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	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manahawkin Health and Rehabilitation Center	1211 Rt 72 West Manahawkin, NJ 08050

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Complaint # 2564823 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain a safe and comfortable room temperature levels in residents' shower rooms and in the facility elevator. This deficient practice was identified in 2 of 4 resident shower rooms and in 1 of 1 facility elevator (elevator car 1). This deficient practice was evidenced by the following:On 07/18/2025 at 10:23 A.M., the surveyor checked temperatures in different locations throughout the facility in the presence of the Maintenance Person (MP) and the following were obtained: The second-floor East shower room has room temperature of 84.4 degrees Fahrenheit (F). which is above the required temperature range of 71 to 81 F. There were no residents present at this time.The second-floor [NAME] shower room had room temperature of 84.4 degrees F in the shower stall and 84.2 degrees F outside of the stall. No residents were present in the shower room.In the Elevator car 1, the air temperature was 84.6 degrees F. No residents present in the elevator. After the temperature checks, the surveyor observed residents, visitors, and staff using the elevator Car 1throughout the day.On 07/18/2025 at 3:06 P.M. , the surveyor interviewed the facility Maintenance Director (MD). The MD stated that the air conditioning had been working properly since the power was restored after a brief outage on 07/16/2025. The MD further stated that he was not aware of any work orders related to room temperatures. On 07/18/2025 at 4:36 P.M., the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who confirmed that the facility had a power outage on 07/16/2025. The LNHA stated that the facility's generator switched on and functioned properly. The LNHA further stated that the facility did not have an interruption in air conditioning during the power outage. The LNHA also stated that as far as she knew, the air conditioning system was functioning properly. NJAC 8:39 -31.6(p)4

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review, interview, and facility policy review, the facility failed to ensure a family member's concern regarding missing clothing and personal items were filed as a grievance and investigated for one of nine sample residents (Resident (R) 3) reviewed for grievances. This had the potential for residents' rights not being supported, to have their lost belongings searched for, and/or reimbursed.Review of the facility's policy titled, Grievance Guideline, revised on 05/31/23, revealed Purpose: To provide a process to voice grievances (such as those about treatment, care, management of funds, lost clothing, or violation of rights) and respond with prompt efforts to resolve while keeping the resident and/or resident representative appropriately apprised of progress toward resolution.Grievance Official: Our facility Grievance Official is the Administrator and/or Designee appointed by the Administrator.A grievance or concern may be expressed orally or in writing to the Grievance Official or facility staff. RESOLUTION: The Grievance Official and/or designee will complete a response within 5 days of receipt to the resident and/or resident representative. Review of R3's admission Record located in the electronic medical record (EMR) under the admission tab revealed the resident was admitted to the facility on 07/22 with a diagnosis of dementia without behavior disturbances. The resident was discharged to the hospital in 2/25 and did not return to the facility.Review of R3's Progress Note, dated 01/17/25, located in the EMR under the Progress Note tab, revealed the resident's family was in for a visit and had concerns because the resident's lock was off her closet. The nurse told the family member they would look into it.Review of the facility's Grievances for January 2025 and provided by the facility revealed no evidence of grievance being filed by the facility on behalf of R3's family. During an interview on 07/30/25 at 1:00 PM, the Licensed Practical Nurse (LPN) 2/ Unit Manager (UM) revealed back in January 2025, R3's family member said the facility could cut the lock off the resident's closet so staff could get into the closet and get the resident a change of clothes. LPN2/UM was not aware of the family reporting there was missing clothing and personal items from the closet.During an interview on 07/31/25 at 2:20 PM, the Administrator confirmed R3's family did have concerns that the resident was missing clothing and personal items from her closet back in January 2025 when the lock was removed. She confirmed she did send an email to the family on 01/18/25 stating that she would submit a request for reimbursement in the amount of $200.00 to cover the missing clothing and personal items. She stated, however, that the facility had not sent R3's family $200.00 or followed up with the family. The Administrator confirmed she did not complete a formal grievance or look into the concern. She confirmed a grievance should have been filed in order to complete a thorough investigation, so a resolution could be presented to the family of R3.

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	315206	A. Building B. Wing	07/31/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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	315206	A. Building B. Wing	07/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint # 2564823 Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 07/18/2025, it was determined that the facility failed to administer medications according to the acceptable standards of nursing practice. This deficient practice was identified for 1 of 3 residents reviewed (Resident #3).This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem. According to the admission Record (AR), Resident #3 was admitted to the facility with diagnoses that included but not limited to: spondylosis (degenerative changes in the spine), depression, unspecified anxiety disorder and other chronic pain. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 05/25/2025, reflected that Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. During an interview with Resident #3 on 07/18/2025 at 9:55 A.M., the surveyor observed the resident in bed with their head under the covers. The surveyor observed multiple pills of varying shapes, sizes and colors in a medicine cup on top of Resident # 3's overbed table. When interviewed, Resident #3 stated that the nurse handed the medication to them, and that they placed the cup of medication on the table and forgot about them. At that time, the surveyor called the Unit Manager (UM) and showed her the medications left at Resident #3's bedside. The UM removed the medication cup with the pills from Resident #3's bedside. On 07/18/2025 at 1:54 P.M., the surveyor interviewed the Registered Nurse (RN #1), who stated that she was the nurse caring for Resident #3 and confirmed that that during the morning medication administration, she handed a cup containing the resident's morning medications to the resident and left the room without waiting for the resident to take the medications. RN #1 stated that the usual process was to watch the resident take their medications before leaving the room. RN #1 further stated that she was in a rush that morning and did not wait for Resident #3 to take their medications. RN #1 stated that the medications she left with Resident #3 were Gabapentin (medication to treat seizures) along with the resident's other morning medications. RN #1 further stated that it was important for safety to watch residents take their medication in order to prevent accidents and medication diversion. A review of the resident's Medication Administration Record (MAR) revealed that RN #1 prepared for administration to Resident #3 the following medications: Aspirin 81 milligram (MG) delayed release tablet Escitalopram Oxalate 10 MG tablet 9 Meloxicam 15 MG tablet Multivitamin-Minerals tablet Vitamin D3 125 microgram (MCG) tablet Buspirone HCl 10 MG tablet Gabapentin 800 MG tablet (used to treat seizure disorder) An interview was conducted with the UM on 07/18/2025 at 2:30 P.M. The UM stated that that the expectation was for the nurses to watch the residents take their medications to ensure the medication was taken and that it was tolerated well. The UM stated the if the resident was not observed taking their medication, they may not receive the prescribed treatment, or another resident could take the medication. The UM further stated that the administering nurse was responsible to watch the resident take their medications. An interview was conducted with the Director of Nursing (DON) on 07/18/2025 at 4:45 P. M. The DON stated the expectation was that nurses observed the residents take their medications. The DON stated that leaving pills at the bedside did not comply with the facility's policy or his expectations for medication administration. The DON further stated that watching residents take their medications was important to in order to ensure that the resident got their ordered medications and that another resident did not get them. A review of the undated facility policy titled, Medication Administration, revealed under Policy, Medications are administered by licensed nurses [.] as ordered by the physician and in accordance with professional standards of practice. Under Policy Explanation and Compliance Guidelines: the policy

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	315206	A. Building B. Wing	07/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	315206	A. Building B. Wing	07/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, review of hospital records, interview, and review of facility policy, the facility failed to ensure ordered treatments were completed for fungal dermatitis (skin infection) and arterial ulcers for one of three residents (Resident (R) 2) reviewed for skin integrity out of a total sample of nine residents. This had the potential for fungal dermatitis and arterial ulcers to worsen and a potential for infection.Review of the facility's policy titled, Skin Integrity-Incontinence Associated Dermatitis (IAD) with a date implemented 02/14/23, revealed Residents who are incontinent will receive appropriate treatment and services for the prevention and management of IAD.e. For residents with fungal skin infection, apply antifungal products as ordered by the physician.Review of R2's admission Record located in the electronic medical record (EMR) under the admission Record tab revealed R2 was admitted to the facility on 05/25 with diagnoses including peripheral vascular disease (PVD) and gangrene. The resident was discharged from the facility in 07/25. Review of R2's Hospital Record located in the EMR under the Evaluation tab, dated 05/23/25, revealed the resident was being discharged to the facility with a wound infection, osteomyelitis (bone infection), gangrene due to atherosclerosis (buildup of substances in and on the artery walls) of extremity, gangrene of right foot, and sepsis likely due to multiple poor healing lower extremity wounds.Review of R2's Care Plan located in the EMR under the Care Plan tab with an initiated date 05/29/25, revealed the resident had multiple wounds related to PVD. The goal was for the resident to have intact skin free of redness, blisters, or discoloration. Intervention included complete treatments as ordered.Review of R2's Multi Wound Chart Details, dated 05/30/25 located in the EMR under the Evaluation tab and completed by the Nurse Practitioner/Certified Wound Specialist (NP/CWS), revealed R2's fungal dermatitis and arterial ulcers were assessed and treated with the Licensed Practical Nurse (LPN) 3/Unit Manager (UM) at the bedside. The resident's following arterial ulcers and fungal dermatitis with treatment orders included the following:1.Arterial ulcer of the right medial (inner edge of foot) extending to the great toe measuring 20.0 centimeters (cm) by 8.0 cm with no depth and 100 percent (%) necrotic (dead or dying tissue), with an order to paint the wound with betadine, apply abdominal dressing pad (ABD), and wrap with Kling (bandage) daily. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.2.Arterial ulcer of the right fourth toe measuring 5.0 cm by 4.0 cm with no depth and 100% necrotic with an order to paint the wound with betadine, apply ABD pad, and wrap with Kling daily. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.3. Arterial ulcer of the right lateral foot measuring 15.0 cm by 3.0 cm with no depth and 100% necrotic with an order to paint the wound with betadine, apply an ABD pad and wrap with Kling daily. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.4. Arterial ulcer of the right dorsal (back) ankle measuring 2.0 cm by 1.0 cm with no depth and 100% necrotic with an order to paint the wound with betadine, apply and ABD pad and wrap with Kling daily. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.5.Arterial ulcer of the right distal posterior lower leg measuring 7.0 cm by 9.0 cm by 0.2 cm in depth and between 25% and 50% necrotic with an order to apply honey gel with a dressing of calcium alginate and apply an ABD pad and wrap with Kling. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.6.Right groin fungal dermatitis with measurements of 15.0 cm by 11.0 cm with no depth with erythematous (redness) with an order to cleanse the area with soap and water with a primary dressing of zinc and antifungal, dry well after cleansing, apply 1:1 nystatin powder and zinc oxide, to be completed twice a day. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.8. Left groin fungal dermatitis with measurements of 15.0 cm by 11.0 cm with no depth with erythematous (redness) with an order to cleanse the area with soap and water with a primary dressing of zinc and antifungal, dry well after cleansing, apply 1:1 nystatin powder and zinc oxide, to be completed twice a day. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.9. Sacrum extending to bilateral buttocks fungal dermatitis with measurements of 30.0 cm by 20.0 cm with no depth with erythematous, macerated (red moist area) with an order to cleanse the area with soap and water with a primary dressing of zinc and antifungal, dry well after cleansing, apply 1:1 nystatin powder and zinc oxide, to be completed twice a day. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility. Review of R2's Treatment Administration Record (TAR) for May 2025 located in the EMR under the Orders

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	07/31/2025

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Manahawkin Health and Rehabilitation Center	1211 Rt 72 West Manahawkin, NJ 08050

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	315206	A. Building B. Wing	07/31/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, review of hospital records, interview, and review of facility policy, the facility failed to ensure ordered treatments were completed for pressure ulcers for one of three residents (Resident (R) 2) reviewed for pressure ulcers out of a total sample of nine residents. This had the potential for the pressure ulcers to worsen and a potential for infection. Review of the facility's policy titled, Pressure Injury Prevention and Management with a date implemented 02/14/23, revealed This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcers/ injuries.2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment.Review of R2's admission Record located in the electronic medical record (EMR) under the admission Record tab revealed R2 was admitted to the facility on 05/25 with diagnoses including peripheral vascular disease (PVD) and gangrene. The resident was discharged from the facility in 07/25.Review of R2's Hospital Record located in the EMR under the Evaluation tab, dated 05/23/25, revealed the resident was being discharged to the facility with a wound infection, osteomyelitis (bone infection), gangrene due to atherosclerosis (buildup of substances in and on the artery walls) of extremity, gangrene of right foot, and sepsis likely due to multiple poor healing lower extremity wounds. Review of R2's Care Plan located in the EMR under the Care Plan tab with an initiated date 05/29/25, revealed the resident had multiple wounds related to PVD. Intervention included complete treatments to the wounds as ordered.Review of R2's Multi Wound Chart Details, dated 05/30/25 located in the EMR under the Evaluation tab and completed by the Nurse Practitioner/Certified Wound Specialist (NP/CWS) revealed R2's wounds were assessed and treated with the Licensed Practical Nurse (LPN) 3/ Unit Manager (UM) at the bedside. The resident's following pressure ulcers with treatment orders included the following:1.Unstageable pressure ulcer of the right heel measuring 8.0 centimeters (cm) by 8.0 cm with no depth and 100% necrotic, with an order to paint the wound with betadine, apply an abdominal dressing (ABD) pad, and wrap with Kling daily. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.2. A stage IV pressure ulcer of the right medial posterior knee measuring 2.0 cm by 3.0 cm with a depth of 0.5-cm with the tendon exposed. The order revealed to apply honey gel with a dressing of calcium alginate and apply a bordered gauze daily. The treatment was completed by the NP/CWS, and subsequent treatments were to be completed by the staff of the facility.Review of R2's Treatment Administration Record (TAR) for June 2025 located in the EMR under the Orders tab, revealed only one combined entry for all of R2's wounds, the treatment for all of R2's wounds were to cleanse right lower extremity wounds with Dakin's solution, pat dry, and wrap with Kling. This was documented as completed from 06/01/25 through 06/23/25. However, the treatment documented as completed was not the specific orders that were ordered by the NP/CWS on 05/30/25. The TAR for June 2025 revealed the orders received by the NP/CWS on 05/30/25 were not started until 06/26/25. There was no evidence that any treatments were completed on the resident's pressure ulcers on 06/24/25 and 06/25/25.Review of the weekly Multi Wound Chart Details, dated 06/06/25, 06/13/25, 06/20/25, and 06/27/25, located in the EMR under the Assessment tab, revealed the NP/CWS completed the treatments once a week and assessed the residents pressure ulcers. The status of the above pressure ulcers remained unchanged.During an interview on 07/31/25 at 9:30 AM, the Director of Nursing (DON) confirmed the documentation of R2's pressure ulcers completed by the facility from 06/01/25 to 06/23/25 were not according to the orders received by the NP/CWS on 05/30/25. He confirmed there was no evidence treatments were completed at all on 06/24/25 and 06/25/25. The DON confirmed the only time R2's pressure ulcer treatments were completed per order was when the NP/CWS came to the facility once a week (06/06/25, 06/13/25, and 06/20/25) and completed them as well as assessed the pressure ulcers.During a telephone interview on 07/31/25 at 10:15 AM, the LPN3/UM of the unit R2 resided on revealed she did not know why the treatments to R2's pressure ulcers were not completed as ordered by the NP/CWS.

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	315206	A. Building B. Wing	07/31/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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	315206	A. Building B. Wing	07/31/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Complaint: 2564823Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain refrigerated potentially hazardous foods at appropriate temperatures to prevent potential microbial growth, b.) discard foods that were past their date of expiration and showed signs of spoilage, c.) maintain the kitchen in a sanitary manner, e.) accurately record appropriate cooking and holding temperatures, and f.) accurately record refrigeration temperatures. This deficient practice was evidenced by the following: 1.) On 07/18/2025 at 9:30 A.M., the surveyor and the [NAME] toured the kitchen and observed the needle of the dial type external thermometer on the chest refrigerator was resting in the lowest possible position (below -40 degrees Fahrenheit (F)). The thermometer did not appear to be functioning. The internal thermometer read 50 degrees F. There was cloudy liquid pooled at the bottom of the chest refrigerator. During a follow up tour and interview on 07/18/2025 at 12:00 P. M., the Food Service Director (FSD) confirmed that the exterior thermometer of the chest refrigerator was not functioning, and that the internal thermometer read 50 degrees F. The FSD confirmed the presence of cloudy liquid at the bottom of the chest refrigerator. The FSD attempted to calibrate two digital probe thermometers which belonged to the facility, but was unsuccessful. The surveyor calibrated a digital probe thermometer in an ice bath to 32 degrees F and obtained the following temperatures from products that were held in the chest refrigerator:A single serving carton of fat free milk was 44.2 degrees F.A single serving carton of whole milk was 48.5 degrees F. The following temperatures were obtained from food items stored inside of the double-door reach-in refrigerator:A peach flavored yogurt cup was 41.9 degrees F.A butterscotch pudding was 43.3 degrees F. 2.) On 07/18/2025 at 9:44 A.M., the surveyor and the [NAME] toured the kitchen and observed on the shelving unit directly outside of the FSD's office door, a cardboard box containing bags of long rolls. The rolls were dotted with circles of a blue-green fuzzy substance. The cook stated, that is mold. The cook removed the two bags of rolls containing the blue/green fuzzy substance from the cardboard box. During a follow up tour and interview on 07/18/2025 at 12:19 P.M., the surveyor returned to the shelving unit outside of the FSD's office with the FSD. The FSD looked in the cardboard box and confirmed the presence of a blue/green fuzzy substance on an additional six packs of long rolls. The FSD stated that the substance was mold. The FSD confirmed that the expiration date of the rolls was 07/15/2025. The FSD stated that they should have been discarded on that date. 3.) On 07/28/2025 at 9:15 A.M., the surveyor and the FSD toured the kitchen. The surveyor observed on the wall next to the walk-in refrigerator and walk-in freezer, multiple spots of a black fuzzy substance extending approximately two feet up the metal wall. The floors outside of the walk-in refrigerator and walk-in freezer had standing cloudy water with small, black items in it. The FSD stated that the standing water could have been rain from outside or water left over from power-washing that occurred two or three days prior. The FSD further stated that the black substance on the wall may have been mold and the black items in the water on the floor may have been fruit flies. During the kitchen tour on 07/28/2025 at 9:15 A.M., the FSD stated that cleaning was done according to a cleaning matrix. The FSD stated that cleaning tasks were documented on a sanitation checklist by the person who completed the task. The FSD stated that completed sanitation checklists were kept in a binder in the kitchen. The FSD was unable to provide a completed sanitation checklist for the previous week. 4.) On 07/28/2025 at 8:15 A.M., the surveyor and the facility's Director of Nursing (DON) entered the kitchen, and the DON informed the [NAME] that the surveyor intended to check food temperatures. The [NAME] informed the surveyor that he did not have a thermometer, and that the facility's steam table was not working. The remaining breakfast food were disposed of by the [NAME] at that time. During an interview on 07/28/2025 at 9:10 A.M., the FSD stated that the facility's process for checking food temperatures was to take the temperatures food was finished cooking on the stove or in the oven. The FSD stated when the food was then transferred to the steam table for serving, the temperatures were checked again. The FSD acknowledged that temperatures should have been checked with a thermometer prior to service. During a follow-up interview on 07/28/2025 at 11:04 A.M., the FSD stated that food temperatures were recorded on a log that was kept in a binder in the kitchen. A review of the SERVICE LINE CHECKLIST (SLC)document with 7/28, written at the top was reviewed with the FSD. The document revealed the following under, BREAKFAST: Milk 38 degrees F, coffee 150 degrees F, [orange juice]/cereal 38 degrees F, oatmeal 160 degrees F, oatmeal 160 degrees F, bacon 175 degrees F, sausage 175 degrees F, sausage 175 degrees F, and French toast 170 degrees F. The FSD stated that food temperatures were not taken for the breakfast meal on 07/28/2025, and he filled in the SLC for the breakfast