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	03/25/2026

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the medical records, and review of other pertinent facility documents, it was determined that the facility failed to ensure a safe discharge for a resident. This deficient practice was identified for 1 of 18 residents reviewed (Resident #18).Resident #18, who had a history of intravenous (IV) drug use and was admitted to the facility with endocarditis to receive IV antibiotics, was discharged from the facility with their Peripherally Inserted Central Catheter (PICC) in place. The PICC is thin, flexible tube inserted into a large upper arm [NAME] and guided to the large [NAME] near the heart. Resident #18 had documented complications of up to 9 dislodgements of their PICC line. During an interview on 3/10/26, with the Director of Nursing (DON), the DON confirmed that a resident with a history of IV drug use discharged with a PICC line in place had the potential for harm or death. During an interview on 3/10/26 with the Licensed Nursing Home Administrator (LNHA), the LNHA confirmed that Resident #18's discharge was not safe.The facility's failure to ensure Resident #18 was safely discharged from the facility placed Resident #18, as well as all residents being discharged from the facility, at risk for an unsafe discharge. This posed the likelihood of serious harm, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation.The IJ began 10/27/25 at 4:05 P.M., when Resident #18 was discharged from the facility. The facility was notified of the IJ on 3/10/26 at 5:44 P.M. The facility submitted an acceptable Removal Plan (RP) on 3/23/26 at 3:37 P.M. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 3/25/26 and determined that the immediacy was removed as of 03/20/2026 at 7:00PM.Complaint #: 2806068, 2789654, 2789700, 2794269, 2679147, 2639889, 2588899, 2806341 The deficient practice was evidenced by the following: A review of the facility's policy titled Discharge Planning Process with a date reviewed/revised of 5/12/2025, included It is the guideline of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Under Procedure: 4. In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care: a. Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location.b. Offer other, more suitable, options of locations that are equipped to meet the needs of the resident. Document any discussion related to the options presented.c. Document refusals of other options that could meet the resident's needs.d. At time of discharge, follow policies regarding discharges Against Medical Advice, and refer to Adult Protective Services (or other state entity charged with investigating abuse and neglect), as necessary. 5. If discharge to community is a goal, an active discharge care plan will be implemented and will involve the interdisciplinary team, including the resident and/or resident representative. The plan shall be documented on (list facility-specific form, comprehensive care plan, etc). 6. An active individualized discharge care plan will address, at a (continued on next page)

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

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	minimum: a. Discharge destination, with assurances the destination meets the resident's health/safety needs and preferences. b. Identified needs, such as medical, nursing, equipment, educational, or psychological needs. c. Caregiver/support person availability and the resident's or caregiver's/support person's capacity and capability to perform required care. d. Resident's goals of care and treatment preferences. 7. The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications. 8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community. 9. The facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. The surveyor reviewed the closed medical record for Resident #18. According to the admission Record (AR), Resident #18 was admitted to the facility with diagnoses which included but were not limited to: generalized anxiety disorder and acute and subacute endocarditis (infection often caused by bacteria on normal heart valves, resulting in high fever and significant destruction). According to the discharge Minimum Data Set (MDS), an assessment tool dated 10/27/25, Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. While not included under Resident #18's AR, Resident #18 also had diagnoses which included but were not limited to: alcohol use disorder, severe, in early remission and opioid use disorder, severe, in sustained remission. These diagnoses were in the discharge paperwork provided to the facility by the hospital from which Resident #18 was transferred. A review of the Electronic Medical Record (EMR) revealed the following: Resident #18's Care Plan (CP) included the following: Under Focus date initiated 9/8/25: The resident is on antibiotic therapy related to (r/t) endocarditis. Under Goal: The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Under Interventions: Administer ANTIBIOTIC medications as ordered by physician and Monitor/document/report PRN (as needed) adverse reactions to ANTIBIOTIC therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat). Under Focus date initiated 9/8/25: The resident is on pain/opioid medication therapy (SPECIFY medication) r/t. Under Goal: The resident will be free of any discomfort or adverse side effects from pain medication through the review date. Under Focus date initiated 9/9/25: [Resident #18] has endocarditis and is on oxacillin 12g (grams) daily til 10/02/2025 and requires enhanced barrier precautions r/t indwelling medical device. Under Goal: The resident will be free from complications related to infection through the review date. Under Interventions: Administer antibiotic as per MD (medical Doctor) orders and Monitor/document/report to MD s/sx (signs and symptoms) of delirium: Changes in behavior, Altered mental status, Wide variation in cognitive function throughout the day, Communication decline, Disorientation, Periods of lethargy, Restlessness and agitation, Altered sleep cycle. Under Focus date initiated 9/29/25: The resident has infection of the (SPECIFY) Under Goal: The resident will be free from complications related to infection through the review date. Under Interventions: Follow facility policy and procedures for line listing, summarizing and reporting infections. Under Focus date initiated 10/16/25: Resident at risk for injury r/t PICC line dislodging. Under Goal: Resident will notify nursing of any changes in condition of PICC line site. Under Interventions: Monitor site Q-shift [every shift] for s/s (signs and symptoms) of infection and infiltration. Resident #18's CP did not include any focus, goals, or interventions for Resident #18's discharge or discharge planning. A review of Resident #18's Progress Notes (PN) showed that Resident #18's PICC had documented complications of up to 9 dislodgements on the following dates: 10/22/25, 10/16/25, 10/15/25, 10/7/25, 9/21/25, 9/20/25, 9/14/25, 9/11/25, and 9/10/25. A review of Resident #18's PN dated 10/27/25 created at 3:46 PM by the Licensed Practical Nurse (LPN) that discharged Resident #18 home stated that Resident #18 had met all goals for discharge home. A review of Resident #18's PN dated 10/27/25 created at 4:11 PM by the Director of Nursing (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(DON) #3 at the time revealed that Resident #18 was discharged from the facility with their PICC line after Resident #18 refused to allow the facility to remove the PICC due to concerns for possible excess bleeding. The PN created by DON #3 was the last PN for Resident #18 and there was no documentation that the facility notified the MD related to Resident #18 leaving the facility with a PICC line or further efforts to ensure Resident #18's safety after discharge. There were no PNs by the Social Worker (SW) related to Resident #18's discharge from the facility. A review of Resident #18's Discharge Instructions and Review of Systems for Resident (DIRSR) under Discharge Location indicated that Resident #18 was being discharged home.The DIRSR under Current Physical Status (Therapy/Nsg [Nursing]) stated that Resident #18 required set up or clean-up assistance for personal hygiene, shower/baths, dressing, and transfers. It also stated that Resident #18 was dependent when it came to bed mobility. Resident #18's weight bearing status was partial, but no equipment was ordered for discharge. The DIRSR under Follow-Up Physician Care (Nsg) revealed that Resident #18 had no follow up appointments. The DIRSR under Person Receiving Instructions (Nsg) revealed that Resident #18's girlfriend was the one receiving instructions for discharge. On 3/9/26 at 2:45 PM, the surveyors interviewed the Unit Manager (UM) of the second floor. UM #2 stated that if a resident has a PICC line in place, typically the PICC is removed before discharge. She stated that if a resident was being discharged home and refused to have their PICC line removed she would reach out to the MD and notify them of the refusal. She further stated she would inform her DON as well and escalate the situation because it would be an infection and safety concern for the resident. On 3/9/26 at 3:02 PM, the surveyors interviewed UM #1 who stated that she had not heard of a resident being discharged with a PICC or IV and stated it would be a concern because a PICC is a direct line to their heart. On 3/10/26 at 10:30 AM, the surveyors interviewed the Social Worker (SW) regarding what the typical process is for discharging a resident from the facility. The SW responded that she does the discharge summary, and discussions are held regarding resident therapy, equipment, and scripts with staff. The SW could not recall participating in an Interdisciplinary Team (IDT) meeting related to Resident #18's PICC dislodgements and admitted an IDT should have been held. The SW also stated that as a SW, if a resident was being discharged with antibiotic therapy that was to continue out of the facility, she would have set up home care services. The SW confirmed she did not set up home care services for Resident #18. She then stated that when she informs the nurses that a resident with a PICC is being discharged , the nurses call the doctors and the PICC line is typically removed before discharge. On 3/10/26 at 1:19 PM, the surveyors interviewed DON #2 who stated that discharge planning starts when a resident enters the facility. She stated that discharge should be a part of a resident's CP. DON #2 was handed Resident #18's CP and reviewed it. She confirmed that Resident #18's CP did not include discharge planning and that there was no documentation to confirm that the MD had been notified that Resident #18 left the facility with a PICC line. On 3/10/26 at 2:10 PM, the surveyors asked DON #2 why a resident with a history of drug use should not leave a facility with a PICC. She replied that the resident could leave the facility and go shoot something from the street into the PICC and die. She further stated that the facility would not want to be responsible for death, let alone an infection. Referring to Resident #18, DON #2 stated if antibiotics were completed there was no need for line access and that it was an inappropriate discharge. On 3/10/26 at 4:41 PM, the surveyors interviewed LNHA regarding discharging residents. The LNHA stated that a discharge must be safe for residents. When asked if Resident #18's discharge was safe she stated, No, it is not a safe discharge. In the same interview with the LNHA, the surveyors requested the LNHA review the Order Summary Report (OSR) for Resident #18. After reviewing, the LNHA confirmed there was no discharge order for Resident #18 and that there should have been because discharge documentation starts from the day of admission. NJAC 8:39-5.4(c); 39.1

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint: 2639889Based on interviews, medical record reviews and reviews of other pertinent facility documentation on 3/5/26, 3/9/26, 3/10/26, and 3/18/26, it was determined that the facility failed to develop and implement a comprehensive, person-centered Care Plan (CP) for residents: with a Peripherally Inserted Central Catheter (PICC) line, methadone use, oxygen use, smoking and a history of substance abuse. The CPs lacked foci, goals and interventions addressing proper line integrity, monitoring dislodgement, safe administration of methadone, safe utilization of oxygen, addressing residents who were found smoking in their rooms, and for residents with history of substance abuse. This failure resulted in the residents experiencing multiple PICC dislodgements without clear staff directions for response, placing the residents at risk for improper handling and monitoring which could have led to potential harm. This deficient practice was identified for 5 of 20 residents reviewed for resident records (Resident #8, Resident #9, Resident #15, Resident #18 and Resident #20), and was evidenced by the following:Complaint #: 2806068, 2789654, 2789700, 2794269, 2679147, 2639889, 2588899, 2806341 1. During the survey, the surveyor reviewed Resident #18's CP which did not address Resident #18's documented complications of up to 9 dislodgements for their PICC nor had interventions in place for clear staff direction to respond.According to the admission Record (AR), Resident #18 was admitted to the facility with diagnoses which included but were not limited to: generalized anxiety disorder and acute and subacute endocarditis (infection often caused by bacteria on normal heart valves, resulting in high fever and significant destruction).According to the discharge Minimum Data Set (MDS), an assessment tool dated 10/27/25, Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact.While not included under Resident #18's AR, Resident #18 also had diagnoses which included but were not limited to: alcohol use disorder, severe, in early remission and opioid use disorder, severe, in sustained remission. These diagnoses were in the discharge paperwork provided to the facility by the hospital that Resident #18 was transferred from.Resident #18's CP included the following:Under Focus date initiated 9/8/25: The resident is on antibiotic therapy related r/t (related to) endocarditis. Under Goal: The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Under Interventions: Administer ANTIBIOTIC medications as ordered by physician and Monitor/document/report PRN (as needed) adverse reactions to ANTIBIOTIC therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat).Under Focus date initiated 9/8/25: The resident is on pain/opioid medication therapy (SPECIFY MEDICATION) r/t. Under Goal: The resident will be free of any discomfort or adverse side effects from pain medication through the review date.Under Focus date initiated 9/9/25: [Resident #18] has endocarditis and is on oxacillin 12g (grams) daily til 10/02/2025 and requires enhanced barrier precautions r/t indwelling medical device. Under Goal: The resident will be free from complications related to infection through the review date. Under Interventions: Administer antibiotic as per MD (Medical Doctor) orders and Monitor/document/report to MD s/sx (signs and symptoms) of delirium: changes in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness and agitation, altered sleep cycle.Under Focus date initiated 9/29/25: The resident has infection of the (SPECIFY) Under Goal: The resident will be free from complications related to infection through the review date. Under Interventions: Follow facility policy and procedures for line listing, summarizing and reporting infections.Under Focus date initiated 10/16/25: Resident at risk for injury r/t PICC line dislodging. Under Goal: Resident will notify nursing of any changes in condition of PICC line site. Under Interventions: Monitor site Q-shift [every shift] for s/s (signs and symptoms) of infection and infiltration.Resident #18's CP did not include proper foci, goals, or interventions for Resident #18's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	line integrity or monitoring for dislodgement of their PICC. The facility did not specify which infection Resident #18 had.2. During the survey, the surveyor reviewed Resident # 15 and Resident #18's CP for safe administration and use of methadone.According to the AR face sheet, Resident #15 was admitted to the facility with diagnoses including but not limited to: Parkinsonism (an umbrella term for a neurological syndrome characterized by motor symptoms similar to Parkinson's disease, including bradykinesia [slowed movement], resting tremor, muscle rigidity, and postural instability), Chronic Obstructive Pulmonary Disease (COPD) (a progressive, treatable lung disease that causes long-term breathing problems by damaging airway tissue, leading to inflammation and blocked airflow) and mild intermittent asthma.According to the MDS, dated [DATE], Resident #15's BIMS was a score of 15 out of 15, which indicated the resident was cognitively intact.Resident #15's CP did not address the resident's administration of or use of methadone.Resident #18's CP did not address the resident's administration of or use of methadone. 3. During the survey the surveyor reviewed Resident #15's and Resident 18's CP for safe monitoring and utilization of oxygen.Resident #15's CP did not address the resident's safe monitoring and utilization of oxygen.Resident #18's CP did not address the resident's safe monitoring and utilization of oxygen. 4. During the survey, the surveyor reviewed, Resident #8 and Resident #9's CPs which did not address the residents who were found smoking in their rooms. According to the AR face sheet, Resident #8 was admitted to the facility with diagnoses including but not limited to: chronic embolism and thrombosis of unspecified vein (to the presence of a blood clot in a vein that has persisted for an extended period, leading to potential complications and requiring medical management), localized edema (abnormal accumulation of fluid in a specific area of the body), and an anxiety disorder, unspecified. According to the MDS, dated [DATE], Resident #8's BIMS had a score of 15 out of 15, which indicated the resident was cognitively intact. Resident #8's CP did not include any foci, goals, or interventions for Resident #8's smoking or addressing the documented occurrences of Resident #8 being caught smoking in their room on 9/15/2025. According to the AR face sheet, Resident #9 was admitted to the facility with diagnoses including but not limited to: osteomyelitis (a serious infection and inflammation of the bone caused by bacteria or fungi, which can destroy bone tissue), type 2 Diabetes Mellitus with hyperglycemia (a chronic metabolic condition where the body resists insulin and fails to produce enough to manage blood sugar, resulting in persistently high glucose levels), and hypertensive heart disease with heart failure (a condition where long-term high blood pressure forces the heart to work harder, causing the left ventricle to thicken, stiffen, and eventually weaken). According to the MDS, dated [DATE], Resident #9's BIMS had a score of 15 out of 15, which indicated the resident's cognition was cognitively intact. Resident #9's CP included the following: Under Focus date initiated 7/21/23: Smoking: Under Goal: Resident #9 will remain compliant with facility smoking procedure and smoking restrictions. Under Interventions: Inform [Resident name] and/or responsible party of facility smoking policy and document accordingly, Nursing to maintain/monitor all smoking materials in designated smoking area, and Report Resident #9's non-compliance with facility smoking policy or unsafe smoking practices to supervisor as indicated. Resident #9's CP did not include proper foci, goals, or interventions for any of Resident #9's five documented occurrences of being caught smoking in their room on 08/02/2025, 08/07/2025, 10/29/2025, 12/18/2025, and 01/28/2026. 5. During the survey, the surveyor reviewed Resident # 20's care planAccording to the AR face sheet, Resident #20 was admitted to the facility with diagnoses including but not limited to: opioid abuse, neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), and mixed hyperlipidemia (inherited disorder characterized by elevated levels of both bad cholesterol and triglycerides in the blood, increasing the risk of cardiovascular disease).According to the MDS, dated [DATE], Resident #20's BIMS had a score of 12 out of 15, which indicated the resident's cognition was moderately impaired.Resident #20's CP did not include any foci, goals, or interventions for Resident #20's history of opioid abuse. On 3/9/26 at 1:32 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), LPN #2 stated that residents with a PICC should have a CP for it. LPN #2 further stated that if issues (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	occur with a resident's PICC, she would document the issue, and then take the proper steps to fix it and then go over the process with the Director of Nursing (DON) to see if anything else needed to be done.On 3/9/26 at 2:45 PM, the surveyor interviewed the Unit Manager (UM) of the 1st floor who stated that the UM is responsible for updating the CP for residents with PICCs.On 3/9/26 at 3:43 PM, the surveyor interviewed the UM of the 2nd floor who stated that residents should have care plans specific to methadone if they are taking methadone. She agreed that care plans are the plan of care for residents.On 3/9/26 at 5:29 PM, the surveyor interviewed the UM of the 1st floor who stated if residents are on oxygen they should have a CP for it. She also stated that if residents are on methadone they should also have a CP for it.On 3/10/26 at 1:19 PM, the surveyor interviewed the DON. DON #2 stated that the CP should be revised for safety measures for residents who smoke and are caught smoking in their rooms. DON #2 further stated that she expects the CP to list interventions and anything pertaining to smoking such as education if the smoking policy is not followed. She stated that interventions are put in place so that staff and residents are aware of their own CP. DON #2 also said that if residents have a physician order for oxygen or methadone, they should also have a CP for it.On 3/10/26 at 4:41 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that CP for all residents should be kept updated. The LNHA also stated that a CP could be generalized but must be inclusive to the resident's orders and plan of care.A review of the facility's policy titled Baseline Care Plan with a revision date of 5/12/25, included the following information under Guideline:The facility will develop and implement a baseline care plan for each resident that include the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Under Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including but not limited to: i. Initial goals based on admission orders. ii. Physician orders. 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified need for supervision, behavioral interventions, and assistance with activities of daily living. iii. Any special needs such as for IV therapy, dialysis or wound care. A review of the facility's policy titled Comprehensive Care Plans with a revision date of 5/12/25, included the following information under Guideline:It is the guideline of this facility to develop and implement a comprehensive person-centered care plan for reach resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Under, Explanation and Compliance Guidelines: 3. The comprehensive care plan will describe, at minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment.d. The resident's goals for admission, desired outcomes, and preferences for future discharge.f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity.NJAC 8:39-11.2 (e)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 03/05/2026, 03/09/2026, and 03/10/2026, it was determined that the facility failed to provide a safe environment for its residents. The facility failed to ensure that a resident (Resident #9) who had smoked inside the facility against facility policy on four previous occasions since 08/02/2025 did not have smoking materials in their possession or smoke in the facility and in the presence of a resident (Resident #16) who was receiving oxygen therapy on 01/28/2026. The facility failed to provide adequate supervision to prevent smoking in the resident's room on 12/18/2025 when the resident refused to surrender their smoking materials; and on 01/28/2026, when Resident #9 was discovered smoking indoors, in the presence of a roommate who was receiving oxygen therapy and refused to surrender their smoking materials. The facility also failed to investigate and implement interventions to prevent smoking against policy when Resident #9 was found smoking on 08/02/2025, 08/07/2025, 10/29/2025, 12/18/2025, and 01/28/2026; and when Resident #8 was observed smoking an electronic cigarette indoors on 09/15/2025. This deficient practice was identified for 2 of 3 residents (Resident #8 and Resident #9) reviewed for smoking. On 03/05/2026, the surveyor observed Resident #9 smoking in the facility smoking area. On 03/05/2026, the surveyor observed what appeared to be burn holes in the sleeves of a blue and white fleece jacket worn by Resident #9. Review of the Progress Notes (PN) revealed that Resident #9 was found smoking in their room on the following dates: 08/02/2025, 08/07/2025, 10/29/2025, 12/18/2025, and 01/28/2025. Further review of the PNs revealed that Resident #9 refused to surrender their smoking materials after they were observed smoking inside on 01/28/2026. An interview was conducted with Resident #9 on 03/05/2026 at 1:30PM. Resident #9 stated that when they smoked in their room in January their roommate (Resident #16) was using oxygen but turned it off so that the resident could smoke in the bathroom. During a follow up interview on 03/09/2026, Resident #9 stated in reference to the 01/28/2026 smoking incident, that they had matches but refused to give them up and that they were not placed under any additional supervision by the facility that day. On 03/10/2026 at 9:15 AM, the facility smoke alarm sounded, and the alarm panel indicated that the source was on the 2nd floor East Wing. The surveyor reported to the unit and determined that the alarm was from Resident #8's room. Upon arrival to Resident #8's room there was no odor of smoke but the room smelled of air freshener. There was no smoking paraphernalia observed but a Febreeze Plug In (an electrical outlet, air freshening device) was noted resting on the heater. The residents denied smoking in the room. The PNs for Resident #8 were reviewed. The PN revealed that on 09/15/2025, Resident #8 was observed smoking an electronic cigarette (e cigarette) indoors at the nurse's station. The PN did not reveal that the resident's e cigarette was removed and stored per facility policy or that the resident received additional supervision. An interview was conducted with the Licensed Nursing Home Administrator (LNHA) on 03/10/2026 at 4:41 PM. The LNHA stated that even without piped-in oxygen improper smoking could cause the whole facility to blow up. The LNHA further stated that vapes (electronic cigarettes) were just as combustible as regular cigarettes. The facility's failure to a.) ensure that Resident #9, who had smoked cigarettes 5 times inside the facility did not have smoking materials in their possession or smoke in the facility in the presence of oxygen and b.) ensure that Resident #8 had their e cigarette properly secured after they were observed smoking at the nurses station placed all residents at risk for serious harm, injury, or death from accidental explosion or fire from unsafe smoking. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 08/02/2025, after Resident #9 was observed smoking in their room. The facility was notified of the IJ on 03/09/2026 at 5:41 PM. The facility submitted an acceptable Removal Plan (RP) on 03/23/2026 at 3:37PM. The surveyor verified the implementation of the RP during the on-site survey on 03/25/2026 and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	determined that the immediacy was removed as of 03/20/2026 at 7:00 PM. The facility further failed to c.) provide adequate supervision to prevent medication misuse by a resident with moderate cognitive impairment who had a history of opioid abuse (Resident #20), who brought outside medication into the facility, and crushed and snorted it together with another resident who had a history of substance abuse (Resident # 19).Complaint #: 2806068, 2789654, 2789700, 2794269, 2679147, 2639889, 2588899, 2806341The facility policy Resident Smoking with a revised date of 03/01/2025 was reviewed. Under Explanation and Compliance Guidelines, the policy revealed that smoking was prohibited in all areas expect the designated smoking area; all residents and family members would be notified of the policy as part of the admission process and as needed; and e-cigarettes can catch fire or explode if not handled and stored safely, use e-cigarettes in designated smoking area only. This section of the facility policy revealed, 12. A resident does not have the right to put others at risk within or on grounds of the facility [.] 15. If a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures and may include a Smoking Contract. This section of the facility policy further revealed that the Activities Director and Nursing Supervisor were jointly responsible for ensuring compliance with the Resident Smoking policy; all staff must immediately report residents smoking in rooms or non-designated areas; and incident reports will be completed and reviewed by administration.Part AThe facility policy Incidents and Accidents with a revised date of 07/01/2024 was reviewed. Under Guideline,' the facility policy revealed that staff were to use the electronic medical record (EMR) to report, investigate, and review any accidents or incidents that occurred on facility property and involved residents. The facility policy defined accidents as an unintentional incident which results in or may result in injury or illness to a resident. The policy defined incident as an occurrence or situation that is not consistent with routine care of a resident or routine operation of the organization. Under Explanation, the policy revealed that the purpose of incident reporting included assuring that appropriate and immediate interventions were implemented and corrective actions were taken to improve resident care and prevent recurrences. This section of the facility policy further revealed that the purpose of incident reporting also included conducting a root cause analysis to determine causative and contributing factors. Under Compliance Guidelines, the facility policy revealed that licensed staff should use the EMR to report incident and accidents and to assist with completion of investigative information to identify the root cause; documentation should include date, time, and nature of the incident, initial findings, immediate interventions, and notifications, orders, and follow-up interventions. This section of the policy further revealed that if the accident or incident was witnessed by other people written documentation of the event should be obtained from those people and submitted to the Director of Nursing (DON) or LNHA. No incident/accident reports, investigation findings, or statements related to the smoking incidents by Resident #9 on 08/02/2025, 08/07/2025, 10/29/2025, 12/18/2025, and 01/28/2026; or the for the smoking incident by Resident #8 on 09/15/2025 were provided. According to the admission Record (AR), Resident #8 was admitted to the facility with diagnoses that included but were not limited to: chronic embolism and thrombosis of unspecified vein; localized edema; post-traumatic stress disorder, chronic; opioid abuse with intoxication, uncomplicated; paranoid schizophrenia; and unspecified asthma, uncomplicated. A review of Resident #8's quarterly Minimum Data Set (MDS), an assessment tool dated 12/17/2025, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. Review of a PN dated 09/15/2025 at 2:33 AM, revealed that staff observed Resident #8 smoking their e-cigarette while standing at the nurse's station and that the resident was educated on facility policy and designated smoking area. No incident report, investigation findings, or root cause analysis were provided related to this incident. Review of the Care Plan (CP) for Resident #8 revealed that no smoking related foci, goals, or interventions were included in the resident's CP after the resident smoked inside the facility on 09/15/2025 and prior to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	03/09/2026. On 03/05/2026 at 10:22 AM, the surveyor observed Resident #9 smoking in the facility smoking area. On the same day at 10:57 AM, the surveyor observed what appeared to be burn holes in the sleeves of the resident's jacket. According to the AR, Resident #9 was admitted to the facility with diagnoses which included but were not limited to: osteomyelitis, unspecified; type 2 diabetes mellitus with hyperglycemia; major depressive disorder, recurrent, unspecified; anxiety disorder; obesity, unspecified; and opioid abuse with intoxication, uncomplicated. A review of Resident #9's comprehensive MDS dated [DATE], revealed that the resident had a BIMS score of 15 out of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed that Resident #9 had impaired range of motion to their lower extremities on both sides, used a manual or electric wheelchair, and required the assistance of two or more helpers to transfer from bed to a chair. A review of the PNs for Resident #9 revealed that the resident was found smoking in the facility as follows: On 08/02/2025 at 10:40 AM, found smoking in their room with a cup full of cigarettes by their bedside. On 08/07/2025 at 10:40 PM, the room was, filled with smoke, and a cup full of used cigarette butts, was observed. On 10/29/2025 at 6:26 AM, the resident was observed smoking in their room and was educated that they were endangering themself and everyone in the building. The resident expressed that they wanted to continue smoking in the room. Facility staff informed the resident that communication with management was the responsibility of all staff. On 12/18/2025 at 7:21 AM, resident was received in bed, non-compliant with the smoking policy and refused to stop smoking or surrender their smoking materials. On 01/28/2026 at 5:26 AM, the resident was found smoking in their bedroom and refused to surrender their smoking materials. There was no facility documentation provided to indicate that the facility Administration was notified of any of the incidents prior to 01/28/2026. Review of the Care Plan (CP) for Resident #9 revealed a Focus, related to smoking initiated on 07/21/2023. The Goal was for the resident to remain compliant with the facility smoking procedure and restrictions. Interventions included completing smoking assessments of the resident, and notifying the resident, family, and physician of the results; informing the resident and/or their responsible party of facility smoking policy; and maintaining and or monitoring all smoking materials in the designated smoking area; and completing periodic smoking evaluation/assessment per policy, or as needed for change in condition. The focus, goals, and interventions were created on 07/21/2025. No interventions were added or adjusted after the five documented smoking episodes in the facility after 08/02/2025. On 03/05/2026 at 1:30 PM, an interview was conducted with Resident #9. Resident #9 confirmed that they had smoked in their room in January. The resident further stated that their roommate at the time (Resident #16) was receiving oxygen but had turned it off when resident #9 informed them that they were going to smoke in the bathroom. On 03/09/2026 at 10:50 AM, a follow-up interview was conducted with Resident #9. The resident confirmed that they had smoked in their bathroom on 01/28/2026 and on that date they had matches in their possession which they refused to surrender to facility staff. The resident stated that they did not have extra supervision by facility staff while they remained in possession of the matches. Resident #9 further confirmed that the holes in their jacket were burn holes that resulted from falling asleep while smoking a cigarette in the facility smoking area. Resident #16 was no longer in the facility; a closed record review was conducted. A review of the AR for Resident #16 revealed that the resident was admitted with diagnoses including but not limited to: borderline personality disorder; hypertensive heart disease without heart failure; alcohol abuse, uncomplicated; and mild intermittent asthma, uncomplicated. A review of Resident #16's admission MDS dated [DATE], revealed that the resident had a BIMS score of 15 out of 15 which indicated that the resident's cognition was intact. A review of the PNs for Resident #16 revealed the following: On 01/27/2026 at 11:05 PM, the resident arrived at 8:46 PM, and the resident had oxygen therapy in place via a nasal cannula at a rate of 2 liters per minute. On 01/28/2026 at 12:06 PM, the resident was receiving oxygen via nasal cannula at a rate of 2 liters per minute. An interview was conducted with the Certified Nursing Assistant (CNA #1) on 03/05/2026 at 10:31AM. CNA #1 stated that residents smoked in their rooms all of the time. CNA #1 stated that if (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaints:2794269, 2679147, 2588899, 2639889, 2789654, 2789700 Based on interviews, review of medical records, and review of pertinent facility documents on 03/05/2026, 03/09/2026 and 03/10/2026, it was determined that the facility failed to a.) ensure that physician ordered medication was obtained and available to be administered and b.) maintain records of, receipt, accountability, and removal from inventory of controlled drugs, for 4 out of 5 residents (Resident #9, Resident #10, Resident #15, and Resident #18) reviewed for methadone (opioid medication that treats severe, chronic pain and substance use disorder). The deficient practice was evidenced by the following:A. According to the admission Record (AR), Resident #9 was admitted to the facility with diagnoses which included but were not limited to: major depressive disorder (mood disorder that causes persistent sadness and loss of interest), recurrent, unspecified; anxiety disorder (condition that causes excessive, uncontrollable worry); and opioid abuse with intoxication, uncomplicated. A review of Resident #9's quarterly Minimum Data Set (MDS), an assessment tool dated 01/24/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. A review of Resident #9's physician orders (POs) revealed the following: An order for methadone HCl (hydrochloride) oral concentrate 10 milligrams (MG) per milliliter (ML), give 100 ML by mouth daily in the morning for opioid dependence. The order start date was 12/27/2025. The order end date was 02/21/2026. An order for methadone HCl oral concentrate 10 MG per ML, give 100 MG daily in the morning for opioid dependence. The order start date was 02/22/2026. The order end date was 03/09/2026. A review of the Care Plan (CP) for Resident #9 revealed a Focus, that the resident was, on pain/opioid medication therapy (METHADONE). Goals related to this focus included administering medication as ordered by the physician and monitoring for side effects. Review of the Medication Administration Record (MAR) for Resident #9 revealed that the code 4 was used for methadone HCl oral concentrate 10 MG per ML, give 100 ML by mouth daily in the morning on the following dates: 01/20/2025, 01/28/2026, and 02/16/2026. Review of the Chart Codes/Follow Up Codes, section of the MAR revealed that the code 4 meant Other/See Nurses Note. Review of the Progress Notes (PNs) for Resident #9 revealed the following related to the resident's methadone doses: A PN dated 01/20/2026 at 1:44 PM, revealed, medication unavailable. A PN dated 01/28/2026 at 9:53 AM, revealed, being delivered later. A PN dated 02/16/2026 at 12:01PM revealed awaiting delivery. The MARs and PNs for Resident #9 revealed no documentation that 01/28/2026 and 02/16/2026 methadone doses were administered. B. According to the AR, Resident #10 was admitted to the facility with diagnoses which included but not limited to opioid dependence, uncomplicated; depression, unspecified; and pain in left knee. A review of the MDS for Resident #10 revealed that the resident had a BIMS score of 15 out of 15, which indicated that the resident's cognition was intact. A review of Resident #10's POs revealed the following: An order for methadone HCl oral solution 10 MG per 5 ML, give 110 MG by mouth daily in the morning for history of substance abuse. The order start date was 11/23/2026. The order end date was 03/09/2026. An order for Tylenol tablet 325 MG, give two tablets by mouth every 4 hours as needed for mild to moderate pain or fever above 100. The order start date was 01/06/2025. A review of the CP for Resident #10 revealed a Focus, that the resident was, on pain/opioid medication therapy (Methadone) [related to] pain management. Goals related to this focus included administering medication as ordered by the physician and monitoring for side effects. A review of the MAR for Resident #10 revealed that the code 4, was used for methadone HCl oral solution 10 MG per 5 ML, give 110 MG by mouth daily in the morning on the following dates: 01/01/2026, 01/02/2026, 01/05/2026, 01/12/2026, 01/20/2026, 01/21/2026, 02/02/2026, and 02/16/2026. Further review of the MAR revealed that Resident #10 received Tylenol for pain on the days that they did not receive their methadone as follows: On 01/01/2025 at 10:13 AM for a pain level (continued on next page)

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

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F 0755 Level of Harm - Actual harm Residents Affected - Some	of five out of 10. On 01/05/2026 at 5:32 PM, for a pain level of six out of 10. Review of the PNs for Resident #10 revealed the following related to the resident's methadone doses: A PN dated 01/01/2026 at 10:10 AM, revealed, on order. A PN dated 01/02/2026 at 9:56 AM, revealed, Awaiting delivery. A PN dated 01/05/2026 at 10:30 AM, revealed, Awaiting delivery. A PN dated 01/12/2026 at 11:13 AM, revealed, none on hand. A PN dated 01/20/2026 at 9:55 AM, revealed, on order. A PN dated 01/21/2026 at 10:13 AM, revealed, Awaiting delivery. A PN dated 02/02/2026 at 10:41 AM, revealed, Awaiting delivery. A PN dated 02/16/2026 at 10:07 AM, revealed, awaiting delivery. The MARs and PNs for Resident #10 revealed no documentation that the 01/01/2026, 01/02/2026, 01/05/2026, 01/12/2026, 01/20/2026, 01/21/2026, 02/02/2026, and 02/16/2026 methadone doses were administered. C. According to the AR, Resident #15 was admitted to the facility with diagnoses including but not limited to: Parkinsonism, unspecified (neurological syndrome characterized by slowed movement, tremors, stiff muscles, and postural instability); schizoaffective disorder (chronic mental illness that causes dramatic changes in thoughts, moods, and behaviors); nicotine dependence, unspecified, uncomplicated; alcohol abuse with alcohol-induced anxiety disorder; and opioid dependence, uncomplicated. According to the quarterly MDS, dated [DATE], Resident #15's BIMS score was 15 out of 15, which indicated that the resident's cognition was intact. A review of Resident #15's POs revealed the following: An order for methadone HCl oral solution 10 MG per 5 ML, give 50 MG by mouth one time a day for opioid withdrawal. The order start date was 04/24/2025. An order for acetaminophen (generic name for Tylenol) tablet 325 MG, give two tablets by mouth every four hours as needed for pain. The order start date was 07/15/2025. A review of the CP for Resident #15 revealed no foci, goals or interventions related to the resident's history of opioid abuse. A review of the MAR for Resident #15 revealed that the code 4, was used for methadone HCl oral solution 10 MG per 5 ML, give 50 MG by mouth one time a day for opioid withdrawal order on the following dates: 01/01/2026, 01/02/2026, and 02/25/2026. Further review of the MAR revealed that Resident #15 received acetaminophen for pain on the days that they did not receive their methadone as follows: On 01/01/2026 at 1:26 PM, for a pain level of three out of 10 pain. Review of the PNs for Resident #15 revealed the following related to the resident's methadone doses: A PN dated 01/01/2026 at 1:02 PM, revealed, Not on hand. A PN dated 01/02/2026 at 8:28 AM, revealed, out of medication. A PN dated 02/25/2026 at 10:52 AM, revealed no documentation of the reason the medication was not given. The MARs and PNs for Resident #15 revealed no documentation that the 01/01/2026, 01/02/2026, or 02/25/2026 methadone doses were administered. D. Resident #18 was no longer at the facility. A closed record review was conducted. According to the AR, Resident #18 was admitted to the facility with diagnoses which included but were not limited to: generalized anxiety disorder; and acute and subacute endocarditis (infection caused by bacteria on normal heart valves, resulting in high fever and significant destruction).According to PNs from the transferring hospital but not included on Resident 18's AR was the resident's history of IV (intravenous) drug use. According to the discharge MDS dated [DATE], Resident #18 had BIMS score of 15 out of 15, which indicated that the resident's cognition was intact. A review of Resident #18's POs revealed the following: An order for methadone HCl oral solution 10 MG per 5 ML, give 50 MG by mouth one time a day for substance use disorder. The order start date was 09/11/2025. The order end date was 09/26/2025. An order for methadone HCL 10 MG per 5 ML, give 50 MG by mouth one time a day for substance use disorder. The order start date was 10/11/2025. The order end date was 11/18/2025. A letter dated 09/08/2025, provided by the facility and signed by Resident #18 was reviewed. The letter revealed that Resident #18 wanted the facility to pick up and administer their methadone during the resident's stay at the facility. Review of the MARs for Resident #18 revealed the code, 4 was used for methadone HCl oral solution 10 MG per 5 ML, give 50 MG by mouth one time a day on the following dates: 09/24/2025, 10/14/2025, 10/15/2025, and 10/22/2025. Review of the PNs for Resident #18 revealed the following related to the resident's methadone doses: A PN dated 09/24/2025 at 10:19 AM, revealed, Awaiting delivery. A PN dated 10/14/2025 at 10:09 AM, revealed, On order. A PN dated 10/15/2025 at 9:33 AM, revealed, (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Some	Awaiting delivery. A PN dated 10/22/2025 at 9:30 AM, revealed, Awaiting delivery. The MARs and PNs for Resident #18 revealed no documentation that the 09/24/2025, 10/14/2025, 10/15/2025, or 10/22/2025 methadone doses were administered. Further review of the PNs for Resident #9, Resident #10, Resident #15, and Resident #18 revealed no documentation indicating the residents' physicians were notified of the aforementioned unavailable methadone doses. An interview was conducted with Resident #10 on 03/05/2025 at 10:05 AM. Resident #10 stated that recently they went three days without their methadone, which caused the resident to have hot flashes, vomiting, and body aches. The resident stated that they were given Tylenol, but it did not help. Resident #10 further stated that Unit Manager (UM) #2 was responsible for picking up the methadone from the clinic. An interview was conducted with Resident #9 on 03/05/2026 at 10:57 AM. Resident #9 stated that approximately one month prior they had missed their methadone dose twice. Resident #9 stated that they had chills and were in pain. Resident #9 further stated that not receiving their methadone affected their state of mind, made them consider using illicit drugs again and did not make them feel secure at the facility. An interview was conducted with Resident #15 on 03/09/2026 at 10:40 AM. Resident #15 stated they remembered missing methadone doses around the new year. The resident stated that they felt sick, had sweats, and had pain when the methadone doses were missed. Resident #15 stated that their doses were late because the facility failed to pick them up from the methadone clinic on time. An interview was conducted with UM #2 on 03/05/2025 at 12:22 PM. UM #2 stated that around the new year, Resident #9 and Resident #10 did not receive their methadone. UM #2 stated that the residents did not receive their methadone because she did not pick it up. UM #2 stated that she thought the residents would have enough medication to carry them through, but they did not. UM #2 stated, that was my mistake. UM #2 stated that either she or the facility Infection Preventionist (IP) pick up the methadone for the residents. UM #2 further stated that there was not a system in place to ensure that the methadone was picked up if she or the IP were not available. During the same interview UM #2 stated that she was not aware that Resident #18 wanted the facility to pick up and administer their methadone. UM #2 further stated that she could not produce documentation of declining counts for methadone for Resident #18. An interview was conducted with the facility's Pharmacy Consultant (PC) on 03/09/2026 at 12:46 PM. The PC stated that he would be involved in ensuring that there was a facility process in place related to methadone. The PC stated that he was not aware that residents had missed doses of methadone. The PC further stated that declining counts should be kept by the facility for any controlled substances (drugs and medications with a risk of misuse and dependence) in order to maintain chain of custody and to allow the facility to look into any concerns. An interview was conducted with Licensed Practical Nurse (LPN) #3 on 03/18/2026 at 12:13 PM. LPN #3 stated that the process for giving methadone included both the nurse and the resident signing the declining count sheet at the time of administration. LPN #3 stated that he was aware of times that Resident #10 did not receive their methadone. LPN #3 stated that Resident #10 experienced pain and he medicated the resident with Tylenol. NJAC 8:39- 29.7 (c)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interviews, medical record reviews and reviews of other pertinent facility documentation on 3/5/26, 3/9/26, 3/10/26, and 3/18/26, it was determined the facility failed to ensure residents medical records were complete, accurate and readily accessible as evidenced by: a.) the facility not being able to provide surveyors with Activities of Daily Living (ADL) logs, b.) the facility not being able to provide surveyors with declining sheets for residents on methadone, c.) the facility not being able to provide surveyors with complete and correctly documented 1:1 logs, and d.) the facility not being able to provide surveyors with a personal belongings log for a resident that was being admitted to the facility. This deficient practice resulted in incomplete and unavailable clinical records, which had the potential to impact the facility's ability to ensure appropriate care, monitor resident conditions, ensure accountability of services provided, and protect residents. This deficient practice was identified for 8 of 21 residents (Resident #3, Resident #4, Resident #9, Resident #10, Resident #14, Resident #15, Resident #18, and Resident #20) and was evidenced by the following:Complaint #: 2806068, 2789700, 2679147, 2639889 The facility was unable to provide ADL documentation to reflect the care and services delivered to Resident #14.According to the admission Record (AR) face sheet, Resident #14 was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia, restlessness, and agitation.A review of Resident #14's quarterly Minimum Data Set (MDS), an assessment tool dated 1/13/2025, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated that the resident's cognition was moderately impaired.During the survey, surveyors requested a copy of Resident #14's ADL logs and the facility was unable to provide them.The facility was unable to provide declining sheets or monitoring documentation for residents receiving methadone until January of 2026, to demonstrate ongoing assessment and response to the medication regimen.According to the AR, Resident #9 was admitted to the facility with diagnoses which included but were not limited to: osteomyelitis, unspecified; type 2 diabetes mellitus with hyperglycemia; major depressive disorder, recurrent, unspecified; anxiety disorder; obesity, unspecified; and opioid abuse with intoxication, uncomplicated.According to the MDS, dated [DATE], revealed that the resident had a BIMS score of 15 out of 15, which indicated that the resident's cognition was intact.According to the AR Resident #10 was admitted to the facility with diagnoses which included but were not limited to: morbid obesity due to excess calories, opioid dependence and depression.According to the MDS, dated [DATE], it revealed that the resident had a BIMS score of 15 out of 15, which indicated that the resident's cognition was intact.According to the AR, Resident #15 was admitted to the facility with diagnoses including but not limited to: Parkinsonism (an umbrella term for a neurological syndrome characterized by motor symptoms similar to Parkinson's disease, including bradykinesia (slowed movement), resting tremor, muscle rigidity, and postural instability), Chronic Obstructive Pulmonary Disease (COPD) (a progressive, treatable lung disease that causes long-term breathing problems by damaging airway tissue, leading to inflammation and blocked airflow) and mild intermittent asthma.According to the MDS, dated [DATE], Resident #15's BIMS was a score of 15 out of 15, which indicated the resident's cognition was intact.According to the AR, Resident #18 was admitted to the facility with diagnoses which included but were not limited to: generalized anxiety disorder and acute and subacute endocarditis (infection often caused by bacteria on normal heart valves, resulting in high fever and significant destruction).According to the MDS, dated [DATE], Resident #18 had a BIMS score of 15 out of 15, which indicated the resident's cognition was intact.During the survey the surveyors requested declination sheets for these residents who were on Methadone and were informed that declination sheets were unable to be provided prior to the end of January of 2026.The facility was unable to provide complete and accurately documented 1:1 observation records for residents (Resident #3 and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4), including missing or incomplete entries necessary to verify continuous monitoring.According to the AR, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: depression and chronic painAccording to the MDS, dated [DATE], Resident #3 had a BIMS score of 15 out of 15, which indicated the resident's cognition was intact.According to the AR, Resident #4 was admitted to the facility with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (neurological deficits caused by left-brain damage, resulting in paralysis (hemiplegia) or weakness (hemiparesis) on the right side of the body), type 2 Diabetes Mellitus, and low back pain.According to the MDS, dated [DATE], Resident #4 had a BIMS score of 15 out of 15, which indicated the resident's cognition was intact.During the survey the surveyors requested the 1:1 observation records for Resident #3 and Resident #4 and the facility was unable to provide complete and accurately documented records and records that matched their policy such as both the residents' Electronic Medical record (EMR) Electronic Treatment Administration Record/Electronic Medication Administration Record (eTAR/eMAR).The facility was unable to provide a personal belongings inventory for a resident upon admission, to account for resident property (Resident #20).According to the AR face sheet, Resident #20 was admitted to the facility with diagnoses including but not limited to: opioid abuse, neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), and mixed hyperlipidemia (inherited disorder characterized by elevated levels of both bad cholesterol and triglycerides in the blood, increasing the risk of cardiovascular disease).According to the MDS, dated [DATE], Resident #20 had a BIMS score of 12 out of 15, which indicated the resident's cognition was moderately impaired.During the survey the surveyors requested a personal belongings inventory for Resident #20 when they were re-admitted into the facility on 3/6/26 which the facility was unable to provide. Surveyors requested this inventory as Resident #20 was alleging to have brought pills back from the hospital that they were inhaling via their nostril. This was observed by staff and reported to the Department of Health (DOH).On 3/5/26 at 12:22 PM, the surveyors interviewed the Unit Manager (UM) on the second floor regarding the declining sheets for methadone. UM #2 stated that she did not keep records of the residents who were on methadone until the end of January of 2026.On 3/9/26 at 10:40 AM, the surveyor interviewed Resident #15 who reported that they do not receive their methadone on time and that caused them to feel sick.On 3/9/26 at 10:50 AM, the surveyor interviewed Resident #9 who reported missing methadone doses and having an inadequate supply of methadone.On 3/9/26 at 1:01 PM, the surveyors interviewed Certified Nursing Assistant (CNA) #2 who confirmed that the care that he provides for residents he documents in the Point of Care (POC) for the facility and that the POC should be completed by the end of his shift. CNA #2 also confirmed that there should not be blanks on 1:1 record as that would indicate that the CNA filling out the 1:1 record is not paying attention to their documentation.On 3/9/26 at 1:32 PM, the surveyors interviewed Licensed Practical Nurse (LPN) #2 who stated that documentation for residents should be complete and accurate so that all personnel would be able to know what care is being provided for a resident. LPN#2 was shown the 1:1 record for Resident #3 and Resident #4 and stated that the forms were filled out incorrectly because there were blanks. When asked why there should be no blanks on the 1:1 record, the LPN stated because the observer is not doing their job correctly if there are blanks.On 3/9/26 at 2:14 PM, the surveyors interviewed UM #2 who stated that Resident #3 and Resident #4's 1:1 record were not filled out per facility policy or her expectations for her staff. UM #2 also stated that the 1:1 log should be able to be provided to surveyors and up to date because it informs all personnel that the facility is properly implementing their own interventions related to 1:1 observation.On 3/10/26 at 2:10 PM, the surveyors interviewed the Director of Nursing (DON) #2 who stated that documentation is what properly allows the facility to care for residents. She further stated that documentation is the driving force for residents, their family, and the facility as it allows everyone to be aware of the care being provided for the residents.On 3/10/26 at 4:41 PM, the surveyors interviewed the Licensed Nursing Home Administrator (LNHA) who confirmed there were (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	errors on the 1:1 logs and that they were not done correctly. The LNHA also confirmed that the facility could not produce declination sheets for methadone. On 3/18/26 at 1:40 PM, DON #2 was interviewed and stated that when residents are admitted to the facility an inventory of their belongings is completed. When asked why inventorying a resident's belonging was important DON #2 stated to know what a resident has when they come in and so that belongings don't get misplaced. She also stated that that typically she does not check a resident's pockets or performs a body check when performing an inventory of a resident's belongings. Surveyor requested Resident #20's inventory of belongings from re-admission in March of 2026.On 3/18/26 at 2:14 PM, DON #2 stated she was unable to provide surveyors with the inventory log for Resident #2.A review of the facility's policy titled Documentation in Medical Record with a revision date of 5/12/25 included the following information under Guideline:Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Under, Explanation and Compliance Guidelines: Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Documentation may be performed manually or as per the facility's specific electronic medical record software program. A review of the facility's policy titled One to One Supervision with a revision date of 12/11/25 included the following information under Purpose:One-to-one observation/supervision is implemented when a resident's clinical assessment indicated a one on one necessary based on an increased safety necessity. Implementation of one-to-one supervision is reserved for extreme situations where they may be a significant risk to the safety and well-being of a resident or other residents.Under, Procedure: 1. One-to-one supervision requires that a resident is always never out of sight of the assigned staff member.a. The resident is always accompanied by the designated staff member (including bathing, showering, shaving, and toileting), unless care plan indicates otherwise. 5. Residents on a one-to-one status will be evaluated at least every shift by a Licensed Nurse.a. In addition, the Interdisciplinary Team (IDT) will reassess the resident every 24 hours or as needed to ensure that one-to-one staff supervision continues to be necessary.b. One-on-one will be added to the EMR (eTAR/eMAR), and the nurse assigned to ethe resident will sign off each shift, verifying supervision is in place and current.c. The patient will be on Alert/Shift-to shift charting every shift for the duration of one-to-one supervision to document the patients activities and both effective and ineffective interventions utilized.d. The designated staff member who is providing one-to-one supervision will utilize the Safety Check Log & Data Collection (One-to-One) form to document resident activity throughout the observation period.A review of the facility's policy titled Resident Personal Belongings with a revision date of 7/12/25 included the following information under Guideline:It is the guideline of this facility to protect the resident's right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. The facility will ensure that personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative, in the event of the resident's death or discharge from the facility.Under, Explanation and Compliance Guidelines: 3. All resident personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the medical record. 5. The facility may refuse to allow a resident to retain his or her personal possession(s) due to the following reasons:b. As protection of health and safety.c. The facility determines through observation that a resident may have access to illegal substances that they have [NAME] into the facility or secured from an outside source. The facility does not act as an arm of law enforcement. Rather, in accordance with state laws, the facility will determine if a referral to local law enforcement is warranted. The facility may choose to provide additional monitoring and supervision determined on a case by case basis. If facility staff identify items or substances that pose risks to residents' health and safety and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are in plain view, they may confiscate them.d. To maintain and prevent the infringement of other resident rights.N.J.A.C. 8:39-35.2