STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	**502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210**

(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 #: NJ00161342 and NJ00158976 Survey Date: 4/27/23 Census:99 Sample: 20 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey Date: 4/27/23 Census:99 Sample: 20 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	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	F 656		5/20/23

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

Electronically Signed | 05/14/2023

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 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). (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: Based on interview, observation, and record review it was determined the facility failed to	F 656	1. A. The deficiency occurred when the facility staff failed to implement a pain	

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F 656	Continued From page 2 develop a person-centered comprehensive care plan to address the residents medical, physical, mental, and psychosocial needs. This practice was identified in 1 of 23 residents reviewed for care plans (Resident #27) and was evidenced by the following: On 04/17/2023 at 11:38 AM, during the initial tour of the facility, the surveyor observed Resident #27 sitting in the hallway on a Ex Order 26. 4B1 crouched over. The resident told the surveyor he/she has a lot of pain all the time. The resident did not say the location of the pain. Review of the Admission Record revealed Resident #27 was admitted to the facility Ex Order 26. 4B1. Medical diagnoses included, but not limited to Ex Order 26. 4B1 [redacted]. Review of the Comprehensive Minimum Data Set (MDS), an annual assessment tool dated 02/08/2023, indicated the resident had a Brief Interview of Mental Status of [redacted], meaning the resident was Ex Order 26. 4B1. Section G of the MDS, functional status showed the resident was a set up for help for hygiene, eating, and ambulation. On 04/18/2023 at 10:15 AM, the surveyor observed Resident #27 sitting in the hallway on a Ex Order 26. 4B1. The resident's head was to the left side, eyes closed but arousable. The resident told the surveyor he/she had just received Ex.Order 26.4(b)(1) at "8-8:15". While the resident was talking with the surveyor, the resident would close eyes and lay head down.	F 656	care plan for resident #27. A comprehensive pain care plan was implemented to reflect current goals and interventions for resident #27 2. A. - A complete audit for all active residents who report pain was conducted on 4/25/23 by the DON to determine if they had pain care plans in place in resident chart. 3. A. On 4/25/23 the DON re-educated nursing staff on pain assessment, initiating care plans and documentation. Weekly audits by the DON and/or assigned designee of all residents who have a risk for pain care plan will be conducted times 2 weeks, then twice a month for the next 2 months and monthly thereafter for 2 additional months starting on 4/25/23. Resident charts will be reviewed for accuracy of care plans and compliance. The DON will report all findings to the QA team during quarterly meetings. 4. All audits will be reviewed by the Administrator, DON and/or designee to ensure compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 4/25/23. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 656	Continued From page 3	F 656		

Surveyor asked if medication always made resident feel that way and the resident said, "yes, but it helps my pain".

On 04/18/2023 at 10:34 AM, the surveyor reviewed the physician orders which showed the resident was receiving the following for [redacted] one tablet by mouth every 12 hours as needed for [redacted]

On 04/18/2023 at 10:39 AM, the surveyor reviewed the resident's current and active care plan. The care plan included a [redacted] medication focus but the surveyor could not locate pain as part of the resident's care plan.

On 04/18/2023 at 10:42 AM, the surveyor reviewed Medication Administration Record (MAR) in the Electronic Medical Record (EMR), which showed that the residents pain was assessed every shift and ranged from [redacted] which is [redacted] pain on the numeric pain scale.

At the same time, the surveyor reviewed the Annual Comprehensive Minimum Data Set (MDS), an assessment tool dated 02/08/2023. Review of section J, health conditions, indicated the resident was receiving as needed [redacted] and at the time of the assessment, the resident's pain was described by the resident as "mild".

On 04/18/2023 at 10:48 AM, the surveyor reviewed the MAR which showed that the resident's pain was assessed on 04/18/2023 at 8:29 AM and the resident was given [redacted] for

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F 656	Continued From page 4	F 656		

Ex Order 26. 4B1 pain. The pain was reassessed after the medication, and it was documented as being effective. The surveyor could not determine where the resident had pain.

On 04/19/2023 at 11:23 AM, the surveyor interviewed West Unit Licensed Practical Nurse #1 (LPN#1) regarding the resident's pain. LPN#1 said, "Normally, the resident always complained of generalized pain everywhere and received *Ex Order 26. 4B1* ".

On 04/25/2023 at 10:50 AM, the surveyor interviewed a West Unit LPN#2 regarding a resident with pain. The surveyor asked if pain would appear on a care plan for a resident receiving Ex.Order 26.4(b)(1) and LPN#2 responded, "Yes it would".

On 04/25/2023 at 10:58 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) of the West Unit regarding Resident #27 and pain. The UM/LPN told the surveyor that all residents with pain are care planned for pain. The UM/LPN proceeded to go into the care plan for Resident #27 in the EMR and was unable to find it. The UM/LPN told the surveyor, "Looks like there isn't one, I will update it".

On 04/27/2023 at 10:41 AM, the Director of Nursing (DON) provided the surveyor with an in-service attendance sign in sheet for care plan education dated 04/25/2023. The DON told the surveyor, "I just want to show you we take these things serious, and we act on them right away".

On 04/28/2023 at 08:51 AM, the surveyor reviewed the policy titled, "Comprehensive Care

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F 656	Continued From page 5 Plans", a policy dated 12/6/2022. The policy indicated that the facility was to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. On 04/28/23 at 10:15 AM, the surveyor reviewed the care plan titled, "Pain Mangement and Intervention", an undated policy. Under the section Practice Guidelines, number IV, it indicated that initial documentation of resident pain will occur on the interim care plan if present at admission. Under section V. (c) it said to use evaluation data and revise care plan.	F 656		
F 695 SS=D	NJAC 8:39-11.2 (e) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain the necessary respiratory care and services according to standards of practice by a.)	F 695	1. A. Resident #74 was not negatively impacted by this deficient practice. Resident #74's [redacted] was replaced, tubing was dated 4/20/23 and	5/20/23

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F 695	Continued From page 6 ensuring a residents Ex Order 26. 4B1 was stored in a manner to prevent the spread of infection b.) follow physicians orders by assessing a residents Ex Order 26. 4B1 saturation every shift and documenting the results and c.) failing to document administration of Ex Order 26. 4B1. This deficient practice was identified for 3 of 3 residents reviewed for Ex Order 26. 4B1 care (Residents #28, #42, and #74) and was evidenced by the following: a. On 04/17/23 at 12:04 PM, during the initial tour of the facility Resident #74 was sitting in a Ex Order 26. 4B1 on the side of the bed having lunch. There was a Ex Order 26. 4B1 with Ex Order 26. 4 connected to the tank and wrapped around the left handle on the back of the Ex Order 26. 4B1. The resident was not wearing the Ex Order 26. 4B1. The Ex Order 26. 4B did not have a date and was not in a plastic bag. The surveyor also observed an Ex Order 26. 4B1 in the room. The surveyor asked the resident how often he/she wore Ex Order 26. 4B1 and the resident said, "I'm supposed to wear it all the time, but they didn't hook it up yet". Review of Resident #74 Admission Record indicated that the resident was admitted to the facility Ex Order 26. 4B1. Medical diagnoses included, but not limited to Ex Order 26. 4B1. Review of the Comprehensive Minimum Data Set (MDS), an assessment tool dated 04/03/23 revealed Resident #74 had a Brief Interview of Mental Status of Ex Ord, meaning the resident was Ex Order 26. 4B1. Under section O, special	F 695	placed in a clear plastic bag for both the Ex Order 26. 4B1 and the Ex Order 26. 4B1 in the room. B. Resident #42 was not negatively impacted by this deficient practice. Education was provided by the DON on 4/24/23 to LPN #2 regarding following Physicians orders for Ex Order 26. 4B1, Physician notification, facility Ex Order 26. 4B1 policy and documentation. C. Resident #28 was not negatively impacted by this deficient practice. Education was provided by the DON on 4/26/23 to LPN regarding following Physicians orders for Ex Order 26. 4B1, facility Ex Order 26. 4B1 policy and documentation. 2. A. A complete audit for all active residents who have a Physicians order for Ex Order 26. 4B1 was done on 4/20/23 by the DON to ensure Ex Order 26. 4B1 was dated and placed in clear plastic bags. All Ex Order 26. 4B1 that was found unbagged was discarded and new Ex Order 26. 4B was applied, dated and bagged. B. A complete audit for all active residents who have a Physicians order for Ex Order 26. 4B1 was done on 4/20/23 by the DON to ensure all physicians orders are accurate, Physician notification was being done, facility Ex Order 26. 4B1 policy was being followed and Documentation was being done correctly. C. A complete audit for all active residents who have a Physicians order for Ex Order 26. 4B1	

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F 695	Continued From page 7 procedures/treatments indicated the resident wore Ex Order 26. 4B1 . On 04/18/23 at 10:30 AM, the surveyor observed Resident #74 in the room in a Ex Order 26. 4B1. The resident's Ex Order 26. 4B1 had a Ex Order 26. 4B1 on the chair with an Ex Order 26. 4B1 attached to the tank. The Ex Order 26. 4B1 was not being worn by the resident and the Ex Order 26. 4B was wrapped around the arm of the Ex Order 26. 4B1. The Ex Order 26. 4B was not in a bag, and no dates could be located on the Ex Order 26. 4B1. On 04/18/23 at 01:27 PM, the surveyor reviewed the Physician Orders which showed the following Ex Order 26. 4B1 order: Ex Order 26. 4B1 per minute via Ex Order 26. 4B1 every shift and another order for Ex Order 26. 4B1 to be changed weekly. On 04/19/23 at 10:17 AM, the surveyor observed the resident sitting on the side of the bed. The resident was wearing Ex Order 26. 4B1 which was connected to an Ex Order 26. 4B1 [redacted] The surveyor also observed the resident's Ex Order 26. 4B1 in the room with a Ex Order 26. 4B1 with a Ex Order 26. 4B1 connected. The Ex Order 26. 4B was wrapped around the arm of the Ex Order 26. 4B1. The Ex Order 26. 4B was not in a bag and the Ex Order 26. 4B was not dated. The surveyor asked the resident if he/she wore the Ex Order 26. 4B on the arm of the Ex Order 26. 4B1 also. As the resident pointed to the Ex Order 26. 4B wrapped around the arm, the resident said, Ex Order 26. 4B1 [redacted] The surveyor asked if it was the same Ex Order 26. 4B from the day prior and the resident said "yes".	F 695	was done on 4/20/23 by the DON to ensure physicians orders are accurate, facility Ex Order 26. 4B1 policy was being followed and Documentation was being done correctly. 3.A. On 4/26/23 the DON re-educated nursing staff on infection control as related to proper storage of Ex Order 26. 4B1 [redacted], dating Ex Order 26. 4B and placing Ex Order 26. 4B in bags when not in use. Audits will continue by the DON and/or assigned designee on all residents who have Physician Ex Order 26. 4B1 orders starting on 4/20/23. These audits will be weekly for 4 weeks, then twice a month for 2 months then monthly for 2 months. B. On 4/24/23 the DON re-educated nursing staff on following Physicians orders for Ex Order 26. 4B1, Physician notification, Oxygen Administration and documentation. Audits will continue by the DON and/or assigned designee on all residents who have Physician Ex Order 26. 4B1 orders starting on 4/20/23. These audits will be weekly for 4 weeks, then twice a month for 2 months then monthly for 2 months. C. On 4/26/23 the DON re-educated nursing staff on Ex Order 26.4(b)(1 Administration and documentation Audits will continue by the DON and/or assigned designee on all residents who have Physician Ex Order 26. 4B1 orders starting on 4/20/23. These audits will be weekly for 4 weeks, then twice a month for 2 months then monthly for 2 months.	

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F 695	Continued From page 8 On 04/19/23 at 01:49 PM, the surveyor observed the resident in the [redacted] room sitting in a [redacted]. The resident was wearing [redacted] via [redacted] hooked to a [redacted] on the [redacted]. On 04/20/23 at 09:42 AM, the surveyor observed the resident in the room in a [redacted]. The [redacted] had a [redacted] attached but there was no [redacted] attached to the [redacted] tank. On 04/20/23 at 10:15 AM, the surveyor interviewed LPN #1 regarding [redacted] storage. The LPN#1 told the surveyor that [redacted] not being used "should be stored in a bag". On 04/27/23 at 10:41 AM, the Director of Nursing (DON) provided the surveyor with an in-service attendance by staff dated 4/26/23, titled, [redacted] in bags education". The DON told the surveyor, "I just want to show you we take these things serious, and we act on it right away". On 04/28/23 at 11:30 AM, the surveyor reviewed the policy titled, "[redacted] Administration", a policy dated 1/5/23. Under the section policy explanation and compliance guidelines, number five (e) was to keep delivery devices covered in plastic bag when not in use. b. On 04/17/23 at11:30 AM, during the initial tour of the facility the surveyor observed Resident #42 sitting on the side of the bed. The resident was wearing [redacted] via [redacted] and was requesting a [redacted] Review of the Admission Record indicated	F 695	4. A. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 4/20/23. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction. B. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 4/20/23. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction. C. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 4/20/23. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 695	Continued From page 9	F 695		

Resident #42 was admitted to the facility on [redacted]. Medical diagnoses included, but not limited to [redacted]. Review of the quarterly Minimum Data Set (MDS), an assessment tool dated 1/31/23 revealed Resident #42 had a Brief Interview of Mental Status of [redacted], meaning the resident was [redacted].

On 04/19/23 at 10:29, the surveyor observed Resident #42 in the room sitting in a [redacted]. The resident was not wearing [redacted] at the time of the observation. Resident #42 told the surveyor he/she wore it when it was needed, but not all the time.

On 04/19/23 10:31 AM, the surveyor reviewed the Physician Orders which showed an order for [redacted] two to three liters per minute via [redacted].

On 04/19/23 at 10:34 AM, the surveyor reviewed the physician orders which revealed an order for [redacted] every shift and notify the doctor if below 90 percent. It was an active order with a start date of 7/25/22. Further review of the [redacted] results in the vital signs section of the EMR showed that on 12/4/22 the resident had a [redacted] of [redacted] percent.

On 04/19/23 at 10:35 AM, the surveyor reviewed the progress notes and could not locate a note indicating the physician was notified for a [redacted] below 90 percent as ordered.

Review of the Medication Administration Record

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F 695	Continued From page 10 (MAR) indicated the resident [redacted] levels were being check daily, not every shift as physician ordered. On 04/19/23 at 10:38 AM, review of the care plan included a focus for [redacted] status: potential risk for altered [redacted] status, initiated on 08/08/22 and revised on 01/25/23. On 04/14/23 another care plan focus of [redacted] was initiated with a revision on 4/18/23 which included an intervention of [redacted] as ordered by the physician. On 04/19/23 at 10:42 AM, the surveyor reviewed the most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 1/23/23. Under section O, special procedures/treatments were marked [redacted] for [redacted]. On 04/24/23 at 11:10, the surveyor interviewed the unit Licensed Practical Nurse #2 (LPN#2) caring for resident #42 regarding [redacted] saturations for the resident. LPN#2 told the surveyor that she would check the resident's [redacted] saturations "throughout the day and after the resident smoked". The surveyor asked where they would be documented and LPN#2 told the surveyor, "On my roster and then I would put it in PCC (meaning the electronic medical record system)". The surveyor asked LPN#2 at what numbers would a physician need to be notified and LPN#2 said, "I would notify the doctor if the [redacted] saturation was in the 80's, but usually when it is below 92 percent". On 04/27/23 at 10:41 AM, the Director of Nursing (DON) provided the surveyor with an in-service attendance sign in sheet dated 4/24/23 showing education was provided to nursing staff for	F 695		

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	315193	A. BUILDING _____ B. WING _____	C 04/27/2023

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F 695	Continued From page 11	F 695		

documenting [redacted] saturation per physician orders. The don told surveyor, "I just want to show you we take these things serious, and we act on it right away".

On 04/28/23 at 1:13 PM, the surveyor reviewed the policy titled, "[redacted] Administration" a policy dated 1/5/23. Under the section Policy Explanation and Compliance Guideline, number 12 stated that staff shall notify the physician of any changes in the resident condition, including changes in vital signs, [redacted], or evidence of complications associated with the use of [redacted].

NJAC 8:39-27.1 (a)

c. On 4/17/23 11:33 AM, the surveyor observed Resident #28 in his/her [redacted]. He/She stated that she uses [redacted].

On 4/18/23 at 12:56 PM the surveyor observed Resident #28 utilizing [redacted] per minute via [redacted]. Subsequent observations were made on 4/19/23 at 10:56 AM, 4/20/23 at 12:33 PM, 4/24/23 at 1:26 PM, 4/25/23 at 11:54 AM of Resident # 28 utilizing [redacted].

A review of the Admission Record showed that Resident #28 was admitted to the facility with medical diagnosis that included but were not limited to [redacted].

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the

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F 695	Continued From page 12 management of care, dated 2/1/23 reflected that Resident #28 was Ex Order 26. 4B1. It also reflected that Resident # 28 utilized Ex Order 26. 4B1. A review of Resident # 28's Physician's Orders reflected an order dated 3/22/23 for Ex Order 26. 4B1 L via Ex Order 26. 4B1 for Ex Order 26. 4B below 93% as needed for Ex Order 26. ". A review of Resident #28's April 2023 Treatment Administration Record (TAR) reflected the order for the as needed Ex Order 26. 4B1. There were no signatures for the use of the Ex Order 26. 4B1. During an interview on 4/26/23 at 11:02 AM, the Licensed Practical Nurse stated Resident # 28 utilizes Ex Order 26. 4B1 as needed. She stated she is not signing it out on the TAR, but she should be. During an interview on 4/26/23 at 12:26 PM the Director of Nursing stated if the Ex Order 26. 4B1 is being delivered it should be signed out. The surveyor reviewed the facility's undated Medication Administration Policy. The policy included to sign administration record after administered.	F 695		
F 761 SS=D	NJAC 8:39-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		5/20/23

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F 761	Continued From page 13 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined that the facility failed to properly store medications and maintain clean and sanitary medication storage areas. This deficient practice was observed in 2 of 2 observed medication carts on 2 of 2 nursing units and was evidenced by the following: On 04/20/23 at 12:29 PM, the surveyor in the presence of Licensed Practical Nurse (LPN #1) observed the East wing nursing unit's "B" medication cart which contained a total of 78 loose medication pills of various colors and sizes	F 761	1. No resident had negative outcomes occurring from this practice. Loose medication (pills) were discarded in the drug buster bottle. Medication carts were cleaned and disinfected. 2. A complete audit of all medication carts in the facility was conducted by the DON on 4/20/23. Any loose medications were disposed of in drug buster bottle and all carts were cleaned and disinfected. 3. On 4/25/23 the DON educated the	

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F 761	Continued From page 14 in the bottom of the drawers. LPN #1 collected these pills as they were discovered and were counted. At this time, LPN #1 informed the surveyor that medication carts were cleaned weekly and that the nurses assigned to each cart should be checking when starting each shift for cart cleanliness and ensured medication pills were not loose in the drawers. LPN #1 further stated that there should not be loose pills in the cart as they could possibly fall out and be picked up and consumed by residents. She also stated the possible reason for so many loose pills could have been due to the overcrowding of medication cards (bingo cards) in the drawers causing pills to be popped out as nurses reach into the drawers. At this time LPN #1 disposed of the found loose medication pills using the medication drug buster bottle in the medication storage room. On 04/24/23 at 10:06 AM, the surveyor in the presence of the Licensed Practical Nurse/Unit Manager LPN/UM observed the East wing nursing unit's "B" medication cart which contained one loose medication pill in the bottom of a drawer. LPN/UM collected this pill as it was discovered and disposed of it in the medication room drug buster bottle. On 04/24/23 at 12:19 PM, the surveyor interviewed the Director of Nursing (DON) who stated there was no official routine cleaning schedule for the medication carts and since the surveyor's observations the facility implemented a new cleaning schedule. The DON further stated that all nurses should be responsible for ensuring carts are clean and have no loose medications. She continued to inform the surveyor that the pharmacy consultant is supposed to also be checking the medication storage areas and carts	F 761	nursing staff on medication storage and medication cart cleaning schedules. Audits will continue by the DON and/or assigned designee on all units starting on 4/20/23. These audits will be weekly for 4 weeks, then twice a month for 2 months then monthly for 2 months. 4. All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance weekly, twice a month and monthly thereafter per the audit timeframes listed in action #3 beginning on 4/20/23. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 761	Continued From page 15 for this as well as part of her inspections. The DON explained a possible reason for loose medications in the cart drawers would be from over crowding of the medication cards which then causes pills to be popped out as the cards are handled by nursing staff. A review of the facility's "Storage of Medications" policy with an implemented date 6/1/22, included that "it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security." Under the section labeled "Policy Explanation and Compliance Guidelines" under "General Guidelines" includes "a. all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) ... b. Only authorized personnel will have access to the keys to locked compartments ... c. during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart." N.J.A.C. 8:39-29.4	F 761		
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards.	F 836		5/20/23

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F 836	Continued From page 16 The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following:	F 836	1. The attorney submitted all requested documentation to the NJDOH for approval. 2. All residents are potentially affected by this practice. 3. Administrator reviewed and was in serviced on regulation 483.70(a) Licensure.	

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F 836	Continued From page 17 According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians,	F 836	4. Administrator/designee will conduct monthly audits for 3 months to ensure compliance. Reports of audits will be submitted to the Quality Assurance Committee who meet quarterly who will review and determine frequency and necessity for future audits.	

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F 836	Continued From page 18	F 836		

nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:

(1) Within 30 days -
(i) A change of ownership;
(ii) Any adverse legal action; or
(iii) A change in practice location.

(2) All other changes in enrollment must be reported within 90 days."

On 04/17/2023 at 9:28 AM, upon arrival of the surveyors to the facility, the surveyor observed a facility entrance sign displayed on the street that had a name of "Fountain Springs at Cape May" that did not correspond with the CMS licensed, approved name and provider registered name "Oceana Rehabilitation and Nursing Center."

As the surveyor entered the facility, there was a displayed sign with the same name "Fountain Springs at Cape May" which was not the CMS licensed, approved and provider registered name, "Oceana Rehabilitation and Nursing Center."

The facility name displayed on the outside of the facility and in the lobby, "Fountain Springs at Cape May" did not correspond with the CMS (Center for Medicaid and Medicare Services) licensed and approved name of "Oceana Rehabilitation and Nursing Center."

On 04/17/2023 at 10:50 AM, the State Surveyor met with the Assistant Licensed Nursing Home

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F 836	Continued From page 19	F 836		

Administrator (ALNHA) and the Director of Nursing (DON) for the Entrance Conference. During entrance conference, the facility management confirmed that the facility's name was changed about a year ago in 2022.

That same day, at 11:16 AM, the surveyor reviewed various documents and facility policies that were provided by the ALNHA that presented with "Fountain Springs at Cape May" demonstrated on the letterhead as the title. The documents provided showed the facility's name that was being used was not in accordance to the facility's licensed name and prior to CMS approved name/change of ownership approval.

On 04/18/2023 at 09:53 AM, the state surveyor met with the ALNHA to clarify the facility's name. At this time, the surveyor discussed the facility's license displayed on the wall in the reception area which reflected the CMS approved name of the facility, "Oceana Rehabilitation and Nursing Center," which was different than the name displayed on all of the signs and documents presented by the ALNHA and the DON with "Fountain Springs at Cape May."

During the meeting with the State Surveyor, the ALNHA provided a letter the facility received from the State of New Jersey Department of Health (NJDOH), dated 10/27/2022. The letter referenced an application for transfer of ownership application received by the NJDOH on 06/16/2022 that has been approved to proceed.

The letter establishes, "approving your request to proceed with the transfer of ownership interests of Oceana Rehabilitation and nursing Center." The letter continues to present, "The referenced

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F 836	Continued From page 20 application submitted is for the transfer of ownership of Oceana Rehabilitation and nursing Center " from the previous owner to the current owner. In addition, the letter establishes, "Simultaneously with the transfer of ownership, the Facility will be renamed Fountain Springs at Cape May." On page 2 of the NJDOH letter, "Although the new owner was authorized to operate the facility following the transaction, the Department will not issue the license under the new ownership until the items listed below are received and reviewed by staff from the Department." The letter continues to list a number of items that need to be submitted for the NJDOH to issue a new license for the new owners allowing them to change the name of the facility. On 04/18/23 at 11:35 AM, the State Surveyor interviewed the ALNHA who explained that the facility was in the "transition process" of converting Oceana Rehabilitation and Nursing Center to Fountain Springs at Cape May and could not confirm that the items listed on page 2, to complete the name change, was sent to the NJDOH nor could the ALNHA provide a copy of the final license. The ALNHA could not provide any additional information to further explain this and stated the LNHA would know more but was out of the country and unavailable. On 04/27/2023 at 11:45 AM, the State Surveyor met with the facility's ALNHA and DON to discuss the deficient practice of utilizing the facility's name change to Fountain Springs at Cape May without NJDOH Licensure approval. No further information or documentation was provided to the survey team to refute these findings.	F 836		

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F 836	Continued From page 21 NJAC 8:39-5.1 (a)	F 836		

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	060503	A. BUILDING: _____ B. WING _____	C 04/27/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: F0560 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios and was deficient in total staff for residents as mandated by the State of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1. Rates were increased, and ads updated to reflect increases allowing us to hire staff to meet the required ratio. In addition, the facility signed contracts with two additional agency staff companies to meet the required staffing ratio. 2. All residents are potentially affected by this practice. 3. The DON to have weekly meetings to determine upcoming schedules to anticipate needs. 4. The DON or designee will conduct monthly audits of the staffing patterns and ratios and report findings to the	5/20/23

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

Electronically Signed | 05/14/23

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the week of 10/02/2022 through 10/08/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 7 of 7 overnight shifts as follows: -10/02/22 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. -10/02/22 had 6 total staff for 110 residents on the overnight shift, required 8 total staff. -10/03/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -10/03/22 had 6 total staff for 110 residents on the overnight shift, required 8 total staff.	S 560	Administrator. In addition, the DON/designee will notify the results to the QA committee monthly for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060503	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(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) COMPLETE DATE
S 560	Continued From page 2 -10/04/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -10/04/22 had 6 total staff for 110 residents on the overnight shift, required 8 total staff. -10/05/22 had 12 CNAs for 109 residents on the day shift, required 14 CNAs. -10/05/22 had 6 total staff for 109 residents on the overnight shift, required 8 total staff. -10/06/22 had 11 CNAs for 109 residents on the day shift, required 14 CNAs. -10/06/22 had 6 total staff for 109 residents on the overnight shift, required 8 total staff. -10/07/22 had 13 CNAs for 109 residents on the day shift, required 14 CNAs. -10/07/22 had 6 total staff for 109 residents on the overnight shift, required 8 total staff. -10/08/22 had 9 CNAs for 109 residents on the day shift, required 14 CNAs. -10/08/22 had 6 total staff for 109 residents on the overnight shift, required 8 total staff. As per the "Nurse Staffing Report" completed by the facility for the weeks of 02/05/2023 through 02/11/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 7 of 7 overnight shifts as follows: -02/05/23 had 8 CNAs for 105 residents on the day shift, required 13 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060503	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(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) COMPLETE DATE
S 560	Continued From page 3 -02/05/23 had 6 total staff for 105 residents on the overnight shift, required 7 total staff. -02/06/23 had 7 CNAs for 103 residents on the day shift, required 13 CNAs. -02/06/23 had 6 total staff for 103 residents on the overnight shift, required 7 total staff. -02/07/23 had 7 CNAs for 103 residents on the day shift, required 13 CNAs. -02/07/23 had 6 total staff for 103 residents on the overnight shift, required 7 total staff. -02/08/23 had 7 CNAs for 103 residents on the day shift, required 13 CNAs. -02/08/23 had 6 total staff for 103 residents on the overnight shift, required 7 total staff. -02/09/23 had 7 CNAs for 102 residents on the day shift, required 13 CNAs. -02/09/23 had 6 total staff for 102 residents on the overnight shift, required 7 total staff. -02/10/23 had 8 CNAs for 102 residents on the day shift, required 13 CNAs. -02/10/23 had 6 total staff for 102 residents on the overnight shift, required 7 total staff. -02/11/23 had 6 CNAs for 102 residents on the day shift, required 13 CNAs. -02/11/23 had 6 total staff for 102 residents on the overnight shift, required 7 total staff.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060503	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(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) COMPLETE DATE
S 560	Continued From page 4 As per the "Nurse Staffing Report" completed by the facility for the weeks of 04/02/2023 through 04/08/2023 and 04/09/2023 through 04/15/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1of 14 evening shifts, and deficient in total staff for residents on 3 of 14 overnight shifts as follows: -04/02/23 had 6 CNAs for 102 residents on the day shift, required 13 CNAs. -04/03/23 had 8 CNAs for 101 residents on the day shift, required 13 CNAs. -04/04/23 had 6 CNAs for 101 residents on the day shift, required 13 CNAs. -04/05/23 had 8 CNAs for 100 residents on the day shift, required 12 CNAs. -04/06/23 had 7 CNAs for 100 residents on the day shift, required 12 CNAs. -04/07/23 had 4 CNAs for 100 residents on the day shift, required 12 CNAs. -04/08/23 had 7 CNAs for 100 residents on the day shift, required 12 CNAs. -04/09/23 had 7 CNAs for 100 residents on the day shift, required 12 CNAs. -04/10/23 had 5 CNAs for 100 residents on the day shift, required 12 CNAs. -04/10/23 had 9 total staff for 100 residents on the evening shift, required 10 total staff. -04/10/23 had 6 total staff for 100 residents on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060503	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(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) COMPLETE DATE
S 560	Continued From page 5 the overnight shift, required 7 total staff. -04/11/23 had 8 CNAs for 99 residents on the day shift, required 12 CNAs. -04/12/23 had 8 CNAs for 99 residents on the day shift, required 12 CNAs. -04/13/23 had 9 CNAs for 99 residents on the day shift, required 12 CNAs. -04/14/23 had 7 CNAs for 99 residents on the day shift, required 12 CNAs. -04/14/23 had 6 total staff for 99 residents on the overnight shift, required 7 total staff. -04/15/23 had 6 CNAs for 99 residents on the day shift, required 12 CNAs. -04/15/23 had 6 total staff for 99 residents on the overnight shift, required 7 total staff. On 04/27/23 at 10:02 AM, the team of surveyors interviewed the staffing coordinator (SC). She was able to verbalize the ratios of all three shifts of staffing. When asked if following ratios said "try our best with staff".	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315193 Y1	A. Building B. Wing Y2	6/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

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	Correction	ID Prefix F0695	Correction	ID Prefix F0761	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	05/20/2023	LSC	05/20/2023	LSC	05/20/2023
ID Prefix F0836	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(a)-(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/20/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/27/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060503 Y1	A. Building B. Wing Y2	6/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/20/2023	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	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	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	
4/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING **01** B. WING _____	**04/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 04/18/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/18/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Oceana Rehabilitation and NC (Fountain Springs at Cape May) is a 1-story building that was built in 1972, It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does 100% of the building as per the Maintenance Director. The current occupied beds are 98 of 120.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		5/20/23

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

Electronically Signed | 05/14/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING **01** B. WING _____	**04/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

(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
K 345	Continued From page 1 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on facility document review, observation, and interview, the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 98 residents of the facility. Findings include: A review of the facility binder, provided by the Maintenance Director, contained inspection and testing reports for the fire alarm system for the calendar year 2021 and 2022. A review of the facility fire alarm "Inspection and Testing Reports" dated 07/19/22 revealed no reference to a smoke detection sensitivity test. An observation on 04/18/23 from 12:10 PM to 2:45 PM with the Maintenance Director revealed the smoke detectors were in the corridors at the smoke barriers, 15 feet from the end of the corridors and 30 feet on center, and other concealed areas throughout the building. In an interview, the Maintenance Director confirmed that the smoke sensitivity testing had not been completed on the smoke detectors on 07/19/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	1. We had a company conduct a smoke detection sensitivity test on the smoke detectors. 2. All residents have the potential to be affected by the deficient practice. 3. Administrator and maintenance director reviewed and was in serviced on regulation NFPA, 101 Fire Alarm System-Testing and Maintenance. The Maintenance Director will schedule all smoke detector testing and sensitivity testing with vendor in a timely manner. 4. The Maintenance Director will submit smoke detector reports to the QAPI committee quarterly for the next year. The Quality Assurance Committee meets quarterly who will review and determine frequency and necessity for future audits.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		5/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING 01 B. WING _____	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

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K 511	Continued From page 2 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that an electrical wiring splice was made in a junction box in accordance with NFPA 70 (2011 Edition) section 314.28(A2). This deficient practice had the potential to affect 44 of 98 residents who resided in the area of Conference Room 101. Findings include: An observation on 04/18/23 at 2:03 PM revealed an open electrical wire splice for the exit sign above the ceiling tiles at the smoke barrier doors near Conference Room 101. An interview with the Maintenance Director at the time of observation confirmed the open electrical wire splice was not in an electrical box. NJAC 8:39-31.2(e) NFPA 70	K 511	1. A junction box was placed above the ceiling tiles for the electrical wire splice for the exit sign. 2. All residents have the potential to be affected by the deficient practice. 3. Administrator and maintenance director reviewed and was in serviced on regulation NFPA, 101 Gas and Electric. The Maintenance Director will do monthly checks for 6 months to ensure that electrical wires are in junction boxes. 4. The Maintenance Director will report any issues quarterly to the QAPI committee for the next year. The Quality Assurance Committee meets quarterly who will review and determine frequency and necessity for future audits.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		5/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING **01** B. WING _____	**04/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

(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
K 761	Continued From page 3 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 98 residents. Findings include: An observation of the facility's fire doors on 04/18/23 from 12:08 PM to 2:45 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. The Maintenance Director was present at the time of the observation and confirmed the fire doors were not inspected annually. NJAC 8:39-31.1(c), 31.2(e)	K 761	1. We had a company conduct an inspection of the fire doors. 2. All residents have the potential to be affected by the deficient practice. 3. Administrator and maintenance director reviewed and was in serviced on regulation NFPA, 101 Maintenance, Inspection & Testing – Doors. The Maintenance Director will log and keep documentation of inspection of the doors. 4. The Maintenance Director will submit door inspection reports to the QAPI committee quarterly for the next year. The Quality Assurance Committee meets quarterly who will review and determine frequency and necessity for future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING **01** B. WING _____	**04/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

(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
K 761	Continued From page 4 NFPA 80	K 761		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315193 Y1	A. Building 01 - OCEANA REHABILITATION CENTER B. Wing Y2	6/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 05/20/2023	ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 05/20/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 05/20/2023
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
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

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
4/27/2023	