STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey 12/09/2024 Census: 109 Sample Size: 28 + 3 closed records C/O # NJ 168072, 168575, 170472, 172859, 175753, 176553, 178172, 179491 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		1/10/25

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

Electronically Signed | 12/27/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other documentation, it was determined that the facility failed to ensure a resident was transported from one area of the unit to another in a dignified manner for 1 of 28 sampled residents, (Resident #84). This deficient practice was evidenced by the following: On 12/04/2024 at 11:37 AM, the surveyor observed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) to pull a resident (Resident #84) backward in his/her wheelchair (w/c) from the nurse's station to the dining/recreation room. Resident #84's [redacted] on which he/she was NJ Exec Order 26.4b1, were NJ Exec Order 26.4b1. There were NJ Exec Order 26.4b1 observed on the w/c for the resident to put his/her NJ Exec O[redacted] on. The surveyor reviewed the EMR on 12/04/2024 11:54 AM, as follows:	F 550	The U. S. FOIA (b) (2) involved in the event with Resident #84 was educated on NJ Exec Orde[redacted]. Education was performed by U. S. FOIA (b) (2) [redacted] All residents have the potential to be affected by this deficient practice. U. S. FOIA (b) (2) have been educated by the U. S. FOIA (b) (2) or designee on proper procedures to move residents in wheelchairs who require assistance by 12/31/24. All residents will be evaluated for the need for footrests by 12/24/24. Therapy screens to be sent for those determined to benefit from footrests. Unit Managers will audit residents in wheelchairs for footrests (if needed) daily Monday through Friday for 1 week then every Monday,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 According to the Admission Record Resident #84 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1. A review of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care dated NJ Exec Order 26.4b1, revealed a Brief Interview for Mental Status score of NJ Exec Order indicating Resident #84 has NJ Exec Order 26.4b1. The MDS further indicated that resident uses a w/c but not attempted for resident to wheel (self) due to medical condition or safety concern. During an interview with the surveyor on 12/04/2024 at 11:39 AM, the surveyor asked LPN/UM #1 if it was appropriate to pull a resident backwards in the w/c. LPN/UM #1 replied he/she (resident) put his/her NJ Exec Order 26.4b1 and resident is NJ Exec Order 26.4b1. Again, the surveyor questioned was it appropriate to pull a resident backwards in the w/c. LPN/UM #1 replied "I would have to say probably not." A review of a facility policy titled Safe Resident Handling/Mobility/Transfers with implemented date of 11292023 did not include documentation of how to transport a resident from one area of the facility to another. During an interview with the surveyor on 12/06/2024 at 01:56 PM, the U.S. FOIA (b)(6) was asked how a resident should be transported in a w/c. The U. S. FOIA (b replied they should be pushed moving forward. If (resident) unable to NJ Exec Order 26 for any reason we would have to get NJ Exec Order 26.4b for the resident. NJAC 8:39-4.1(a)(12)	F 550	Wednesday and Friday for one week then weekly for 4 weeks. These audits will be submitted to the Director of Nursing upon completion starting 12/26/24. The Director of Nursing will submit a monthly report to the facility□s monthly QAPI Committee Meeting for 4 months. Date of completion, January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 4 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents reviewed for SNF (Skilled Nursing Facility) NJ Exec Order 26.4b1 [redacted] (Resident #9 and #22). This deficient practice was evidenced by the following: On 12/04/2024 at 09:35 AM, the surveyor presented the facility certified social worker (CSW) with three (3) SNF [redacted] one (1) resident discharged to home and two (2) residents that remained in the facility with Medicare A time remaining. The CSW explained to the surveyor that she just started issuing the SNF [redacted] forms in [redacted] after her predecessor left the facility. The CSW further told the surveyor on 12/04/2024 at 10:28 AM, I was unable to find the other form for the residents that went home (NOMNC CMS 10123). In my previous experience it just used to be a verbal conversation. The surveyor explained to the CSW that residents discharged to the	F 582	F582 Medicaid/Medicare Coverage/ Liability Notice SS = D Resident #9 and Resident # 22 who both remained in the facility did not receive NJ Exec Order 26.4b1. Resident #9 and Resident #22 were re-issued [redacted]. All residents have the potential to be affected. Social Services, Business Office Manager and Director of Nursing educated by The Administrator on the Notice of Medicare Non-Coverage (NOMNC) Policy and Procedure, the Advance Beneficiary Notice and Non-coverage (ABN) form and the Notice of Medicare Non-Coverage form by 12/31/20224. The Interdisciplinary Team will meet weekly to discuss any residents who will require the ABN and NOMNC form to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 5 facility with Medicare A time remaining required two (2) forms, Notice of Medicare Non-Coverage/NOMNC -Form CMS 10123 and SNF ABN (Skilled Nursing Facility Advanced Notice of Non-Coverage)- Form CMS-10055. The CSW told the surveyor, "I agree that two (2) forms should be issued when a Medicare A resident is discharged to the facility with Medicare A time still remaining." On 12/04/2024 at 01:41 PM, the surveyor reviewed the following Residents for SNF [NJ Exec Orde 1. Resident #9's [NJ Ex Order 26, 4B1] start date was [NJ Exec Order 26.4b1] and last day covered was [NJ Exec Order 26.4b1] Resident #9 remained in the facility. Resident #9 did not receive [redacted]), as required. A review of the form SNF [NJ Exec Orde] revealed under Section 1 Other explain: Facility did not provide. 2. Resident #22 had a [NJ Ex Order 26, 4B1] start date was [NJ Ex Order 26, 4B1] and last day covered was [NJ Ex Order 26, 4B1] Resident #22 remained in the facility. The facility did not provide Resident #22 with [NJ Exec Order 26.4b1] Form 10055 as required. A review of the SNF [NJ Exec Orde] Section 1 under Other explain: revealed that "Facility did not provide.	F 582	completed. A list of these residents will be maintained to include, the resident name, admission date, end of service date and date the forms were completed. The social service department will issue the documents and have them signed and uploaded into the resident's electronic chart. The Director of Social Services or designee will submit a weekly report to the Administrator. The Director of Social Services will report findings at the monthly QAPI meeting for 4 months. Date of Completion January 10, 2025	
F 584 SS=E	NJAC 8:39-4.1(a)(7) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean, safe,	F 584	The wheels on the medication carts, treatment carts and Hoyer lifts were cleaned. The sandwich was removed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 and sanitary environment. This deficient practice was identified for 2 of 2 units (1st floor and 2nd floor) and was evidenced by the following: On 12/03/2024 at 11:22 AM, Surveyor #1 observed the wheels on 2 [redacted] and 2 [redacted] medication carts. There was hair and strings wrapped around the wheels. On 12/03/2024 at 11:26 AM, Surveyor #1 observed hair and debris wrapped around the wheels of the NJ Exec Order 26.4b1. On 12/03/2024 at 11:33 AM, Surveyor #1 observed 1/2 PB&J sandwich under the bed of room [redacted] On 12/03/2024 at 11:42 AM, Surveyor #1 observed the 1 west treatment cart with hair wrapped around the wheels. On 12/03/2024 at12:16 PM, Surveyor #1 observed the wheels on 1 [redacted] with large amount dark hair wrapped around the wheels. On 12/06/24 at 11:18 AM Surveyor #2 observed the interior of Resident #260's room. Resident #260 had there bed against the wall on the (L) side of the room. The [redacted] was disattached from the wall. The end of the NJ Exec Order 26.4b1 noted to have a nail protruding out of the [redacted] pointing towards resident#260's bed, which would be in the area where Resident #260's head would be while lying in bed. On 12/06/2024 at 11:24 AM during an interview with the facility U.S. FOIA (b)(6) the surveyors asked the [redacted] if weekly tours of the facility included visiting resident rooms. The	F 584	The bedrail was repaired by maintenance. Maintenance repaired the exposed drain in the shower room. Liners were placed in trash cans and linen carts were removed. The ceiling tile was replaced. Staff spoke with resident advising them issue was addressed . All residents have the potential to be affected by this deficient practice. Nursing staff and newly hired nursing staff will be educated by the Staff Educator or designee to ensure trashcans have plastic liners inside before placing items in them by 12/30/24. Unit Managers will audit medication carts, treatment carts and Hoyer lifts for cleanliness daily Monday through Friday for 1 week then every Monday, Wednesday and Friday for one week then weekly for 4 weeks. These audits will be submitted to the Director of Nursing upon completion starting 12/26/24. The medication carts, treatment carts and Hoyer lifts will be thoroughly cleaned monthly with records being maintained by the Director of Nursing. Unit Managers will conduct daily rounds of their units and provide findings to the Director of Nursing upon completion starting 12/26/24. Weekly Interdisciplinary team rounds are to be completed with findings reported at the morning meeting. DON or designee will inspect shower rooms for cleanliness daily for one week then every Monday, Wednesday and Friday for one week then weekly for 4 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 U.S. FOIA (b told the surveyors that weekly rounds would include observations of residene rooms. Surveyor #2 then made the U.S. FOIA (b aware of the chair rail observation in Resident #260's room. The U.S. FOIA (b)(replied this was the first time that I'm hearing of that. I must have missed it on my rounds. How long has it been like that? The surveyor told the U.S. FOIA (b that it was observed on the initial tour of the facility on NJ Exec Order 26.4b1 The U.S. FOIA (b went on to say that it was a common occurrence in the facility with residents who have had their beds placed against the wall. On 12/02/2024 at 11:11 AM, Surveyor #3 observed the following: a black trashcan in the shower room on the [redacted] floor, containing trash but lacking a liner. Additionally, trash, including a NJ Exec Order 26.4b1, a white sock, and a clear plastic cap, was found in the linen cart inside the same shower room. The cart also did not have a liner. On 12/05/2024 at 9:08 AM, Surveyor #3 observed floor tiles missing around the shower drain [redacted] hanging air vent with brown particles, wall tiles stained brown inside the shower room on the 1st floor. On 12/05/2024 at 9:16 AM, Surveyor #3 observed a missing baseboard on the [redacted] On 12/05/2024 at 9:24 AM, Surveyor #3 observed a drop ceiling tile with brown stains and bulging in the bathroom inside the shower room on the U.S. FO floor. During an interview with Surveyor #3 on	F 584	The Director of Nursing will submit a monthly report to the facility□s monthly QAPI Committee Meeting for 4 months. Date of completion, January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9 12/06/2024 at 2:08 PM, U.S. FOIA (b)(6) [redacted]), were made aware of the identified environmental concerns. The [redacted] explained that housekeeping is responsible for cleaning the shower rooms during the day, while [redacted] clean after each resident use. Nurses are responsible for cleaning the medication and treatment carts, and housekeeping performs deep cleaning and power washing as necessary. The [redacted] noted that there is no formal cleaning schedule currently in place. A review of a facility provided policy undated, titled "Routine Cleaning and Disinfection" revealed that, " It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible." A review of a facility provided policy undated, titled "Cycle Cleaning" revealed that, " It is the policy of this facility to identify the functional areas in the facility that require cleaning and to use cycle cleaning schedules to outline the frequencies and maintain regularly scheduled environmental service task."	F 584		
F 641 SS=E	8:39-31.4 (a) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10 Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to ensure that an accurate Minimum Data Set (MDS), an assessment tool, was completed. This deficient practice was identified for 6 of 28 residents reviewed (Residents #35, Resident #107, Resident #99, Resident #67. Resident #102, and Resident #1). and was evidenced by the following: 1.During the initial tour of the facility on Resident #35 was observed lying in bed using a cell phone with his/her NJ Exec Order 26.4b1. Resident #35's NJ Exec Order 26.4b1 was observed to be NJ Exec Order 26.4b1 A review of the Electronic Medical Record (EMR) on 12/02/2024 at 2:14 PM revealed the following: According to the Admission Record, Resident #35 was admitted to the facility with diagnoses including but not limited to NJ Exec Order 26.4b1 A review of the most recent comprehensive MDS dated NJ Ex Order 26, 4B1, revealed that Resident #35 had NJ Exec Order 26.4b1 A further review of NJ Exec Order 26.4b1 did not indicate that Resident #35 NJ Exec Order 26.4b1 A review of the Order summary Report (OSR) with active orders as of NJ Exec Order 26.4b1 revealed a physician order dated NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 when out of bed during daily NJ Exec Order 26.4b1. Remove during NJ Exec Order 26.4b1r. Check for NJ Ex Order 26, 4B1 before and after NJ Exec Order application. During an interview with the surveyor on	F 641	Resident #35 MDS dated 7/24/24 MDS dated 7/24/24 was corrected. Resident #107 MDS dated 11/21/24 section A2105 Discharge Status was corrected. Resident #99 MDS dated 4/18/24 Section E and Section P were corrected. Resident #67 MDS dated 11/4/24 Section E and Section P were corrected. Resident #1 MDS dated 9/3/24 Section O was corrected. Resident # 102 MDS dated 10/9/24 Section O was corrected. All residents have the potential to be affected. The U. S. FOIA (b) (2) will be educated by the NJ Ex Order 26, 4B1 on MDS 3.0 Completion policy and MDS Assessment and Interviewing by 12/30/2024. The Interdisciplinary team will develop an acuity grid for the facility to assist the U. S. FOIA (b) (2) by 1/3/2025. The acuity grid will be updated and reviewed weekly at the utilization review meeting. The Interdisciplinary team will review the resident's MDS for accuracy before it is transmitted weekly for 12 weeks. A log will be initiated to track MDS and any concerns. The U. S. FOIA (b) (2) will utilize the log and report findings at the monthly QAPI meeting for 4 months. Date of Completion January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11 12/5/2024 at 12:56 PM, the U. S. FOIA (b) (2) was asked who was responsible to complete the MDS. The U. S. FOIA (b) (2) replied I have to look at all components to make sure it is filled out by the interdisciplinary team. I am responsible to make sure of the accuracy of each block especially section GG. I do nursing parts. The surveyor asked where you get the information from. The U. S. FOIA (b) (2) replied I get the information from the medical and hospital record. I also interview the patient and assess their needs. On 12/05/2024 at 01:09 PM, the surveyor reviewed with the U. S. FOIA (b) (2) that Resident #35 had a NJ Ex Order 26, 4B1. The surveyor asked would this be coded on the MDS. The U. S. FOIA (b) (2) replied NJ Ex Order 26, 4B1 are in section NJ Exec Order 26.4b The U. S. FOIA (b) (2) look at section NJ E and confirmed it was not coded and should have been coded. 2. A review of the EMR for Resident #107 on 12/02/2024 revealed the following: According to the Admission Record Resident #107 was admitted with diagnoses including but not limited to: NJ Ex Order 26, 4B1 A review of a MDS section A 2000 Discharge Date revealed Resident #107 was discharged on NJ Ex Order 26, 4B1 A review of section A2105 Discharge Status was coded as NJ Exec Order 26.4b1. A review of the Progress Notes for Resident #107 dated NJ Exec Order 26.4b1 16:10 4:10 PM), that at 3:45 pm resident was noted to be sitting in the hallway in the NJ Ex Order 2 wing NJ Ex Order 26, 4B1	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 12	F 641		

and NJ Exec Order 26.4b1 . U.S. FOIA (b)(6) at this time. 911 contacted and sent to NJ Exec Order 26.4b1. Physician aware. A further review of the progress notes indicated that on NJ Exec Order 26.4b1) Resident #107 left facility NJ Ex Order 26, 4B1

According to a progress note dated NJ Exec Order 26.4b1) Resident admitted to NJ Exec Order 26.4 with Dx (diagnosis) NJ Exec Order 26.4b1

During an interview with the surveyor on 12/05/2024 at 01:05 PM, the surveyor reviewed with the U. S. FOIA (b) (6 that Resident #107 was sent to the NJ Exec Order 26.4b1. The surveyor asked how the discharge was coded. The U. S. FOIA (b) (6 said it was coded went to NJ Exec Order2 The surveyor asked was this correct. The U. S. FOIA (b) (6 said no that should have been to the NJ Exec Order 26.4 that date.

3. During the initial tour of the facility on 12/02/2024 at 10:35 AM, Resident #99 was observed NJ Exec Order 26.4b1 in the hallway NJ Exec Order 26.4b1. The surveyor observed a NJ Exec Order 26.4b1

A review of the EMR for Resident #99 on 12/02/2024 at 11:01 AM revealed the following:

According to the Admission Record, Resident #99 was admitted with diagnoses including but not limited to: NJ Exec Order 26.4b1 .

A review of the most recent comprehensive MDS dated NJ Exec Order 26.4b1 revealed under section E NJ Exec Order 26.4b1 occurred daily. Under section P alarms wander/elopement coded as not used.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 13 A review of the OSR with Active orders as of [redacted] revealed a physician order dated [redacted] to Monitor [redacted] every shift for [redacted]. The OSR also included an order dated [redacted] [company name for [redacted] check placement and function q (every) shift for safety. During an interview with the surveyor on 12/5/2024 at 12:56 PM, the[redacted]) was asked who was responsible to complete the MDS. The [redacted] replied I have to look at all components to make sure it is filled out by the interdisciplinary team. I am responsible to make sure of the accuracy of each block especially section GG. I do nursing parts. The surveyor asked where you get the information from. The[redacted] and [redacted] record. I also interview the patient and assess their needs. On 12/05/2024 at 01:07 PM, the surveyor said to the [redacted], Resident #99 has a [redacted] bracelet. Please show me where this would be documented on the MDS. The [redacted] said I don't remember. The surveyeyor again asked was this documented on the MDS. The [redacted] said no he/she is not coded as having one. I should look under orders and he/she should have been coded as having one as of [redacted] 4.) On 12/02/2024 at 10:49 AM, Surveyor #2 observed Resident #67 sitting in a [redacted] ([redacted]) with the gate closed and a [redacted] between [redacted], positioned next to the nursing station.	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 14 On 12/03/2024 at 10:16 AM, Surveyor #2 observed Resident #67 sitting in a NJ Ex Order 26, 4B1 with the gate closed and a NJ Exec Order 26.4b1 secured NJ Ex Order 26, 4B1 positioned next to the nursing station. The surveyor asked the resident if he/she could open the gate on the NJ Ex Order 26, 4B1 and remove the NJ Exec Order 26.4b1. The resident responded with a NJ Exec Order Surveyor #2 reviewed the EMR on 12/02/2024 at 2:00 PM as follows: According to the Admission Record, Resident #67 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 A review of the MDS dated NJ Ex Order 26, 4B1 for Resident #67 revealed under section NJE was coded as NJ indicating Resident #67 did not exhibit NJ Exec Order 26.4b1. Section NJ Exec Order 26.4b1 was coded as NJ indicting Resident #67 does not use a NJ Exec Order 26.4b1 A review of the physician orders included the following: a physician order dated NJ Exec Order 26.4b1, for the use of a NJ Exec Order 26.4b1 to promote NJ Exec Order 26.4b1 and NJ Exec Order 26.4b A physician order dated NJ Ex Order 26, 4B1 directing staff to assist the resident in exiting the NJ Exec Order 26.4b1 and NJ Exec Order 26.4 with NJ Exec Order 26.4b1 every 2 hours during each shift. a physician order dated NJ Ex Order 26, 4B1, specifying the use of the NJ Exec Order 26.4b1 when the resident is out of bed for NJ Exec Order and NJ Exec Order 26.4b1 with the	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641		F 641		

Continued From page 15

requirement to release the resident and [NJ Exec Order 26.4b1] for 10 minutes every 2 hours.

During an interview with Surveyor #2 on 12/05/2024 at 1:00 PM, with the MDSC regarding Resident #67's QMDS from [NJ Ex Order 26, 4B1] not being coded for [NJ Ex Order 26, 4B1] said, the resident does [NJ Ex Order 26, 4B] and should have been coded for [NJ Ex Order 26, 4B1]. He/she also considers the [NJ Ex Order 26] a [NJ Exec Order 26.4b] if the resident is unable to release it on his/her own, and in that case, it should be coded as a [NJ Ex Order 26, 4B1]

5.) On 12/03/2024 at 10:21 AM, Surveyor #2 observed Resident #102 lying in bed with a [NJ Exec Order] He/she stated that the [NJ Exec Order 26.4b1] doctor provided the [NJ Exec Order 26.4b1] and a [NJ Exec Order 26.4b1] due to a [NJ Exec Order 26.4b1], but he/she no longer wears the [NJ Exec Order 26.4b1]. He/she puts [NJ Exec Order 26.4b1] on his/her [U.S. FOIA (b)(6)] and removes it when he/she chooses.

On 12/03/2024 at 9:00 AM, Surveyor #2 reviewed the EMR for Resident #102 as follows:

According to the Admission Record Resident #102 was admitted to the facility with diagnoses including but not limited to: [NJ Exec Order 26.4b1]

A review of the most recent comprehensive MDS dated [NJ Exec Order 26.4b1] for Resident #102 revealed under section [NJ Exec Order 26.4b1] Nursing Programs, it was coded as 0, indicating that Resident #102 does not use a [NJ Exec Order 26.4b1], nor does the resident receive [NJ Ex Order 26, 4B1].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 16 A review of the physician orders for Resident #102 did not include current or discontinued orders for a cast on the NJ Exec Order 26.4b1, a NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 A review of the Nurse notes from NJ Exec Order 26.4b1 indicated that Resident #102 was admitted with a NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1, the nurse noted that the resident returned from an NJ Exec Order 26.4b1 appointment with a NJ Exec Order 26.4b1 and on NJ Exec Order 26.4b1, the nurse noted that the NJ Exec Ord had been removed and replaced with a NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 notes dated NJ Exec Order 26.4b1, recommended initiating NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 with NJ Exec Order 26.4b1 as tolerated while using a NJ Exec Order 26.4b1. A follow-up note on NJ Exec Order 26.4b1 outlined a treatment plan that included active NJ Ex Order 26, 4B1, assisted active NJ Exec Order 26.4b1, and the use of a NJ Exec Orde. During an interview with Surveyor #2 on 12/05/2024 at 1:00 PM, the MDSC was questioned regarding Resident #102 from NJ Exec Order 26.4b1 not being coded for NJ Exec Order 26.4b1. NJ Ex Order 26, 4 said, the resident should have been coded for wearing a NJ Exec Order if he/she is wearing one. 6.) On 12/02/2024 at 10:29 AM, Surveyor #2 observed the Resident #1 sitting in a wheelchair in the hallway on the NJ Exec Order 26.4b floor near the nursing station. Resident #2 was not NJ Exec Order 26.4b a NJ Exec Order 26.4b1. A review of the EMR for Resident #1 on NJ Ex Order 26, 4B1, revealed the following: According to the Admission Record Resident #1	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 17 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 A review of the most recent MDS dated NJ Ex Order 26, 4B1 revealed under section NJ Exec Order 26.4b1 Nursing Programs, it was coded as 0, indicating that Resident #1 does not use a NJ Exec Order 26.4b1 assistance. A review of the physician orders included the following: a physician order dated NJ Exec Order 26.4b1, instructing the use of a NJ Exec Order 26.4b1 as tolerated, with NJ Exec Order 26.4b1 every shift when in use; and a physician order dated NJ Exec Order 26.4b1, directing the resident to wear a NJ Exec Order 26.4b1 NJ Exec Orde during NJ Exec Order 26.4b1, remove it at night during NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every shift. During an interview with Surveyor #2 on 12/05/2024 at 1:05 PM, the U.S. FOIA (b)(6) was questioned regarding Resident #1 not being coded for NJ Exec Order 26.4b1. U. S. FOIA (b) (6) said, that the resident should be coded for NJ Exec Order 26.4b1 if he/she is using them. NJAC 8:39-11.1	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 18 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of	F 655	Resident #102 was discharged to home on [redacted]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 19 other facility documentation, it was determined that the facility failed to develop and implement a baseline care plan (BCP) within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident. This deficient practice was identified for 1 of 28 sampled residents (Resident #102) and was evidenced by the following: On 12/03/2024 at 10:21 AM, Surveyor #1 observed Resident #102 lying in bed with NJ Exec Order [redacted]. He/she said that the NJ Exec Order 26.4b1 doctor (NJ Exec Order 26.4b1 [redacted]) provided the NJ Exec Order 26.4b1 [redacted], but he/she no longer wears the NJ Exec Order 26.4b1. He/she puts the NJ Exec Order 26.4b1 [redacted] and removes it when he/she chooses. On 12/03/2024 at 9:00 AM, Surveyor #1 reviewed the EMR for Resident #102 as follows: According to the Admission Record Resident #102 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]. A review of the physician orders for Resident #102 did not include current or discontinued orders for a NJ Exec Order 26.4b1 [redacted] A review of the Nurses note dated NJ Exec Order 26.4b1	F 655	All residents have the potential to be affected by this deficient practice. Nurses and newly hired nurses will be educated by the Staff Educator or designee to complete the ICP-Interim Care Plan when a resident is admitted to the facility by 12/27/24. Nurses will complete ICP-Interim Care Plan upon admission. Unit Manager will audit all new admissions for a completed Interim Care Plan and report findings to DON for 8 weeks. The Director of Nursing will submit a monthly report to the facility's monthly QAPI Committee Meeting for 4 months. Date of completion, January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 20 indicated that Resident #102 was admitted with a [redacted] on the NJ Exec Order 26.4b1 [redacted]. A further review of the Nurses note dated NJ Exec Order 26.4b1 indicated that the resident returned from an NJ Exec Order 26.4b1 appointment with a NJ Exec Order 26.4b1. A U. S. FOIA (b) (2) note dated NJ Exec Order 26.4b1, the nurse noted that the cast had been removed and replaced with a NJ Exec Order 26.4b1. A review of the care plan for Resident #102 did not address or include specific instructions for the care of a NJ Exec Order 26.4b1. During an interview with the surveyor on 12/05/2024 at 10:25 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1), said resident should have had a care plan for a NJ Exec Order 26.4b1 [redacted].	F 655		
F 656 SS=E	NJAC 8:39-11.2(d) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 21 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to develop a person-centered comprehensive care plan to address the use of A. an NJ Ex Order 26, 4B1 [redacted] medication, B. NJ Ex Order 26, 4B1, C. NJ Ex Order 26, 4 [redacted], and D. a	F 656	Resident #8 care plan was updated on NJ Exec Order 26 [redacted]. Resident #18 care plan was updated on NJ Exec Order 26 [redacted]. Resident #35 care plan was updated on NJ Exec Order 26 [redacted]. All residents have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 22 NJ Exec Order 26.4b1 . This deficient practice was identified for 4 of 28 sampled residents, (Resident #8, Resident #18, Resident #35, and Resident #99) and was evidenced by the following: A.) On 12/2/2024 at 11:01 AM, during the initial tour, Resident #8 was identified as being on an NJ Exec Order 26.4b1 A review of Resident #8's EMR on 12/02/2024 at 02:11 PM, revealed the following: A review of Resident #8's Admission Record revealed that he/she had diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted] A review of the (OSR) with an active date as of NJ Exec Order 26.4b1, revealed the following: NJ Exec Order 26.4b1 [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care dated NJ Exec Order 26.4b1, revealed under section "N" Resident #8 was on an NJ Exec Order 26.4b1. A review of Resident #1's care plan on NJ Exec Order 26.4b1 at 02:11 PM, did not include documentation that Resident #8 was on an NJ Exec Order 26.4b1 During an interview with the Surveyor #1 on 12/03/2024 at 10:10 AM, the Licensed Practical	F 656	Nurses and newly hired nurses will be educated by the Staff Educator or designee to update resident care plans with any change of conditions and as needed by 12/31/24. All resident care plans will be reviewed for accuracy and corrected as needed by 12/27/24. DON or designee will audit eight (8) resident care plans daily for 2 weeks then eight (8) resident care plans twice per week for 4 weeks then eight (8) resident care plans weekly for one month. The inter disciplinary team will review and update resident care plans during their care conference meetings. The Director of Nursing will submit a monthly report to the facility□s monthly QAPI Committee Meeting for 4 months. Date of completion, January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 23 Nurse/Unit Manager (LPN/UM #1) agreed that NJ Exec Order 26.4b1 including NJ Exec Order 26.4b1 should be care planned. During an interview with the Surveyor #1 on 12/06/2024 at 01:51 PM, the U.S. FOIA (b)(6) agreed that an NJ Exec Order 26.4b1 should be care planned. B.) During the initial tour of the facility on 12/02/2024 at 10:18 AM, Resident #18 was observed in his/her room sitting on the side of the bed with NJ Exec Order 26.4b1). On 12/03/2024 at 10:30 AM, Surveyor #2 observed Resident #18 in their room, lying in bed with NJ Exec Order 26.4b1 . On 12/04/2024 at 10:33 AM, the Surveyor #2 observed Resident #18 in their room sitting on the side of his/her bed with NJ Exec Order 26.4b1 A review of the EMR on 12/03/2024 at 12:45 PM, revealed the following: According to the Admission Record, Resident #18 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1. A review of the most recent MDS dated NJ Exec Order 26.4b1 revealed under section NJ Exec Order 26.4b1 A review of the OSR with Active Orders as of NJ Exec Order 26.4b1, revealed a physician order dated NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 as	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 24 needed (PRN) for [redacted] A review of Resident #18's care plan on 12/03/2024 at 1:00 PM, did not include that Resident #18 used [redacted] During an interview with Surveyor #2 on 12/05/2024 at 11:00 AM, LPN/UM #1 was questioned regarding the resident's PRN [redacted] LPNUM #1 said that the [redacted] should be dated weekly to indicate when it was changed. The resident should have [redacted] care planned, and if nursing staff administer PRN [redacted], it should be documented in the Treatment Administration Records (TAR). C.) During the initial tour of the facility on 12/02/2024 at 10:45 AM, Resident #35 was observed lying in bed using a cell phone with [redacted]. Resident #35's [redacted] was observed to be contracted. A review of the Electronic Medical Record (EMR) on 12/02/2024 at 2:14 PM, revealed the following: According to the Admission Record, Resident #35 was admitted to the facility with diagnoses including but not limited to: [redacted]). A review of the most recent comprehensive MDS dated [redacted] revealed that Resident #35 had [redacted]. A review of the OSR with active orders as of [redacted], revealed a physician order dated	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 25 NJ Exec Order 26.4b1 to Apply resting NJ Exec Order 26.4b1 when out of bed during daily NJ Exec Order 26.4b1 acts. Remove during NJ Exec Order 26.4b1. Check for NJ Exec O [redacted] A review of the care plan for Resident #35 did not include documentation that he/she used NJ Exec Order 26 as per the physician order. During an interview with Surveyor #3 on 12/05/2024 at 10:19 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) was asked who was responsible for completing the care plan. LPN/UM #1 replied between the U.S. FOIA (b [redacted] we are responsible for the care plan. LPN/UM #1 went on to say the nurses initialize the care plan upon admission and U.S. FOIA (b)(6) finalize them. Surveyor #3 questioned what is expected to be on the care plan for residents. LPN/UM #1 said I would say NJ Exec Order 26.4b1 risk 2 goals and at least 3 nursing interventions per goal. We review and adjust quarterly and as needed based on resident status. We look at NJ Exec Order 26.4b1 [redacted], and Activities of Living. On 12/05/2024 at 10:23 AM, Surveyor #3 questioned if a NJ Exec Order would be care planned. LPN/UM #1 stated Yes, I would expect a NJ Exec Order 26.4b1 to be care planned. We would also monitor the NJ Exec O for staying NJ Exec Orde or NJ Exec Order 26 as needed. On 12/05/2024 at 10:49 AM, the Surveyor #3 requested LPN/UM #1 to review Resident #35's care plan on the EMR for the NJ Exec Order LPN/UM #1 said No, I don't see a care plan for resident's NJ Exec Orde. LPN/UM #1 confirmed that yes, there should be one.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 26	F 656		

During an interview with Surveyor #3 on 12/06/2024 at 01:50 PM, the [redacted] was asked, what are your expectations as to what should be on a resident care plan. The [redacted] replied "Specific for patient with dx (diagnoses) condition, situation. They would include pain risk or actual skin issues, Activities of Daily Living, code status. The [redacted] confirmed this would include a [redacted].

D.) During the initial tour of the facility on 12/02/2024 at 10:35 AM, Resident #99 was observed [redacted] in the hallway [redacted]. The surveyor observed a [redacted].

A review of the EMR for Resident #99 on 12/02/2024 at 11:01 AM, revealed the following:

According to the Admission Record, Resident #99 was admitted with diagnoses including but not limited to: [redacted]

A review of the most recent comprehensive MDS dated [redacted] revealed under section [redacted] occurred daily. Under section P [redacted] coded as not used.

A review of the OSR with Active orders as of [redacted] revealed a physician order dated [redacted] to Monitor [redacted] every shift for [redacted]. The OSR also included an order dated [redacted] [company name for [redacted]] [redacted] placement and function q (every) shift every shift for safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 27 A review of Resident #99's care plan on 12/02/2024 at 11:01 AM, revealed a focus area care plan as follows: Resident #99 is an NJ Exec Order 26.4b1 r/t (related to) NJ Exec Order 26.4b1 with an initiated date of NJ Exec Order 26.4b1. Under the goal section The resident will not NJ Exec Order 26.4b1 through the review date. A further review of the care plan revealed that there were no interventions noted on the care plan for NJ Exec Order 26.4b1. During an interview with Surveyor #3 on 12/05/2024 at 10:19 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) was asked who is responsible for completing the care plan. LPN/UM #1 replied between the U.S. FOIA (b)(6) U.S. FOIA (b) and U.S. FOIA (b) we are responsible for the care plan. LPN/UM #1 went on to say the nurses initialize the care plan upon admission and U.S. FOIA (b)(6) finalize them. Surveyor #3 questioned what is expected to be on care plan for residents. LPN/UM #1 said I would say NJ Exec Order 26.4b1 risk 2 goals and at least 3 nursing interventions per goal. We review and adjust quarterly and as needed based on resident status. We look at NJ Exec Order 26.4b1, and Activities of Living. On 12/05/2024 at 10:27 AM, Surveyor #3 requested LPN/UM #1 look at Resident #99's care plan. She stated, "I don't see any interventions for the NJ Exec Order 26.4b1 care plan." LPN/UM #1 confirmed Yes, there should be interventions. During an interview with Surveyor #3 on 12/06/2024 at 01:50 PM, the U.S. FOIA (b) was asked, what are your expectations as to what should be	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 28 on a resident care plan. The [NJ Exec Order] replied "Specific for patient with dx (diagnoses) condition, situation. They would include pain risk or actual skin issues, Activities of Daily Living, code status. The [NJ Exec Order] confirmed he would expect interventions for a [NJ Exec Order 26.4b1] to be on a care plan. On 12/05/2024 at 11:41 AM, a review of a facility policy titled Comprehensive Care Plans with an implemented date of 06012024 revealed under the Policy section: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Under the Policy explanation and Compliance Guidelines section: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. 3. The comprehensive care plan will describe at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident highest practicable physical, mental, and psychosocial well-being. f. Resident specific interventions that reflect the resident's needs and preferences...	F 656		
F 661 SS=D	NJAC 8:39-11.2 (e)(1), (f) Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary	F 661		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 29 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on the interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to document a discharge summary which included a recapitulation of the resident's stay and a final summary of the resident's status for 1 of 1 resident reviewed for NJ Exec Order 26.4b1 (Resident #109). This deficient practice was evidenced by the	F 661	The closed record of Resident #109 did not reflect any documentation in their progress notes or electronic medical records (EMR). Resident #109 was discharged All residents have the potential to be affected by this deficient practice. Nurses and newly hired nurses will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 30 following: On 12/4/2024 at 1:49 PM, the surveyor reviewed the closed medical record for Resident #109 which revealed the following: Resident #109's Admission Record indicated the resident had been admitted to the facility with medical diagnoses that included NJ Exec Order 26.4b1 [redacted] A review of the resident's Discharge assessment-return not anticipated Minimum Data Set (DRNAMDS), an assessment tool used to facilitate the management of care, reflected the resident had a planned discharge to NJ Exec Order 26.4b1 [redacted] A review of the resident's Progress Notes did not reflect any documentation or note that the resident had been NJ Exec Order 26.4b1 or discharged from the facility. A review of the electronic medical record (EMR) did not reveal any additional information regarding the resident being NJ Exec Order 26.4b1 or discharged and did not include a discharge summary. On 12/5/2024 at 2:26 PM, the surveyor interviewed the facility U.S. FOIA (b)(6) [redacted] (via telephone), together reviewed the resident's EMR and both acknowledged the nurse, or social worker should have entered progress notes in the EMR regarding the	F 661	educated by the Staff Educator or designee on the Discharge Summary policy by 12/27/24 Unit Managers will audit all residents who are discharged for proper discharge documentation and that it is following the facility Discharge Summary policy and report findings to DON weekly for 12 weeks. The Director of Nursing will submit a monthly report to the facility's monthly QAPI Committee Meeting for 4 months. Date of completion, January 17, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 31 discharge/[redacted] of the resident. The Administrative team both acknowledged there was also no discharge summary as required. The facility did not provide additional information. A review of the facility "Discharge Summary" policy dated implemented 10/01/2023 included the following: It is the policy of this facility to ensure that a discharge summary is provided upon a resident's discharge which addresses each resident's discharge goals and needs, including caregiver support and referrals to local agencies. ...The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plan for care after discharge. It must contain an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another... NJAC 8:39-35.2(d)(16)	F 661		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 32 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure that treatment for NJ Ex Order 26, 4B1 limitations were provided for 3 of 3 residents (Resident #102, Resident #1, and Resident #35) reviewed for NJ Ex Order 26, 4B1 . This deficient practice was evidenced by the following: 1. On 12/03/2024 at 10:21 AM, Surveyor #1 observed Resident #102 lying in bed with a NJ Exec Orde on his/her NJ Exec Order 26.4b1 . He/she stated that the NJ Exec Order 26.4b1 doctor provided the NJ Exec Order 26.4b1 , but he/she no longer wears the NJ Exec Order 26.4b1 . He/she puts the NJ Exec Order 26.4b and removes it when he/she chooses. On 12/03/2024 at 9:00 AM, Surveyor #1 reviewed the EMR for Resident #102 as follows: According to the Admission Record Resident #102 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1	F 688	All residents who have splints and/or other orthotic devices were audited to ensure there are orders and it is indicated on their TAR so nursing staff is aware. Any needed corrections were completed. All residents have the potential to be affected by this deficient practice. Nurses and newly hired nurses will be educated by the Staff Educator or designee on the need to include residents' splints and orthotic devices on TAR so staff is aware and applies them in accordance with the physician's orders. Unit Managers will audit residents with splints/orthotics and have them properly applied daily Monday through Friday for 1 week then every Monday, Wednesday and Friday for one week then weekly for 4 weeks. These audits will be submitted to the Director of Nursing upon completion starting 12/26/24. Unit Managers will audit residents with splints/orthotics for proper documentation on the TAR daily Monday through Friday for one week then every Monday, Wednesday and Friday for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 33 A review of the most recent comprehensive MDS dated NJ Exec Order 26.4b1 for Resident #102 revealed under section NJ Exec Order 26.4b1 Nursing Programs, it was coded as [redacted] indicating that Resident #102 does not use a NJ Exec Order 26.4b1 assistance, nor does the resident receive NJ Exec Order 26.4b1 [redacted] A review of the physician orders for Resident #102 did not include current or discontinued orders for a NJ Exec Order 26.4b1 [redacted] The review of the care plan for Resident #102 did not address or include specific instructions for the NJ Exec Order 26.4b1 . A review of the Nurse notes dated NJ Exec Order 26.4b1 indicated that Resident #102 was admitted with a NJ Exec Order 26.4b1 [redacted] On NJ Exec Order 26.4b1, the nurse noted that the Resident #102 returned from an NJ Exec Order 26.4b1 appointment with a NJ Exec Order 26.4b1, and on NJ Exec Order 26.4b1 the nurse noted that the NJ Exec Order had been removed and replaced with a NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 notes dated NJ Exec Order 26.4b1, recommended initiating NJ Exec Order 26.4b NJ Exec Order 26.4 with NJ Exec Order 26.4b1 while using a NJ Exec Order 26.4b1. A follow-up notes on NJ Exec Order 26.4b1 outlined a treatment plan that included active NJ Exec Order 26.4b1 on, assisted NJ Exec Order NJ Ex Order 26, 4B1 , and the use of a NJ Exec Order 26.4b1	F 688	one week then weekly for 4 weeks. These audits will be submitted to the Director of Nursing upon completion starting 12/26/24. The Director of Nursing will submit a monthly report to the facility's monthly QAPI Committee Meeting for 4 months Date of completion, January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 34 During an interview with Surveyor #1 on 12/05/2024 at 10:25 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1), explained that the Resident #102 is supposed to [NJ Exec Order 26.4b1] [redacted]. Resident #102 follows up with an [NJ Exec Order 26.4b1] provider and the [NJ Ex Order 26, 4B1] department for [NJ Exec Order 26.4b1] and evaluation of the [NJ Exec Orde]. 2.) On 12/02/2024 at 10:29 AM, Surveyor #1 observed the Resident #1 sitting in a wheelchair in the hallway on the [NJ Exec Order 26.4] floor near the nursing station. Resident #2 was not wearing a [NJ Exec Order 26.4b1] [redacted]. A review of the EMR for Resident #1 on 12/03/2024 at 12:35 PM, revealed the following: According to the Admission Record Resident #1 was admitted to the facility with diagnoses including but not limited to: [NJ Exec Order 26.4b1]. A review of the most recent MDS dated [NJ Exec Order 26.4b1] revealed under section [NJ Exec Order 26.4b1] Nursing Programs, it was coded as [NJ Ex] indicating that Resident #1 does not use a [NJ Exec Order 26.4b1] [redacted]. A review of the physician orders included the following: a physician order dated [NJ Exec Order 26.4b1] instructing the use of a [NJ Exec Order 26.4b1] as [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] every shift when in use; and a physician order dated [NJ Exec Order 26.4b1] directing the resident to [NJ Exec Orde] a [NJ Exec Order 26.4b1] [NJ Exec Order] during [NJ Exec Order 26.4b1] [redacted], remove it at night during [NJ Exec Order 26.] and [NJ Exec Order 26.4b1] and check for [NJ Exec Order 26.4b1] [redacted] every shift.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 35 A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for [NJ Exec Order 26.4b], indicated that nurses are documenting the application of the resident's [NJ Exec Order 26.4b1]. Surveyor #1 did not observe Resident #1 [NJ Exec Order 26.4b1] roll on [NJ Exec Order 26.4b1] Additionally, the order for the [NJ Exec Order 26.4b1] was not reflected in either the MAR or TAR. During an interview with Surveyor #1 on 12/05/2024 at 10:12 AM, LPN/UM #1, explained that Resident #1 wears the [NJ Exec Order 26.4b1] daily, and both certified nurse assistants (CNAs) and nurses are responsible for putting them on and removing them. LPN/UM #1 confirmed that the resident should be care planned for the [NJ Exec Orde], and a physician's order is required. The resident follows up with [NJ Ex Order 26, 4B1] for adjustments and evaluation of the [NJ Ex Order 26, 4B1] 3. On 12/02/24 at 10:45 AM, Surveyor #2 observed Resident #35 lying in bed while using her phone. A contracture was noted in her [NJ Exec Orde], but [NJ Exec Order 26.4b1] was observed. A review of the EMR for Resident #35 on [NJ Exec Order 26.4b1], revealed the following: According to the Admission Record Resident #35 was admitted to the facility with diagnoses including but not limited to: [NJ Exec Order 26.4b1]. A review of the most recent MDS dated [NJ Exec Order 26.4b1], revealed under section [NJ Exec Order 26.4b1] Nursing Programs, it was coded as	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 36 [redacted] indicating that Resident #35 does not use a [redacted] A review of the physician orders revealed the following: apply a [redacted] to the [redacted] when the resident is [redacted] and during daily [redacted] activities. The [redacted] should be removed during [redacted] or [redacted] should be checked before and after applying the [redacted] A review of the MARs/TARS for [redacted] revealed no documentation regarding the times the [redacted] was applied or removed. Additionally, there was no indication that the [redacted] was checked before or after the [redacted] was applied. The review of the care plan for Resident #35 did not address or include specific instructions for the [redacted]. A review of the [redacted] notes from [redacted] indicated that Resident #35 received [redacted], to promote continued [redacted]. An [redacted] note dated [redacted] also indicated that nursing staff was informed about the [redacted] and provided with a storage bin for it, along with the [redacted] for the [redacted]. During an interview with Surveyor #2 on [redacted] at 10:17 AM, LPN/UM #1 regarding Resident #35[redacted]. LPN/UM #1 said, initially, [redacted] will provide the devices and conduct an in-service	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 37 for nurses and CNAs on how to properly apply and remove the NJ Ex Order 26, 4B1. LPNUM #1 confirmed that staff members are required to sign off after receiving the in-service training. She also stated that the use of a NJ Ex Order 26, 4B1 should be included in the resident's care plan. Additionally, there will be a wearing schedule, and physician orders will specify details, such as applying the NJ Ex Order2 in the morning and removing it at bedtime, or adjusting the schedule based on the resident's needs. The morning application would be done during the day shift. During an interview with the surveyors on 12/06/2024 at 01:50 PM, the U.S. FOIA (b)(6) was asked if a resident has physician order for a NJ Exec Order 26.4b1, where would the staff document the application/removal and skin checks before and after. The U. S. FOIA (b) replied, "It should be on the TAR." 12/06/24 02:01 PM U.S. FOIA (b)(6) agreed yes would expect the brace to be coded on MDS. The facility was unable to provide a policy regarding NJ Exec Order 26.4 services and treatment for NJ Exec Order 26.4b1.	F 688		
F 695 SS=E	NJAC 8:39 - 27.1 (a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 38 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of other facility documentation, it was determined that the facility failed to obtain a physician's order for NJ Ex Order 26, 4B1 and not replacing and properly storing a NJ Ex Order 26, 4B1 (NJ Ex Order 26, 4B1) in accordance with facility policy. This deficient practice occurred for 3 of 3 residents (Resident #54, Resident #261, and Resident #18) reviewed for NJ Exec Order 26.4b1. The deficient practice was evidenced by the following: 1. On 12/3/2024 at 1:38 PM, Surveyor #1 observed Resident #54 in their room sitting on their bed and was being administered NJ Ex Order 26, 4B1 . The resident informed the surveyor they had NJ Exec Order 26.4b1 when in their room but when they wanted to go outside their room, they used the NJ Exec Order 26.4b1. The surveyor reviewed the medical record for Resident #54 and the following was revealed: A review of the Admission Record reflected the Resident #54 was admitted to the facility with diagnoses including NJ Exec Order 26 A review of the most recent Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, reflected that the resident had a brief interview for mental status (BIMS) score of a NJ Exec Order 26.4b1, which indicated a NJ Exec Order 26.4b1. A further review	F 695	Resident #54 had a physician order for NJ Exec Order 26.4 obtained and NJ Exec Order 26 use added to the NJ Exec Order 26 care plan. Resident #261 physician consulted. The NJ Exec Order 26 was removed because the doctor did not order NJ Exec Order 26.4b1. Resident #18 physician was consulted due to the resident utilizing NJ Exec Order 26 frequently. A new order was obtained on NJ Exec Order 26.4 for NJ Exec Order 26.4b1 while in bed and was added to the TAR. NJ Exec Order 26.4b1 was changed, dated and stored in a bag when not in use. All residents receiving oxygen therapy have the potential to be affected by this deficient practice. Nurses and newly hired nurses will be educated by the Staff Educator or designee on the Oxygen Administration Policy and respiratory tubing to be changed by 12/30/24. The Director of Nursing will review all new admissions for the need for oxygen therapy and ensure physician orders and care plans are in place. Unit Managers will audit all residents receiving oxygen therapy for physician orders and ensure that the orders are on the TAR by 12/27/24. Unit Managers will audit residents receiving respiratory therapy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 39 reflected the resident received [NJ Exec Order 26.4b1]) while in the facility. A review of the Order Summary Report (OSR) from [NJ Ex Order 26, 4B1] did not include a physician's order (PO) for the resident to receive [NJ Exec Order 26.4b1] A review of the corresponding [NJ Ex Order 26, 4B1] Medication Administration Record (MAR) included a PO dated [NJ Ex Order 26, 4B1] and discontinued [NJ Ex Order 26, 4B1] for [NJ Ex Order 26, 4B1] as needed for monitoring. A review of the corresponding [NJ Ex Order 26, 4B1] Medication Administration Record (MAR) did not include a PO for [NJ Ex Order 26, 4B1]. A further review of the resident's Electronic Medical Record (EMR) revealed an [NJ Exec Order 26] summary report (a report where nurses would document the d[NJ Exec Order 26.4b1] indicating the resident had used [NJ Exec Order 26] and revealed the following: [NJ Ex Order 26, 4B1] on [NJ Ex Order 26, 4B1] [NJ Ex Order 26, 4B1] on [NJ Ex Order 26, 4B1] [NJ Ex Order 26, 4B1] on [NJ Ex Order 26, 4B1] A review of the individualized person-centered care plan included a focus area initiated [NJ Ex Order 26, 4B1] for resident's resistance to care by [NJ Exec Order 26.4b1] on his/her [NJ Exec Order 26.4b1] with a history of [NJ Ex Order 26.4] Interventions were to educate the	F 695	every Friday for dated tubing for 12 weeks. The audit will be submitted to DON upon completion. Unit Managers will audit residents receiving respiratory therapy for proper tubing storage daily Monday through Friday for 1 week then every Monday, Wednesday and Friday for one week then weekly for 4 weeks. These audits will be submitted to the Director of Nursing upon completion. The Director of Nursing will submit a monthly report to the facility□s monthly QAPI Committee Meeting for 4 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 40 resident/family/care givers of the possible outcomes of not complying with treatment of care. A further review of the care plan included a focus area initiated NJ Exec Order 26.4b1. Interventions included to give NJ Exec Order 26. or NJ Exec Order 26.4b1 NJ Ex Order 26, 4B1 as ordered. Monitor/document any side effects and effectiveness. It did not indicate the use of NJ Ex Order 26, 4B1 During an interview with Surveyor #1 on 12/6/2024 at 12:12 PM, Licensed Practical Nurse/Unit Manager (LPN/UM#2) stated resident #54 was NJ Ex Order 26, 4B1. At that time the Surveyor #1 and LPN/UM #2 reviewed the resident's EMR and confirmed the resident did not have an active PO to receive NJ Ex Order 26, 4B1. LPN/UM #2 further confirmed the resident should have had a PO for the NJ Ex Order 26, 4B1 During an interview with Surveyor #1 on 12/6/2024 at 1:50 PM, the U.S. FOIA (b)(6) confirmed Resident #54 did not have a current order for NJ Exec Order 26.4 use as required. 2. On 12/03/2024 at 08:27 AM, Surveyor #2 observed an NJ Ex Order 26, 4B1 in the room near the head of the bed. The NJ Ex Order 26, 4B was observed to be on and the NJ Ex Order 26, 4B1 (NJ Ex Order 26, 4B1) and NJ Ex Order 26 were draped over the top of the resident's NJ Exec Order 26.4b1 and were not being utilized by Resident #261. The surveyor did not observe a date on NJ Ex Order 26, 4B1 and Resident #261 stated he/she does not NJ Ex Order 26, 4B1 when	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 41 asked by the surveyor. On 12/03/2024 at 11:59 AM Resident #261 was observed lying in bed with the NJ Exec Order 26.4b1 [redacted] Resident #261 complained that the room was [redacted] and wanted the surveyor to turn the [redacted]. The surveyor explained he could not do that. Resident #262 was observed with an NJ Ex Order 26, 4B1 at the head of the bed on the floor. The NJ Ex Order 26, 4B1 was set at [redacted] and was turned on. The surveyor observed the n/c draped over the top corner of the mattress and the n/c was in contact with the floor. In addition, close observation of the NJ Exec Order 26.4b1 determined that the [redacted] was not dated. On 12/04/2024 at 08:57 AM Resident #261 was observed NJ Ex Order 26, 4B1 [redacted]. No NJ Exec Order 26.4b1 [redacted] was noted. The NJ Ex Order 26, 4B1 was against the wall at the head of the bed. The NJ Ex Order 26, 4B1 was turned off and not in use on this observation. The NJ Ex Order 26, 4B1 was observed coiled up on the floor of the room without protection and no date was observed on the [redacted]. The [redacted] NJ Ex Order 26, 4B1 [redacted]. On 12/05/2024 at 08:59 AM Resident #261 was observed lying in bed with NJ Exec Order 26.4b1 [redacted] Resident #261 stated he/she was [redacted]. Resident #261 had no order for NJ Exec Order 26.4b1 at the time of administration. A review of the Admission Record revealed that Resident #261 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted]	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 42 NJ Exec Order 26.4b1 According to the MDS dated NJ Ex Order 26, 4B1 Resident #261 had a Brief Interview for Mental Status score of [redacted], indicating NJ Exec Order 26.4b1. Section [redacted] indicated that Resident #262 had an active diagnosis of NJ Exec Order 26.4b1 [redacted]. According to Section O of the MDS, Resident #261 did not receive any NJ Exec Order 26.4b1 treatments, including NJ Exec Order 26.4b1. A review of the Order Summary Report with Active Orders As of: NJ Ex Order 26, 4B1 did not reveal a physician order for the use of NJ Ex Order 26, 4B1 [redacted] A review of Resident #261's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the periods of NJ Exec Order 26.4b1 [redacted] did not reveal an order for NJ Exec Order 26.4b1 for Resident #261. A review of Resident #261's comprehensive care plan did not indicate a care planned focus for NJ Exec Order 26 [redacted] for Resident #261. During an interview with the surveyor on 12/05/2024 at 12:53 PM, Licensed Practical Nurse (LPN #3) assigned to Resident #261 was asked if residents who receive NJ Exec Order 26.4b1 U.S. FOIA (b)(6) require a physician order. LPN #3 told the surveyor, 'Yeah." The surveyor then asked LPN #3 to check Resident #261's electronic medical record (EMR) for a NJ Ex Order 26, 4B1 order. LPN #3 went into the EMR of Resident #261 and told the surveyor that there was no order for NJ Exec Order 26.4b1. The surveyor then asked	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 43	F 695		

LPN #3 if Resident #261 should have an order. LPN #3 told the surveyor, "Yeah." The surveyor asked LPN #3 what the facility practice was for NJ Exec Order 26.4b1 when not in use. LPN #3 responded that the NJ Exec Order 26.4b1 is supposed to be protected from NJ Ex Order 26, 4B1 when not in use.

During an interview with the surveyor on 12/05/2024 at 01:24 PM, LPN/UM #2 was asked if residents receiving NJ Ex Order 26, 4B1 required a physician order. LPN/UM #2 told the surveyor, "yes." The surveyor then asked LPN/UM #2 what the facility practice was for NJ Ex Order 26, 4B1 when not in use. LPN/UM #2 told the surveyor it should be in NJ Ex Order 26 for sanitary reasons while not in use. In addition, the surveyor asked LPN/UM #2 what the facility practice was for NJ Ex Order 26, 4B1 for residents receiving NJ Ex Order 26, 4B1. LPN/UM #2 explained NJ Ex Order 26, 4B1 is changed on the 11-7 shift I think every Thursday, once a week. The surveyor asked LPN/UM #2 the importance of NJ Ex Order 26, 4B1 and LPN/UM #2 said to ensure the patency of the NJ Ex Order 26, 4B1 reasons. The surveyor then asked if Resident #261 had an order for NJ Ex Order 26, 4B1 and LPN/UM #2 stated that Resident #261 never had NJ Ex Order 26, 4B and she didn't know why he/she had it right now.

During an interview with the surveyor on 12/06/2024 at 01:54 PM, the U.S. FOIA (b)(6) was asked if the use NJ Exec Order 26.4b1 by a resident required a physician order. The U.S. FOIA (b) told the surveyor that resident's receiving NJ Ex Order 26, 4B1 required a physician order unless it was an emergency, and an order would be obtained after the emergency was resolved. The surveyor then asked what the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 44	F 695		

facility practice was for [NJ Exec Order 26.] when not in use. The [NJ Exec Order] explained that the equipment should be bagged when not in use. The [U.S. FOIA (b)] also stated that [NJ Exec Order 26.4b1] is to be changed once per week on 11-7 shift on Sundays and that it should be dated on that date.

3.) During the initial tour of the facility on 12/02/2024 at 10:18 AM, Resident #18 was observed in his/her room sitting on the side of the bed with [NJ Exec Order 26.4b1]

On 12/03/2024 at 10:30 AM, Surveyor #2 observed Resident #18 in their room, lying in bed with [NJ Exec Order 26.4b1]

On 12/04/2024 at 10:33 AM, the Surveyor #2 observed Resident #18 in their room sitting on the side of his/her bed with [NJ Exec Order 26.4b1]

A review of the EMR on 12/03/2024 at 12:45 PM, revealed the following:

According to the Admission Record, Resident #18 was admitted to the facility with diagnoses including but not limited to: [NJ Exec Order 26.4b1].

A review of the most recent MDS dated [NJ Exec Order 26.4b1] revealed under section [NJ Exec Order 26.4b1]

A review of the OSR with Active Orders as of [NJ Exec Order 26.4b1], revealed a physician order dated [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] as needed (PRN) for [NJ Exec Order 26.4b1]

A review of the TAR for [NJ Ex Order 26.4b1], Surveyor #3 noted that nurses were not documenting the administration of [NJ Exec Order 26.4] to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 45 During an interview with Surveyor #3 on 12/05/2024 at 11:00 AM, LPN/UM #1 was questioned regarding the resident's PRN [redacted]. LPN/UM #1 said that the [redacted] should be dated weekly to indicate when it was changed. The resident should have [redacted] care planned, and if nursing staff administer PRN [redacted] it should be documented in the Treatment Administration Records (TAR). During an interview with the surveyor on 12/06/2024 at 01:54 PM, the [redacted] asked if the use of supplemental [redacted] by a resident required a physician order. The [redacted] told the surveyor that resident's receiving [redacted] required a physician order unless it was an emergency, and an order would be obtained after the emergency was resolved. The surveyor then asked what the facility practice was for [redacted] when not in use. The [redacted] explained that the equipment should be bagged when not in use. The [redacted] also stated that [redacted] is to be changed once per week on 11-7 shift on Sundays and that it should be dated on that date. A review of a facility policy titled Oxygen Administration; date reviewed/revised: 01082024, revealed under Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The following was revealed under Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 46 such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. e. Keep delivery devices covered in a plastic bag when not in use. NJAC 8:39-27.1(a)	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a U. S. FOIA (b) (2) worked 7 days a week for	F 727	Staffing was reviewed for the referenced dates/shifts. An emphasis on hiring RNs was initiated with company recruiters. RN schedules adjusted to ensure RN	1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 47 at least 8 consecutive hours a day for 2 of 14 days reviewed 11/17/2024 through 11/30/2024. Based on interview and review of Nurse Staffing Report sheets, it was determined that the facility failed to ensure a U. S. FOIA (b) (2)) worked 7 days a week for at least 8 consecutive hours a day for 2 of 14 days reviewed. This deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the week of 11/17/2024 through11/23/2024, revealed the facility had no U. S. FO coverage for all shifts on 11/18/2024 and 11/23/2024. During an interview with the surveyor on 12/06/2024 at 2:06 PM, the U. S. FOIA (b) (2) expressed that staffing needs are met to some extent but not fully. When an U. S. FOIA is unavailable to work the required 8 consecutive hours, the U. S. FOIA (b) steps in as a supervisor, rather than fulfilling the U. S. FOIA (b) role. At that time, the U. S. FOIA (b) (2) confirmed that the U. S. FOIA (b) can not be counted as the U. S. FOIA on duty. A review of a facility provided policy undated titled, [facility name] Staffing" revealed that, "To ensure there are a sufficient number of staff members (RN, Licensed Practical Nurse, Certified Nursing Assistant) with the appropriate competencies and skill sets necessary to care for its residents' needs requirements eight (8) hours per day for RN is required daily." NJAC 8:39-25.2(h)	F 727	coverage 8 hours per day 7 days per week. In the event of no RN coverage an RN on call rotation schedule was created. All residents have the potential to be affected Education on Staffing Policy to be completed for Staffing Coordinator, Director of Nursing, Unit Managers and Human Resources by 12/27/2024. Daily review of staffing by the Director of Nursing or designee to ensure compliance with the requirement of 8 hours per day for an RN. The facility is working with recruiters to hire additional RNs. A staffing agency will be engaged as needed. Employee referral bonus program put in place for employees to encourage peers to work at the facility. Weekly staffing meetings will be held to include the Director of Nursing or designee and the Staffing Coordinator to determine upcoming schedules and anticipate staffing needs. The Director of Nursing will report findings to the Administrator weekly for 4 weeks then monthly for 3 months with results reported at the monthly QAPI meeting. Date of completion, January 10, 2025	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On	F 756		1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 48 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 49 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to address recommendations made by the U. S. FOIA (b) (2) [redacted] in a consistent and timely manner. This deficient practice was identified for 2 of 5 residents reviewed for medication management (Resident #22 and Resident #90) and was evidenced by the following: The deficient practice was evidenced by the following: 1. On 12/2/24 at 10:28 AM, during initial tour the Surveyor #1 observed Resident #22 in their room seated in a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 When asked if the staff took good care of them the resident responded by NJ Exec Order 26.4b1 [redacted] then proceeded to get up from the chair and walk out of the room and down the hallway. Surveyor #1 reviewed Resident #22's medical record on 12/03/2024 at 09:51 AM as follows: A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included NJ Exec Order 26.4b1 [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4 [redacted], reflected that the Resident #22's Brief Interview for Mental Status (BIMS) score was NJ Exe [redacted] which indicated that the resident's NJ Exec Order 26.4b1 . A further review of the	F 756	Resident #22 and Resident #90 physicians were notified of the deficiency regarding these residents. The NJ Exec Order 26.4b1 [redacted] Pharmacist Consultant monthly recommendations were reviewed by Unit Managers and DON to ensure all recommendations were completed on 1/15/2025. All residents have the potential to be affected. Nurses and newly hired nurses will be educated by the Staff Educator or designee on the Addressing Medication Regimen Review Irregularities (Pharmacist Recommendations) by 12/30/24. Upon receiving the Pharmacist Consultant monthly recommendations, the Director of Nursing will make copies of the reports and distribute them to the Unit Managers within 24 hours of receipt. The unit Managers will then have the recommendations assigned to nursing completed within 72 hours and a copy of the recommendations with changes made returned to the DON. The unit Managers will contact physicians regarding the Pharmacists Consult to the physicians and obtain verbal or written orders within 7 days of receiving the recommendations. The Unit Managers will return completed pharmacy recommendations to the DON within 14 days of receiving the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 50 MDS revealed Resident #22 was taking [redacted] medication during the last seven days or since admission. A review of the Order Summary Report (OSR) (physician's order sheet) dated [redacted] revealed a Physician order (PO) dated [redacted] for [redacted] give [redacted] every [redacted]. A review of the [redacted] Medication Administration Record (MAR) revealed an order dated [redacted], for [redacted], give [redacted] with a discontinued date of [redacted]. A review of the [redacted]- "Pharmacist's Consult to Physician" revealed the following recommendations: On [redacted] the [redacted] recommended D/C (discontinue current order for PRN (as needed) [redacted]. May renew PRN [redacted] with a stop date exceeding [redacted] if clinical rationale and anticipated during (sic)[duration] of therapy are documented in the resident's medical record. As per new CMS requirement for initial [redacted] and [redacted] PRN medication, orders are to be limited to 14 days. Requirements for renewal of PRN [redacted] after physician review and reason for continuation must be documented by the [redacted] ordering PRN use of the [redacted] medication in the resident's chart. On 10/1/2024 the [redacted] made the following	F 756	recommendations. A copy of the recommendations and the physician's response will be returned to the DON. Addressing Medication Regimen Review Irregularities (Pharmacist Recommendations) revised on The Director of Nursing or designee will audit all monthly Consultant Pharmacist recommendations for completion and report findings at the monthly QAPI meeting for 4 months for review. Date of Completion January 17, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 51 recommendation assigned to: Nursing. Nursing: If not already done, please contact and document physician's response to my previous recommendation. recommended D/C (discontinue current order for PRN (as needed) [redacted] May renew PRN [redacted] with a stop date exceeding [redacted] days if clinical rationale and anticipated during (sic)[duration] of [redacted] are documented in the resident's medical record. As per new CMS requirement for initial [redacted] and [redacted] PRN medication, orders are to be limited to [redacted] days. Requirements for renewal of PRN [redacted] after physician review and reason for continuation must be documented by the medical practitioner ordering PRN use of the [redacted] medication in the resident's chart. During an interview with Surveyor #1 on 12/6/2024 at 10:45 AM, Licensed Practical Nurse/Unit Manager #2 (LPN/UM #2) who stated nursing was responsible for ensuring the U. S. FOIA (b) (2) recommendations were addressed within 10 days of receiving them. Once the recommendations were completed, they were returned to the U.S. FOIA (b)(6) [redacted] During an interview with Surveyor #1 on 12/6/24 at 2:10 PM, in the presence of the survey team, the [redacted] stated the [redacted] recommendations should be addressed as soon as possible, and before the next month's U. S. FOIA (b) (2) review. Both the [redacted] and the U.S. FOIA (b)(6) [redacted]) acknowledged the CP report and recommendations should have been addressed prior to the next [redacted] review.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 52 2. Surveyor #2 reviewed the medical record for Resident #90 on 12/03/2024 at 08:37 AM as follows: A review of the Admission Record revealed that Resident #90 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b [redacted] A review of the comprehensive MDS dated NJ Ex Order 26, 4B1, revealed Resident #90 had a BIMS score of NJ Exec Orde, indicating he/she was NJ Exec Order 26.4b1 [redacted]. Section N revealed that Resident #90 received NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 daily, NJ Exec Order 26.4b1 daily, NJ Exec Order daily and NJ Exec Order 26.4b1 daily. On 12/04/2024 at 09:54 AM, Surveyor #2 reviewed the U.S. FOIA (b)(6) monthly medication regimen review (MRR) for the past 6 months as provided by the facility U.S. FOIA (b)(6) [redacted]. The following recommendations were revealed: 1. On 08/02/2024, the CP made the following recommendation for Resident #90: Please clarify NJ Exec Order 26.4b1 [redacted] order as needs specific instructions when to give- add order to PRN (as needed) NJ Ex Order 26, 4B1 [redacted] A review of the NJ Ex Order 26, 4B1 Medication Administration Record (MAR) for Resident #90 revealed that the recommendation was addressed by the facility on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted] order 40 days after the CP recommendation.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 53 2. On [redacted], the [redacted] recommended [redacted] is missing an amount to administer on the MAR please clarify and update order. According to the NJ Ex Order 26, 4B1 MAR the facility responded [redacted] and discontinued the order for [redacted] The follow up occurred 40 days after receiving the CP recommendation. 3. On [redacted], the [redacted] made the following recommendation: Change medication [redacted] NJ Ex Order 26, 4B1) = 8 AM and 5 PM? The facility responded on [redacted] and discontinued [redacted]. The facility did not respond to the [redacted] recommendation for a period of 40 days. On [redacted] the [redacted] made the following recommendations: 1. Nursing Recommendation: Please clarify [redacted] order as needs specific instructions when to give - add to order PRN [redacted] if NJ Ex Order 26, 4B1 Facility responded on [redacted] by discontinuing [redacted] order, however [redacted] made the same recommendation on [redacted] MRR and facility failed to respond until [redacted] as described previously. 2. Nursing Recommendation: [redacted] t is missing an amount to administer on the MAR please clarify and update order. Facility responded on [redacted] and discontinued the [redacted] order as described previously. On [redacted] the [redacted] made the following Physician recommendation:	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 54	F 756		

1. Patient is receiving NJ Exec Order 26.4b1 [redacted]. NJ Exec Order 26.4b1 cannot be applied for more than [redacted] hours per manufacturer as medication can be systematically NJ Ex Order 26, 4B1 [redacted]. Recommend change to QD - apply daily and remove 12 hours later. Also please indicate if NJ Ex Order 26, 4B1 should be used (current order does not specify)> The facility failed to respond to [redacted] recommendation until NJ Ex Order 26, 4B1 35 days after recommendation, by discontinuing the order the order for the U.S. FOIA (b)(6) [redacted].

During an interview with Surveyor #2 on 12/06/2024 at 10:45 AM, Licensed Practical Nurse/Unit Manger (LPN/UM #2) was asked to briefly describe the facility process for addressing the [redacted] MRR recommendations. LPN/UM #2 told the surveyor that the recommendations are distributed to the appropriate units. Nursing is responsible for following through on the recommendations. If it is a physician recommendation, we will call the physician and get their response. Nursing recommendations are handled by the nursing staff on the unit. For the most part I am responsible for making sure it is done. Surveyor #2 then asked LPN/UM #2 what the expected timeframe for nursing staff was to complete the MRR recommendations made by the [redacted] LPN/UM #2 explained that the recommendations were to be completed within 10 days of receiving the report. She further stated that we document on the [redacted] recommendation sheet and once they are completed, we return them to the U.S. FOIA (b)(6) [redacted]).

During an interview with Surveyor #2 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 55 12/06/2024 at 02:19 PM, the [U.S. FOIA (b)] was asked what the facility process was for responding to the [U.S. FO] monthly MRR recommendations. The [U.S. FOIA (b)] told the surveyor's that the [U.S. FO] recommendations are emailed to the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)(6)]) or I make a copy of it and give it to them. The [U.S. FOIA] is responsible for carrying out the recommendations for nursing and to call the physician for physician recommendations. The surveyor asked the [U.S. FOIA (b)] what the expected timeline was for completion. The [U.S. FOIA (b)] stated the timeline is "quickly as possible." I would expect the recommendations to be completed before the next month's visit. The surveyor then asked the [U.S. FOIA (b)] who was responsible for ensuring that the recommendations were completed in a timely manner. The [NJ Exec Off] replied he would be responsible to ensure that all recommendations are completed and done in a timely manner. The [U.S. FOIA (b)] further explained that the nurse (s) should document on the recommendation sheet to indicate that the recommendation was addressed. A review of a facility policy titled "Addressing Medication Regimen Review Irregularities (Pharmacist recommendations) dated 11/11/2024 revealed... It is the policy of this facility to provide a Medication Regimen review (MRR) for each resident to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event... An irregularity refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services... the report should be submitted to the DON within	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 56 10 working days of the review and subsequent follow-up should occur by next MRR. A review of a facility policy titled Consultant Pharmacist Services, undated, revealed under Procedures: F. The consultant pharmacist documents activities performed and services provided on behalf of the residents and the facility. 1) A written or electronic report of findings and recommendations resulting from the activities as described above is given to the, attending physician, director of nursing, medical director, administrator, and others as may be appropriate at least monthly. The facility has a process to ensure that the findings are acted upon. 2) Resident-specific recommendations are documented by nursing when completed.	F 756		
F 803 SS=F	NJAC 8:39-29.3(a)(1) Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 57 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Repeat deficiency from recertification survey of 09/23/2023 Based on observations, interviews, and review review of other facility documentation, it was determined that the facility failed to follow the planned, written menu and ensure residents were notified in advance of menu changes for 3 of 3 meals observed. This deficient practice was evidenced by the following: 1. On 12/03/2024 at 12:12 PM, the surveyor observed the lunch meal on the 2nd floor dining/activity room. The surveyor observed Resident #48 and seven (7) additional residents at the lunch meal. All eight (8) residents were observed to have received NJ Exec Order 26.4b1 [redacted] According to the NJ Exec Order 26.4b1 4 cycle menu provided to the surveyor on entry to the facility, residents were to receive yellow cake for the dessert at the lunch meal on NJ Exec Order 26.4b1. There was no yellow cake observed. When interviewed the U.S. FOIA (b)(6) [redacted]) told the surveyor that "they (kitchen staff) didn't make	F 803	The U. S. FOIA (b) (2) [redacted] was educated by the U. S. FOIA (b) (2) on 12/10/2024 to notify the dietician and obtain her signed approval for menu changes. Resident #48 voiced NJ Exec Order 26.4b1 regarding the menu change. Alternatives were offered and resident preferences were updated. Resident #84 voiced NJ Exec Order 26.4b1 regarding the menu change. Alternatives were offered and resident preferences were updated. All residents have the potential to be affected by this deficient practice. Food Preparation Guidelines policy revised to include menu substitutions. The facility has changed Food Service Directors. The U. S. FOIA (b) (2) [redacted] has been educated on the new policy by the U. S. FOIA (b) (2). Menus are posted daily. The Food Service Director will notify the Dietician and Administrator of any needed menu changes prior to making any changes. Once approved,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 58 any." In addition, the lunch menu also included that a dinner roll was to be served. Observation of the 8 residents at the lunch meal revealed that 8 of 8 residents did not receive a dinner roll at the lunch meal. When interviewed the [redacted] told the surveyor on interview that the facility had run out the previous Friday [redacted] and that they only received a delivery once a week. 2. On 12/04/2024 at 12:07 PM, the surveyor observed the lunch meal on the [redacted] Floor dining room. The surveyor observed Resident #84 at the lunch meal being assisted by a staff nurse. Resident #84 received the following menu items: [redacted]). There was no scalloped corn and there were no dinner rolls served. In addition, the menu revealed that residents were to receive a baked apple as dessert. There were no baked apples. On 12/04/2024 at 12:15 PM, the surveyor went to the kitchen and interviewed the [redacted] and cook. The surveyor asked the cook why residents had no received scalloped corn at the lunch meal as listed on the menu. The cook told the surveyor that they only had a few cans of corn, so she mixed it with the other vegetables, so we had enough. According to the [redacted] he did not contact the [redacted]) to obtain an approval of menu substitution prior to the lunch meal that day. The [redacted] told the surveyor that there were no dinner rolls in the facility and told the surveyor that they did not make yellow cake yesterday and substituted diced peaches. When asked if the [redacted] contacted the [redacted] for approval of menu substitutions prior	F 803	notification of the change will be made to the residents, and a record will be kept accordingly. The Food Service Director will submit a report weekly to the Administrator for 2 months, then bi-weekly for 1 month. The Administrator will submit a copy of the report to the facilitys monthly QAPI Committee Meeting for 3 months. Date of completion, January 17, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 59 to the meal the [U.S. FOIA] stated he did not contact the [U.S. FOIA (b)] for approval prior to the lunch meal and that he had not contacted her at the time of interview. The surveyor asked the [U.S. FOIA] if the facility process was to contact the [U.S. FOIA (b)] prior to making menu substitutions. The [NJ Exec Orde] agreed that he should contact the [U. S. FOIA (b)] for menu substitutions and document the substitutions in the meal substitution log. 3. On 12/05/2024 at 11:47 AM, during observation of tray line temperatures in the presence of the [U.S. FOIA], the surveyor observed that the vegetable to be served at the lunch meal on [NJ Exec Order 26.4b1] was a mixed vegetable that consisted of peas, carrots, corn, and green beans. This was the same vegetable that was observed to be served at the lunch meal on [redacted] lunch meals. The surveyor asked the [redacted] if he realized that they had served the same vegetable at the lunch meal 3 days in a row. The [redacted] stated, "Well, the menu said mixed vegetable." The [U.S. FOIA] responded by saying that he would "change" the menu. A review of the Week 4 menu provided to the surveyor upon the initial tour revealed that the following vegetable was to be served at lunch meals: On [NJ Exec Order 26.4b1] the vegetable to be served according to the [NJ Exec Order 26.4b1] was seasoned green peas. Residents received a mixed vegetable as described previously. On [NJ Exec Order 26.4b1] lunch menu revealed that residents were to receive scalloped corn at the lunch meal. Residents received the same mixed vegetable that they had received at lunch on [NJ Exec Order 26.4b1]. On [NJ Exec Order 26.4b1] according to the [NJ Exec Order 26.4b1] menu, residents were to receive vegetable blend.	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 60	F 803		

The [redacted] stated to the surveyor that the vegetable served was a mixed vegetable and agreed that the kitchen had served the same mixed vegetable at lunch for 3 days consecutively.

On 12/05/2024 at 12:09 PM, the surveyor interviewed the facility [redacted]. The surveyor asked the [redacted] if she had been contacted by the [redacted] for any menu substitutions. The [redacted] told the surveyor that yesterday was supposed to be corn. The surveyor corrected the [redacted] and told her it was supposed to be [redacted]. The [redacted] further stated she called yesterday (the [redacted] right around 12:30 PM and she asked the [redacted] if there were any substitutions and he said that he made a [redacted]. I called earlier in the week, and I was told that there were no substitutions for the week. I was not contacted for a substitution for the yellow cake on Tuesday [redacted] The surveyor asked if the [redacted] contacted her before or after the lunch meal to get approval for the [redacted]. The [redacted] told the surveyor that it was after the lunch meal.

4. On 12/06/2024 at 12:06 PM, the surveyor observed the meal delivery cart outside the 2nd floor dining room prior to the lunch meal. The surveyor observed diced fruit in a clear plastic portion control cup on resident trays. The dessert to be served according to the [redacted] menu on [redacted] was sherbet.

On 12/06/2024 at 12:40 PM, the surveyor interviewed the facility [redacted]. The surveyor asked the [redacted] if he had completed a menu substitution for the lunch meal because the residents received diced, canned fruit as dessert and not sherbet as the menu had indicated. The [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 61 stated, "I'm going to do it right now." The surveyor asked the [redacted] when the substitution should have been completed and approved. The [redacted] stated that it should have been done prior to the lunch meal. The surveyor asked the [redacted] if he had sherbet and the [redacted] stated, "No." The facility was unable to provide the surveyor with a facility policy and procedure for menu substitutions. NJAC 8:39-17.2(b)	F 803		
F 812 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: Based on observation, interview, and review of there facility documentation, it was determined	F 812	The top shelf of a multitier rack in the dry storage area had coffee filters removed	1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 62 that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 12/02/2024 at 9:23 AM, the surveyor, accompanied by the U.S. FOIA (b)(6) [redacted]), observed the following in the kitchen: 1. On the top shelf of a multi-tiered rack in the dry storage area, a previously opened pack of coffee filters were removed from their original packaging and left uncovered. The usable surface was exposed to contamination. 2. On a middle shelf of the walk-in freezer contained frozen pizza box previously opened. The lids to the box were open and the plastic bag inside that contained the pizza was opened and the pizza was exposed to the air and contamination. 3. The surveyor observed the kitchen staff operating the high temperature dish machine after the breakfast meal. The staff were actively washing dishes during this observation. The surveyor asked the [redacted] what the facility process was for operation of the dish machine. The [redacted] told the surveyor, "First we check to assure proper temperatures (wash and final rinse) and record those temperatures on the temperature log prior to initiating dish washing." The surveyor then asked the [redacted] to provide the surveyor with the December 2024 dish machine temperature log. A review of the December dish machine temperature log revealed that no temperatures had been recorded for the month of December 2024 for the breakfast, lunch, and dinner meals for the dates 12/01/2024 up to and including	F 812	from their original packaging and left uncovered. These coffee filters were discarded. Pizza was exposed to air and contamination from being in an open box with the inner plastic bag opened in the walk-in freezer. This pizza was discarded. The dishwasher machine had no temperature log. A temperature log was initiated. Wet pans were noted on a storage rack on top of each other. The pans were re-washed and properly fried before being put away. The industrial can opener was observed with a brown/black substance on the cutting blade that was immediately removed, cleaned and sanitized. The first-floor refrigerator in the nourishment room did not have a temperature log as well as no log for the freezer which also did not have an internal thermometer. Temperature logs were initiated for the refrigerator. A thermometer was placed in the freezer portion and a freezer temperature log was initiated. The second-floor nourishment room had undated applesauce and diced fruit in the refrigerator. The items were discarded. The temperature probe was not cleaned with appropriate sanitizer when food temperatures were checked. The dietary department provided alcohol swaps to clean the temperature probe. All residents have the potential to be affected by this deficient practice. Dietary staff will be educated on Food Safety Requirements, proper storage and labeling of food items, maintaining temperature logs for the dishwasher,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 63 breakfast on 12/02/2024. On interview the [redacted] agreed that dish machine temperatures must be at the required minimum temperatures and recorded on the temperature log prior to initiating dish washing. The surveyor attempted to interview the kitchen staff that was observed operating the dish machine, however the staff failed to provide the surveyor with an explanation when asked why the temperatures for the wash and final rinse had not been recorded. 4. A stack of three (3) quarter pans on a middle shelf of the pot and pan storage rack were observed to have a wet liquid substance on the interior and exterior of the pans when the surveyor lifted the top pan on the stack. On the same shelf next to the three quarter pans, a stack of four (4) half pans were observed to have a wet, clear liquid substance on the interior and exterior of the pans when the surveyor picked up the top half pan. On an adjacent rack on the middle shelf, the surveyor observed a sheet pan that was not inverted and was facing in the upward position. The pan was observed to have a clear liquid substance on the food contact surface. On interview, the [redacted] agreed that all pans should be air dried prior to stacking on top each other. The [redacted] further stated, "That's wet nesting" (occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating a condition that is ripe for microorganisms to grow). 5. An industrial can opener was attached to the end of the prep table in the center of the kitchen. The can opener was not currently in use, according to the [redacted] When removed out of its receptacle the surveyor observed a brown/black sticky substance on the cutting blade and on the stem of the can opener. The [redacted] removed the	F 812	proper storage of pots and pans and proper procedure for cleaning the temperature probe when checking food temperatures by the Food Service Director by 12/31/24. All food items were observed to identify if any items needed to be covered or dated which was completed on 12/09/24. The Food Service Director will audit the dishwasher temperature log for completion daily Monday through Friday for 2 weeks then every Monday, Wednesday and Friday x 2 weeks then weekly times 4 weeks and submit these audits to the Administrator upon completion. Unit Managers will audit the nourishment room refrigerators and freezers temperature log for completion daily Monday through Friday for 2 weeks then every Monday, Wednesday and Friday x 2 weeks then weekly times 4 weeks and submit these audits to the DON upon completion. Unit Managers will audit the nourishment room refrigerators for dated and non-expired food daily Monday through Friday for 2 weeks then every Monday, Wednesday and Friday x 2 weeks then weekly times 4 weeks and submit these audits to the DON upon completion. The Food Service Director will submit a monthly report to the facility's monthly QAPI Committee Meeting for 4 months The Director of Nursing will submit a monthly report to the facility's monthly QAPI Committee Meeting for 4 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 64 can opener to the dish room to be cleaned and sanitized in the presence of the surveyor. The U.S. FOIA told the surveyor that he did not have the can opener on the cleaning schedule and stated, "I screwed up." On 12/03/2024 at 01:09 PM, the surveyor observed the first floor resident/dietary nourishment room. The surveyor reviewed the November 2024 and December 2024 Nourishment Room Refrigerator Temperature Log for the first floor nourishment room.A review of the temperature logs revealed that refrigerator temperatures had not been recorded from 11/27/2024 up to and including 12/3/2024. The temperature log also revealed that the facility was only monitoring temperatures for the refrigerator and no monitoring of the freezer temperatures was being conducted. observation of the interior of the freezer revealed that there was no internal thermometer present. The surveyor interviewed Licensed Practical Nurse (LPN #2) who told the surveyor that the 11-7 shift was responsible for the recording of refrigeration temperatures on the first floor unit pantry. On 12/05/2024 at 09:35 AM, the surveyor observed the 2nd floor nourishment room/resident pantry, accompanied by the U.S. FOIA (b)(6)). On an upper shelf, a clear plastic portion control cup contained what appeared to be apple sauce and a second portion control cup contained what appeared to be diced fruit. The portion control cups had no dates. The U.S. FOIA indicated that it was sent from the kitchen. When interviewed the U.S. FO agreed that all foods require dates. On interview with the facility U.S. FOIA the surveyor was told that staff on the unit must have removed the portion control cups of	F 812	Date of completion, January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 65	F 812		

applesauce and diced fruit from resident trays and placed them in the nourishment refrigerator because all foods that come from the kitchen are dated using a labeling gun.

On 12/05/2024 at 11:24 AM, the surveyor, accompanied by the [U. S. FOIA], observed the following in the kitchen:

1. The surveyor told the [U.S. FOIA] upon entry to the kitchen that they needed to observe tray line food temperatures for the lunch meal. The [U.S. FOIA] told the surveyor that he would be conducting the food temperatures and proceeded to obtain a red digital thermometer and a brown paper hand towel from the hand towel dispenser wall mounted in the designated hand washing area. The [U. S. FOIA] then approached the steam table where the lunch meal was waiting to be served from their respective pans. The [U.S. FOIA (D)] set the brown paper hand towel on the steam table ledge, proceeded to turn on the digital thermometer and inserted the thermometer into the first food item which was described as baked chicken. The [U.S. FOIA (D)] obtained a temperature of 160 F (Fahrenheit). The [NJ Exec Offic] then removed the digital thermometer from the baked chicken and proceeded to grab the brown paper hand towel. At this point the surveyor told the [U.S. FOIA (D)] that they needed to obtain an alcohol wipe to disinfect the probe before taking the temperature of the next food item. The [NJ Exec Offic] responded, "I don't have any" and proceeded to wipe the probe of the thermometer in then insert the thermometer into the next food item which was fried rice. After obtaining a temperature of 160.3 F, the [U.S. FOIA] removed the thermometer from the rice and proceeded to wipe the probe with the brown paper hand towel previously used to clean the thermometer after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 66 the chicken. The [U.S. FOIA (b)] repeated this pattern for six additional food items. The digital thermometer probe was never cleaned with an approved sanitizer between foods, presenting a risk of contamination. The surveyor then conducted an interview with the facility [U.S. FOIA (b)(6)]). The surveyor explained the process that the [U.S. FOIA] utilized to sanitize the digital thermometer during the observation of lunch tray line temperatures. The [U.S. FOIA (b)] told the surveyor, "I agree that the thermometer probe should have been cleaned with an appropriate sanitizer between foods. Using a paper towel is unacceptable." The surveyor reviewed the facility policy titled Record of Food Temperatures, undated, revealed under the heading Policy Explanation and Compliance Guidelines: Food temperatures will be verified using a thermometer which is both clean, sanitized and calibrated to ensure accuracy. The surveyor reviewed the facility policy titled Use and Storage of Food Brought in by Family and Visitors, undated, revealed under Policy Explanation and Compliance Guidelines: 2. All food items brought in that are already prepared by the family or visitor brought in must be labeled with content and dated. a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. The surveyor reviewed the facility policy titled Dishwasher Temperature, undated, revealed under Policy Explanation and Compliance Guidelines: Water temperatures shall be measured and recorded prior to each meal and/or	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 67 after the dishwasher has been emptied or re-filled for cleaning purposes. The facility failed to provide the surveyor a policy/procedure related to wet nesting. NJAC 18:39-17.2(g)	F 812		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	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	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview 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 was evident for 1. For the week of Complaint staffing from 07/21/2024 to 07/27/2024, the facility was deficient in CNA staffing for resident care on 6 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts, 2. For the 2 weeks of Complaint staffing from 09/22/2024 to 10/05/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts, and deficient in total staff for residents on 4 of 14 overnight	S 560	Staffing was reviewed for the referenced dates/shifts. Sign-on bonuses are being offered to attract more applicants to apply to the facility. All residents have the potential to be affected Education on minimum staffing requirements to be completed for Staffing Coordinator, Director of Nursing, Unit Managers and Human Resources by 12/27/2024. Daily review of staffing by the Director of	1/10/25

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

Electronically Signed | 12/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 shifts, 3. For the week of Complaint staffing from 10/13/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, 4. For the 2 weeks of staffing prior to survey from 11/17/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts and deficient in total staff for residents on 4 of 14 overnight shifts. 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. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer 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	S 560	Nursing or designee to ensure compliance with NJSA 30:13-18 minimum staffing requirements for nursing homes for all shifts. Call out policy reviewed. A staffing agency will be engaged as needed. Employee referral bonus program put in place for employees to encourage peers to work at the facility. Weekly staffing meetings will be held to include the Director of Nursing or designee and the Staffing Coordinator to determine upcoming schedules and anticipate staffing needs. The Director of Nursing will report findings to the Administrator weekly for 4 weeks then monthly for 3 months with results reported at the monthly QAPI meeting for 4 months. Date of completion, January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 07/21/2024 to 07/27/2024, the facility was deficient in CNA staffing for resident care on 6 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -07/21/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/21/24 had 7 total staff for 110 residents on the overnight shift, required at least 8 total staff. -07/22/24 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/24/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/25/24 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/26/24 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/27/24 had 9 CNAs for 112 residents on the day shift, required at least 14 CNAs. 2. For the 2 weeks of Complaint staffing from 09/22/2024 to 10/05/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts, and deficient in total staff for residents on 4 of 14 overnight shifts as follows: -09/22/24 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -09/22/24 had 7 total staff for 115 residents on the overnight shift, required at least 8 total staff. -09/23/24 had 6 CNAs for 115 residents on the day shift, required at least 14 CNAs. -09/24/24 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -09/25/24 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. -09/26/24 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -09/27/24 had 9 CNAs for 111 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 day shift, required at least 14 CNAs. -09/28/24 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -09/28/24 had 10 total staff for 111 residents on the evening shift, required at least 11 total staff. -09/28/24 had 5 total staff for 111 residents on the overnight shift, required at least 8 total staff. -09/29/24 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -09/29/24 had 7 total staff for 111 residents on the overnight shift, required at least 8 total staff. -09/30/24 had 6 CNAs for 111 residents on the day shift, required at least 14 CNAs. -09/30/24 had 9 total staff for 111 residents on the evening shift, required at least 11 total staff. -09/30/24 had 7 total staff for 111 residents on the overnight shift, required at least 8 total staff. -10/01/24 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/02/24 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/03/24 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/04/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/05/24 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. 3. For the week of Complaint staffing from 10/13/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/13/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/14/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/15/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 -10/16/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/17/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/18/24 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. -10/19/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. 4. For the 2 weeks of staffing prior to survey from 11/17/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts and deficient in total staff for residents on 4 of 14 overnight shifts as follows: -11/17/24 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -11/18/24 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -11/20/24 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -11/20/24 had 6 tot al staff for 110 residents on the overnight shift, required at least 8 total staff. -11/21/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -11/22/24 had 7 total staff for 108 residents on the overnight shift, required at least 8 total staff. -11/23/24 had 7 CNAs for 108 residents on the day shift, required at least 13 CNAs. -11/23/24 had 5 total staff for 108 residents on the overnight shift, required at least 8 total staff. -11/24/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -11/25/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -11/26/24 had 7 total staff for 108 residents on the overnight shift, required at least 8 total staff. -11/27/24 had 12 CNAs for 108 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 day shift, required at least 13 CNAs. -11/28/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -11/28/24 had 10 total staff for 108 residents on the evening shift, required at least 11 total staff. -11/29/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -11/30/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. During an interview with the surveyor on 12/05/2024 at 10:20 AM, the Staffing Coordinator (SC) who is also a Certified Nursing Assistant said that the facility is not meeting staff requirements. Staffing levels are determined using ratios based on the census. During an interview with the surveyor on 12/06/2024 at 2:06 PM, the Director of Nursing expressed that staffing needs are met to some extent but not fully.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (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	S1680		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1680	Continued From page 6 corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1680	Continued From page 7 This REQUIREMENT is not met as evidenced by: "Based on review of the Nurse Staffing Reports for the weeks of 11/17/2024, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 11/17/24 Required Staffing Hours: 277.25 -11/18/24 had 272 actual staffing hours, for a difference of -5.75 hours. -11/23/24 had 248 actual staffing hours, for a difference of -29.75 hours. During an interview with the surveyor on 12/05/2024 at 10:20 AM, the Staffing Coordinator (SC) who is also a Certified Nursing Assistant said that the facility is not meeting staff requirements. Staffing levels are determined using ratios based on the census. During an interview with the surveyor on 12/06/2024 at 2:06 PM, the Director of Nursing expressed that staffing needs are met to some extent but not fully.	S1680	AAS-12 form is utilized to calculate the minimum staffing required for the next day to ensure the facility is properly staffed. All residents have the potential to be affected. Corporate representative to educate the Administrator, DON, Unit Managers, Staff Educator and Staffing Coordinator on how to calculate minimum staffing levels. The Director of Nursing or designee will calculate the minimum staffing level for the upcoming day before the facility's morning meeting and report the need at the meeting. Weekend needs will be reported at the Friday meeting. The Staffing Coordinator will utilize the provided information to ensure proper staffing is scheduled for the upcoming day. The Staffing Coordinator and DON will meet daily Monday through Friday to discuss whether staffing requirements are being met. The Director of Nursing will report findings to the Administrator weekly for 4 weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1680	Continued From page 8	S1680	then monthly for 3 months with results reported at the monthly QAPI meeting for 4 months. Date of Completion January 10, 2025	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315206 Y1	A. Building B. Wing Y2	2/12/2025 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0582	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	01/10/2025	LSC	01/10/2025	LSC	01/10/2025
ID Prefix F0641	Correction	ID Prefix F0655	Correction	ID Prefix F0656	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	01/10/2025	LSC	01/10/2025	LSC	01/10/2025
ID Prefix F0661	Correction	ID Prefix F0688	Correction	ID Prefix F0695	Correction
Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	01/17/2025	LSC	01/10/2025	LSC	01/10/2025
ID Prefix F0727	Correction	ID Prefix F0756	Correction	ID Prefix F0803	Correction
Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(c)(1)-(7)	Completed
LSC	01/10/2025	LSC	01/17/2025	LSC	01/17/2025
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/10/2025	LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/9/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061520 Y1	A. Building B. Wing Y2	2/12/2025 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1680	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed	Reg. #	Completed
LSC	01/10/2025	LSC	01/10/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/9/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Manahawkin Health And Rehabilitaion Center is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems.	E 015		1/20/25

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

Electronically Signed | 12/27/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 1 (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the [redacted] and [redacted]), it was determined that the facility failed to ensure that the facility maintained an emergency backup food supply to provide subsistence needs for staff and residents. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview on 12/04/2024 at 11:10 AM, the surveyor asked the [redacted] if the facility had enough backup emergency food for 3 days for staff and	E 015	Criteria 1 Supplies were ordered to comply with regulatory standard. Inventory sheet developed. 3 day supply ordered, delivered and arrived at facility and is on hand. Criteria 2 Identified, created menu with inventory to ensure that supply is readily available at all times in the event this has to be implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 2 patients. The [U.S. FOIA] stated, "Right now, no we do not." The surveyor then asked, why not? The [U.S. FOIA] stated, "A delivery got messed up about 2 weeks ago and we had to use the emergency food to feed the residents and we also threw away some of the expired food about 4 days ago". A request for the Emergency menu and emergency food inventory list was made to the [U.S. FOIA] at that time but the [U.S. FOIA] was unable to pull it up on the computer and stated, "I will get back to you". Record review revealed the emergency preparedness plan did not contain an emergency backup food menu, nor did it contain an emergency food supply inventory list. In an interview at 12:10 PM, the [U.S. FOIA (b)] provided documentation showing confirmation of a food order. The documentation indicated and the [U.S. FOIA] stated that the order was just placed that day and should be delivered by Friday. The surveyor again requested for the emergency food menu and emergency food supply inventory list to ensure that the ordered items would cover the 3-day food requirement. The [U.S. FOIA] stated, "I am sorry I can't find it". No further documentation was provided regarding the emergency food menu or the emergency food supply inventory list. The U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM.	E 015	Criteria 3 The food Service Director and Administrator will review the provisions on a monthly basis to ensure sufficient provisions are available. Should the inventory have to be altered immediately replacement provisions will be ordered and noted on the inventory sheet Criteria 4 Will be referred to QAPI the outcome of safety committee inspection for a period of three months, and reviewed by qapi committee on a monthly basis for a period of three months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 3 NJAC 8:39-31.2(e), 31.6	E 015		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/03/24 and 12/04/24. Manahawkin Health and Rehabilitaion Center was found to be in noncompliance 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 Manahawkin Health and Rehabilitation Center is a 2- building with a partial basement, that was built in 80's. It is composed of Type I (fire resistant) construction. The facility is divided into 10 smoke zones. The interrior diesel generator powers approximately 65 % of the building. It was noted that the facility once had a fire pump system. The system is currently supported by city pressure.	K 000		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and	K 223		1/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223	Continued From page 4 * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that doors in exit stairway enclosure were equipped with smoke-resistant doors that are positive latching and either self-closing or automatic-closing in accordance with NFPA 101 (2012) Sections 19.2.2.2.7, 7.2.1.8.2 and NFPA 80 Section 5.2.4.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/04/2024 at 10:11 AM revealed the Central stairway enclosure on the first floor was not provided with latching hardware. This condition would prevent the door from closing and positively latching in the event of an emergency when the controlled access device was de-energized by the fire alarm system. In an interview at the time, the [redacted] confirmed the observation. The U. S. FOIA (b) (2) [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 223	Criteria 1 New devices have been installed that will ensure self-closing or automatic self-closing hardware. The Central Stairway door was repaired by installing latching hardware on 12/7/24. All doors were checked and latch properly by the Maintenance Director. Criteria 2 The facility identified that all residents have the potential to be affected by this deficient practice. The Maintenance Director and or designee will perform an audit ensuring 100 percent of all doors are in compliance with the appropriate apparatuses. If apparatuses will be installed to ensure compliance. Criteria 3 Systemic Changes The maintenance department was educated by the regional Maintenance Manager on how this device is to properly function. In the event of any malfunction, the maintenance department will be notified to address the issue. Monthly checks were added into the TELS system for monitoring. Criteria 4 Monitoring The Maintenance Director or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223	Continued From page 5	K 223	submit a report monthly to the QAPI committee for 3 months to ensure compliance. Target Date for completion. Jan 20	
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the[redacted], it was determined that the facility failed to ensure that discharge from exits was arranged in accordance with NFPA 101:2012 Edition, Sections 19.2.7, 7.1.7, 7.2.5, 7.2.5.3.3, 7.2.5.4.2, 7.2.5.6.2 and 7.7. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/03/2024 at 1:06 PM revealed the "access ramp" exit discharge was not provided with handrails on either side. Additionally, the outside ramp landing was not designed to minimize water accumulation as evidenced by the large puddle of ice that formed where the exit discharge met with the public way.	K 271	Crieria 1 A ramp with handrails that meets ADA requirements was purchased on 01/27/25, delivered on 2/7/25 and installed on 2/10/25. This ramp has railings and is 48 inches wide. The ramp will negate the 10-inch drop off the curb. Criteria 2 All residents have the potential to be effected. This area, is not utilized by residents, this would be utilized the event of a facility wide evaculation Criteria 3 Systemic Changes Staff educated on the utilization of the ramp on 1/9/25 by the Regional Maintenance Manager Criteria 4 Monitoring The Director of Maintenance and or	2/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 271	Continued From page 6 An observation at 1:32 PM revealed the exit discharge ramp leading to a public way was not provided with guardrails. An observation at 1:49 PM revealed, the Koi Pond courtyard exit discharge contained a 10-inch drop-off between the exit discharge and the public way. In interviews at the time, the [redacted] confirmed the observations. The[redacted] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM.	K 271	designee will inspect the ramp on a monthly basis ensure it is functioning as intended. Inspection outcomes will be reported to the qapi team monthly for their review, and action if necessary for a period of three months.	
K 293 SS=F	N.J.A.C 8:39-31.2(e) Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the[redacted] it was determined that the facility failed to ensure that a sign with directional indicator showing the direction of travel was provided in every location	K 293	Criteria 1 : New lighted exit signage installed 1/8/25 and is operating Criteria 2 All residents have the potential to be effected. Director of Maintenance	1/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 7 where the direction of travel to reach the nearest exit is not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/04/2024 revealed, when traveling north passing through the fire/smoke barrier on the first floor, there was no directional exit sign to the nearest exit. In an interview at the time, the [redacted] confirmed the observation. The [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 293	installed and verified operations of all exit signage to ensure full visibility, in accordance NFPA to ensure directional indication of travel was well illuminated Criteria3 Systemic Changes The Director of Maintenance will do an audit of all exit signage and ensure 100 percent compliance with operation. Audit will be done monthly and will also be incorporated into the monthly preventative mainenance program Criteria 4 Monitoring Continued monitoring will be done by safety committee whcih will report their outcomes of audit to the QAPI committee for a period of 3 months to ensure compliance. Date of Compliance 1/9/25	
K 353 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	K 353		1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 8 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 REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that sprinklers systems were maintained in accordance with NFPA 25: 2011 Edition, Sections 5.2, 5.2.1.1.1, and 5.2.1.1.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/03/2024 at 1:15 PM in the first-floor West shower room, revealed a sprinkler head that had been painted white. An observation at 1:25 PM revealed a sprinkler head in the 1st floor East shower room contained signs of oxidation. In interviews at the time, the [redacted] confirmed the observation. The U. S. FOIA (b) (2) [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 25	K 353	Criteria one Facility corrected deficient practice by cleaning /removing paint and oxidation to ensure sprinkler head is fully operational. all residents had potential to be affected by this deficient practice Criteria two The U. S. FOIA (b) (2) [redacted] educated on the requirements by the NJ Ex Order 26, 4B1 [redacted] on 1/9/25. Sprinklers repaired on 1/16/25. Annual sprinkler inspection completed on 1/16/25. Criteria three monitoring The Maintenance Director or designee will inspect the sprinkler monthly. He will report the outcome to the QAPI committee to ensure 100% compliance monthly for three months Date of completion, January 17, 2025	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 9 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that portable fire extinguishers were installed and maintained in accordance with NFPA 101:2012 Edition, Sections 9.7.5 and NFPA 10: 2010 Edition, Sections 6.1.3.8.1 and 7.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/03/2024 at 1:50 PM revealed the monthly inspection tag on the fire extinguisher in the Koi pond courtyard had no signatures on it. An observation at 1:52 PM revealed that the fire extinguisher in the dining room was installed 66-inches above the ground, exceeding the maximum height requirement of 5-feet. In interviews at the time, the U.S. FOIA (b) confirmed the observation. The U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 10	K 355	Fire extinguisher reinstalled to regulatory requirement. This deficient practice had potential to impact all residents have the potential to be affected by this deficient practice. The maintenance director or designee will conduct 100% rounds on all the fire extinguishers to ensure that they are signed monthly and inspected annually. This deficient practice has not applied to other Fire extinguisher placements, with the exception of one, which was repositioned to ensure compliance with regulatory standards. Criteria three monitoring, the maintenance director or designated will submit a report the outcome to the qapi committee for the next three months to ensure complaince. Will then add to preventaitve maintenance for extinguisher inspection on a monthly basis for a period of six months. Date of completion, January 10, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363 SS=F	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 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.	K 363		1/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that doors in the corridor were: a) capable of being closed and maintained closed against the force of 5 lb applied at the latch edge of the door and b) able to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.2 and 19.3.6.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/03/2024 at 12:44 PM revealed the second-floor dining room contained 2 doors. The doors were not provided with a means of keeping the door closed against the force of 5 lbs. An observation on 12/04/2024 revealed the dining room on the first floor contained a pair of doors that were held open by devices that would release upon activation of the fire alarm system. When tested, the door coordinating device (automatic door closer) did not function properly, causing the door provided with an astragal to close first and leaving an opening between the meeting edges. In interviews at the time, the U.S. FOIA (b) [redacted] confirmed the observation. The U. S. FOIA (b) (2) [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM.	K 363	Door repaired on 1/6/25 Criteria2 identification of similar concerns. All residents have the potential to be affected by deficient practice. The maintenance director and or designee will review all resident room, doors and dining room doors to ensure that the standard is met and can properly resist leaving a gap up on the activation of the fire alarm system. Criteria 3 Systemic changes the maintenance staff and staff reinserviced on the requirements on 1/9/25. Maintenance Director on doors, including resident rooms as well as resident occupied areas. Criteria 4 Monitoring maintenance director or DESIGNEE will submit a report on a monthly basis to the QAPI committee for the next three months for their review and action as warranted. Data completion Jan 20 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 12 N.J.A.C 8:39-31.2(e)	K 363		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of smoke/fire in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: On 12/03/2024, the following unprotected penetrations through fire/smoke barriers were observed: 1. At 12:22 PM, a 1-inch by 1-inch unprotected	K 372	Criteria one p Penetrations were corrected witht he installation of a sealant, photos submitted with poc. Criteria2 All residents have the potential to be affected by this deficient practice Criteria 3 Systemic changes the maintenance director will incorporate this during preventative maintenance rounds, selecting areas of the building quarterly to ensure compliance throughout the whole building Criteria 4	1/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 13 penetration in the 2nd floor West fire/smoke barrier. 2. At 12:59 PM, a 1.5-inch unprotected penetration in the 1st floor West fire/smoke barrier. 3. At 1:22 PM, a 1-inch unprotected penetration in the 1st floor East fire/smoke barrier. 4. At 1:43 PM, a 2-inch by 2-inch unprotected penetration in the 1st floor Main Hallway fire/smoke barrier. In interviews at the time, the [U.S. FOIA (b)] confirmed the observations. The [U. S. FOIA (b) (2)] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM.	K 372	This will be referred to QAPI committee on a monthly basis for a period of three months other information that will provide compliance or fire marshal□s inspections, as well as safety rounds performed by qapi committee	
K 521 SS=F	N.J.A.C 8:39-31:2(e) HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on	K 521	Criteria, one	1/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 14 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2, 9.2.1 and NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/03/2024 at 12:27 PM revealed the bathroom ventilation in room NJ Ex Ord was not functioning when tested by the . An observation at 12:36 PM revealed the bathroom ventilation in room NJ Ex Ord was not functioning when tested by the U.S. FOIA (b). An observation at 1:37 PM revealed the bathroom ventilation in room NJ Ex Ord was not functioning when tested by the U.S. FOIA (b)(6). In interviews at the time, the U.S. FOIA (b)(6) confirmed the observation. The U. S. FOIA (b) (2) was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM.	K 521	Bathroom ventilation was not functioning when tested in rooms NJ Ex Order 26, 4B1. It was determined to be caused by a broken belt on the exhaust fan on the roof. The belt was repaired on 12/27/24. The Maintenance director completed a full review of all resident bathroom ventilation systems ensuring that they were functioning properly Criteria two All residents have the potential to be affected by this deficient practice Criteria three The belt was repaired on 12/27/24. The NJ Ex Order 26, 4B1 was educated by the U. S. FOIA (b) (2) on 1/10/25 to conduct monthly audits that all bathroom ventilation is properly working. The Maintenance Director and or designee will conduct monthly rounds on all resident ventilation systems to ensure proper operations Criteria four Maintenance director's audits will be reported on a monthly basis to the QAPI committee for the next three months to ensure 100% compliance	
K 531 SS=F	N.J.A.C 8:39-31.2(e) Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4.	K 531		2/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 15 Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to properly inspect, test and maintain 2 of 2 elevators in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B 44, Safety Code for Elevators and Escalators and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6 . This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 12/03/2024 revealed the annual elevator certificate of continued occupancy/compliance that was provided was from 2022 for for 1 or 2 elevators (P2-02). The certificate was temporary and expired	K 531	Criteria one The facility followed to schedule inspection with DCA. NJ Dept Elevator Safety Unit directed that hte facility vendor had to arrange inpections with DCA. Elevators inspected on 2/10/25 Criteria two All residents have the potential to be affected by deficient practice. The facility has only two elevators and both emergency communication systems have been checked in our operational. Criteria three System changes, the Maintenance director will be in service on these requirements and or designate will check both elevator emergency communication systems upon a monthly basis to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 16 10/18/2023. An annual certificate for 2023 and 2024 were not provided for 2 of 2 elevators. Observations at 11:50 AM and 12:55 PM revealed the elevator emergency communication systems did not function when tested for 2 of 2 elevators. A record review on 12/04/2024 revealed that that annual Fire Service Operations Phase 1 and Phase 2 tests were conducted on 9/22/2024 for passenger elevator 1 and 2. Monthly Fire Service Operations was conducted on passenger elevator 2 on 10/18/2024. Documentation regarding regularly scheduled monthly preventive maintenance and testing of Fire Service Operation Phase 1 and Phase 2 were not provided. In interviews at the time, the [redacted] confirmed the observation. The [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM.	K 531	continued operation of self equipment Criteria four The Maintenance Director and/or designate will submit a report to the quality committee for the next three months	
K 741 SS=F	N.J.A.C 8:39-31.2(e) 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,	K 741		1/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 17 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 REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that ashtrays of noncombustible materials and safe design, and metal containers with self-closing cover devices were readily available to all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/05/2024 at 1:58 PM revealed the resident smoking area contained 4	K 741	Criteria one Additional containers that are specifically designed to extinguish cigarettes smoke etc, have been purchased and placed in designated smoke area. Criteria two All residents have the potential to be affected by this deficient practice Criteria three U. S. FOIA (b) (2) [redacted] and the U. S. FOIA (b) (2) [redacted] educated by the NJ Ex Order 26, 4B1 [redacted] on 1/10/25 on the appropriate containers to be used and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING 01 B. WING _____	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 18 outdoor smokers receptacle ashtrays constructed of combustible plastic material. Three of the 4 ashtrays had metal bases and plastic tops. One of the 4 ashtrays had a plastic base and top. A metal container with a self-closing cover device into which ashtrays can be emptied was not provided or readily available to the area. In an interview at the time, the [redacted] confirmed the observation. The [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 741	ensure that the area is within compliance. The receptacles are utilized and the resident smokers reviewed the policy. The Maintenance Director or designee will audit for appropriate containers daily for 2 weeks then twice per week for 4 weeks then weekly for one month. . Criteria four The administrator along with Maintenance will be required to submit a report to the to the safety committee for a period of three months. The report will also be reviewed at the QAPI meeting for a period of three months as well.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)	K 761		1/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING **01** B. WING _____	**12/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/03/2024 and 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that all fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed annual fire door inspections were in accordance with NFPA 80 but the list did not include the fire doors to any of the stairway enclosures throughout the entire facility. In an interview at the time, the U.S. FOIA (b) [redacted] confirmed the observation and stated that they would add all the stairway enclosure doors from inspection. The U. S. FOIA (b) (2) [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 12/04/2024 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 761	Criteria 1 : Fire rated doors have not been checked in accordance with regulatory standards to ensure that the doors continue to meet the standard. All fire doors were inspected on 1/6/25 and porperly functioning Criteria 2 This practice has the potential to affect the residents in the event of a fire, that the protections is compromised if not checked to ensure there ae not any penetrations or compromises in the structure. Criteria3 Systemic Changes a monthly monitoring will be incorporated to ensure compliance, any noncompliance the door will be addressed or replaced as warranted. Criteria 4 Monitoring The Director of Maintenance and or designee will inspect the doors on a monthly basis, and report any changes to the QAPI committee ,for their review and action. Date of Compliance 1/15/25	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315206 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/12/2025 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0223	01/20/2025	LSC K0271	02/10/2025	LSC K0293	01/14/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	01/17/2025	LSC K0355	01/10/2025	LSC K0363	01/20/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	01/23/2025	LSC K0521	01/20/2025	LSC K0531	02/10/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0741	01/20/2025	LSC K0761	01/15/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/9/2024	☐ YES ☐ NO