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	03/03/2026

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 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** Based on interviews, medical record reviews and reviews of other pertinent facility documentation on 3/2/26 and 3/3/26, it was determined the facility failed to ensure that medical records for residents were accurate as evidenced by a.) an inaccurate weight being entered for a Resident #5 b.) the Licensed Practical Nurse (LPN) who did not sign out the Medical Administration Record (MAR) after administering (Resident #8) and c.) nurses clicking the wrong button under Nutrition while documenting their skilled evaluations for a Resident #4. This resulted in inaccurate medical records and failure to identify potential medication, weight, and documentation errors. This deficient practice was identified for 3 of 10 residents reviewed for resident records (Resident #4, Resident #5 and Resident #8), and was evidenced by the following:A. On 3/2/26 the surveyor reviewed Resident #5's documented weights while at the facility. Resident #5 had a weight of 166.5 pounds on 11/28/25 and 150 pounds on 11/29/25.According to the admission Record (AR) face sheet, Resident #5 was admitted to the facility with diagnoses including but not limited to: heart failure, unspecified atrial fibrillation (common heart arrhythmia characterized by an irregular, rapid heart rhythm caused by chaotic electrical signals in the heart's upper chambers), and respiratory disorder.According to the Minimum Data Set (MDS), an assessment tool dated 12/8/25, Resident #5's Brief Interview for Mental Status (BIMS) was a 15 which indicated that Resident #5 was cognitively intact.On 3/2/26 at 11:25 AM, the surveyor interviewed an LPN from the facility's Post Acute Care Unit (PACU) who stated that if a resident was gaining or losing too much weight, the staff would notify speech and dietary.On 3/2/26 at 11:31 AM, the surveyor interviewed the Unit Manager (UM) of the PACU. In relation to a resident's weight gain or loss, she stated she would inform the doctor, confirm the weight change, and aid the resident to support the weight gain or loss. The UM stated that depending on what the resident and family wants, the care team is informed, and a decision is made collaboratively to address weight gain or loss.On 3/3/26 at 12:08 PM, the surveyor interviewed a CNA from the facility's Lighthouse unit who stated that CNAs are responsible for taking a resident's weight. She stated that typically she would weigh a resident and compare the weights for a 2-pound weight gain or loss. If there was a weight gain or loss greater than 2 pounds, she would reweigh the resident. The CNA also stated she did not think a 15-pound weight loss would occur in a day but that she would notify the nurse so that the nurse could address the situation. On 3/3/26 at 12:12 PM, the surveyor interviewed the UM of the PACU unit who stated a resident with a 15-pound weight loss would lead to nutrition reaching out to her to notify her of the weight loss. At this time, the surveyor showed the UM the weights for Resident #5. The UM stated she is not sure what happened and that her CNAs know to notify the nurse and nutrition related to weight loss such as Resident #5's. She stated that it was probably an error.On 3/3/26 at 12:44 PM, the surveyor conducted a phone interview with one of the facility's nutritionists. She stated that nutrition typically gets a weight trigger for a 15-pound weight loss and that nutrition would email the UM and ask for a re-weight and ask for further clarification and the team would analyze the weight loss.On 3/3/26 at 1:02 PM, the surveyor interviewed the Director of Nursing (DON). The DON showed Resident #5's weights as well as the facility's policy regarding (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident weights. The DON stated that based off what the surveyor was showing her and stating related to Resident #5, the facility policy was not followed and that she believed that Resident #5's weight from 11/29/25 was a mistake.B. On 3/3/26 the surveyor reviewed Resident #8's February 2026 MAR. For 2/14/26, the MAR for oxycodone was blank on 12/14/26.According to the AR face sheet, Resident #8 was admitted to the facility with diagnoses including but not limited to: displaced intertrochanteric fracture of right femur (a common, severe hip fracture occurring between the greater and lesser trochanters of the upper right thigh bone), subsequent encounter for closed fracture with routine healing, muscle weakness, and other abnormalities of gait and mobility.According to the MDS, dated [DATE], Resident #8's BIMS was an 8 which indicated that Resident #8's cognition was moderately impaired.On 3/2/26 at 11:13 AM, the surveyor interviewed an LPN from the facility's PACU unit regarding medication administration documentation. The LPN stated medications are signed out on the MAR and the expectation is to be documented in real time as the medication is being given.On 3/2/26 at 11:31 AM, the surveyor interviewed UM of the PACU unit. When asked what her expectations are when it comes to documentation the UM stated she expects all her staff to fill out their required documentation including MARs.On 3/3/26 at 1:02 PM, the surveyor interviewed the DON who stated that her staff are well educated and trained in documentation and facility policies.C. On 3/3/26 the surveyor reviewed Resident #4's Nursing Advanced Skilled Evaluations ([NAME]) and three nurses had clicked the wrong button under Nutrition which created documentation errors for Resident #4.According to the AR face sheet, Resident #4 was admitted to the facility with diagnoses including but not limited to: encounter for surgical aftercare following surgery on the circulatory system, pneumonitis (general inflammation of the lung tissue) due to inhalation of food and vomit, and acute respiratory failure with hypoxia (oxygen deficiency).According to the Social Services Assessment and Documentation dated 2/24/26, Resident #4's BIMS was a 9 which indicated that Resident 4's cognition was moderately impaired.On 3/3/26 at 9:53 AM the surveyor conducted a phone interview with one of the LPNs who had been inaccurately documenting Resident 4's [NAME]. The surveyor asked the LPN if the [NAME] was an attestation for a head-to-toe assessment for a resident and she replied yes.On 3/3/26 at 12:12 PM the surveyor interviewed the UM of the PACU unit who confirmed that the [NAME] was the nurse's head-to-toe assessment for a resident and expectation is that it is to be completed daily. She further stated that staff are to be doing a new and daily [NAME] per shift and that staff need to pay attention to what they are documenting because their documentation is their attestation.On 3/3/26 at 1:02 PM, the surveyor interviewed the DON who confirmed that she also expects her staff to complete a new [NAME]. The DON also stated that staff should document accurately as one shift can be different from another and that things change. She also stated she was not sure what was occurring with her staff's documentation regarding Resident #4's NASEs. The surveyor pointed out that under the Nutrition the nurses were clicking met for where the [NAME] was asking if residents were Taking nutrition and hydration orally. No complaints of thirst. No signs/symptoms of a swallowing disorder. Mucous membranes moist. The DON confirmed what the surveyor pointed out and then stated she could see how this could be confusing for her staff and that is why they were incorrectly clicking it. The surveyor pointed out that 3 nurses made this documentation error, but other nurses did not for Resident #4.A review of the facility's policy titled NSG113 Nursing Documentation with a revision date of 5/1/23, included the following information under Policy: Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's/patient's (hereinafter patient) condition, situation, and complexity. A review of the facility's policy titled OPS402 Clinical Record: Charting and Documentation with a revision date of 7/15/25, included the following information under Purpose: to provide a complete account of the patient's total stay from admission through discharge, provide information about the patient that will be used in developing a plan of care, and as a tool for measuring the quality of care provided to the patient. Under, Process:2. Licensed staff and interdisciplinary team members shall document all assessments, observations and services provided (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 patient's medical records in accordance with state law.3. Document pertinent changes in the patient's condition, reaction to treatment, medication, etc., as well as routine observations.4. Documentation shall be completed at the time of service, but no later than during the shift in which the assessment, observation, or care service occurred.6. Principles of documentation include but are not limited to the following. 6.1 Documentation shall be factual, objective, and patient centered.A review of the facility's policy titled NSG 244 Weights and Heights with a revision date of 1/15/26, included the following information under Policy: Based on the patient's comprehensive assessment, the Center will ensure that all patients maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, . Under, Purpose: To obtain baseline weight and identify significant weight change. To determine possible causes of significant weight change. Under, Process: 2. If the body weight of a patient is not as expected, re-weigh the patient.NJAC 8:39-35.2

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 3/2/26 and 3/3/26, it was determined that the facility failed to ensure staff properly wore the appropriate personal protective equipment (PPE) when providing care for patients on Enhanced Barrier Precautions (EBP) for four residents (Resident #1, Resident #7, Resident #9 and Resident #10). The facility also failed to follow its policy titled IC 308 Enhanced Barrier Precautions. This deficient practice was identified for 4 of 10 residents reviewed for infection prevention and was evidenced by the following:According to Resident #1's admission Record (AR), the resident was admitted with diagnoses that included but were not limited to: periprosthetic fracture around internal prosthetic left hip joint (a break in the hip socket next to a hip implant), presence of left artificial hip joint, and heart failure.According to the Minimum Data Set (MDS), an assessment tool dated 2/14/26, Resident #1's Brief Interview for Mental Status (BIMS) was a 15 which indicated that Resident #1 was cognitively intact.According to Resident #1's Care Plan (CP) with a date initiated of 2/8/26, under Interventions stated: Enhanced Barrier Precautions: Enhanced Barrier Precautions: Use gown and gloves when performing high-contact activities: dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (e.g. central line, urinary catheter, feeding tube, tracheostomy, or ventilator), wound care (any skin opening requiring a dressing).According to Resident #7's AR, the resident was admitted with diagnoses that included but were not limited to: right hip bursitis (the painful inflammation of a small, fluid-filled sac that acts as a cushion to reduce friction between bones, tendons, and muscles near joints), pain in right hip, and unilateral primary osteoarthritis of right hip (a chronic, degenerative joint disease affecting only the right hip, characterized by the gradual wear and breakdown of articular cartilage without a known underlying cause).According to the MDS, dated [DATE], Resident #7's BIMS was a 15 which indicated that Resident #7 was cognitively intact.According to Resident #7's CP with a date initiated of 1/30/26, under Interventions stated: Enhanced Barrier Precautions: Change PPE before caring for another [name redacted].According to Resident #9's AR, the resident was admitted with diagnoses that included but were not limited to: nutritional anemia (a condition caused by a deficiency of nutrients-most commonly iron, folate, or vitamin B-12), Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out daily tasks), and rheumatoid arthritis (chronic, autoimmune disease where the immune system mistakenly attacks the lining of joints, causing painful inflammation, stiffness, and potential bone erosion or deformity).According to the MDS, dated [DATE], Resident #9's BIMS was a 9 which indicated that Resident #9's cognition was moderately impaired.According to Resident #9's CP with a date initiated of 4/3/25, under Interventions stated: Enhanced Barrier Precautions: Use gown and gloves when performing high-contact activities: dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (e.g. central line, urinary catheter, feeding tube, tracheostomy, or ventilator), wound care (any skin opening requiring a dressing).According to Resident #10's AR, the resident was admitted with diagnoses that included but were not limited to: acute cystitis with hematuria (common infection that causes inflammation, resulting in painful, urgent urination and blood in the urine), malignant neoplasm of prostate (a cancerous tumor that develops from cells in the prostate gland), and peripheral vascular disease (slow, progressive circulation disorder caused by the narrowing, blockage, or spasms of blood vessels outside the heart and brain, most commonly in the legs).According to the MDS, dated [DATE], Resident #10's BIMS was a 15 which indicated that Resident #10 was cognitively intact.According to Resident #10's CP with a date initiated of 4/3/25, under Interventions stated: Enhanced Barrier Precautions: Use gown and gloves when performing high-contact activities: dressing, bathing and showering, transferring, providing hygiene, changing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	linens, changing briefs or assisting with toileting, device care or use of a device (e.g. central line, urinary catheter, feeding tube, tracheostomy, or ventilator), wound care (any skin opening requiring a dressing).On 3/2/26 at 9:24 AM, the surveyor observed the lab technician with no PPE on who was finishing up lab work for Resident #7 in their room.On 3/2/26 at 9:53 AM, the surveyor observed a therapist who was transporting Resident #1 to therapy with no PPE while in Resident #1's room. Resident #1 also questioned staff in the room, such as the Unit Manager and Certified Nursing Assistant (CNA) who did have the appropriate PPE on, why they had a yellow gown on.On 3/3/26 at 9:20 AM, the surveyor observed a staff member in scrubs in Resident #9's room. At this time, the staff member appeared to be exiting Resident #9's room with the Hoyer lift. However, on 3/3/26 at 9:23 AM, the surveyor passed Resident #9's room again and observed the same staff member was utilizing the Hoyer lift for Resident #9 with just gloves on and no gown.On 3/3/26 at 9:21 AM, the surveyor observed another staff member in Resident #10's room providing care with Resident #10 in the bed who also had gloves on and no gown.On 3/2/26 at 10:52 AM, the surveyor interviewed a CNA from the facility's Garden Unit who stated that residents who are on EBP have signs outside their door to indicate they are on EBP. She stated that if direct care is provided, PPE is supposed to be worn.On 3/2/26 at 11:25 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) from the facility's Post Acute Care Unit (PACU) who stated that EBP residents have signs on the door to indicate which type of isolation precautions a resident should be on. She stated that if staff enter that resident's room, they should always have PPE on so that infection does not spread. The LPN further stated that with all care, staff are expected to have PPE on for residents with EBP.On 3/2/26 at 12:38 PM, the surveyor interviewed the Director of Nursing (DON) who stated that EBP residents have signs outside the rooms and that all staff are educated on EBP and that the expectation is for staff to have the proper PPE on.On 3/3/25 at 1:50 PM, the surveyor interviewed the DON and the Licensed Nursing Home Administrator (LNHA) together. The surveyor asked when staff would be expected to where the appropriate PPE for EBP. They stated that if staff are touching the bed, providing care, touching wounds or catheters, or in direct contact with a resident they should have the appropriate PPE on.Review of the facility policy titled, IC308 Enhanced Barrier Precautions with a revision date of 11/14/25 under POLICY states:In addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be used (when Contact precautions do not otherwise apply) for novel or targeted multi-drug resistant organisms (MDROs).EBP expands on the use of gown and gloves beyond anticipated blood and body fluid exposures, focusing on use of gown and gloves only during high contact patient care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body exposure is not anticipated.Under Purpose: to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.N.J.A.C. 8:39-19.4(n)