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	09/08/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and review of the facility's policy, the facility failed to implement their abuse policies and procedures by ensuring a resident (Resident #104) was free from verbal abuse. This deficient practice was identified for 1 of 1 resident reviewed for abuse (Resident #104) and was evidenced by the following:A review of the admission Record (admission summary) indicated that Resident # 104 was admitted to the facility with the diagnoses which included but was not limited to Parkinson's disease, atrial fibrillation, depression and diabetes mellites (DM). The annual Minimum Data Set (MDS), an assessment tool used to facilitate a resident's care dated 5/29/25, indicated that Resident #104 scored a 11/15 on the Basic Interview for Mental Status (BIMS) which indicated that the resident had moderate cognitive impairment. The MDS also reflected that the resident did not exhibit any behaviors.A review of the form AAS-45 (Facility Reportable Event) dated 8/5/25, indicated that on 8/2/25 a housekeeper told Resident #104 to learn to use the toilet when the housekeeper had to clean up feces from the resident's toilet. A review of a Physical Therapist (PT) untimed statement dated 8/4/25, indicated that as the therapist was attempting to take Resident #104 for a PT session, the resident refused to go and was emotionally upset because the resident reported that a staff member humiliated them. The resident reported that a staff member had to clean the resident's toilet too often because the resident was going to the bathroom (defecating) often.A review of Resident #104's untimed statement taken 8/4/25, revealed that on 8/2/25 a housekeeper was cleaning, and the resident overheard the housekeeper saying that she had to Wipe shit off the floor and from around the toilet. I cleaned up shit this morning and now I have to do it again.A review of the emailed statement dated 8/8/25 at 12:35 PM, from the alleged perpetrator (housekeeper), reflected that the housekeeper admitted that an aide had told her that Resident #104 defecated all over the front of the toilet and it went down the front of the toilet and on the floor. The housekeeper stated, I said to [Resident #104] to come and see how you shit all over the toilet and this is so nasty, can't you shit in the toilet.The facility provided the surveyor with the full investigation and conclusion and summary related that the incident.A review of the Summary and Conclusion dated 8/6/25, indicated that the facility immediately provided the resident with 1:1 emotional support and the housekeeper was placed on administrative leave and was not permitted to return to work pending the outcome of an internal investigation.During the investigation the facility contacted the housekeeper, and the housekeeper admitted to making the comments aloud in the hall and then entered the resident's room and told the resident that he/she needed to learn how to use the toilet. As a result, the housekeeper was immediately terminated, and the facility proceeded to interview other residents in the area where Resident #104 resided. No other residents had complaints regarding any mistreatment from the housekeeper.On 9/03/2025 at 10:54 AM, the surveyor interviewed Resident #104 who stated that he/she felt that the facility did a good job and fired the housekeeper that embarrassed him/her. The resident stated that they had been doing ok and stated that they felt safe in the facility. During the interview the resident's psychologist entered the resident's room for a session with the resident.On 9/04/2025 at 11:02 AM the surveyor interviewed the Social Worker (SW) who stated that when Resident #104 reported that a housekeeper verbally abused him/her, the housekeeper was immediately terminated. The SW stated that the facility reported the incident to the Department of Health and investigated. He confirmed that the abuse was verified because the housekeeper admitted that she made derogatory comments to the resident about learning how to use the toilet by not getting feces on the toilet or on the floor. He stated that the facility provided the resident with 1:1 emotional support and the resident was being followed by a mental health specialist. The SW continued to explain that during the investigative process, the resident was interviewed, and statements were obtained from staff and other residents. He stated that he interviewed other residents that were alert and oriented and who were exposed to the housekeeper. He stated that was very important to interview other residents to ensure that it was not happening to them and to know as to what extent this was happening. The SW provide the surveyor with typed list of other residents interviewed in the immediate area of Resident #104 and according to the list, no other residents were affected.On 9/04/2025 at 11:18 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that she had reported the event to the New Jersey Department of Health (NJDOH) the same day the resident reported the incident on 8/4/25. She stated that she remembered that the SW conducted interviews with other residents on the unit or exposed to the housekeeper. The ADON stated that interviews with other residents would be important to ensure that any abuse was not happening to others and if it was, as to what extent it was occurring and to