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
CAPE MAY SNF LLC	**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: Electronically Signed — TITLE: — (X6) DATE: 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
CAPE MAY SNF LLC	**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
CAPE MAY SNF LLC	**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 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
CAPE MAY SNF LLC	**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
CAPE MAY SNF LLC	**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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315193	A. Building 01 - OCEANA REHABILITATION CENTER B. Wing	6/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPE MAY SNF LLC	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 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	
4/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO