STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315332	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Ocean Center	1361 Route 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Complaints: NJ00176578, NJ00181499, NJ00184013, NJ00184932 Based on interviews, record review, and review of other pertinent facility documents on 06/04/2025 and 06/06/2025, it was determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, by failing to ensure that; a.) medications were administered according to Physician orders (POs), b.) bloodwork was obtained and faxed according to POs, and c.) Physicians were notified that medications were not administered or available. This deficient practice was identified for 1 out of 3 residents reviewed for quality of care (Resident #5). This deficient practice 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 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 well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Review of Resident #5's undated admission RECORD revealed that Resident #5 was admitted to the facility with diagnosis that included but were not limited to acute myeloblastic leukemia (AML) (an aggressive cancer of the blood and bone marrow), not having achieved remission; anemia, unspecified; post-traumatic stress disorder; muscle weakness (unspecified); chronic kidney disease; and difficulty walking, not elsewhere classified. Review of Resident #5's Minimum Data Set (MDS), an assessment tool dated 07/04/2024, was conducted. The MDS revealed that Resident #5 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident had severely impaired cognition. Review of Resident#5's Medication Review Report (MRR), was conducted. The MRR revealed POs that included but were not limited to: Epoetin Alfa Injection Solution (a medication used to treat anemia by helping the body produce red blood cells) 1000 UNIT/ML (milliliter). Inject 2 ml subcutaneously one time a day every 7 days for anemia. HOLD RETACRIT (another name for epoetin alfa) IF HGB (hemoglobin) EXCEEDS 10. The order start date was 06/30/2024. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Venclexta (a medication used in combination with other medications to treat AML) Oral Tablet 100 MG. Give 1 tablet by mouth once a day, 14 days on and 14 days off, for AML. The order start date was 07/16/2024 CBC (a blood test that measures the number and size of the different cells in the blood), and CMP (a blood test that aims to evaluate the function of essential organs in the body) every Monday and Thursday. The order start date was 07/10/2024. Fax lab results to Resident #5's Oncologist on evening shift every Monday and Thursday. The order start date was 07/11/2024. Resident #5's Medication Administration Records (MARs) for June, July, and August 2024 were reviewed. The MAR revealed no documentation for the 08/05/2024 dose of Epoetin Alfa Injection Solution. The MAR revealed that the code NN was entered for the following medication doses and orders: Epoetin Alfa Injection Solution on: 06/30/2024, 07/07/2024, and 07/14/2024. Venclexta Oral Tablet on: 07/16/2024, and 08/21/2024. Fax CBC and CMP results to Resident #5's Oncologist on: 08/19/2024. Review of the Chart Codes/ Follow Up Codes section of the MAR revealed that the code NN indicated No/See Nurse Notes. A review of Resident #5's progress notes (PNs) was conducted. An eMAR (electronic medication administration record) PN written by LPN #1, effective 06/30/2024 at 8:50 P.M., revealed that Epoetin Alfa injection solution was on order. An eMAR PN written by LPN #2 effective 07/07/2024 at 8:13 P.M., revealed that Epoetin Alfa injection solution was on order. An eMAR PN written by LPN #2 effective 07/14/2024 at 8:46 P.M., revealed that Epoetin Alfa injection solution was on order. An eMAR PN written by LPN #2 effective 07/16/2024 at 8:30 A.M., revealed that Venclexta oral tablet was on order. An eMAR PN written by LPN #2 effective 08/21/2024 at 9:00 A.M., revealed, [family member] bringing in due to comes from oncology pharmacy and it is shipped to her home. when she arrives will administer. Review of Resident #5's PN revealed no documentation that the aforementioned medications were administered. Resident #5's PNs revealed no documentation that the resident's physician was notified that the medication doses were not available and not given. An eMAR PN written by LPN #3 effective 08/19/2024 at 10:49 P.M., revealed that lab results were not available. Review of Resident #5's PN revealed no documentation that the aforementioned lab test results were obtained or faxed. Resident #5's PNs revealed no documentation that the resident's physician was notified that the lab test results were not available or faxed to Resident #5's Oncologist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #5's PNs revealed a Lab Result Note written by Nurse Practitioner (NP)#1, dated 07/12/2024 at 11:03 P.M. The note indicated that Resident #5's Oncologist was notified of an abnormal bloodwork result and transfusion was discussed. The note further revealed Pt [patient] also get Epo [Epoetin Alfa] in center. A follow-up note dated 08/08/2024 at 3:57 P.M., written by NP #1 was reviewed. The follow-up note revealed under the Assessment & Plan section, pt gets epo inj in center weekly. and under the Health Concerns section, Pt is on Epo weekly in center. An interview was conducted with Licensed Practical Nurse (LPN) #2 on 06/06/2025 at 10:18 A.M. LPN #2 stated that the process if ordered medications were not available was to follow up with the pharmacy, notify the patient and their family, and notify the doctor. LPN #2 stated that if medications were not given the reason would be documented in the electronic medical record. LPN #2 stated that if medications were not given the doctor was notified and the notification was documented in the electronic medical record (EMR). During the same interview LPN #2 stated that when she documented on order in the PN it meant that the medication was not given. LPN #2 further stated that the pharmacy should have been called and physician notified in these instances. An interview was conducted with LPN #1 on 06/06/2025 at 11:19 A.M. LPN #1 stated that the process if ordered medications were not available was to notify the resident's doctor or use the facility's on-call service to notify a doctor. LPN #2 stated that if a medication was not available sometimes a doctor would decide to order a different medication. LPN #1 stated that if a medication was not given, she would document that in the EMR. LPN #1 stated that when she documented, on order, in the PN it meant that delivery by the pharmacy was scheduled. LPN #1 further stated that when the medication arrived and was given, the administration would have been documented in the EMR. LPN #1 stated that all documentation should have been completed by the end of the shift. An interview was conducted with Nurse Practitioner (NP) #1 on 06/06/2025 at 11:36 A.M. NP #1 stated that Epoetin Alfa was important for anemia treatment because it helped with hemoglobin levels and red blood cell production. NP#1 stated that what when she documented in center, it meant, at this facility. NP#1 further explained that if Epoetin Alfa were unavailable or not administered, she would have expected to be notified so that adjustments could have been made. An interview was conducted with the Director of Nursing on 06/06/2025 at 12:14 P.M. The DON stated that it was the expectation a resident's doctor was notified if an ordered medication was not available. The DON stated that the assigned nurse or Unit Manager were responsible for making the notification. The DON stated that the notification should have been documented in the MAR or PN. The DON stated that it was the assigned nurse's responsibility to ensure that labs were completed as ordered. The DON stated that if something was not documented in the medical record, it was not done. The DON further stated that the expectation was that all documentation was completed before the end of that shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 06/06/2025 at 1:19 P.M., the DON confirmed that no documentation of physician notification was available for the NN codes or blanks in the MAR on the aforementioned dates. The DON confirmed that there was no documentation that a physician was notified that Resident #5's labs were not drawn or that results were not available. The DON further stated that if lab results were not available, the expectation was that a doctor was notified, and labs were obtained as soon as possible. A follow-up telephone interview was conducted with Resident #5's physician, the facility's Medical Director (MD) on 06/10/2025 at 2:09 P.M. The MD stated that when medication were ordered it was his expectation that they were given. The MD stated that if ordered labs were not obtained he expected to have been notified. The MD stated, medications are ordered for a reason and we need to be informed if medications are not given because it can affect what we do next, it can guide our decisions. The MD further stated that Resident #5's Oncologist (ONC) should have been notified if Venclexta was not given. A telephone interview was conducted with Resident #5's ONC on 06/12/2025 at 1:50 P.M. The ONC stated that Resident #5 was treated for an aggressive form of AML. The ONC stated that Venclexta was part of the resident's chemotherapy regimen and timing of this medication was very important because it was part of a combination treatment. The ONC stated that he was not aware that Resident #5 had missed doses of Venclexta. The ONC further stated that it was his expectation that he would have been notified of missed doses of Venclexta. The facility Charge Nurse- LPN (job code NCL1) job description with a revision date of 6/16/17 was reviewed. On page 1 of 6 under POSITION SUMMARY, the job description revealed, [.] The Charge Nurse-LPN ensures the delivery of efficient and effective nursing care while achieving positive clinical outcomes and patient/family satisfaction. Page 2 of 6 of the job description document revealed under Clinical Leadership, 2.11 Ensures that Physician Orders are followed as prescribed; [.] 2.13 Ensures that patient's attending physician and family or responsible party are promptly notified of any significant change in the patient's health condition; The facility policy NSG115 Physician/Advanced Practice Provider (APP) Notification, with a revision date of 12/16/2024 was reviewed. The policy revealed on page 1 of 2 under POLICY, Upon identification of a patient who has a change in condition, abnormal laboratory values, or abnormal diagnostic, a licensed nurse will: [.] Collect pertinent patient information (e.g., age, diagnoses, .labs, recent changes in medications, [.] etc.), Report to physician/advanced practice provider (APP). If unable to contact attending physician/APP, the Medical Director will be contacted. Page 1 of 2 of the policy revealed under PURPOSE, To support effective communication and notification of physicians/APPs. N.J.A.C. : 8:39-27.1 (a)