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	01/05/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2701205Based on observations, interviews, medical record reviews, and review of other pertinent facility documentation on [DATE], it was determined that the facility failed to a.) obtain a physician order for a resident (Resident #4) to go out of the facility on pass (OOP) or take leave of absence (LOA) from the facility, and b) update care plans for two residents (Resident #4 and Resident #6) with focuses and interventions related to the residents going OOP or LOA from the facility. This deficient practice was identified for 2 of 6 residents reviewed for care plans and was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 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. On [DATE] at 9:30 AM and 12:23 PM, the surveyor observed both sampled and unsampled residents in the facility lobby and interacting with the Receptionist (who operated the button to unlock the facility's front door). An interview was conducted with the Receptionist on [DATE] at 12:23 PM. The Receptionist stated that only one resident (Resident #4) in the facility was able to leave independently. The Receptionist stated that when Resident #4 wanted to go out, the nursing staff would call her and tell her that the resident was on their way to the lobby to go out. The Receptionist stated that she would then assist the resident in getting their wheelchair out of the facility's front doors. The medical record for Resident #4 was reviewed. According to the admission Record (AR), Resident #4 was admitted to the facility with diagnoses including but not limited to: person injured in unspecified motor-vehicle accident, traffic, initial encounter; and polyneuropathy (damage or disease affecting the nerves and resulting in weakness, numbness, and burning pain). According to the Quarterly Minimum Data Set (MDS), an (continued on next page)

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: 315206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Manahawkin Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment tool dated [DATE], Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. The MDS also indicated that Resident #4 used a motorized wheelchair or scooter for mobility. A review of the Resident Responsibility/Sign Out Sheet, for Resident #4 revealed that Resident #4 had signed out of the facility with self listed as the responsible party on the following dates in November and December of 2025: [DATE], [DATE], [DATE], [DATE], and [DATE]. A review of the Order Summary Report (OSR) for Resident #4 revealed no physician order (PO) indicating whether the resident could go OOP or for LOA, or what level of supervision the resident required. A review of the Care Plan Report, (CPR) for Resident #4 revealed no focus, goals, or interventions related to Resident #4 going OOP or for LOA. The medical record for Resident #6 was reviewed. According to the AR, Resident #6 was admitted to the facility with diagnosis including but not limited to cellulitis of unspecified part of limb (infection of the skin and soft tissue underneath); benign neoplasm of meninges, unspecified (tumor that grows from the membranes that surround the brain and spinal cord); unspecified cirrhosis of liver (condition in which scar tissue gradually replaces healthy liver cells); muscle weakness (generalized); and difficulty walking, not elsewhere classified. According to the Comprehensive MDS dated [DATE], Resident #6 had a BIMS score of 14, which indicated that the resident's cognition was intact. A review of the OSR for Resident #6 revealed the following POs: May go out on LOA with medications. The PO had a start date of [DATE]. May go out on LOA with a responsible party. The PO had a start date of [DATE]. A review of the CPR for Resident #6 revealed no focus, goals, or interventions related to Resident #6 going OOP or for LOA. An interview was conducted with Resident #6 on [DATE] at 12:41 PM. Resident #6 stated that they had gone out of the facility with their family in the past. An interview was conducted with Resident #4 on [DATE] at 1:09 PM. Resident #4 stated that they go out of the facility independently on their motorized scooter once or twice a week. Resident #4 stated that the usual process was for them to notify a nurse and sign out in a logbook at the nurse's station. Resident #4 stated that the Nurses would then call and notify the Receptionist, who would let the resident out through the front door. An interview was conducted with the Director of Nursing (DON) on [DATE] at 2:46 PM. The OSR and CPR were reviewed with the DON. The DON confirmed that Resident #4's OSR did not contain a PO indicating if Resident #4 could go OOP or LOA. The DON stated that the resident should have had an order so that staff would know if the resident could go out. The DON stated that a resident's OOP or LOA status should have been included in the resident's CP because CPs were how nurses knew how to care for residents and what residents could do. The facility policy, Comprehensive Care Plans, with an implemented date of [DATE], and a reviewed/revised date of [DATE], was reviewed. Under Guideline: the facility policy revealed that it was the guideline of the facility to develop and implement comprehensive person-centered care plans for each resident that were consistent with resident rights. The policy revealed that the CP should include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and meet professional standard of quality. Under Definitions, the facility policy revealed that person-centered care meant to focus on the resident and support them in making their own choices and having control of their own lives. The same section of the facility policy revealed that Professional standard of quality, meant that care and services were provided according to accepted standards of clinical practice. NJAC 8:39-23.2 (a)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint #: 2701205 Based on interviews, review of medical records, and review of other pertinent facility documents on 12/29/2025, it was determined that the facility failed to create a safe environment and provide adequate supervision to prevent the elopement of a resident (Resident #2) with poor decision-making abilities. The deficient practice was identified for 1 of 3 residents reviewed for elopement (Resident #2). During the survey a finding that constituted Immediate Jeopardy (IJ) was identified under CFR 483.12(a)(1) F689. The facility failed to: a) provide adequate supervision to prevent the elopement of a resident with poor decision-making abilities (Resident #2), b) develop appropriate interventions to prevent elopement, and c) follow their elopement and wandering policy. On 12/24/2025 at approximately 1:40 AM, Resident #2 was seen by Certified Nursing Assistant (CNA) #2 walking in the hallway. Resident #2 eloped from the facility by watching staff type a code into a pin-pad near the exit door and waiting for a light on the door's locking mechanism to turn green to exit the building. The resident stated that they went out of the facility to get coffee at a convenience store, but got tired during the walk, so they accepted a ride to the store from a stranger. Resident #2 was returned to the facility by police on 12/24/2025 at approximately 2:00 AM. The facility's failure to a.) provide a safe environment and adequate supervision to prevent the elopement of a resident with poor decision-making abilities and b.) follow their elopement and wandering policy placed Resident #2 as well as all residents at risk for elopement and posed a likelihood of serious harm, injury, impairment, or death and resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 12/24/2025, when Resident #2 eloped from the facility. The facility Administration was notified of the IJ on 12/29/2025 at 5:50 PM. The facility submitted an acceptable Removal Plan (RP) on 12/31/2025 at 1:05 PM. The surveyor verified the implementation of the RP during the continuation of the on-site survey on 01/05/2026. The evidence was as follows: The facility policy Elopements and Wandering Residents, with a review/revision date of 04/22/2025 was reviewed. Under Guideline, the policy revealed that the guideline ensured that residents who exhibited wandering behavior or were at risk for elopement received adequate supervision to prevent accidents and received care according to their individualized care plan. Under Definitions, the policy revealed that elopement occurs when a resident leaves the premises or a safe area without authorization or the necessary supervision to do so. Under Explanation and Compliance Guidelines, the facility policy revealed that the facility would utilize a systematic approach to monitoring and managing residents at risk for elopement which included identification and assessment of risk. A review of the Facility Reportable Event (FRE) dated 12/24/2025, that the facility submitted to the New Jersey Department of Health (NJDOH), revealed that at approximately 2:00 AM on 12/24/2025, Resident #2 eloped from the facility by waiting for others to enter the door code. The FRE revealed that Resident #2 stated that they waited for a light to turn green, then exited the building. The FRE further revealed that the police returned Resident #2 to the facility. An undated Summary of investigation, document with Elopement: [Resident #2], and Date of incident: 12/24/2025, at the top was reviewed. The Overview and description of event: section of the document revealed that at approximately 2:00 AM police arrived at the facility with Resident #2 and stated that the resident was picked up from a local convenience store. This section of the facility document revealed that Resident #2 stated that they went out of the facility to get coffee. A handwritten statement by CNA #2 dated 12/24/2025 was reviewed. The statement revealed that on 12/24/2025 she saw Resident #2 at 1:30 AM or 1:40 AM. The statement further revealed that approximately 30 minutes later the police came to the building and stated that a facility resident was at a convenience store nearby and returned the resident to the facility. A handwritten statement by (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licensed Practical Nurse (LPN) #1 dated 12/24/2025 was reviewed. The statement revealed that Resident #2 said goodnight to LPN #1 at 1:00AM on 12/24/2025. The statement further revealed that at 2:00 AM, the police brought Resident #2 back to the facility from a convenience store. No additional staff statements were provided on 12/29/2025. A Incident Detail Report, provided by the responding police department was reviewed. The report revealed that on 12/24/2025 at 1:40 AM, a caller reported that an elderly person with no jacket and pajama pants was observed on the side of the roadway. The elderly person identified themself to the caller with Resident #2's first name and was wearing an identification bracelet. The caller took Resident #2 to the convenience store and gave them two dollars and then left. The report further revealed that Resident #2 was picked up from the store by police at 2:00AM and returned to the facility staff 2:08AM. An interview was conducted with Resident #2 on 12/29/2025 at 11:24 AM. Resident #2 stated that they were only allowed to leave the facility with their family. Resident #2 stated that they exited the facility five or six days ago by watching staff exit, then going through the door while a light on the door remained green. Resident #2 stated that they wanted to walk to a convenience store to get coffee but became tired along the way. Resident #2 stated that a guy, gave them a ride to the store and three or four dollars. Resident #2 stated that the police then arrived at the convenience store and brought the resident back to the facility. Resident #2 stated that they were wearing pajamas, rubber clog-style shoes, and no coat when they left the facility. Resident #2 further stated that they forgot their cane. A telephone interview was conducted with CNA #2 on 12/29/2025 at 12:22 PM. CNA #2 stated that at approximately 1:45AM or 2:00AM, on 12/24/2025, she saw Resident #2 walking around the facility, which was their usual behavior. CNA #2 stated that later, a police officer rang the doorbell and informed staff that Resident #2 was found at the convenience store and returned the resident to the facility. A telephone interview was conducted with the Nursing Supervisor (NS) #1 on 12/29/2025 at 1:09 PM. NS #1 stated that she was the NS on duty on 12/24/2025 when Resident #2 eloped. NS #1 stated that Resident #2 told her that they knew the door code. NS #1 also stated the lock on the facility's front door did not lock right away when the door was closed and it was possible for a someone to get out when the door was that way. NS #1 further stated that Resident #2 had, poor judgement on making safe decisions. An interview was conducted with the Unit Manager (UM) #1 on 12/29/2025 at 1:32 PM. UM #1 stated that if the resident was found outside of the facility it was considered an elopement. UM #1 stated that elopements allow residents to get hurt and it was the job of the facility to keep residents safe and secure. UM #1 further stated that it was not safe for Resident #2 to go to the convenience store and that she would not advise that Resident #2 was safe to go out of the facility independently. An interview was conducted with the DON on 12/29/2025 at 2:17 PM. The DON stated that an elopement is when no one knows that a resident has left the facility or the expected safe areas in the facility. The DON stated that when residents eloped, they could fall, be attacked, or anything could happen. The DON stated that after an elopement the expectation was that the resident was assessed by the charge nurse or NS, a risk management form was completed in the computer, staff statements were collected, and the resident's family and physician were notified. The DON stated that the process allowed the facility to do a thorough investigation, determine the root cause of the elopement, and prevent it from happening again. A review of the medical record for Resident #2 revealed the following: According to the admission Record, Resident #2 was admitted to the facility with diagnoses including but not limited to: diabetes mellitus due to underlying condition with diabetic mononeuropathy (diseases that affect how the body uses blood sugar); schizoaffective disorder (mental health condition marked by a mix of symptoms such as hallucinations and delusions, and mood disorder symptoms); bipolar disorder, current episode (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	depressed, severe with psychotic features (mental health condition that causes extreme mood swings, paranoia, delusions, or hallucinations); muscle weakness; and difficulty walking, not elsewhere classified. A review of Resident #2's Elopement Risk Review (ERR) dated 03/27/2025 at 12:05 PM, revealed that Resident #2 was at low or no risk for elopement. A review of Resident #2's ERR dated 12/24/2025 at 2:46 AM, revealed that Resident #2 verbalized the desire to, or plans to leave the facility without authorization or supervision. Further review of the facility document revealed that the resident was cognitively impaired, had decreased safety awareness, had disturbances in judgement or had a history/risk of wandering. The resident was assessed as at risk of elopement. No ERRs dated between 03/27/2025 and 12/24/2025 were provided. A review of Resident #2's Care Plan (CP) revealed a focus initiated on 10/28/2022 and revised on 12/06/2022, that Resident #2 had a self-care deficit related to cognitive deficits and confusion. Interventions included but were not limited to watching the resident for fatigue, encouraging rest periods and segmenting tasks. Resident #2's CP revealed a focus initiated on 11/21/2024 and revised on 12/24/2025 that the resident was at risk for falls, accident, and incidents. Interventions included but were not limited to keeping the resident's call bell in reach and responding promptly to requests for assistance. The Progress Notes (PN) for Resident #2 were reviewed. A PN written by NS #1 on 12/24/2025 at 2:42 AM, revealed that at 2:00 AM, on the same day a police officer arrived at the facility and informed NS #1 that Resident #2 was picked up by a passerby on a nearby road and driven to a convenience store to get coffee. The passerby then called the police. The PN revealed that another officer brought Resident #2 back to the facility. The PN further revealed that Resident #2 told NS #1 that they knew the code to the facility door but refused to further discuss the elopement. An acceptable Removal Plan (RP) was received on 12/31/2025 at 1:05 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: On 12/24/2025 Resident #2 was safely returned to the facility and placed on one-to-one supervision. On 12/24/2025 Resident #2 had a wander guard applied and its functionality verified, was placed on enhanced supervision, and was moved to a room closer to the nurse's station. On 12/24/2025 Resident #2's CP was updated. On 12/24/2025 Resident #2 was reassessed for elopement risk. On 12/24/2025 a facility headcount was conducted. On 12/24/2025 facility exit doors, keypads, alarms, and wander guard system were inspected to validate proper functioning. On 12/24/2025 the facility's front door was updated to eliminate delay in opening and closing. On 12/26/2025 the facility elopement policy was reviewed. On 12/26/2025 facility-wide staff were re-educated on elopement prevention and emergency protocols was completed and competency was validated. On 12/26/2025 reassessments of at-risk residents were completed. During an interview on 01/05/2026 at 1:41 PM, the DON stated that the facility's elopement binder was revised to contain only residents at risk for elopement on 12/30/2025. The surveyor verified the implementation of the Removal Plan on-site on 01/05/2026, and determined the immediacy was removed as of 12/30/2025. NJAC 8:39-27.1 (a)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2701205 Based on observation, interviews, medical record review, and review of other pertinent facility documentation on [DATE] and [DATE], it was determined that facility staff failed to document interventions intended to prevent elopement that were provided to a resident with a history of elopement from the facility (Resident #2). This deficient practice was identified for 1 of 6 residents (Resident #2) reviewed for documentation. This deficient practice was evidenced by the following: On [DATE], at 11:24 A.M., the Surveyor conducted an interview with Resident #2 and observed a wandeguard (system that uses wearable tags to limit access to areas of the facility) tag on the resident's ankle. Resident #2 explained that they wore the tag because they had escaped, from the facility 5 or 6 days prior. The Surveyor reviewed the medical record for Resident #2. According to the admission Record, Resident #2 was admitted to the facility with diagnoses including but not limited to: diabetes mellitus due to underlying condition with diabetic mononeuropathy (diseases that affect how the body uses blood sugar); schizoaffective disorder (mental health condition marked by a mix of symptoms such as hallucinations and delusions, and mood disorder symptoms); bipolar disorder, current episode depressed, severe with psychotic features (mental health condition that causes extreme mood swings, paranoia, delusions, or hallucinations); muscle weakness; and difficulty walking, not elsewhere classified. A review of the Minimum Data Set, an assessment tool, dated [DATE], revealed that Resident #2 had a Brief Interview for Mental Status score of 15, which indicated that the resident's cognition was intact. A review of Resident #2's Elopement Risk Review, (ERR) dated [DATE] at 2:46 AM, revealed that Resident #2 verbalized the desire to, or plans to leave the facility without authorization or supervision. Further review of the ERR revealed that the resident was cognitively impaired, had decreased safety awareness, had disturbances in judgement or had a history/risk of wandering. The resident was assessed as at risk of elopement. A review of Resident #2's Care Plan (CP) revealed a focus initiated on [DATE], and revised on [DATE], that Resident #2 was at risk for elopement related to their attempts to leave the facility and an incident, on [DATE]. Interventions related to this focus included but were not limited to the use of a wanderguard tag for the resident. The Order Summary Report, (ORS) for Resident #2 revealed the following physician orders (POs): Check placement of the wanderguard every shift for safety and elopement. The PO had a start date of [DATE]. Check skin integrity under the wanderguard on the resident's left ankle every shift for safety and elopement. The PO had a start date of [DATE]. Check skin integrity, function, placement and expiration of wanderguard every shift and replace the wanderguard immediately if expired, in ill repair, or not functioning. The PO had a start date of [DATE]. Review of Resident #2's Treatment Administration Record (TAR) revealed blank boxes for the aforementioned orders on night shift of [DATE]. The Progress Notes (PN) for Resident #2 were reviewed. A PN written by NS #1 on [DATE] at 2:42 AM, revealed that at 2:00 AM, on the same day a police officer arrived at the facility and informed NS #1 that Resident #2 was picked up by a passerby on a nearby road and driven to a convenience store to get coffee. The passerby then called the police. The PN revealed that another officer brought Resident #2 back to the facility. The PN further revealed that Resident #2 told NS #1 that they knew the code to the facility door but refused to further discuss the elopement. The PNs revealed no documentation indicating that the skin integrity, placement, or function related to Resident #2's wanderguard were checked. The Surveyor attempted to contact the Licensed Practical Nurse (LPN #2) who cared for Resident #2 during the night shift on [DATE] but was unsuccessful. An untitled and undated facility document was reviewed. The top of the document revealed, To ensure that all entries (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the Medication Administration Record (MAR) and Treatment Administration record (TAR) are signed promptly and accurately after each medication or treatment is administered. Review of the document further revealed that proper documentation is essential for supporting accurate medical records and promoting resident safety. The document revealed that all records should be reviewed for completeness at the end of that shift. Under. Acknowledgement, the document revealed. I acknowledge that I have read and understand the contents of this memo regarding timely and accurate signing of MAR and TAR documentation. This section of the document further revealed the name and signature of LPN #2 and the date [DATE]. An interview was conducted with the Director of Nursing on [DATE] at 1:41 PM. The DON stated that nurses were in-serviced regarding checks of Resident #2's wanderguard and documentation in the TAR. The DON stated that the resident's wanderguard should have been checked every shift, which meant every eight hours. The DON confirmed that there was no documentation indicating the checks of Resident #2's wanderguard were performed according to the POs on the night shift of [DATE]. During a follow up interview on [DATE] at 2:46 PM, the DON stated that blank spaces on the TAR meant that there was no way to know if the care was provided. The DON further stated, I tell the nurses that if they didn't document something, it didn't happen. NJAC 8:39-35.2 (d)