STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEANA REHABILITATION & NURSING CENTER	**502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210**

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F 000	INITIAL COMMENTS Survey Date: 2/18/22 Census: 107 Sample: 22 + 2 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 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636		3/31/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/06/2022

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F 636	Continued From page 1 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete an annual Minimum Data Set Assessment (MDS), an	F 636	1.Resident #1 had comprehensive assessment completed on 3/2/22 and transmitted to CMS on 3/2/22	

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F 636	Continued From page 2 assessment tool, as required for 5 of 5 residents (Resident #1, #6, #9, #11, and #21) system selected for MDS over 120 days and was evidenced by the following: On 2/11/22 at 10:00 AM, the surveyor interviewed the MDS Coordinator who stated that she was unable to provide the survey team with a matrix (provider tool utilized to identify all the residents in the facility and their pertinent care categories) since she had only been at the facility for three weeks and not all the residents were in the system. On 2/14/22 at 9:44 AM, the surveyor re-interviewed the MDS Coordinator who stated that she completed the MDS for all the residents upon admission, quarterly, annually, and if there was a significant change of two or more activities of daily living or significant weight loss or wounds. The MDS Coordinator stated that each assessment had an assessment reference date (ARD) which the facility completed a seven day look back period from that date. The facility had fourteen days to complete the assessment from the ARD and then they had an additional seven days after to submit the assessment. The MDS Coordinator stated that when she started this job, MDS was a "mess" and there were a lot of "late and not completed MDS assessments" and she was trying to put everything in order. The MDS Coordinator stated that billing for the MDS was still not completed for December of 2021, and she was unsure when the previous MDS Coordinator resigned. At this time, the surveyor provided the MDS Coordinator with a list of twenty-two system selected residents with their MDS record that was	F 636	Resident #6 had comprehensive assessment completed on 2/19/22 and transmitted to CMS on 3/2/22 Resident #9 had comprehensive assessment completed on 2/22/22 and transmitted to CMS on 3/2/22 Resident #11 had comprehensive assessment completed on 2/22/22 and transmitted to CMS on 3/2/22 Resident #21 had comprehensive assessment completed on 2/19/22 and transmitted to CMS on 3/2/22 2.A complete audit for all active residents was conducted on 2/19/22 by the MDS coordinator to determine the number of incomplete comprehensive assessments that were flagging as late to determine immediate action for compliance. It was determined that all incomplete assessments would be completed by 3/31/22. 3.The Administrator, DON and/or appointed designee will conduct weekly audits starting on 2/21/22 to ensure the timeliness of all comprehensive assessments for the next 60 days, then twice a month for the next 2 months and monthly thereafter for 2 additional months. The Administrator provided re-education on 2/21/22 to the MDS coordinator regarding the timeliness for completing the comprehensive assessments and his expectations for timely compliance. 4.All audits will be review by Administrator, DON and/or designee to ensure timely compliance weekly, twice a month and	

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F 636	Continued From page 3 over 120 days and asked her to provide the survey team with the date the last MDS was submitted and the next MDS that was due. On 2/14/22 at 9:57 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that the MDS Coordinator was new to the facility and the Licensed Practical Nurse (LPN) East Side medication cart nurse was completing MDS assessments in the interim. The DON stated that she had only been at the facility for three months and since she started, the facility had been behind on MDS assessments. The DON stated that she was unsure how long the facility did not have a MDS Coordinator. On 2/14/22 at 10:30 AM, the surveyor interviewed the LPN who confirmed that she was the previous MDS Coordinator but resigned from that position in March of 2021. The LPN stated that the facility had several other MDS Coordinators since, but they had all resigned. The LPN thought the last MDS Coordinator resigned in September of 2021. The LPN stated that in the interim, she was helping complete MDS assessments if she had time, but she did not have a set schedule for when she completed resident assessment that were due, she would just complete an assessment if she had time to. On 2/16/22 at 10:10 AM, the MDS Coordinator provided the surveyor with the requested system selected MDS information. The MDS Coordinator confirmed that all the selected residents were overdue for their next MDS assessment, and the facility had identified that MDS assessment completion was an issue. A review of the twenty-two system selected MDS	F 636	monthly thereafter per the audit timeframes listed in action #3 beginning on 2/21/22. If any assessment is found to be late, immediate action will be taken to ensure assessment is completed within 48 hours and determine the reason for the assessment not being timely. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 636	Continued From page 4 assessments over 120 days not completed, five residents did not have a completed annual MDS as follows: 1. Resident #1 last completed MDS was a quarterly dated 8/22/21. The next ARD was 11/20/21, that was not completed. 2. Resident #9's last completed MDS was a quarterly dated 9/17/21. The next ARD was 12/17/21, that was not completed. 3. Resident #11's last completed MDS was a quarterly dated 9/17/21. The next ARD was 12/17/21, that was not completed. 4. Resident #6's last completed MDS was a quarterly dated 9/27/21. The next ARD was 12/26/21, that was not completed. 5. Resident #21's last completed MDS was a quarterly dated 10/6/21. The next ARD was 1/4/22, that was not completed. On 2/17/22 at 3:20 PM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and survey team, stated that the facility was transitioning ownership and acknowledged that the facility was behind on MDS assessments.	F 636		
F 638 SS=E	NJAC 8:39-11.1 Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than	F 638		3/31/22

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F 638	Continued From page 5 once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete a quarterly Minimum Data Set Assessment (MDS), an assessment tool, as required for 17 of 17 residents (Resident #2, #3, #4, #5, #7, #10, #12, #13, #14, #15, #16, #17, #18, #19, #20, #22, and #23) system selected for MDS over 120 days and was evidenced by the following: On 2/11/22 at 10:00 AM, the surveyor interviewed the MDS Coordinator who stated that she was unable to provide the survey team with a matrix (provider tool utilized to identify all the residents in the facility and their pertinent care categories) since she had only been at the facility for three weeks and not all the residents were in the system. On 2/14/22 at 9:44 AM, the surveyor re-interviewed the MDS Coordinator who stated that she completed the MDS for all the residents upon admission, quarterly, annually, and if there was a significant change of two or more activities of daily living or significant weight loss or wounds. The MDS Coordinator stated that each assessment had an assessment reference date (ARD) which the facility completed a seven day look back period from that date. The facility had fourteen days to complete the assessment from the ARD and then they had an additional seven days after to submit the assessment. The MDS Coordinator stated that when she started this job, MDS was a "mess" and there were a lot of "late and not completed MDS assessments" and she was trying to put everything in order. The MDS Coordinator stated that billing for the MDS was	F 638	1.Resident #2 quarterly assessment was completed on 2/21/22 and transmitted to CMS on 3/2/22 Resident #3 quarterly assessment was completed on 2/23/22 and transmitted to CMS on 3/2/22 Resident #4 quarterly assessment was completed on 2/24/22 and transmitted to CMS on 3/2/22 Resident #5 quarterly assessment was completed on 2/24/22 and transmitted to CMS on 3/2/22 Resident #7 quarterly assessment was completed on 2/25/22 and transmitted to CMS on 3/2/22 Resident #10 quarterly assessment was completed on 2/23/22 and transmitted to CMS on 3/2/22 Resident #12 quarterly assessment was completed on 2/24/22 and transmitted to CMS on 3/2/22 Resident #13 quarterly assessment was completed on 2/25/22 and transmitted to CMS on 3/2/22 Resident #14 quarterly assessment was completed on 2/25/22 and transmitted to CMS on 3/2/22 Resident #15 quarterly assessment was completed on 2/25/22 and transmitted to CMS on 3/2/22 Resident #16 quarterly assessment was completed on 2/19/22 and transmitted to CMS on 3/2/22 Resident #17 quarterly assessment was completed on 2/24/22 and transmitted to CMS on 3/2/22	

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F 638	Continued From page 6 still not completed for December of 2021, and she was unsure when the previous MDS Coordinator resigned. At this time, the surveyor provided the MDS Coordinator with a list of twenty-two system selected residents with their MDS record that was over 120 days and asked her to provide the survey team with the date the last MDS was submitted and the next MDS that was due. On 2/14/22 at 9:57 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that the MDS Coordinator was new to the facility and the Licensed Practical Nurse (LPN) East Side medication cart nurse was completing MDS assessments in the interim. The DON stated that she had only been at the facility for three months and since she started, the facility had been behind on MDS assessments. The DON stated that she was unsure how long the facility did not have a MDS Coordinator. On 2/14/22 at 10:30 AM, the surveyor interviewed the LPN who confirmed that she was the previous MDS Coordinator but resigned from that position in March of 2021. The LPN stated that the facility had several other MDS Coordinators since, but they had all resigned. The LPN thought the last MDS Coordinator resigned in September of 2021. The LPN stated that in the interim, she was helping complete MDS assessments if she had time, but she did not have a set schedule for when she completed resident assessment that were due, she would just complete an assessment if she had time to. On 2/16/22 at 10:10 AM, the MDS Coordinator provided the surveyor with the requested system	F 638	Resident #18 quarterly assessment was completed on 2/22/22 and transmitted to CMS on 3/2/22 Resident #19 quarterly assessment was completed on 2/21/22 and transmitted to CMS on 3/2/22 Resident #20 quarterly assessment was completed on 2/25/22 and transmitted to CMS on 3/2/22 Resident #22 quarterly assessment was completed on 2/21/22 and transmitted to CMS on 3/2/22 Resident #23 quarterly assessment was completed on 2/21/22 and transmitted to CMS on 3/2/22 2.A complete audit for all active residents was conducted on 2/19/22 by the MDS coordinator to determine the number of incomplete quarterly assessments that were flagging as late to determine immediate action for compliance. It was determined that all incomplete assessments would be completed by 3/31/22. The MDS coordinator implemented a schedule system to reflect dates when the next MDS's are due to track dates and timeliness of assessments. 3.The Administrator, DON and/or appointed designee will conduct weekly audits starting on 2/21/22 to ensure the timeliness of all quarterly assessments for the next 60 days, then twice a month for the next 2 months and monthly thereafter for 2 additional months. The Administrator provided re-education on 2/21/22 to the MDS coordinator regarding the timeliness	

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F 638	Continued From page 7 selected MDS information. The MDS Coordinator confirmed that all the selected residents were overdue for their next MDS assessment, and the facility had identified that MDS assessment completion was an issue. A review of the twenty-two system selected MDS assessments over 120 days not completed, seventeen residents did not have a completed quarterly MDS as follows: 1. Resident #13's last completed MDS was a quarterly dated 9/16/21. The next ARD was 12/17/21, that was not completed. 2. Resident #10's last completed MDS was a quarterly dated 9/17/21. The next ARD was 12/18/21, that was not completed. 3. Resident #18's last completed MDS was a quarterly dated 9/18/21. The next ARD was 12/19/21, that was not completed. 4. Resident #19's last completed MDS was an annual dated 9/18/21. The next ARD was 12/19/21, that was not completed. 5. Resident #2's last completed MDS was a quarterly dated 9/24/21. The next ARD was 12/25/21, that was not completed. 6. Resident #3's last completed MDS was a quarterly dated 9/25/21. The next ARD was 12/26/21, that was not completed. 7. Resident #4's last completed MDS was a quarterly dated 9/26/21. The next ARD was 12/27/21, that was not completed.	F 638	for completing the quarterly assessments, accuracy and his expectations for timely compliance. 4.All audits will be review 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 2/21/22. If any assessment is found to be late, immediate action will be taken to ensure assessment is completed within 48 hours and determine the reason for the assessment not being timely. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 638	Continued From page 8	F 638		

8. Resident #5's last completed MDS was a quarterly dated 9/28/21. The next ARD was 12/29/21, that was not completed.

9. Resident #7's last completed MDS was an annual dated 9/29/21. The next ARD was 12/30/21, that was not completed.

10. Resident #20's last completed MDS was an admission dated 9/29/21. The next ARD was 12/30/21, that was not completed.

11. Resident #12's last completed MDS was a quarterly dated 10/3/21. The next ARD was 1/3/22, that was not completed.

12. Resident #14's last completed MDS was a quarterly dated 10/4/21. The next ARD was 1/4/22, that was not completed.

13. Resident #15's last completed MDS was a quarterly dated 10/6/21. The next ARD was 1/6/22, that was not completed.

14. Resident #16's last completed MDS was a quarterly dated 10/6/21. The next ARD was 1/6/22, that was not completed.

15. Resident #22's last completed MDS was an annual dated 10/7/21. The next ARD was 1/7/22, that was not completed.

16. Resident #17's last completed MDS was a quarterly dated 10/7/21. The next ARD was 1/7/22, that was not completed.

17. Resident #23's last completed MDS was a quarterly dated 10/10/21. The next ARD was 1/10/22, that was not completed.

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F 638	Continued From page 9 On 2/17/22 at 3:20 PM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and survey team, stated that the facility was transitioning ownership and acknowledged that the facility was behind on MDS assessments. NJAC 8:39-11.1	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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). (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	F 656		3/15/22

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F 656	Continued From page 10 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to implement interventions in accordance with residents' individualized person-centered care plans for a.) a resident with chronic pain on pain management and b.) two residents who used tobacco products. This deficient practice was identified for 3 of 22 residents (Resident #3, #145, and #146) reviewed for implementation of care planning and was evidenced by the following: 1. On 2/11/22 at 11:50 AM, the surveyor observed Resident #3 sitting in his/her room. The resident stated that he/she had [redacted] and [redacted]. The resident appeared to be in [redacted]. On 2/16/22 at 11:43 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was alert, oriented, and able to make their needs known. The CNA stated that the resident liked to stay in their room by themselves.	F 656	1- A. The deficiency occurred when the facility staff failed to implement a pain assessment every shift as stated in the care plan and/or documentation in the resident chart for resident #3. A shift pain scale assessment was immediately started on the residents MAR. B. – The deficiency occurred when the facility staff failed to implement a [redacted] assessment for Resident #145 & #146. Social worker immediately initiated a [redacted] assessment for both residents. 2. A. - A complete audit for all active residents who are care planned for risk for pain was conducted on 2/22/22 by the DON to determine if they had a pain scale assessment in place on the MAR or documentation supporting pain assessment by nurse in the residents chart. B. A complete audit of all smokers was	

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F 656	Continued From page 11 On 2/16/22 at 11:58 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN #1) who stated that the resident was able to express their needs and was very particular. LPN #1 stated that the resident had [redacted] and received a standing order for [redacted]. The surveyor reviewed the medical record for Resident #3. A review of the Face Sheet (an admission summary) indicated that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted]. A review of the last completed quarterly Minimum Data Set (MDS), an assessment tool dated 9/25/21, reflected that the resident had a brief interview for mental status (BIMS) score that was unable to be completed. The resident had [redacted] with [redacted] cognitive skills for daily decision making. A review of the February 2022 Physician's Orders reflected a physician order (PO) dated 12/21/21, for [redacted]. A review of the resident's individualized person-centered Care Plan (CP) initiated 12/30/2020, included a problem area of at risk for [redacted] to [redacted]. Interventions included to [redacted]	F 656	performed by the Social Worker on 2/21/22 to see if they had a care plan for [redacted] and a [redacted] assessment. 3. A. On 2/17/22 the DON re-educated nursing staff on pain management, intervention 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 weekly times 2 weeks, then twice a month for the next 2 months and monthly thereafter for 2 additional months starting on 2/21/22. Resident charts and MAR's will be reviewed for accuracy and compliance with proper documentation. The DON will report all findings to the QA team during quarterly meetings. B. On 2/21/22 the Administrator educated the social worker on the importance of the facility [redacted] policy, Care plans for [redacted] and [redacted] assessments. Staff was also re-educated on the same on 2/21/22. Audits by the SW and/or assigned designee of all residents who currently smoke will be conducted monthly for two months then quarterly for six months starting on 2/21/22. 4. All audits will be review by Administrator, DON and/or designee to ensure compliance monthly for two months then quarterly for six months per the audit timeframes listed in action #3 beginning on 2/21/22. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and	

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F 656	Continued From page 12 assessment upon admission and as needed; assess for signs and symptoms of pain every shift verbal and nonverbal; and medicate for pain as needed. A review of the February 2022 Medication Administration Record (MAR) did not include pain assessment. A review of the Interdisciplinary Progress Notes did not include any Nurse's Notes documented for the month of February 2022. On 2/17/22 at 10:34 AM, the surveyor observed the resident sitting in his/her room and appeared to be in no distress. The resident stated that he/she received [redacted] On 2/17/22 at 12:25 PM, the surveyor interviewed the resident's medication nurse for the day, LPN #2 who stated that the nurses monitored for pain verbally and nonverbally by looking for facial grimacing or moaning when administering medications. LPN #2 stated that if the resident was on a [redacted], then a [redacted] scale would be on that resident's MAR. LPN #2 stated that Resident #3 did not complain of [redacted] to her, and she did not document the resident's [redacted] level. On 2/18/22 at 11:17 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident was on [redacted] medications for [redacted]. The DON stated that nurses should be assessing pain every shift and documenting on the MAR or in the Nurse's Notes. At this time, the DON acknowledged that the nurses were not documenting the resident's pain level every shift.	F 656	necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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A review of the facility's undated "Pain Management Policy" included that all residents will be assessed for pain by the nursing staff upon admission and on an ongoing basis... Initial documentation of resident's pain will occur on the interim care plan if the pain is present upon admission... (b) Nurses are responsible for implementation and coordination of the plan for managements of pain, using clinical and administrative resources to ensure progress towards achieving relief or control of pain... Evaluation by nurses of resident's responses to interventions for pain control. (a) evaluate responses. (b) document responses on MDS, in the Interdisciplinary and Functional Care Plans and in the Nurses' Notes. (c) use evaluation data to revise care plan...

2. On 2/11/22 at 11:25 AM, the surveyor observed outside Resident #146's door on the floor next to a small trash receptacle [redacted] with [redacted].

On 2/11/22 at 11:28 AM, the surveyor interviewed LPN #2 who stated that residents were not allowed to hold onto their own cigarettes and lighters, that the Smoke Monitor held onto them. LPN #2 stated that residents were able to smoke throughout the day in a designated smoking area outside. The surveyor showed LPN #2 the [redacted] on the floor. LPN #2 identified Resident #146 as a [redacted]

At this time, LPN #2 interviewed Resident #146 regarding the [redacted] outside their door. Resident #146 stated that the [redacted] from his/her pocket and that he/she swept it from his/her room

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F 656	Continued From page 14 into the hallway. The resident stated that he/she does not [redacted] in the building. On 2/16/22 at 11:04 AM, the surveyor observed that the resident was not in their room. The resident's roommate stated that they were outside [redacted] On 2/16/22 at 11:36 AM, the surveyor observed the resident with their coat on in the hallway returning to their room. The resident stated that he/she was outside and that they smoked earlier today. The resident stated that he/she had no more cigarettes and needed to purchase more. The surveyor reviewed the medical record for Resident #146. A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses which included [redacted] A review of the resident's individualized person-centered CP initiated 10/28/2020, for a problem area at risk for injury/complications with regards to use of tobacco. Interventions included to: will continue to follow the facility [redacted] policy and only [redacted] in the designated area of the facility; staff will continue to monitor and assess for safety; and complete smoking assessment at least quarterly and thereafter. There was no smoking assessment located in the resident's chart. On 2/17/22 at 11:52 AM, the surveyor interviewed the Social Worker (SW) who stated that she was new to the facility and was in charge of [redacted]	F 656		

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assessments. The SW stated that since she had been at the facility, she started identifying smokers and updating their smoking assessments. She stated that some residents had smoking assessments, and some did not. The SW stated that Resident #146 was not her list as a [redacted], and she did not have a smoking assessment completed for that resident.

On 2/17/22 at 12:05 PM, the surveyor interviewed the Smoke Monitor who stated that their job was to ensure that the residents smoked safely. The Smoke Monitor stated that he held onto the residents' cigarettes and lighters. The Smoke Monitor stated that Resident #146 was a [redacted] and that he/she currently had no cigarettes. The Smoke Monitor stated that the resident smoked safely; did not burn themselves or others; did not try to light their own cigarettes; and did not try to carry their cigarettes or lighters.

On 2/17/22 at 12:57 PM, the SW informed the surveyor that she did not find any completed smoking assessment for the resident.

On 2/18/22 at 11:21 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and survey team, stated that the facility was transitioning ownership and acknowledged that not all residents had smoking assessments.

3. On 2/14/22 at 12:40 PM, the surveyor observed Resident #145 sitting in their wheelchair in their room. The resident stated that he/she usually ate their breakfast after they went outside at 9:00 AM for their morning [redacted]. At this time, the surveyor observed no [redacted] on the resident.

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F 656	Continued From page 16 On 2/16/22 at 11:39 AM, the surveyor interviewed the resident's CNA who stated that the resident liked to [redacted] all day and [redacted]. On 2/16/22 at 11:50 AM, the surveyor interviewed LPN #1 who stated that the resident went outside to smoke cigarettes daily. The LPN stated that she was new to the facility and was unsure if the residents were allowed to hold onto their cigarettes and lighter, but she had not observed Resident #145 to have [redacted] or a [redacted] on them. LPN #1 stated that there was a Smoke Monitor outside with the residents. On 2/16/22 at 12:13 PM, the surveyor interviewed LPN #2 who stated that the resident was very pleasant and went outside to smoke cigarettes. The surveyor reviewed the medical record for Resident #145. A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted]. A review of the last completed quarterly MDS dated 7/25/21, reflected a BIMS score of [redacted] out of [redacted] which indicated [redacted] cognition. A review of the resident's individualized person-centered CP initiated 12/30/2020 included a problem area for at risk for EX Order 26 § 4b1 [redacted] with a history of being	F 656		

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F 656	Continued From page 17 observed in the lobby of the building EX Order 26 § 4b1 [redacted]. Interventions included to: will continue to follow facility smoking policy and only smoke in the designated area of the facility; staff will continue to monitor and assess for safety; and complete smoking assessment at least quarterly and thereafter. A review of the Resident Smoking Assessment reflected for "Include in Nursing Care Plan & Interdisciplinary resident Care Plan" was dated second quarter assessment 3/19/2021 and was not completed or signed. The document was also blank for the third and fourth quarter. On 2/17/22 at 11:52 AM, the surveyor interviewed the SW who stated that she was new to the facility and was in charge of smoking assessments. The SW stated that since she had been at the facility, she started identifying smokers and updating their smoking assessments. She stated that some residents had smoking assessments, and some did not. The SW stated that Resident #145 was not her list as a [redacted] and she did not have a [redacted] assessment completed for that resident. On 2/17/22 at 12:05 PM, the surveyor interviewed the Smoke Monitor who stated that their job was to ensure that the residents smoked safely. The Smoke Monitor stated that he held onto the residents' cigarettes and lighters. The Smoke Monitor stated that Resident #145 was a [redacted] who [redacted] safely; did not burn themselves or others; did not try to light their own cigarettes; and did not try to carry their cigarettes or lighters. On 2/17/22 at 12:56 PM, the SW informed the surveyor that Resident #145 has not had a	F 656		

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F 656	Continued From page 18 completed smoking assessment since 2019. On 2/18/22 at 11:21 AM, the LNHA in the presence of the DON and survey team, acknowledged that all residents did not have completed smoking assessments. A review of the facility's "Care Planning-Resident Participation" dated copyright 2021, included that the care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care... NJAC 8:39-27.1 (a)	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a) accurately assess a resident for smoking and b) implement the facility's smoking policy and procedure for a resident who smoked cigarettes. This deficient practice was identified for 1 of 3 residents (Resident #56) reviewed for smoking and the evidence was as follows:	F 689	1.Resident #56 was not negatively impacted by this deficient practice. Resident #56 has since been assessed by nursing staff to ensure safety during smoking activities. The resident was re-educated on the facility smoking policy and not keeping smoking materials on his person and they must be secured in the locked box.	3/15/22

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F 689	Continued From page 19 On 2/11/22 at 10:31 AM, the surveyor observed Resident #56 resting in their room with a [redacted] on the nightstand by their bed. The resident stated that they were "not really" supposed to keep their own [redacted] and confirmed they were a [redacted]. On 2/11/22 at 10:48 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that residents who smoked were assessed quarterly for smoking, and the residents were not supposed to hold on to their own cigarettes or lighters. LPN #1 stated that all cigarettes and lighters were locked-up and kept by the facility, and residents were provided smoking material by the Smoke Monitor at the time they were smoking. On 2/11/22 at 11:00 AM, the surveyor interviewed the Director of Activities (DA) who confirmed that all smoking paraphernalia were locked in a box and kept by the facility. On 2/11/22 at 11:17 AM, LPN #1 approached the surveyor and informed them that after speaking with the facility Smoking Monitor, she was informed that no residents were supposed to have a lighter; that "all lighters are locked up." The surveyor reviewed the medical record for Resident #56. A review of the Face Sheet (an admission summary) reflected that the resident was originally admitted to the facility in [redacted] with diagnosis which included [redacted]	F 689	2.A complete audit for all active residents who smoke was conducted on 2/21/22 by the Social worker. All active smokers will be re-educated on the facility smoking policy. All residents who smoke will have care plans for smoking and smoking assessments are in place by 3/15/22. 3.The Administrator, DON and/or appointed designee will in-service nursing staff on the importance of the smoking assessment and smoking care plan to be completed on admission, quarterly and with a significant change starting on 2/21/22. Audits by the SW and/or assigned designee of all residents who currently smoke will be conducted monthly for two months then quarterly for six months starting on 2/21/22 to check for care plans, smoking assessments and make sure all new admissions are educated on the current facility smoking policy. 4.All audits will be review by Administrator, DON and/or designee to ensure timely compliance monthly and quarterly thereafter per the audit timeframes listed in action #3 beginning on 2/21/22. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated 11/22/2021, reflected a brief interview for mental status (BIMS) score of [redacted] out of [redacted], which indicated a [redacted]. A further review reflected the resident was a current [redacted].

A review of the resident's individualized resident-centered Care Plan initiated on 11/24/2020, included a problem area for [redacted] use. Interventions included to: complete a [redacted] assessment at least quarterly and thereafter; a copy of the facility [redacted] policy to be provided to the resident upon admission and as the policy is revised; and the resident will continue to follow the facility [redacted] policy.

A review of the facility "Resident Smoking Assessment" reflected quarterly assessments completed on 11/26/19 and 2/21/20, and a "Safe Smoking Assessment" dated 2/7/2022. There was no documentation that the resident was assessed for smoking quarterly in 2021 or a smoking contract with the resident.

On 2/16/22 at 8:57 AM, the surveyor observed Resident #56 walking out from their room to the [redacted] courtyard and removed a [redacted] and a [redacted] from their jacket pocket. The resident [redacted] the [redacted] and proceeded to [redacted]

On 2/16/22 at 9:09 AM, the surveyor interviewed the Temporary Nursing Aide (TNA) who stated that he was currently acting as a [redacted] for the [redacted] who was currently out of the facility with a resident. The TNA stated that no residents were allowed to carry their own [redacted]. When asked if Resident

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F 689	Continued From page 21 #56 was able to carry their own EX Order 26 § 4b1 EX Order 26 § 4b1, the TNA responded, "No, I do not know how [he/she] got them, they were all supposed to be locked up in the box." On 2/16/22 at 9:21 AM, the surveyor interviewed the Social Worker (SW) who confirmed that residents were not supposed to carry their own cigarettes or lighters. The SW stated that there were many smoking assessments that were not completed. On 2/16/22 at 10:00 AM, the SW and the Director of Nursing (DON) confirmed the facility did not have an initial admission EX Order 26 § 4b1 agreement for Resident #56. They were also unable to provide any quarterly smoking assessments for 2021. On 2/16/22 at 10:46 AM, the surveyor observed the resident in their room watching television. The resident confirmed that he/she had been an active EX Order 26 § 4b since they were [redacted] or [redacted] years old with no attempts to quit smoking. On 2/17/22 at 2:31 PM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, Assistant Administrator, and the survey team, confirmed that no residents should be holding onto their own lighters or cigarettes in the building. A review of the facility's undated "Smoking Policy" included procedures: 1. Upon admission, an assessment will be completed... 3. A smoking monitor has been designated by the facility to handle all tobacco products and smoking apparatus and paraphernalia... All residents shall be encouraged to have products lit by the smoking monitor or designated staff members.	F 689		

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F 689	Continued From page 22 NJAC 8:39- 33.1(d)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		3/15/22

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F 690	Continued From page 23 possible. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain an [er 26 § 4b1] off the floor to prevent the spread of infection and b.) ensure [redacted] care was performed and documented every shift in accordance with a physician's order. This deficient practice was identified for 1 of 2 residents (Resident #52) reviewed for [redacted] care and was evidenced by the following: On 2/11/22 at 11:22 AM, the surveyor observed Resident #52 lying in bed asleep. The surveyor observed an [redacted] secured to the bed frame in a [EX Order 26 § 4b1]. On 2/16/22 at 11:47 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated that the resident was [redacted] and had an [redacted] The CNA stated that the resident had a history of [redacted] and had a [redacted] so she emptied the resident's [redacted] during her shift. The CNA stated that she reported the amount of [redacted] to the nurse. On 2/16/22 at 11:55 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that the resident was recently re-admitted from the [redacted] LPN #1 stated that the CNA emptied the resident's [redacted] but she was unsure if the CNA recorded the [redacted] amount because it was not documented on the Medication Administration	F 690	1.Resident #52 was not negatively impacted by this deficient practice. Resident #52's [redacted] collection bag was changed by the LPN on 2/17/22. The CNA working with Resident #52 was educated on foley catheters, foley cath care and infection control on 2/17/22. 2.A complete audit for all active residents who have a urinary catheter was done on 2/17/22 to ensure physicians orders are accurate, urinary catheter care orders are transcribed to TAR and nursing staff are documenting for urinary catheter care provided each shift. 3.On 2/17/22 the DON re-educated nursing staff on Urinary catheters policy, Physician orders for urinary catheters, Urinary catheter documentation and care and Infection control. Audits will continue from the DON and/or assigned designee on all residents who have indwelling urinary catheters starting on 2/21/22. 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 review 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 2/21/22. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who	

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	315193	A. BUILDING _____ B. WING _____	02/18/2022

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F 690	Continued From page 24 Record (MAR) or Treatment Administration Record (TAR). On 2/16/22 at 12:22 PM, the surveyor interviewed LPN #2 who stated that the nurses performed [redacted] for the resident and the CNA emptied the [redacted]. LPN #2 stated that the CNA did not record [redacted]. The LPN stated that the resident had a history of [redacted] but he/she had no recent [redacted]. The surveyor reviewed the medical record for Resident #52. A review of the Face Sheet (an admission summary) reflected that the resident was last admitted to the facility in [redacted] with diagnoses which included [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 11/2/21, reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted], which indicated a EX Order 26 § 4b1. It further included that the resident had an EX Order 26 § 4b1. A review of the resident's individualized person-centered Care Plan (CP) included a problem area initiated on 11/8/2020 for reoccurring [redacted] associated UTIs secondary to [redacted] placement. Interventions included to: monitor, document, notify medical doctor of signs and symptoms of EX Order 26 § 4b1 [redacted]	F 690	will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 690	Continued From page 25 protocol. A review of the telephone Physician's Orders sheet reflected a physician's order (PO) dated 1/7/22 to transfer resident to the [redacted] room for evaluation. A review of the January 2022 TAR from 1/1/22 until transfer to the [redacted] revealed the following: A PO dated 11/30/21 for change [redacted] bag weekly reflected a blank for the change on 1/1/22. A PO dated 11/30/21 for [redacted] care every shift, reflected blanks for: the 11:00 PM to 7:00 AM shifts on 1/1/22, 1/2/22, 1/3/22, and 1/4/22; the 7:00 AM to 3:00 PM shift on 1/3/22; and the 3:00 PM to 11:00 PM shift on 1/3/22 and 1/4/22. A review of the January 2022 TAR from 1/24/22 until 1/31/22 revealed the following: A PO dated 1/24/22 for [redacted] care every shift, reflected blanks for the following: For the 11:00 PM to 7:00 AM shift on 1/25/22, 1/26/22, 1/27/22, 1/28/22, 1/29/22, 1/30/22, 1/31/22. For the 7:00 AM to 3:00 PM shift on 1/25/22, 1/26/22, 1/27/22, 1/28/22, 1/29/22, 1/30/22, and 1/31/22. For the 3:00 PM to 11:00 PM shift on 1/25/22, 1/26/22, 1/27/22, 1/28/22, 1/29/22, 1/30/22, and 1/31/22. A PO dated 1/24/22 to change [redacted] weekly, reflected no [redacted] were	F 690		

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F 690	Continued From page 26 done. On 2/17/22 at 10:03 AM, the surveyor observed the resident sitting in their EX Order 26 § 4b1 with their [redacted] lying directly on the floor underneath their EX Order 26 § 4b1. The CNA was with the resident and stated that she had just transferred the resident from bed into their EX Order 26 § 4b1 and emptied their EX Order 26 § 4b1. The CNA stated that she was going to put the EX Order 26 § 4b1 into the EX Order 26 § 4b1 and attach it to the back of the resident's EX Order 26 § 4b1. The CNA picked up the resident's EX Order 26 § 4b1 to show the surveyor the clear yellow urine, and then placed the EX Order 26 § 4 [redacted] directly back on the floor. Then the CNA retrieved the EX Order 26 § 4b1 and placed the EX Order 26 § 4 [redacted] in the EX Order 26 § 4b1 and attached it to the back of the resident's EX Order 26 § 4b1. On 2/17/22 at 10:07 AM, the surveyor interviewed the CNA who stated that the resident does not use a leg EX Order 26 § 4b1, only the large EX Order 26 § 4b1 that she placed in the EX Order 26 § 4b1. The CNA stated that when the resident was in bed, she attached the EX Order 26 § 4b1 to the bed frame, but when the resident was in his/her EX Order 26 § 4b1, she attached the bag to the back of the chair. The CNA stated that the EX Order 26 § [redacted] was too short for her to be able to reach from the front of the EX Order 26 § 4b1 to the back, that she placed the EX Order 26 § 4b1 on the floor while she went to the back of the EX Order 26 § 4b1. When asked, the CNA confirmed that the EX Order 26 § 4 [redacted] should not be on the floor because it was an infection control issue, so she needed to inform the nurse that the bag needed to be changed. On 2/17/22 at 10:39 AM, the surveyor interviewed the resident who confirmed that his/her EX Order 26 § 4 [redacted]	F 690		

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F 690	Continued From page 27 bag was just changed, and he/she had no recent [redacted] On 2/17/22 at 12:50 PM, the surveyor interviewed the Director of Nursing (DON) who stated that [redacted] care should be completed every shift and documented as completed on the TAR. The DON stated that the [redacted] should be kept off the floor for infection control and placed in a dignity bag for privacy. The DON stated that if the [redacted] was on the floor, then the nurse changed the bag and not the CNA because it was a sterile process. On 2/18/22 at 11:02 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team confirmed that the CNA should not have placed the resident's [redacted] on the floor. The DON acknowledged the blanks in the January TAR and stated that [redacted] was being done, but not documented. The DON also stated that she spoke to the night nurse, who stated that she changed the resident's [redacted] in January but did not document it. The DON acknowledged that not documenting was equivalent to not being done. A review of the facility's "Catheter Care" policy dated copyright 2021, included catheter care will be performed every shift and as needed by nursing personnel... The policy does not include that urinary catheter bags should be maintained off the floor. NJAC 8:39- 19.4 (a)5; 27.1 (a)	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		3/15/22

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F 695	Continued From page 28 § 483.25(i) Respiratory care, including tracheostomy care and EX Order 26 § 4b1 . The facility must ensure that a resident who needs respiratory care, including EX Order 26 § 4b1 care and EX Order 26 § 4b1 , 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 review of pertinent facility documents, it was determined that the facility failed to follow the physician's order for the administration of EX Order 26 § 4 . This deficient practice was identified for 1 of 2 residents (Resident #10) reviewed for respiratory care and was evidenced by the following: On 2/11/22 at 11:35 AM, the surveyor observed Resident #10 in bed with EX Order 26 § 4b being administered at EX Order 26 § 4b1 [redacted] On 2/14/22 at 9:57 AM, the surveyor observed the resident in their bed with EX Order 26 § 4b being administered at EX Order 26 § 4b1 . The resident appeared to be in no distress. On 2/15/22 at 9:24 AM, the surveyor observed the resident in bed with EX Order 26 § 4b1 [redacted] The resident appeared to be in [redacted] . The surveyor reviewed the medical record for Resident #10.	F 695	1.Resident #10 was not negatively impacted by this deficient practice. Resident #10's EX Order 26 § 4b EX Order 26 § 4b1 [redacted] was decreased to EX Order 26 § . Residents EX Order 26 § 4b1 was checked and within normal limits. Education was provided by the DON on 2/17/22 to the LPN regarding following Physicians orders for EX Order 26 § 4b , facility EX Order 26 § 4b policy and documentation. 2.A complete audit for all residents who have a Physicians order for EX Order 26 § 4b was done on 2/17/22 by the DON to ensure physicians orders are accurate, facility EX Order 26 § 4b policy was being followed and Documentation was being done correctly. 3.On 2/17/22 the DON re-educated nursing staff on EX Order 26 § 4b Administration and documentation. Audits will continue by the DON and/or assigned designee on all residents who have Physician EX Order 26 § 4b orders starting on 2/21/22. 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 29 A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted]. A review of the last completed Minimum Data Set (MDS), an assessment tool dated 9/17/21, reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted] which indicated a fully EX Order 26 § 4b1. A further review in Section O. Treatment and Procedures, indicated that the resident received EX Order 26 § 4b treatments in the facility. A review of the February 2022 Treatment Administration Record (TAR) reflected a physician's order (PO) dated [redacted] for EX Order 26 § 4b to be administered at EX Order 26 § 4b1 every shift. An additional PO dated 3/13/19 to check EX Order 26 § 4b1 [redacted] every shift. The corresponding administration record reflected that the 7:00 AM to 3:00 PM shifts on 2/13/22, 2/14/22, 2/15/22, and 2/16/22 were blank for both. The TAR also reflected that the 3:00 PM to 11:00 PM shifts on 2/14/22 and 2/15/22 were blank for both. A review of the undated individualized person-centered Care Plan included a problem area for at risk for EX Order 26 § 4b1 related to EX Order 26 § 4b1 [redacted]. Interventions included to: administer EX Order 26 § 4b1 EX Order 26 § 4b1	F 695	4.All audits will be review 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 2/21/22. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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EX Order 26 § 4b1 [redacted]

On 2/17/22 at 9:49 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident received EX Order 26 § 4b at [redacted] continuously. The LPN stated that the EX Order 26 § 4b setting was checked by the nurse every shift and signed on the TAR that it was checked. The LPN accompanied the surveyor into Resident #10's room. The LPN confirmed that the EX Order 26 § 4b was not set to [redacted] and not the ordered [redacted]. The LPN stated that she had administered the resident medications earlier, but she did not check the EX Order 26 § 4b setting at that time.

At this time, the surveyor requested the LPN check the resident's EX Order 26 § 4b1 [redacted] The LPN checked the resident's EX Order 26 § 4b1 which was at EX Order 2, an acceptable range.

On 2/17/22 at 2:38 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team regarding the concern with the oxygen not being administered in accordance with the resident's PO. The DON stated that the nurses were expected to follow the PO and check the EX Order 26 § 4b setting and the resident's EX Order 26 § 4b1 each shift and document this in either the Nurse's Notes or on the Medication Administration Record (MAR). The surveyor asked the DON if she was aware the nurses were documenting on the TAR, and she responded that she was unaware. The surveyor then reviewed the February TAR for the resident with the administration team. The DON

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F 695	Continued From page 31 acknowledged the omissions on the record and stated that the nurse should have recorded the resident's EX Order 26 § 4b1 and also signed/initialed the TAR on the corresponding dates to indicate the EX Order 26 § 4b1 and EX Order 26 § 4b [redacted] had been completed. A review of the facility's policy and procedure titled "Oxygen Administration" and dated issued 4/5/22, included that ...oxygen will be administered as per MD order to aid in breathing... Note: Residents using oxygen will be checked at the beginning of each shift to make sure that the dial is at the correct setting, and that the equipment(s) is in proper working order.... NJAC 8:39-27.1 (a)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documentation it was determined that the facility failed to a.) follow the physician's order to document the monitoring of the EX Order 26 § 4b access site every shift and b.) follow the facility's policy by assessing and documenting care upon return on resident's EX Order 26 § 4b days. This deficient practice was identified for 1 of 1 resident (Resident #69) reviewed for EX Order 26 § 4b and was evidenced by the following:	F 698	1.Resident #69 was not negatively impacted by this deficient practice. Resident #69 EX Order 26 § 4b access was assessed and found to be without EX Order 26 § 4b1 [redacted]. On 2/16/22 resident #69's was assessed upon return from EX Order 26 § 4b and all findings were within normal limits, LPN documented findings on DCR. Education was provided by the DON on 2/17/22 to	3/15/22

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F 698	Continued From page 32 On 2/14/22 at 9:54 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that Resident #69 was currently out of the facility to [redacted]. The surveyor reviewed the medical record for Resident #69. A review of the Face Sheet (an admission summary) reflected that the resident was originally admitted to the facility in [redacted] and then readmitted in [redacted] with diagnoses which included end stage [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/11/21, reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating a moderately impaired cognition. A review of Section O, Special Treatment and Procedures, reflected that the resident received EX Order 26 § 4b1 [redacted]. A review of the individualized Care Plan initiated 3/15/21, included to assess the EX Order 26 § 4b1 [redacted] every shift and before/after each EX Order 26 § 4b1 session - check for EX Order 26 § 4b1 [redacted] at the site. A review of the physician's orders (PO) which reflected the following: 1. A PO dated 9/30/21, to monitor EX Order 26 § 4b1 [redacted] to th EX Order 26 § 4b1 [redacted]	F 698	the LPN regarding following Physicians orders for dialysis, Assessing and documenting pre and post dialysis, assessing dialysis access every shift and following facility Dialysis policy. 2.A complete audit for all active residents who are on dialysis was done on 2/17/22 by the DON to ensure physicians orders are accurate, facility Dialysis policy was being followed and Documentation was being done correctly. 3.On 2/17/22 the DON re-educated nursing staff on the facility Dialysis policy, assessing dialysis residents pre and post treatment, assessing dialysis access every shift and documentation. Audits will continue by the DON and/or assigned designee on all residents who are on Dialysis starting on 2/21/22. 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 review 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 2/21/22. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 698	Continued From page 33	F 698		

2. A PO dated 9/30/21, for [redacted] every Monday, Wednesday, and Friday.

A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for December 2021 and January 2022 did not reflect the monitoring for the [redacted] to the right chest wall which was ordered on 9/30/21.

A review of the Nurse's Notes and Interdisciplinary Progress notes from December 2021 to February 14, 2022, reflected the documentation of monitoring of the [redacted] every shift and vital signs and assessment upon returning from [redacted] was not consistent.

On 2/15/22 at 9:36 AM, the surveyor observed Resident #69 lying in bed. The resident asked the surveyor "what do you want?" and briefly spoke with the surveyor. Resident #69 stated he/she was tired because he/she had [redacted] yesterday.

On 2/15/22 at 9:43 AM, the surveyor interviewed LPN #2 who stated that Resident #69 was picked up between 4:30 AM and 5:00 AM for [redacted] on Monday, Wednesday, and Friday. She further stated the resident had a right chest wall [redacted] which they monitored. LPN #2 stated the resident had [redacted] She further stated the resident was scheduled for a revision of the [redacted] in March of 2022. At the time, the LPN #2 showed the surveyor the [redacted] binder. LPN #2 explained the staff nurse filled out the top portion and the

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F 698	Continued From page 34 EX Order 26 § 4b facility filled out the bottom portion. She concluded if the EX Order 26 § 4b facility needed to provide additional information it would be in an envelope upon the resident's return. A review of the DCR which contained four (4) separate sections to be filled out: the top section - Facility communication to EX Order 26 § 4b1 center, the second section - Facility to complete prior to EX Order 26 § 4b, the third section - EX Order 26 § 4b center to complete for facility, and the fourth section - Facility to complete upon return from EX Order 26 § 4b. The DCR forms from 12/17/21 to 2/14/22 reflected the fourth section - Facility to complete upon return from EX Order 26 § 4b was not completed. On 2/15/22 at 12:13 PM, LPN #2 stated they did not have to complete the bottom portion because they do an assessment upon return. She stated that they documented the assessments in the Nurse's Notes every time Resident #69 came back from EX Order 26 § 4b. LPN #2 stated they conducted a head-to-toe assessment and monitored for any signs of EX Order 26 § 4b1 [redacted] The surveyor and LPN #2 reviewed the DCR binder together. LPN #2 stated she "honestly never paid attention to the bottom portion." LPN #2 acknowledged all sections of the DCR should be completed before and after EX Order 26 § 4b. On 2/16/22 at 10:45 AM, the surveyor interviewed LPN #1 who stated that she took care of Resident #69 on 2/14/22 and explained the process for EX Order 26 § 4b residents which included taking vital signs before and after EX Order 26 § 4b and checking the DCR for new orders. LPN #1 stated that she completed the DCR prior to sending the resident to EX Order 26 § 4b but was not sure if the form had to be filled out	F 698		

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upon return. The surveyor and LPN #1 reviewed the DCR binder together. LPN #1 acknowledged the bottom portion was not filled out and that she should have filled it out. LPN #2 further stated she did take the resident's vital signs but did not remember if she put them in the Nurse's Notes. She concluded the assessment should have been in the Nurse's Notes and filled out on the DCR and that they always did assessments on all their residents returning to the facility.

On 2/16/22 at 11:11 AM, the Director of Nursing (DON) explained to the surveyor the process for [EX Order 26 § 4b] residents which included, the nurses would conduct vital signs and an assessment before [EX Order 26 § 4b] which was documented on the DCR, the [EX Order 26 § 4b] facility filled out their portion, and then upon return the nurse conducted vital signs and an assessment which should be documented on the bottom portion of the DCR. The surveyor reviewed with the DON the bottom portion of the DCR from the above dates that were not completed. The DON acknowledged the bottom portion should have been completed upon the resident's return from [EX Order 26 § 4b].

On 2/16/22 at 12:48 PM, the surveyor observed the resident lying in bed resting with his/her eyes closed after returning from [EX Order 26 § 4b].

On 2/16/22 at 12:53 PM, the DON provided a copy of the TAR for February 2022 which reflected an undated "for your information" (FYI) no blood pressure (BP)/ labs to left arm which was left blank. The surveyor interviewed the DON regarding the undated FYI, no BP/labs on the left arm and that it was not being signed off. The DON stated Resident #69 had a [EX Order 26 § 4b1] and the resident was scheduled for

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a revision on 3/1/22. The DON concluded the FYI note written on the TAR did not have a PO date and it was "just an FYI."

On 2/16/22 at 1:07 PM, the surveyor interviewed LPN #3 who stated that the resident had left arm restrictions. She stated "honestly, I just learned today" that the resident had EX Order 26 § 4b1. The LPN #3 stated Resident #69 does not let her use that EX Order because he/she referred to it as the EX Order 26 § 4b1

On 2/16/22 at 1:09 PM, Resident #69 stated they only used his/her EX Order 26 § 4b1 because the EX Order 26 § 4b was EX Order 26 and that he/she had "one of those things" in his/her EX Order 26 § 4b1 but "EX Order 26 § 4b1

On 2/18/22 at 11:04 AM, the DON in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Assistant LNHA stated that Resident #69's EX Ord was not working because it did not have a EX Order 26 § 4b1 by placing a stethoscope over the area and felt (thrill) by placing fingers over the access site). The DON stated the EX Order 26 § 4b1 was originally ordered 9/30/21 but then reordered on 2/17/22 with the EX Order 26 § 4b no blood pressures or needlesticks. The DON acknowledged the facility did not receive an order from the physician or update the care plan until after the surveyor inquired.

A review of the facility's "Care Planning Special Needs - EX Order 26 § 4b" policy dated 10/31/21 included ..."3. Interventions will include, but not limited to: ...a. Documentation and monitoring of complications, ...c. EX Order 26 § 4b1 as applicable

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F 698	Continued From page 37 ...f. vital signs .....5. If no written report is received upon return from [EX Order 26 § 4b] nursing staff will call the [EX Order 26 § 4b] provider to receive a report." NJAC 8:39-27.1(a)	F 698		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face to face visits and wrote progress notes at least every thirty days. This deficient practice was identified for 19 of 20 long-term care residents (Resident #1, #3, #10, #13, #22, #31, #32, #39,	F 712	1.Resident #1, #3, #10, #13, #22, #31, #32, #39, #50, #52, #56, #69, #79, #83, #85, #88, #129, #145 and #146 have been seen by their Physician and progress notes have been updated and signed. 2.A complete audit for all active residents	3/15/22

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F 712	Continued From page 38 #50, #52, #56, #69, #79, #83, #85, #88, #129, #145, and #146) sampled and evidenced by the following: On 2/16/22 at 10:30 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that the physician came in monthly to see the residents. LPN #1 could not speak to which residents the physician saw when he was in the building. On 12/16/22 at 12:13 PM, the surveyor interviewed LPN #2 who stated that the facility had two physicians who physically came into the building to see the residents. LPN #2 stated that the physicians did not use nurse practitioners, so it was the physician seeing the residents. LPN #2 stated that the physicians saw the residents once a month and in between if needed. LPN #2 stated that all the residents should be seen by the physician at least once a month. On 2/16/22 at 12:30 PM, the surveyor interviewed LPN #3 who stated that the physicians came in monthly to the facility and should see every resident monthly. On 2/16/22 at 1:14 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the facility had two physicians (Physician #1/Medical Director and Physician #2). The DON stated that Physician #1/Medical Director was in the facility frequently and Physician #2 usually came late on Sunday nights to look at the residents' charts. The DON stated that she could not speak to how often Physician #2 was in the building because he came to the facility late at night when she was not there. The DON stated that both physicians documented on the chart in the Physician's	F 712	was conducted and all Physicians have been notified to review their charts to ensure physician visits and progress notes have been entered in accordance with federal regulations. 3.On 2/21/22 the Administrator and DON met with the medical director. Administrator, DON and Medical director reviewed and was in serviced on regulation 483.30 – physician visits-frequency/timeliness/ Alt NPP. A copy of the facility policy was given to the Medical Director and attending Physicians for review. An audit will be conducted by the DON and/or assigned designee on all residents starting on 2/21/22 to check for timeliness of Physician progress notes. These audits will be monthly for 3 months, then quarterly for 6 months. 4.All audits will be reviewed by Administrator, DON and/or designee to ensure timely compliance monthly, quarterly thereafter per the audit timeframes listed in action #3 beginning on 2/21/22. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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Progress Notes and all the notes should be on the residents' charts. At this time the surveyor requested copies of the twenty long-term care sampled residents' Physician Progress Notes from April 2021 until present.

On 2/17/22 at 9:25 AM, the DON provided the surveyor with the requested Physician Progress Notes. The DON stated that "this was all the Physician's Progress Notes I could find."

The surveyor conducted observations, interviews, and reviewed the medical records including the Physician's Progress Notes provided by the DON for Residents #1, #3, #10, #13, #22, #31, #32, #39, #50, #52, #69, #79, #83, #85, #88, #129, #145, and #146 as follows:

1. On 2/11/22 at 10:31 AM, the surveyor observed Resident #56 lying in bed asleep.

A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted EX Order 26 § 4b1] [redacted].

A review on the most recent annual Minimum Data Set (MDS), an assessment tool dated 11/22/21, reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated a [redacted EX Order 26 § 4b1].

A review of the resident's medical record reflected no Physician's Progress Notes.

On 2/17/22 at 9:25 AM, the surveyor interviewed the resident who stated that he/she had not seen the physician in over a year and that they would

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like to see the physician.

2. On 2/11/22 at 10:32 AM, the surveyor observed Resident #50 in their room. The surveyor interviewed the resident who stated that he/she had not seen the physician in "a while".

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted].

A review of the most recent annual MDS dated 11/30/21, reflected that the resident had a BIMS score of [redacted] out of [redacted], which indicated a [redacted].

A review of the Physician's Progress Notes reflected that for the year of 2021, the physician only saw the resident on 11/21/21. A further review reflected that the resident was seen in 2022 on 2/6/22. The resident was not seen in January of 2022.

3. On 2/11/22 at 10:37 AM, the surveyor observed Resident #1 sitting in their room.

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted].

A review of the last completed quarterly MDS dated 8/22/21, reflected that the resident had a BIMS score of [redacted] out [redacted], which indicated a [redacted].

A review of the Physician's Progress Notes

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reflected that the resident was only seen by the physician from April 2021 until present on 5/15/21. The physician had not seen the resident in 2022.

On 2/17/22 at 12:40 PM, the surveyor interviewed the resident who stated that the physician came to the facility monthly, and he/she saw the physician last two weeks ago. The resident continued that he/she did not always see the physician monthly though because "he had a lot of patients to see when he comes in."

4. On 2/11/22 at 10:55 AM, the surveyor observed Resident #88 sitting in their EX Order 26 § 4b1 in activities.

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted]

A review of the Physician's Progress Notes reflected no physician's progress notes for the year of 2021 to present. The last physician's progress note was dated 5/22/2020.

5. On 2/11/22 at 10:21 AM, the surveyor observed Resident #85 sitting in their EX Order 26 § 4b1

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted]

A review of the Physician's Progress Notes reflected that the resident was only seen by the

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physician on 3/10/21. There was no further documentation for 2021 or 2022.

6. On 2/11/22 at 11:22 AM, the surveyor observed Resident #52 in bed asleep.

A review of the Face Sheet reflected a re-admission to the facility in [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted].

A review of the most recent quarterly MDS dated 11/2/21, reflected that the resident had a BIMS score of EX Ord [redacted] out of [redacted] which indicated an EX Order 26 [redacted].

A review of the Physician's Progress Notes reflected the resident was seen from April 2021 until present on 8/6/21, 11/6/21, and 2/8/22. There was no documentation that in 2021, the resident was seen by the physician in April, May, June, July, September, October, or December.

On 2/17/22 at 10:39 AM, the surveyor interviewed the resident who stated that he/she could not recall the last time that they had seen their physician. The resident stated that he/she did not see the physician routinely.

7. On 2/11/22 at 11:28 AM, the surveyor observed Resident #146 sitting in their EX Order 26 § 4b1 in their room.

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included EX Order 26 § 4b1.

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A review of the most recent annual MDS dated 10/29/21, reflected that the resident had a BIMS score of [redacted] out of 15, which indicated a [redacted]

A review of the Physician's Progress Notes reflected that since April 2021, the resident saw the physician on 8/13/21, 11/10/21, and 2/8/22. There was no documentation that the resident was seen in 2021 by the physician in April, May, June, July, September, October, November, and December. There was no documentation that the resident was seen in January of 2022.

On 2/17/22 at 10:31 AM, the surveyor interviewed the resident who stated that he/she did not see the physician routinely.

8. On 2/11/22 at 11:20 AM, the surveyor observed Resident #145 sitting in their [redacted] in the hallway.

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted]

A review of the last completed quarterly MDS dated 7/25/21, reflected that the resident had a BIMS score of [redacted] out of [redacted], which indicated a [redacted].

A review of the Physician's Progress Notes from April 2021 until present, reflected that the resident was seen by the physician monthly until 7/9/21. There was no documentation that the resident was seen from August of 2021 until present.

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On 2/16/22 at 10:18 AM, the surveyor interviewed the resident who stated that he/she did not see the physician often; "if there is nothing wrong with me, do not see the doctor." The resident stated that he/she did not see the physician routinely, but they could ask to see the physician.

9. On 2/11/22 at 10:50 AM, the surveyor observed Resident #3 sitting in their EX Order 26 § 4b1 in their room.

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses that include EX Order 26 § 4b1 [redacted]

A review of the Physician's Progress Notes reflected that from April 2021 to present, the resident saw the physician on 8/13/21, 11/6/21, and 2/8/22. There was no documentation that the resident saw the physician in 2021 in April, May, June, July, September, October, and December. There was no documentation that the resident saw the physician in January of 2022.

10. On 2/11/22 at 10:26 AM, the surveyor observed Resident #13 outside EX Order 26 § 4b1 [redacted]

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted]

A review of the last completed quarterly MDS dated 9/16/21, reflected that the resident had a

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F 712	Continued From page 45 BIMS score of [redacted] out of [redacted], which indicated [redacted]. A review of the Physician's Progress Notes reflected the following dates the resident was seen: 6/8/21, 7/30/21, 11/5/21, 12/3/21 and 2/6/22. The resident was not seen in 2021 for the months of April, May, August, September, and October. On 2/14/22 at 10:30 AM, the surveyor interviewed the resident who stated that he/she had seen the physician recently due to [redacted] and a [redacted] 11. On 2/11/22 at 11:26 AM, the surveyor observed Resident #22 lying in bed. The resident was unable to be interviewed. A review of resident's Face Sheet reflected that the resident was re-admitted to the facility in [redacted] with diagnoses which reflected [redacted] A review of the last completed MDS dated 10/7/21, reflected that the resident had a [redacted] A review of the resident's Physician Progress Notes reflected that the resident was not seen by the physician from April 2021 through present times. The last documented physician visit was 2/26/21. 12. On 2/11/22 at 10:41 AM, the surveyor observed Resident #29 in bed asleep. A review of the resident's Face Sheet reflected that the resident was admitted to the facility in	F 712		

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[redacted] with diagnoses which included EX Order 26 § 4b1 [redacted]

A review of the last completed annual MDS dated 10/15/21, reflected that the resident had a BIMS score of a [redacted] out of [redacted] which indicated a [redacted]

A review of the Physician's Progress Notes reflected that the resident was seen not seen by the physician from April 2021 until present day. The last documented physician visit was 3/9/21.

On 2/17/22 at 10:04 AM, the surveyor observed the resident awake in bed. The surveyor interviewed the resident who stated that he/she saw Physician #1/Medical Director every couple of months.

13. On 2/11/22 at 12:09 PM, the surveyor observed Resident #31 sitting in the dining room waiting for lunch.

A review of the Face Sheet reflected that the resident was re-admitted to the facility in [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted]

A review of the last completed quarterly MDS dated 10/16/21, reflected that the resident had EX Order 26 § 4b1 [redacted]

A review of the Physician's Progress Notes reflected that the last time the resident was seen by the physician was 6/30/21.

14. On 2/11/22 at 11:57 AM, the surveyor

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OCEANA REHABILITATION & NURSING CENTER	**502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210**

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F 712	Continued From page 47 observed Resident #32 sitting in their [redacted] A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] A review of the last completed quarterly MDS dated 10/19/21, reflected that the resident had a BIMS score of [redacted] out [redacted], which indicated a [redacted] A review of the Physician's Progress Notes reflected that the last time the resident saw the physician was on 6/30/21. On 2/17/22 at 10:01 AM, the surveyor interviewed the resident who stated that he/she last saw the doctor two weeks ago. 15. On 2/11/22 at 11:44 AM, the surveyor observed Resident #69 lying in bed. The resident stated that he/she just returned from their [redacted] treatment; they go to [redacted] on [redacted]. A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] A review of the most recent quarterly MDS dated 12/11/21, reflected that the resident had a BIMS score of [redacted] out of [redacted], which indicated a [redacted] A review of the resident's Physician's Progress Notes reflected that the physician had not seen	F 712		

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the resident from April 2021 until present. The last documented physician visit was 2/18/21.

16. On 2/11/22 at 11:35 AM, the surveyor observed Resident #10 sitting in their room.

A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses that included [redacted].

A review of the last completed MDS dated 9/17/21, reflected a BIMS score of [redacted] out of [redacted] which reflected an [redacted].

A review of the Physician's Progress Notes from April 2021 until present reflected that the resident was seen in May, June, July, and August only. The was no documentation that the resident was seen by the physician in 2021 in April, September, October, November, and December. There was no documentation that the resident was seen by the physician in 2022.

On 2/17/22 at 11:46 AM, the surveyor interviewed the resident who stated that he/she saw Physician #1/Medical Director. The resident stated that they did not see the physician "often." The resident stated that last week Physician #1/Medical Director saw his/her roommate, so when the physician was walking out the room, he stopped by to say "hi." The resident stated they "tried to ask him about my teeth and my hip but he just walked out and didn't answer."

17. On 2/11/22 at 11:57 AM, the surveyor observed Resident #39 in their room. The resident stated that they were informed that their

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F 712	Continued From page 49 physician was coming to visit them tomorrow. A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses that included EX Order 26 § 4b1 [redacted]. A review of the most recent admission MDS dated 10/22/21, reflected that the resident had a BIMS score of [redacted] out of [redacted], which indicated a EX Order 26 § 4b1 [redacted]. A review of the Physician's Progress Notes from admission until present, reflected that the resident was seen by the physician on 10/13/21 and 11/6/21. There was no documentation that the resident was seen by the physician in December of 2021 or January of 2022. 18. On 2/11/22 at 11:46 AM, the surveyor observed Resident #79 lying in bed. A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted] A review of the Physician's Progress Notes reflected that from April 2021 until present, the resident was seen by the physician on 8/6/21 and 11/4/21. There was no documentation that the resident was seen by the physician in 2021 in April, May, June, July, September, October, and December. There was no documentation that the resident was seen by the physician in 2022. 19. On 2/11/22 at 10:30 AM, the surveyor observed Resident #83 lying in bed.	F 712		

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A review of the Face Sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses that included [redacted].

A review of the most recent annual MDS dated 12/26/21, reflected that the resident had a BIMS score of [redacted] out of [redacted], which indicated a [redacted].

A review of the Physician's Progress Notes from April 2021 until present reflected that the resident was seen by the physician on 8/13/21, 11/6/21, 11/10/21, and 2/8/22. There was no documentation that the resident was seen by the physician in 2021 in April, May, June, July, September, October, and December. There was no documentation that the resident was seen by the physician in January of 2022.

On 2/17/22 at 11:42 AM, the surveyor interviewed the resident who stated that last time he/she saw Physician #2 was before Thanksgiving in 2021. The resident stated that Physician #2 was their primary physician, and he did not see them monthly. The resident stated that he/she saw Physician #2 monthly walking the hallways, but he/she did not visit them monthly.

On 2/18/22 at 10:37 AM, the surveyor attempted to interview Physician #1/Medical Director on the telephone. A Receptionist answered the telephone who stated that Physician #1/Medical Director was on a medical leave and Physician #2 was covering his patients. The Receptionist stated that she would leave a message for one of the physicians to call back.

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F 712	Continued From page 51 On 2/18/22 at 11:21 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, stated that physicians were supposed to see every resident monthly. At this time, the LNHA acknowledged that there was no documentation that the above residents were seen monthly. On 2/18/22 at 12:23 PM, the surveyor interviewed Physician #1/Medical Director via telephone who stated that he was in the facility twice a week and saw "most" residents monthly. Physician #1/Medical Director stated that he made rounds with the nurses and talked to the residents to see if they had any concerns. Physician #1/Medical Director stated that he documented all his notes in the Physician's Progress Notes and was "behind" on progress notes. A review of the facility's "Physician Services" policy dated 12/2014, included hat physician visits will be conducted as required by state and federal guidelines, or based on resident's individual needs. NJAC 8:39-23.2 (d)	F 712		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		3/15/22

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F 755	Continued From page 52 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure Narcotic Shift Count logs were completed for accuracy and accountability and b.) ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 form) were completed with sufficient detail to enable accurate reconciliation. This deficient practice was identified on 1 of 2 medication carts (High cart West Unit) observed and for 3 of 5 provided DEA forms. The evidence was as follows: 1. On 2/15/22 at 12:06 AM, the surveyor in the	F 755	1. No negative outcome occurred from this practice. 2 - A. A complete audit of all narcotic shift logs was performed by the DON on 2/21/22. B. Pharmacy representative re-educated DON on 2/22/22 on proper way to fill out DEA 222 forms 3 - A. On 2/21/22 the DON re-educated the staff nurses regarding signing the narcotic shift log after counting narcotics with the off going and/ or incoming nurse.	

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F 755	Continued From page 53 presence of the Licensed Practical Nurse (LPN) inspected the High medication cart on West unit. A review of the facility's "EX Order 26 § 4b1 [redacted]" ([redacted]) for February 2022 reflected on 24 of 87 occasions the log was not completed properly and were as follows: The incoming nurse or outgoing nurse did not endorse the total number of controlled medications on the following dates: 2/1/22, 2/2/22, 2/3/22, 2/6/22, 2/8/22, 2/9/22, 2/12/22, 2/13/22 and 2/14/22. The incoming or outgoing nurse did not sign their signature that the controlled medication count was completed on the following dates: 2/7/22, 2/9/22, 2/13/22, and 2/14/22. At that same time, the LPN confirmed that there should be no blanks on the controlled medication accountability count sheet. She stated that we counted the number of bingo cards, at shift change, and verified counts were correct, and then both nurses signed the log. The LPN stated that the medication count should be checked to ensure there were no discrepancies or diversion, and to ensure nothing was missing. On 2/17/22 at 2:47 PM, the surveyor and the Director of Nursing (DON) reviewed the Controlled Medication Accountability Count sheet for February 2022. The DON stated that the log sheet was used on change of shift when the nurses counted the narcotics. The nurse coming on and the one going out counted together; the on coming nurse counted the number of cards present and the outgoing checked the declining sheets. The DON acknowledged the blanks on	F 755	Audits beginning 2/22/22 will be weekly for the first 4 weeks, then every 2 months for the next 2 months then monthly for 2 months after that. B. On 2/22/22 the Administrator re-educated the DON on importance of filling out narcotic DEA 222 with accuracy. The Administrator will audit DEA 222 forms prior to sending to the pharmacy for the next 3 months to ensure accuracy. 4.All audits will be review by Administrator, DON and/or designee to ensure timely compliance monthly per the audit timeframes listed in action #3 beginning on 2/21/22. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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the log and stated that there should have been no blanks on the log, because the log was used to ensure the controlled medication count was correct and a double count was a way to prevent diversion.

2. On 2/15/22 at 12:47 AM, the surveyor reviewed the facility's DEA 222 forms which revealed that the facility did not complete Part 5, the number of packages received or the date the medication was received as instructed to on the reverse of the DEA 222 form. The inaccuracies were as follows:

Order Form:

#203549072, No number received, No date received.
#201611427, No number received, No date received.
#203460170, No number received, No date received.

On 2/17/22 at 2:52 PM, the surveyor interviewed the DON who stated that one of the responsibilities of the DON was to complete the DEA 222 forms. The DON stated she was aware that Part 5 of the form was to be completed when the facility received the medications from the provider pharmacy; that she was new to the facility and the omission had occurred prior to her becoming the facility DON. Upon review, the DON acknowledged the previous DON had not completed that portion of the form that indicated when the facility had received the narcotic mediations and that he/she should have filled in the quantity received as well as the date the medication was received.

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F 755	Continued From page 55 A review of the instructions for submission of the DEA 222 form included ...e. The purchaser must record on its copy of the DEA Form 222 the number of commercial or bulk containers furnished on each item and the dates on which the containers are received by the purchaser... NJAC 8:39-29.7(c)	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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:	F 761		3/15/22

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F 761	Continued From page 56 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a.) label and date opened insulin pens and b.) dispose of controlled medications for a deceased resident. This deficient practice was identified in 1 of 2 medication carts (High cart West unit) and 1 of 1 medication refrigerators inspected and was evidenced by the following: On 2/15/22 at 11:48 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #1) inspected the High cart on the West unit. Located in the top drawer were four insulin pens, for three unsampled residents, each in a clear zip top bag. Three of the four insulin pens were either opened and undated or opened and not labeled with the resident's name as follows: 1. Insulin lispro pen, opened and undated, the bag was dated 2/14/22. There was no date on the pen, and no resident name labeled on the pen. 2. Insulin lispro pen, opened and undated, the bag was dated 2/6/22. The pen was labeled with the resident's name but was not dated. 3. Insulin glargine pen, opened and not labeled. There was no pharmacy label on the zip top bag and instead written in red marker was a resident's name and dated 2/4/22. The pen was dated but had no resident name label. On 2/15/22 at 12:06 PM, the surveyor interviewed LPN #1 who stated that when we needed a new insulin pen, the nurse removed the insulin pen from the refrigerator and dated it with the date it was opened, the insulin pen was then placed into	F 761	1 - A. No resident had negative outcomes occurring from this practice. All insulin pens were discarded properly, and new insulin pens were ordered sent from the Pharmacy STAT delivery. B. No resident had negative outcomes occurring from the practice. Both bottles of Lorazepam were discarded properly. 2 - A. A complete audit of all insulin pens in the facility was conducted by the DON on 2/22/22 no other insulin pens were found to be unlabeled or undated. B. A complete audit of all medications stored in the medication refrigerator was performed by the DON on 2/22/22 and no findings of undated, unlabeled or discontinued medication was found. 3 - A. On 2/22/22 the DON re-educated the nursing staff that all insulin pens should be labeled by the pharmacy and dated when opened, the same date should also be documented on the bag the pen is stored in as well. Audits will continue by the DON and/or assigned designee on all units starting on 2/22/22. These audits will be weekly for 4 weeks, then twice a month for 2 months then monthly for 2 months B. On 2/22/22 the DON re-educated the nursing staff that all medications stored in the medication refrigerator should be labeled, dated when opened and discarded properly when discontinued. Audits will continue by the DON and/or	

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F 761	Continued From page 57 the bag. The insulin pen and bag should both be labeled with the resident's name and dated when opened. On 2/17/22 at 11:59 AM, the surveyor in the presence of LPN #2 inspected the East unit medication room and made the following observations: At 12:09 PM, LPN #2 opened the locked narcotic box in the medication room refrigerator and found two boxes of lorazepam oral concentrate (controlled substance) for an unsampled resident. One bottle was opened and undated. A second box was unopened with safety tamper seal attached. LPN #2 stated that the resident had passed away some time ago and the nursing staff was supposed to remove medications from active stock when a resident was deceased, or the mediation was discontinued and gave to the Director of Nursing (DON) to destroy. On 2/17/22 at 2:47 PM, the survey team met with the DON who stated that insulin pens came labeled from the pharmacy and were stored in the refrigerator until needed. When needed, we dated the pen and the bag with the date the pen was opened and removed from the refrigerator. The DON then stated that the process for when a resident was no longer taking a controlled medication was that the nurse first ensured there was a discontinuation order from the physician, then the nurse removed the narcotic from active inventory and gathered the corresponding declining inventory sheets. Once that was done, the nurse brought the medication and paperwork to me and with a witness, we destroyed it using the drug buster. The DON acknowledged the lorazepam liquid medications should have been	F 761	assigned designee on all medication refrigerators on 2/22/22. 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 review 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 2/22/22. These audits will be reviewed at the quarterly QA meetings for recommendations and/or feedback, who will review and determine frequency and necessity for future audits. The Administrator and DON will be responsible for implementing this plan of correction.	

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F 761	Continued From page 58 removed from active inventory and destroyed. The process was the same if a resident was deceased. A review of facility's "Medication Storage" policy with an implementation date of 11/5/21, included ...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... NJAC 8:39-29 (f)(h)	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		3/15/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEANA REHABILITATION & NURSING CENTER	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 59 by: Based on observation and interview, it was determined that the facility failed to a.) maintain kitchen equipment in a manner to prevent microbial growth and b.) label and date potentially hazardous food to prevent foodborne illness. This deficient practice was identified by the following: On 2/11/22 at 10:03 AM, the surveyor interviewed the Dietary Director (DD) who stated that she just started the job yesterday after the previous food service director resigned. At this time, the surveyor and the DD conducted a kitchen tour and observed the following: 1. In dry storage, one sugar bin with the scoop stored directly in the sugar. The DD confirmed the scoop should not be in the sugar. 2. In dry storage, opened graham crackers were on the floor. The DD acknowledged the area needed to be cleaned. 3. In reach-in refrigerator, one opened quart of lactaid milk. The milk had a manufacturer's expiration date of 2/22/22, but no labeled date when opened. The DD stated that milk should be discard after being opened for two days. 4. The steamer gasket was worn. The DD confirmed the gasket needed to be replaced. 5. There were one large green, red, brown, and light blue colored cutting boards that were pitted and discolored. There was one large blue cutting board pitted and discolored a yellowish/brown color. The DD confirmed these cutting boards all needed to be replaced because bacteria could	F 812	1. The sugar, graham crackers, lactaid milk were discarded. The steamer gasket was replaced with a new gasket. Cutting boards were discarded and replaced with new cutting boards. The milk refrigerator was defrosted and cleaned. The can opener base was cleaned, and the can opener and blade were replaced with a new can opener and blade. 2. All residents have the potential to be affected by this practice. 3. Administrator and food service director reviewed and was in serviced on regulation 483.60 - food safety requirements. An in-service was given to all dietary staff on Food procurement, store, prepare, serve sanitary and food safety requirements. 4. Administrator/designee will conduct daily audits for one month and weekly audits for 3 months to ensure compliance and submit reports to the administrator. Reports of audits will be presented to Quality assurance committee who meet quarterly who will review and determine frequency and necessity for future audits.	

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F 812	Continued From page 60 grow in the pits. 6. In the milk refrigerator, a large accumulation of ice buildup on the walls. The DD confirmed the refrigerator need to be defrosted and cleaned. 7. One can opener, the blade was covered in a thick black debris with a white thread-like material attached to it. The can opened base attached to the cook prep table appeared greasy with black debris. The DD confirmed that the can opener needed to be cleaned. On 2/18/22 on 11:21 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) and survey team, acknowledged these findings. A review of the facility's "Food Storage" policy dated 3/14/14, included to ensure that all food served by the facility is of excellent quality and safe for consumption, all food will be stored according to current Federal and State Food Code...provide scoops for items stored in bins, such as sugar, flour, rice, and other items. Store scoops covered in a protected area near the scoops... Date, label and tightly seal all refrigerated foods, including leftovers, using clean, nonabsorbent, covered containers that are approved for food storage. All items should include name of item and a use-by date. NJAC 8:39-17.2 (g)	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060503	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY 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: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 24 out of 42 shifts reviewed. 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	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 will use agency staff when there is a need 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.	3/15/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/06/22

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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, 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 Certified Nurse Aide (CNA) to every eight residents for the day shift. One 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 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. During entrance conference on 2/11/22 at 10:45 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the MDS Coordinator and the Assistant Administrator, informed the surveyor that the facility staff varied depending on the time. The LNHA stated that the facility used contracted Agency staff to help with shortages as well as hiring new staff. As per the "Nurse Staffing Report" completed by the facility for the weeks of 1/23/22 to 1/29/22 and 1/30/22 to 2/5/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift and 1 direct care staff to 14 residents for the overnight shift as documented below: 1/23/22 had 11 CNAs for 108 residents on the	S 560	4. The DON or designee will conduct monthly audits of the staffing patterns and ratios and report findings to the Administrator. In addition, the DON/designee will notify the results to the QA committee monthly for action as appropriate.	

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	060503	A. BUILDING: _____ B. WING _____	02/18/2022

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S 560	Continued From page 2	S 560		

day shift, required 14 CNAs.
1/23/22 had 6 total staff for 108 residents on the overnight shift, required 8 total staff.
1/24/22 had 10 CNAs for 107 residents on the day shift, required 14 CNAs.
1/24/22 had 6 total staff for 107 residents on the overnight shift, required 8 total staff.
1/25/22 had 10 CNAs for 107 residents on the day shift, required 14 CNAs.
1/25/22 had 6 total staff for 107 residents on the overnight shift, required 8 total staff.
1/26/22 had 6 total staff for 107 residents on the overnight shift, required 8 total staff.
1/27/22 had 13 CNAs for 107 residents on the day shift, required 14 CNAs.
1/27/22 had 6 total staff for 107 residents on the overnight shift, required 8 total staff.
1/28/22 had 6 total staff for 107 residents on the overnight shift, required 8 total staff.
1/29/22 had 11 CNAs for 107 residents on the day shift, required 14 CNAs.
1/29/22 had 6 total staff for 107 residents on the overnight shift, required 8 total staff.
1/30/22 had 10 CNAs for 106 residents on the day shift, required 14 CNAs.
1/30/22 had 6 total staff for 106 residents on the overnight shift, required 8 total staff.
1/31/22 had 12 CNAs for 105 residents on the day shift, required 14 CNAs.
1/31/22 had 7 total staff for 105 residents on the overnight shift, required 8 total staff.
2/1/22 had 6 total staff for 105 residents on the overnight shift, required 8 total staff.
2/2/22 had 6 total staff for 106 residents on the overnight shift, required 8 total staff.
2/3/22 had 12 CNAs for 102 residents on the day shift, required 13 CNAs.
2/3/22 had 6 total staff for 102 residents on the overnight shift, required 8 total staff.
2/4/22 had 10 CNAs for 102 residents on the day

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S 560	Continued From page 3 shift, required 13 CNAs. 2/4/22 had 6 total staff for 102 residents on the overnight shift, required 8 total staff. 2/5/22 had 10 CNAs for 101 residents on the day shift, required 13 CNAs. 2/5/22 had 6 total staff for 101 residents on the overnight shift, required 8 total staff. NJAC 8:39-5.1(a)	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	5/18/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEANA REHABILITATION & NURSING CENTER	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 F0636	Correction	ID Prefix F0638	Correction	ID Prefix F0656	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.20(c)	Completed	Reg. # 483.21(b)(1)	Completed
LSC	03/31/2022	LSC	03/31/2022	LSC	03/15/2022
ID Prefix F0689	Correction	ID Prefix F0690	Correction	ID Prefix F0695	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	03/15/2022	LSC	03/15/2022	LSC	03/15/2022
ID Prefix F0698	Correction	ID Prefix F0712	Correction	ID Prefix F0755	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	03/15/2022	LSC	03/15/2022	LSC	03/15/2022
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	03/15/2022	LSC	03/15/2022	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?
2/18/2022	☐ YES ☐ NO

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	315193	A. BUILDING **01** B. WING _____	**02/18/2022**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 2/18/2022 and Oceana Rehabilitation and Healthcare 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 Occupancies. Oceana Rehabilitation and Healthcare is a single (1) story, Type II Protected building that was built in January 1990. The facility is divided into 6 smoke zones.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches	K 321		3/15/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/06/2022

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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K 321	Continued From page 1 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 02/18/2022, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing and shall be separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in 1 of 6 hazardous locations and the evidence was as follows: Starting at 9:16 AM, in the presence of the facility's Director of Maintenance (DOM) a tour of the building was conducted. Along the tour at 11:00 AM, an inspection of the Medical Records storage room was performed. The surveyor observed that the 3/4 hour fire rated corridor door	K 321	1. The door to the medical records storage room had the closing device on the door fixed and reconnected, the door now has the ability to self-close. 2. All residents have the potential to be affected by the deficient practice. 3. Maintenance director will conduct weekly audits for three months to ensure all doors are properly connected. 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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K 321	Continued From page 2 had no means to self-close. The surveyor observed that the door's automatic door closure had been disconnected. The door did not self-close into its frame as required by code. The surveyor observed inside the room 53 banker size boxes and six boxes three feet by twelve inches by eleven inches (3' x 12" x 11") filled with combustible paper medical records files. At this time, the surveyor measured and recorded the "L" shaped room. The room measured 12'-4" by 7'-4" (90.3789 square feet) and 3' by 3'-6" (10.5 square feet). The total measurement of the room is 100.879 square feet, which was larger than 50 square feet. A review of an evacuation diagram posted in the area, identified this room was in the primary exit access path to reach an exit. This condition would allow fire, smoke and poisonous gases to pass from the Medical Records room into the exit access corridor in the event of a fire. The findings were verified and confirmed by the DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 02/18/2022 at 12:55 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		3/15/22

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K 341	Continued From page 3 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/18/2022, it was determined that the facility failed to provide notification by audible and visible signals for 3 of 3 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 02/18/2022 starting at 9:16 AM, with the facility's Director of Maintenance (DOM), a tour of the facility was conducted. During the tour, the surveyor observed no evidence of an audio and visual (horn and strobe) alarm connected the buildings fire alarm and detection system to notify residents in the event of an fire alarm going on in	K 341	1. We had a company add three new horn / strobe in the three courtyards. The work was completed on 3/15/22. 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 4. Administrator/designee will conduct weekly audits for 3 months to ensure compliance. Reports of audits will be presented to the Quality assurance committee who meet quarterly who will review and determine frequency and necessity for future audits.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEANA REHABILITATION & NURSING CENTER	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 4 the following locations: 1. At 9:42 AM, the surveyor observed no evidence of a horn and strobe in the enclosed outside West Wing resident outside gated patio area. At this time, the surveyor asked the DOM, do you have an audio and visual alarm for the fire alarm system out here? The DOM looked around and said, "no". 2. At 10:04 AM, the surveyor observed no evidence of a horn and strobe in the outside enclosed center courtyard. 3. At 10:46 AM, the surveyor observed no evidence of a horn and strobe in the outside enclosed [redacted] resident smoking area The findings were verified and confirmed by the DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 02/18/2022 at 12:55 PM.	K 341		
K 363 SS=D	NJAC 8:39-31.2(a) Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors	K 363		3/15/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING **01** B. WING _____	**02/18/2022**

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K 363	Continued From page 5 to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/18/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was observed in 1 of 81 resident room/storage/office corridor doors and was evidenced by the following:	K 363	1. The corridor door leading into the kitchen has been replaced with a new door and now fully closes into its frame. 2. All residents have the potential to be affected by the deficient practice. 3. Administrator and maintenance director reviewed and was in serviced on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING **01** B. WING _____	**02/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEANA REHABILITATION & NURSING CENTER	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 6 Starting at 9:16 AM, in the presence of the facility's Director of Maintenance (DOM), a tour of the building was conducted. Along the tour at 10:22 AM, an inspection of the main kitchen was performed. The surveyor observed that the corridor door leading into the kitchen was not fully closed into its frame. The surveyor recorded measurements of the opening. There was a two and a quarter inch(2-1/4") gap between the corridor door and the doors frame. At this time, the DOM informed the surveyor that when the kitchen hood exhaust system was running, it drew air in from the corridor into the kitchen. When the exhaust system was shut off, the door closed. Room doors with gaps larger than 1/8 of an inch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This would allow fire, smoke and poisonous gasses to pass into the exit access corridor in the event of a fire. The findings were verified and confirmed by the DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code exit conference on 02/18/2022 at 12:55 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	regulation NFPA, 101 Corridor - Doors 4. Administrator/designee will conduct weekly audits for 3 months to ensure compliance. Reports of audits will be presented to the Quality assurance committee who meet quarterly who will review and determine frequency and necessity for future audits.	

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	5/18/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEANA REHABILITATION & NURSING CENTER	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 K0321	Correction Completed 03/15/2022	ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 03/15/2022	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 03/15/2022
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
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	
2/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO