m)(n) N.J.A.C. 8:39-21.1(d)	F0880		

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S0000	Initial Comments The facility is 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.	S0000		10/21/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint # 426049 Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 21 out of 21 day shifts and 3 out of 21 night shifts reviewed. Findings Include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and	S0560	1. All residents present in the facility were affected by the deficient practice on the dates and shifts noted. 2. All residents have the potential to be affected by this deficient practice. 3. The Administrator, Director of Nursing and Staffing Coordinator were re-educated on the NJ minimum staffing mandate by the Regional Clinical Lead. The facility will continue to provide CNA classes at the facility and convert temporary CNAs into permanent CNAs. Agency staff is currently being utilized to help maintain staff to resident ratio. The facility continues to recruit efforts using various forms of media to increase the number of applicants. Agency requisition will be posted to bring in outside CNA. The facility will continue to have weekly staffing meetings and weekly follow up calls with corporate regional support teams. The Human Resources Manager or designee will manage a list of on-going recruiting efforts and document the result of these attempts. The Staffing Coordinator or designee will audit daily staffing sheets to determine if the facility is meeting the minimum staff to resident ratio. 4. The Staffing Coordinator or Designee will report findings to the monthly Quality Assurance meetings for three months then quarterly for 1 year. The Quality	10/21/2025

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

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S0560	Continued from page 1 pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One Certified Nursing Assistant (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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. As per the "Nursing Staffing Report" completed by the facility as documented below: 1. For the week of Complaint staffing from 06/22/2025 to 06/28/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -06/22/25 had 10 CNAs for 123 residents on the day shift, required at least 15 CNAs. -06/23/25 had 10 CNAs for 122 residents on the day shift, required at least 15 CNAs. -06/24/25 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs. -06/25/25 had 9 CNAs for 122 residents on the day shift, required at least 15 CNAs. -06/26/25 had 13 CNAs for 122 residents on the day shift, required at least 15 CNAs. -06/27/25 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -06/28/25 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. 2. For the 2 weeks of staffing prior to survey from 08/17/2025 to 08/30/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and was deficient in total staff for residents on 3 of 14 night shifts as follows: -08/17/25 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs.	S0560	Continued from page 1 Assurance Meeting will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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S0560	Continued from page 2 -08/18/25 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs. -08/19/25 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/20/25 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/21/25 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/22/25 had 15 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/23/25 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -08/23/25 had 8 total staff for 125 residents on the night shift, required at least 9 total staff. -08/24/25 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -08/25/25 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -08/25/25 had 8 total staff for 125 residents on the night shift, required at least 9 total staff. -08/26/25 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -08/26/25 had 7 total staff for 125 residents on the night staff, required at least 9 total staff. -08/27/25 had 10 CNAs for 125 residents on the day shift, required at least 16 CNAs. -08/28/25 had 10 CNAs for 125 residents on the day shift, required at least 16 CNAs. -08/29/25 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -08/30/25 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. On 9/8/2025 at 9:40 AM, during an interview with the surveyor, the Director of Nursing (DON), confirmed that they were familiar with the minimum staffing requirements for CNAs. The DON stated that the requirements were 1 CNA to 8 residents on the day shift	S0560		

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S0560	Continued from page 3 (7:00 AM until 3:00 PM); 1 CNA to 10 residents on the evening shift (3:00 PM until 11:00 PM); and 1 CNA to 14 residents on the night shift (11:00 PM until 7:00 AM). When asked if the facility was meeting the requirements, the DON responded no. The DON stated that managers come in when they are short of staff, and they also used CNAs from agencies. On 9/8/2025 at 9:47 AM, during an interview with the surveyor, the Staffing Coordinator (SC) confirmed that they were familiar with the minimum staffing requirements for CNAs. The SC stated that the requirements were 1 CNA to 8 residents on the day shift (7:00 AM until 3:00 PM); 1 CNA to 10 residents on the evening shift (3:00 PM until 11:00 PM); and 1 CNA to 14 residents on the night shift (11:00 PM until 7:00 AM). When asked if the facility was meeting the requirements, the SC responded no. The SC stated that managers come in when they are short of staff, they switch days off, and the facility conducted classes and trainings for Nursing Assistants to be certified. A review of the facility-provided policy revised on 8/7/2023 titled “Staffing/ Center Plan” did not include the minimum requirement for direct care staff.	S0560		
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day	S1680	1. All residents present in the facility were affected by the deficient practice on the dates and shifts noted. 2.All residents have the potential to be affected by this deficient practice. 3. The Administrator, Director of Nursing and Staffing Coordinator were re-educated on the NJ minimum staffing mandate by the Regional Clinical Lead. The facility staffing matrix was reviewed, and the staffing coordinator implemented a daily staffing review system using HPPD (Hours Per Patient Day). CNA classes will continue to be provided at the facility and convert temporary CNAs into permanent CNAs. There is an ongoing recruitment campaign including job fairs, sign-on bonuses, and referral incentives. The scheduling coordinator will finalize schedules 2 weeks in advance to allow planning for coverage. All call-outs are now required to be reported to the DON or ADON for immediate shift planning. All nursing supervisors and schedulers were trained on the importance of maintaining sufficient staffing to meet regulatory compliance and resident care needs.	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN OCEAN CENTER	1361 ROUTE 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
S1680	Continued from page 4 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 the review of the Nurse Staffing Reports for the weeks of 8/17/2025 to 8/30/2025, it was determined that the facility failed to provide the least minimum staffing levels for 14 of 14 days. The required staffing hours and actual staffing hours are as follows: For the 2 weeks of AAS-12 staffing from 8/17/2025 to 8/30/2025, the facility was deficient in staffing for resident required services on 14 of 14 days as follows: 1.) For the week of 8/17/2025 - Required Staffing Hours: 442 -08/17/25 had 392 actual staffing hours, for a difference of -50.0 hours. -08/18/25 had 336 actual staffing hours, for a difference of -106.0 hours. -08/19/25 had 328 actual staffing hours, for a difference of -114.0 hours. -08/20/25 had 392 actual staffing hours, for a difference of -50.0 hours. -08/21/25 had 368 actual staffing hours, for a difference of -74.0 hours. -08/22/25 had 400 actual staffing hours, for a difference of -42.0 hours. -08/23/25 had 384 actual staffing hours, for a difference of -58.0 hours.	S1680	Continued from page 4 4. The Staffing Coordinator or Designee will report findings to the monthly Quality Assurance meetings for three months then quarterly for 1 year. The Quality Assurance Meeting will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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S1680	Continued from page 5 2.) For the week of 08/24/25 - Required Staffing Hours: 408.75 -08/24/25 had 408 actual staffing hours, for a difference of -0.75 hours. -08/25/25 had 352 actual staffing hours, for a difference of -56.75 hours. -08/26/25 had 368 actual staffing hours, for a difference of -40.75 hours. -08/27/25 had 368 actual staffing hours, for a difference of -40.75 hours. -08/28/25 had 376 actual staffing hours, for a difference of -32.75 hours. -08/29/25 had 392 actual staffing hours, for a difference of -16.75 hours. -08/30/25 had 352 actual staffing hours, for a difference of -56.75 hours. On 9/8/2025 at 9:40 AM, during an interview with the surveyor, the Director of Nursing (DON), who was aware of the minimum staffing ratio requirements, stated that the facility did not meet the staffing requirements for nursing. The DON also stated that managers come in to meet those needs and that the facility used staff from agencies. A review of the facility-provided policy revised on 8/7/2023, titled “Staffing/ Center Plan” included under Process: 4.) The Center maintains appropriate staffing levels, with qualified personnel, 24 hours/day, seven days/week on each shift to assure that patients are safe, and their needs are met. Inquiries concerning nursing staffing should be referred to the Director of Nursing…	S1680		

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/13/2025 in relation to the 9/8/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		10/21/2025

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

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/13/2025 in relation to the 9/8/2025 State of New Jersey Re-Licensure 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		10/21/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/08/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/4/25 and 9/5/25. Southern Ocean Center was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.	K0000		10/21/2025
K0222 SS = F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the	K0222	The thumb latches and key tumblers were removed on the sets of inner double doors within the lobby area. New signage reading PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPEN IN 15 SECONDS was installed on the end of the corridor on the Post acute care unit by room 142 and on the corridor exterior exit door on the Lighthouse unit. The Maintenance Department has performed an inspection of all remaining exit doors on 9/30/2025 and indicated that no other doors are out of compliance with 7.2.1.6.1. The Maintenance Department has also performed an inspection of all door signage on 9/30/2025 and indicated that no other signage is out of compliance with NFPA 101:2012 Edition, Section 19.2 and 19.2.2.2.1, 7.2.1.5.3 and 7.2.1.6.1(4) Maintenance Department personnel were educated on NFPA 101: Utilities - Egress Doors on 9/30/2025. Monthly rounding inspections and audits of egress doors and signage per NFPA 101 requirements will be performed by the Maintenance Director or designee facility wide times 3 months, and then annually, and as needed with vendor repairs and maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits .	10/21/2025

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

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K0222 SS = F	Continued from page 1 locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 9/4/25 in the presence of the U.S. FOIA (b) (6)), it was determined the facility failed to ensure: 1. Doors within a required means of egress were equipped with a latch or lock that required the use of a key, a tool, or special knowledge or effort for operation from the egress side for 2 of 9 exterior exits and 2. Delayed egress locking systems were provided with a readily visible, durable sign with contrasting background located on the door leaf that read: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPEN IN 15 SECONDS for 3 of 9 exterior exits in accordance with NFPA 101: 2012 Edition, Section 19.2 and 19.2.2.2.1, 7.2.1.5.3, and 7.2.1.6.1.1(4). This deficient practice had the potential to affect all residents and was evidenced by the following: 1. Observations during a facility tour between 9:30 AM	K0222		

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K0222 SS = F	Continued from page 2 and 12:51 PM revealed the following: The exterior exit from the lobby into the open courtyard had 2 sets of double sliding doors. The inner set of doors was equipped with a thumb latch lock in the path of egress. The designated exit door had the required signage instructing, IN EMERGENCY PUSH TO OPEN. The lock would prevent egress.The main entrance / exterior exit from the lobby to the front parking lot had 2 sets of double sliding doors. The inner set of doors was equipped with a thumb latch lock in the path of egress. The designated exit door had the required signage instructing, IN EMERGENCY PUSH TO OPEN. The lock would prevent egress. In interviews at the times the U.S. F confirmed the observations. 2. Observations during a facility tour between 9:30 AM and 12:51 PM revealed the following exits had glass doors equipped with delayed egress locking systems: The Post Acute Care Unit (PACU) end of corridor exterior exit by room 142. The Light House Unit end of corridor exterior exit.The rear service area exterior exit by employee bathrooms. The required signs reading, PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPEN IN 15 SECONDS, had red letters on a transparent sticker. The letters were faded making the instructional signs difficult to read. In interviews at the times, the U.S. F confirmed the observations. The facility's U.S. FOIA (b) (6) and the U.S. F were informed of the deficient practice at the Life Safety Code exit conference on 9/5/25 at 2:45 PM. N.J.A.C. 8:39 - 31.2 (e)	K0222		
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K0324	The Kitchen wet chemical fire suppression system inspection was performed monthly June through September 2025 and is in accordance with NFPA 17a:2009 Edition, Section 7.2, 7.2.1 through 7.2.6. Kitchen Suppression system inspection tag was moved from the Pull Station to the Suppression tank location on 9/29/25. The facility has determined that all residents have the	10/21/2025

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K0324 SS = F	Continued from page 3 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observations, interview and record review on 9/4/25 and 9/5/25 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to ensure the kitchen wet chemical fire suppression system monthly owner's inspection was performed for 8 of the last 12 months in accordance with NFPA 17A: 2009 Edition, Section 7.2, 7.2.1 through 7.2.6. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 9/4/25 at 12:15 PM of the kitchen, revealed there was a wet chemical fire suppression system with a 3-gallon tank and 6 nozzles protecting the cooking line. There was no semi-annual inspection tag on the tank. There was an inspection tag on the manual pull station dated 6/18/25 with the back of the tag blank. A record review on 9/5/25 of the facility's Work History Report document, revealed the owner's inspection was not performed for the months of May, April. March, February, and January 2025 and December, November, and October 2024. No further documentation was provided. In an interview at the time, the U.S. F[redacted] confirmed the record review.	K0324	Continued from page 3 potential to be affected. Maintenance Department personnel were educated on NFPA 17a:2009 Edition, Section 7.2.1 through 7.2.6. on Sept 29, 2025. Monthly rounding inspections and audits of the suppression system per NFPA 17a:2009 Edition, Section 7.2.1 through 7.2.6. Audits will be performed by the Maintenance Director or designee times 3 months, and then annually, and as needed with vendor repairs and maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits.	

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K0324 SS = F	Continued from page 4 The facility's U.S. FOIA (b) (6) and the U.S. F were informed of the deficient practice at the Life Safety Code exit conference on 9/5/25 at 2:45 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 17A, 96	K0324		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 9/5/25 in the presence of the U.S. FOIA (b) (6)), it was determined the facility failed to ensure the fire alarm system had semi-annual tests and inspections and bi-annual smoke detector sensitivity testing in accordance with NFPA 101: 2012 Edition, Section 19.3.4.1, 9.6.1.3 and NFPA 72: 2010 Edition, Section 14.3.1, 14.3.4, 14.4.2.2, 14.4.5, 14.4.5.3, 14.4.5.3.1 to 14.4.5.3.7 and 14.6.2. This deficient practice had the potential to affect all residents and was evidenced by the following: Record review of the fire alarm system inspection reports revealed there were 2 reports provided, one dated 6/3/25 and the other 6/17/24. The annual reports did not include sealed lead acid battery inspections and tests and there was no semi-annual battery tests and inspections. There was no smoke detector sensitivity report provided for the 190 smoke detectors. There was no semi-annual visual inspection of system components to ensure there was no change that affected equipment performance. In an interview at the time, the U.S. F confirmed the	K0345	The fire alarm system inspection sensitivity was performed on 6/17/24 and is in accordance with NFPA 101. Our vendor is looking for alarm battery testing and semi annual visual inspection of system components and will make arrangements for inspection if one cannot be found. The facility has determined that all residents have the potential to be affected. Maintenance Department personnel were educated on NFPA 101 Fire alarm testing and maintenance on 9/29/25. Fire alarm systems and maintenance audits will be performed by the Maintenance Director or designee facility wide times 3 months, and then annually, and as needed with vendor repairs and maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits.	10/21/2025

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K0345 SS = F	Continued from page 5 record review and stated that the batteries were sealed lead acid. The facility's U.S. FOIA (b) (6) and the [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 9/5/25 at 2:45 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 72	K0345		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record review on 9/4/25 and 9/5/25 in the presence of the U.S. FOIA (b) (6) [redacted] it was determined the facility failed to ensure the fire sprinkler system was maintained in accordance with NFPA 101: 2012 Edition, Section 19.3.5, 9.7 and NFPA 25: 2011 Edition, Section 3.7.1.4, 5.4.1.6, 5.4.1.6.1, 5.2, 5.2.1.1.1, 5.2.1.1.2(2)(5). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 9/4/25 at 10:52 AM of the dry valve	K0353	The special sprinkler wrench was added to the dry valve sprinkler room. The overhead sprinkler that was coming down 1 inch from the ceiling was repaired and relocated to be flush with the ceiling on 9/30/25. The sprinklers in the walk-in refrigerator and by the dishwasher were cleared of corrosion on 9/20/25. The missing 10/9/24 quarterly sprinkler inspection was obtained. The facility has determined that all residents have the potential to be affected. Maintenance Department personnel were educated on NFPA 101 Sprinkler System Maintenance and Testing on 9/29/25. Monthly rounding inspections and audits of Sprinkler systems in accordance with NFPA 101 Sprinkler Systems maintenance and testing. Audits will be performed by the Maintenance Director or designee facility wide times 3 months, and then annually, and as needed with vendor repairs and maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits.	10/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN OCEAN CENTER	1361 ROUTE 72 WEST , MANAHAWKIN, New Jersey, 08050

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K0353 SS = F	Continued from page 6 sprinkler room, revealed a special wrench was not provided. A special wrench is required for each type of sprinkler. Observations on 9/4/25 at 12:02 PM of the kitchen revealed the sprinkler head over the serving line was coming down approximately 1-inch from the ceiling and the sprinklers in the walk-in refrigerator, by the dishwasher and by the exit had corrosion. In interviews at the times, the U.S. F confirmed the observations. A record review on 9/5/25 at 11:37 revealed a quarterly sprinkler inspection was missing, leaving 5 months between quarterly inspections. A quarterly inspection was performed on 7/8/24 and the next quarterly inspection was performed on 1/15/25. There should have been a quarterly in October 2024. No further documentation was provided. In an interview at the time, the U.S. F confirmed the record review. The facility's U.S. FOIA (b) (6) and the U.S. F were informed of the deficient practice at the Life Safety Code exit conference on 9/5/25 at 2:45 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 25	K0353		
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS	K0363	Resident room doors 140, 102 and 236 were all corrected to be in compliance with NDPA 101:2012 Edition, section 19.3.6.3 on 10/1/25. The facility has determined that these residents have the potential to be affected. Maintenance Department personnel were educated on NDPA 101:2012 Edition, section 19.3.6.3 on 9/29/25. Monthly rounding inspections and audits of Doors in accordance with NDPA 101:2012 Edition, section 19.3.6.3. Audits will be performed by the Maintenance Director or designee facility wide times 3 months, and then annually, and as needed with vendor repairs and	10/21/2025

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K0363 SS = D	Continued from page 7 regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 9/4/25 in the presence of the U.S. FOIA (b) (6)), it was determined the facility failed to ensure corridor doors resist the passage of smoke for 3 of 32 doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect 6 residents and was evidenced by the following: Observations during a facility tour between 9:30 AM and 12:51 PM revealed the following: 1. Resident room 140 had approximately 5/8-inch space between the door face and the doorstop. 2. Resident room 102 had approximately 3/4-inch space between the door face and the door stop and a 1/2-inch space between the top of the door and the top door frame. 3. Resident room 236 had approximately 1/2-inch space between the door face and the doorstop. In interviews at the times, the U.S. F confirmed the observations.	K0363	Continued from page 7 maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits.	

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K0363 SS = D	Continued from page 8 The facility's U.S. FOIA (b) (6) and the U.S. F were informed of the deficient practice at the Life Safety Code exit conference on 9/5/25 at 2:45 PM. N.J.A.C. 8:39 - 31.2 (e)	K0363		
K0741 SS = F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 9/4/25 in the presence of the U.S. FOIA (b) (6)), it was determined the facility failed to ensure ashtrays of non-combustible material and safe design were provided in all areas where smoking is permitted in accordance with NFPA 101: 2012 Edition, Section 19.7.4 (5). This	K0741	Smoking ashtrays made from non-combustible material and safe design were provided in all areas where smoking is permitted in accordance with NFPA 101: 2012 Edition, Section 19.7.4 (5) The facility has determined that all residents have the potential to be affected. Maintenance Department personnel were educated on NFPA 101: 2012 Edition, Section 19.7.4 (5) 9/29/25. Monthly rounding inspections and audits of smoking areas in accordance with NFPA 101: 2012 Edition, Section 19.7.4 (5) Audits will be performed by the Maintenance Director or designee facility wide times 3 months, and then annually, and as needed with vendor repairs and maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits.	10/21/2025

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K0741 SS = F	Continued from page 9 deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:34 AM of the courtyard smoking area revealed there were 2 cigarette towers made of plastic that showed signs of melting where butts had been extinguished. There were no ashtrays of non-combustible material and safe design provided for smokers. In an interview at the time, the U.S. F confirmed the observation. The facility's U.S. FOIA (b) (6) and the U.S. F were informed of the deficient practice at the Life Safety Code exit conference on 9/5/25 at 2:45 PM. N.J.A.C. 8:39 - 31.2 (e)	K0741		
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration	K0918	A generator load bank test was performed on 9/9/2025 for the desired load time and requirements. This load bank will be scheduled to be an annual test moving forward. The generator fuel polishing work was completed on 10/3/25. The facility has determined that all residents have the potential to be affected. Maintenance Department personnel were educated on NFPA 101 Electrical Systems- Essential Electric Systems Maintenance and testing. Generator Audits will be performed by the Maintenance Director or designee times 3 months, and then annually, and as needed with vendor repairs and maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits.	10/21/2025

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K0918 SS = F Bldg. 01	Continued from page 10 for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record reviews and interview on 9/5/25 in the presence of the U.S. FOIA (b) (6)), it was determined the facility failed to ensure: 1. diesel generator sets that do not meet the monthly exercise 30% load requirements are exercised annually with supplemental loads of not less than 50% of the nameplate kilowatt (kW) rating for 30 continuous minutes and not less than 75% of the nameplate kW rating for 1 continuous hour for a total of 1.5 hours, and 2. Identified abnormal fuel conditions were addressed in a timely manner, in accordance with NFPA 110: 2010 Edition, Sections 8.4, 8.4.2, 8.4.2.3 and 8.3.8. These deficient practices had the potential to affect all residents and were evidenced by the following: A record review of the diesel generator logs and reports revealed the generator was not exercised at 30% of its nameplate kW rating for 7 of the last 12 months, which would have required a 1.5-hour annual load bank test to be performed. No annual load bank test report meeting the requirements as described in NFPA 110 was provided. The facility ran the generator for 4 hours with various loads up to a maximum of 42% of the nameplate kW rating. A record review of the last annual fuel sample report dated 4/4/25, revealed the analysis indicated abnormal fuel conditions, water and sediment content is high and water content is high. There were no actions taken to address the fuel condition in the last 5 months between the current survey and when the results were identified. In an interview at the time, the U.S. F confirmed the observation. The facility's U.S. FOIA (b) (6) and the U.S. F were informed of the deficient practices at the Life Safety Code exit conference on 9/5/25 at 2:45 PM. N.J.A.C. 8:39 - 31.2 (e)	K0918		

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K0918 SS = F Bldg. 01	Continued from page 11 NFPA 110	K0918		

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E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/4/25 and 9/5/25. Southern Ocean Center was found to be in substantial compliance with CFR 483.73, Requirements for Long Term Care Facilities.	E0000		10/21/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

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K0000	INITIAL COMMENTS An on-site revisit was conducted on 11/21/2025 to verify the facility's Plan of Correction for the 9/8/2025 Recertification survey. The facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		11/24/2025
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: REPEAT DEFICIENCY Based on record review and interview on 11/21/25 in the presence of the U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted]), it was determined the facility failed to ensure the fire alarm system had semi-annual tests and inspections in accordance with NFPA 101: 2012 Edition, Section 19.3.4.1, 9.6.1.3 and NFPA 72: 2010 Edition, Section 14.3.1, 14.3.4, 14.4.2.2, 14.4.5, 14.4.5.3, 14.4.5.3.1 to 14.4.5.3.7 and 14.6.2. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the fire alarm system inspection reports revealed there were 2 reports provided, one dated 6/3/25 and the other 6/17/25. The annual reports did not include sealed lead acid battery inspections	K0345	Fire panel alarm battery testing and semi annual visual inspection was performed on 11.21.2025 and is in accordance with NFPA 101. The facility has determined that all residents have the potential to be affected. Maintenance Department personnel were re-educated by the senior director of maintenance on NFPA 101 Fire alarm testing and maintenance on 11.21.2025. Fire alarm systems and maintenance audits will be performed by the Maintenance Director or designee facility wide times 3 months, and then annually, and as needed with vendor repairs and maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits.	11/24/2025

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

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

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K0345 SS = F	Continued from page 1 and tests and there were no semi-annual battery tests and inspections. There was no semi-annual visual inspection of system components to ensure there was no change that affected equipment performance. In an interview at the time, the U.S. FOIA (b) (6) confirmed the record review and stated that the batteries were sealed lead acid, and the last inspections were not conducted on a semi-annual basis as required by NFPA 72. A review of the facility's Plan of Correction (POC) for the 09/04/2025 recertification survey revealed the POC stated in part: " The fire alarm system inspection sensitivity was performed on 6/17/24 and is in accordance with NFPA 101. Our vendor is looking for alarm battery testing and semi-annual visual inspection of system components and will make arrangements for inspection if one cannot be found." The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code revisit exit conference on 11/21/25 at 1:30 PM. N.J.A.C. 8:39 - 31.2 (e) NFPA 72	K0345		
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with	K0363	Resident room door 102 was corrected to be in compliance with NFPA 101:2012 Edition, section 19.3.6.3 on 11.24.2025 The facility has determined that these residents have the potential to be affected. Maintenance Department personnel were re-educated by the senior director of maintenance on NFPA 101:2012 Edition, section 19.3.6.3 on 11.21.2025. Monthly rounding inspections and audits of Doors in accordance with NFPA 101:2012 Edition, section 19.3.6.3 . Audits will be performed by the Maintenance Director or designee facility wide times 3 months, and then annually, and as needed with vendor repairs and maintenance. To ensure compliance, maintenance supervisor or designee will report the process of work performed and	11/24/2025

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K0363 SS = D Bldg. 01	Continued from page 2 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: REPEAT DEFICIENCY Based on observations, documentation review and interview on 11/21/25 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined the facility failed to ensure corridor doors resist the passage of smoke for 1 of 16 sets of doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect 6 residents and was evidenced by the following: An observation at 10:32 AM with the U.S. FOIA (b) revealed the door to resident room 102, when in the closed position, had an approximately 3/4-inch space between the door face and the door stop and a 1/2-inch space between the top of the door and the top of the frame. In an interview the AMSM confirmed the observations. A review of the facility's Plan of Correction (POC) for the 09/04/2025 Recertification survey revealed the POC stated in part: " Resident room doors 140, 102 and 236 were all corrected to be in compliance with NFPA 101:2012 Edition, section 19.3.6.3 on 10/1/25." The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 11/21/25 at 1:45 PM.	K0363	Continued from page 2 audits at our next monthly QAPI meeting times 3 months with corrections needed or taken during the course of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0363 SS = D Bldg. 01	Continued from page 3 N.J.A.C. 8:39 - 31.2 (e)	K0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/6/2025 in relation to the 11/21/2025 onsite revisit for the 9/8/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		11/24/2025

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

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