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 _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	**1211 RT 72 WEST MANAHAWKIN, NJ 08050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint#: NJ159383 Census: 111 Sample: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		12/19/22

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

Electronically Signed | 12/19/2022

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.

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F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: C#: NJ159383 Based on interviews, medical record review, and other pertinent facility documents on 11/15/2022, it was determined that the facility failed to develop and implement a baseline care plan for a resident (Resident #1) who had a [redacted] The facility also failed to follow its policy titled "Care Plans, Comprehensive Person-Center." This deficient practice was identified for 1 of 3 residents	F 656	1. Resident #1 no longer resides at the facility. 2. Due to the nature of this deficiency, all residents have the potential to be affected by this practice. 3. The Director of Nursing educated all nurses on the development and implementation of baseline care plans. In addition, the Director of Nursing reviewed the facility policy titled "Care Plans,	

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F 656	Continued From page 2 reviewed (Resident #1) and was evident by the following: Review of the medical record (MR) was as follows: According to the "Admission Record," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was [redacted]. The MDS documentation included that Resident #1 had a diagnosis of EX. Order 26.(4) B1 site EX. Or. Order 26.(4) B1 and required minimal staff assistance with Activities of Daily Living (ADLs). Review of Resident #1's Progress Notes (PNs) written on [redacted] at 8:57 p.m. by the Licensed Practical Nurse/Unit Manager (LPN/UM) revealed that Resident #1 was noted on admission with a [redacted] to the [redacted]. Clean, dry, no drainage noted. No S/S (Signs and Symptoms) of infection. TX (Treatment) in place. Clean with EX. Order 26.(4) B1, pat dry, and cover with CDD (Clean Dry Dressing). A review of Resident #1's Person-Center Care Plan initiated on [redacted] indicated that Resident #1 did not have a care plan for a [redacted].	F 656	Comprehensive Person-Center" with all nurses to ensure it is followed going forward. 4. The Director of Nursing or designee will conduct random audits each week for three months to ensure baseline care plans are completed for all residents and that the facility policy on care plans is followed. The results of these audits will be submitted to the QAPI committee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 656	Continued From page 3 During an interview on 11/15/2022 at 2:04 p.m., the LPN/UM acknowledged that Resident #1's [redacted] was not developed on the Person- Center Care Plan. The LPN/UM further stated, "I am responsible to initiate and update a resident's care plan upon admission and with any changes." The LPN/UM further stated she could not answer if the site had been monitored but that Resident #1 had a weekly [redacted] assessment done while at the facility. During an interview on 11/15/2022 at 2:45 p.m., when asked by the Surveyor if the [redacted] was care planned, the Director of Nursing (DON) replied, "No, the [redacted] was not care planned." The DON confirmed that all [redacted] care treatment should be reflected in the care plan, and the LPN/UM is responsible for initiating and updating the care plan. The DON stated she expects the care plan to be initiated upon admission and updated with any new changes to include Focus, Goals, and Interventions. Review of Resident #1's progress notes revealed no [redacted] issues or adverse reaction was mentioned to the [redacted] condition while at the facility. Review of the facility's undated policy titled "Care Plan, Comprehensive Person-Centered" under Policy reveals: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the Resident's physical, psychological and functional needs is developed and implemented for each Resident.	F 656		

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F 656	Continued From page 4 N.J.A.C.: 8:39-11.2(d)(2)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: C#: NJ159383 Based on interviews, medical record review, and other pertinent facility documentation on [redacted], it was determined that the facility failed to transcribe a Physician's Order (POs) for a treatment to the Resident's (Resident #1) [redacted]. The facility also failed to follow its policy titled "Medication and Treatment Orders." This deficient practice was identified for 1 of 3 residents and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized	F 658	1. Resident #1 no longer resides at the facility. 2. Due to the nature of this deficiency, all residents have the potential to be affected by this practice. 3. The Director of Nursing educated all nurses on transcription of Physician Orders for treatment to residents. In addition, the Director of Nursing reviewed the facility policy titled "Medication and Treatment Orders" with all nurses to ensure it is followed going forward. 4. The Director of Nursing or designee will conduct random audits each week for three months to ensure proper transcription of Physician Orders for treatment to residents and that the facility policy on medication and treatment orders is followed. The results of these audits will be submitted to the QAPI committee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	12/19/22

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F 658	Continued From page 5 physician or dentist." Review of the medical record (MR) was as follows: According to the "Admission Record," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was [redacted] The MDS also showed Resident #1 required minimal staff assistance with Activities of Daily Living (ADLs). Review of Resident #1's Progress Notes (PNs) written on 10/28/2022 at 8:57 p.m. by the Licensed Practical Nurse/Unit Manager (LPN/UM) revealed Resident #1 noted to have a [redacted] EX. Order 26.(4) B1 to the [redacted] EX. Order 26.(4) B1. Clean, dry, no drainage noted. No S/S (Signs and Symptoms) of infection. TX (Treatment) in place. Clean with [redacted] EX. Order 26.(4) B1, pat dry, and cover with CDD (Clean Dry Dressing). However, review of the Order Recap Report (ORR) for [redacted] for Resident #2 should no Physician's Orders for the [redacted]. During an interview on 11/15/2022 at 2:04 p.m., the LPN/UM revealed that she wrote the Admission Assessment notes for Resident #1 and mentioned the [redacted]. The LPN/UM further stated that she obtained the order from the Physician but did not write the	F 658		

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F 658	Continued From page 6 order on the ORR or TAR. The LPN/UM agreed that the POs for Resident #1's treatment for the [redacted] should have been written on the OOR and TAR. The LPN/UM also stated that she didn't follow the facility's policy for transcribing orders. During an interview on 11/15/2022 at 2:45 p.m., the Director of Nursing (DON) stated she expects the LPN to follow the facility's protocol for new orders. The DON further stated that the LPN should write the Physician's order, fax the order to the pharmacy, transcribe the order, update/initiate the care plan, notify the family/resident and write a note in the Resident's PNs. Review of Resident #1's MR showed no evidence of worsening to the [redacted]. Review of the facility's undated "Medication and Treatment Orders" under Interpretation and Implementation reveals: Verbal orders must be recorded immediately in the Resident's chart by the person receiving the order and must include prescriber's last name, credentials, date, and the time of the order.	F 658		
F 677 SS=D	N.J.A.C: 8:39-23.2(a) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		12/19/22

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F 677	Continued From page 7 This REQUIREMENT is not met as evidenced by: C#: NJ159383 Based on interviews, medical record review, and review of other pertinent facility documentation on 11/15/2022, it was determined that the facility failed to consistently complete the Resident's "Documentation Survey Report v2 (DSR)" and follow the facility's policies titled "Activities of Daily Living (ADLs), Supporting" and "Charting and Documentation, for 1 of 3 residents (Resident #1) reviewed for documentation. This deficient practice was evidenced by the following: Review of the medical record (MR) was as follows: According to the "Admission Record," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was [redacted]. The MDS documentation included that Resident #1 had diagnosis of [redacted] and required minimal staff assistance with Activities of Daily Living (ADLs). The surveyor reviewed Resident #1's DSR forms [an ADLs care task provided to the Resident and documented by the Certified Nursing Assistants (CNAs) during their assigned shift] for October	F 677	1. Resident #1 no longer resides at the facility. 2. Due to the nature of the deficiency, all residents have the potential to be affected by this practice. 3. The Director of Nursing educated all staff on consistent completion of the "Resident's Documentation Survey Report". In addition, the Director of Nursing reviewed the facility policies titled "Activities of Daily Living (ADLs), Supporting" and "Charting and Documentation" with all staff to ensure they are followed going forward. 4. The Director of Nursing or designee will conduct random audits each week for three months to ensure consistent completion of the "Resident's Documentation Survey Report" and that the facility policies titled "Activities of Daily Living (ADLs), Supporting" and "Charting and Documentation" are followed. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 677	Continued From page 8	F 677		

through November 2022, which revealed the following:

The DSR forms had assigned ADLs care tasks which included but were not limited to Bed Mobility, Behavior Symptoms (Advance Reporting), Bladder Documentation/continence, Bowel Documentation, Dressing, Eating, Fluid Intake, HS Snacks, Locomotion off unit, Locomotion on Unit, Oral Care, Personal Hygiene, Toilet Use, Transferring, Turned and Reposition, Walk in Corridor, Walk in Room, 3 Day B & B Tracker, Meal Intake, Sleep log.

Further review of the aforementioned ADLs care tasks on the DSR forms revealed that all tasks from October 28, 2022, through November 4, 2022, were left blank or unsigned every day and on all shifts.

During an interview on 11/15/2022 at 1:10 p.m., the CNA stated she usually documents on the DSR form once care has been provided to the residents. The CNA further said the DSR forms should be documented with the time a task was performed. The CNA stated she did not know what the printed DSR looked like but also revealed that the missing initials or blank spaces on the forms indicated that the task was not completed for the shift.

During an interview on 11/15/2022 at 1:38 p.m., the Licensed Practical Nurse/Unit Manager (LPN/UM) stated the LPN should ensure that the CNA completes the DSR forms daily. The LPN/UM stated, "I am assuming the task was not completed because of the blank spaces/missing initials." She stated the tasks are supposed to be

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F 677	Continued From page 9	F 677		

completed, and the CNAs initial the DSR forms. The LPN/UM explained that her expectations are for the CNAs to complete their task and initial it on the DSR forms at the end of their shift.

Review of the facility's undated policy "Activities of Daily Living (ADLs), Supporting," under "Policy Interpretation and Implementation" revealed: Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the residents in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. elimination (toileting); d. Dinning (meals and snacks).

Review of the facility's undated policy "Charting and Documentation," under "Policy," indicated: All services provided to the Resident, progress toward the care plan goals or any changes in the Resident's medical, physical, functional, or psychosocial condition, shall be documented in the Resident's medical record. The medical records should facilitate communication between the interdisciplinary team regarding the Resident's condition and response to care. Interpretation and Implementation: 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

NJAC 8:39-35.2 (a)(g)1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315206	A. Building B. Wing	12/27/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 12/19/2022	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 12/19/2022	ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 12/19/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/15/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO