PRINTED: 07/09/2019 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		315193	B. WING _			06/13/2019
	ROVIDER OR SUPPLIER REHABILITATION AND N	С	•	STREET ADDRESS, CITY, STATE, ZIP CO 502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08		
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F 000	INITIAL COMMENTS		F 0	00		
	STANDARD SURVE	Y 06/13/19				
	CENSUS: 107					
	SAMPLE: 23 + 32 + 3	CLOSED RECORDS				
		ubstantial compliance with 2 CFR Part 483, Subpart B, ilities.				
F 636 SS=D	Comprehensive Asse CFR(s): 483.20(b)(1)(	<u> </u>	F6	36		7/5/19
	a comprehensive, acc	luct initially and periodically				
	A facility must make a assessment of a resic goals, life history and resident assessment by CMS. The assess the following: (i) Identification and di) Customary routine (ii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavior (vii) Psychological we (viii) Physical function (ix) Continence.	ent Assessment Instrument. In comprehensive Ident's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least emographic information				
ARORATORY	. ,	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE		(X6) DATE

Electronically Signed 06/26/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 636	(xvi) Discharge plar (xvii) Documentatio regarding the addition the care areas to the Minimum Data (xviii) Documentatio assessment. The a include direct obserwith the resident, as licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribed through (iii) of this sprescribed in §413. apply to CAHs. (i) Within 14 calend excluding readmiss significant change is mental condition. (For "readmission" mear following a temporar or therapeutic leaver (iii) Not less than on This REQUIREMENT.	ents and procedures.  Ining. In of summary information In onal assessment performed Iniggered by the completion of In of participation in Inssessment process must Invation and communication Inssessment process must Invation and communication with Instead direct care staff Intition In required. Subject to the Inseed direct care staff Intition In required in §413.343(b) of this Insust conduct a comprehensive Insident in accordance with the India in paragraphs (b)(2)(i) Insection. The timeframes Insust conduct a comprehensive Insident in accordance with the India in paragraphs (b)(2)(i) Insection. The timeframes Insustration In the resident's physical or Interproperse of this section, Insus a return to the facility Insustration Insustratio	F 6	1) The MDS for residents #13, #1	9, and
	Annual Minimum Da federally mandated	facility failed to complete the ata Set (MDS), a periodic and , standardized assessment ired time frame. This deficient		<ul><li>#21 were completed.</li><li>2) All residents have the potentia affected by the deficient practice.</li></ul>	I to be

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F 636	(Resident #13, 19, ar comprehensive assess by the following:  The Centers For Med Resident Assessmen 3.0 Manual classified Back) Period as the tresident's condition oby the MDS. The Ass (ARD) referred to the (or "look back") period covered for the reside are required to complete are required to complete assessment for each days after admission a significant change in not less than once everesident, where 12 m within 366 days.  1. The electronic heat that an Annual Minimassessment tool for eresident with an asse (ARD) of the complete design of the complete design.	d for 3 of 55 residents and 21) reviewed for esements and was evidenced dicare and Medicaid (CMS) t Instrument (RAI) Version the Observation (Look time period over which the r status was to be captured essment Reference Date last day of the observation d that the assessment ent. At a minimum, facilities	F 63		s in-serviced completing DS coordinator lar to DON for DON and weekly to: 1) into and l assessment w MDS ess in the ind MDS tial calendar le after ed.  MDS calendar with the so for three ents are indar with the completion is will be uality			
	EHR reflected that the completed until  3. The EHR identified	#13. When reviewed, the e Annual MDS had not been  . I that an Annual MDS, with as due to be completed by						

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F 636		e 3 #21. When reviewed, the e Annual MDS had not been	F	636			
F 638 SS=E	and approved by CMs once every 3 months. This REQUIREMENT by: Based on interview a determined that the fa Quarterly Minimum D and federally mandata assessment tool, with as required.  This deficient practice residents (Residents #15, #53, #16, #36, ##10, #18, #27, #6, #2 #4, #20, and #30), which were reviewed and with following:  The Centers For Med Resident Assessment 3.0 Manual classified Back) Period as the tiresident's condition of	Review Assessment a resident using the ument specified by the State S not less frequently than is not met as evidenced and record review it was acility failed to complete the ata Set (MDS), a periodic ed, standardized in the specified timeframe e was identified for 29 of 55 #13, #21, #8, #17, #50, #34, 33, #1, #26, #9, #35, #25, 9, #19, #14, #28, #7, #12, nose MDS assessments	F	538	1) MDS for residents #13, #21, #8, #17, #50, #34, #15, , #53, #16, #36, #33, #726, #9, #35, #25, #10, #18, #27, #6, #19, #28, #7, #12, #4, #20, and #30 we completed. Resident #14 was discharger from the facility on 2/21/19 and was removed from the Sigmacare system.  2) All residents have the potential to be affected by the deficient practice. An audit was done and all MDS are current up to date.  3) The MDS coordinator was in-service on required time frames for completing quarterly MDS. The MDS coordinator was understand to DON for assessment due routinely. DON and MDS coordinator will meet weekly to: Review status of assessments and communicate any additional assessment.	7, 1, 1, 129, ere ged httly	7/5/19

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F 638	(or "look back") period covered for the reside assessment was con Assessment Referent Quarterly MDS was of the previous MDS was no later than 14 On 6/13/19 11:49 AM following:  1. The Electronic Heath that a Quarterly Minimal Assessment Reference was due to be computed was due to be computed in the for Resident EHR reflected that the been completed until the sen c	e last day of the observation of that the assessment lent. The Quarterly insidered timely if 1). The ince Date (ARD) of the within 92 days after the ARD and; 2). the completion date days after the ARD.  If the surveyors reviewed the days after the ARD, with example of the completed length of the example of the completed length of the example of the completed length of the example of the example of the completed length of the example of t	F 638	added to the calendar; 2) Reviet assessments for completeness Sigmacare system; 3) Review the discharged residents are remove the Sigmacare system. DON a coordinator will date and initial calendar next to each assessmafter verifying that it was completed.  4) The DON will review the MD and Sigmacare dashboard with Administrator every 2 weeks for months to check assessments a completed timely. The calenda ARD dates along with the completes for MDS assessments will reviewed quarterly at the Qualit Assurance Meeting for 2 quarters.	in the hat red from and MDS on the ent due eted.  S calendar the three are r with the oletion I be		

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F 638	for Resident EHR reflected that to been completed unt  6. The EHR identifican ARD of for Resident EHR reflected that to been completed unt  7. The EHR identifican ARD of for Resident EHR reflected that to been completed unt  8. The EHR identifican ARD of for Resident EHR reflected that to been completed unt  9. The EHR identifican ARD of for Resident EHR reflected that to been completed unt  10. The EHR identifican ARD of for Resident EHR reflected that to been completed unt  10. The EHR identifican ARD of for Resident EHR reflected that to been completed unt  11. The EHR identifican ARD of for Resident Felected that the Quickless of the Completed until	was due to be completed by #15. When reviewed, the he Quarterly MDS had not ill  ed that a Quarterly MDS, with was due to be completed by the Hamiltonian and the Quarterly MDS had not ill  ed that a Quarterly MDS, with was due to be completed by #16. When reviewed, the he Quarterly MDS had not ill  ed that a Quarterly MDS, with was due to be completed by the Hamiltonian and the Quarterly MDS had not ill  ed that a Quarterly MDS, with was due to be completed by #33. When reviewed, the he Quarterly MDS had not ill  ed that a Quarterly MDS, with was due to be completed by #33. When reviewed, the he Quarterly MDS had not ill  ed that a Quarterly MDS, with was due to be completed by #11. When reviewed, the EHR was due to be completed by #11. When reviewed, the EHR was due to be completed by #11. When reviewed, the EHR was due to be completed by #11. When reviewed, the EHR was due to be completed by #12. When reviewed, the EHR was due to be completed by #13. When reviewed, the EHR was due to be completed by #14. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When reviewed, the EHR was due to be completed by #15. When revie	F	538		
	for Residen	was due to be completed by t #26. When reviewed, the he Quarterly MDS had not				

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F 638	been completed until  12. The EHR identified MDS, with an ARD of completed by reviewed, the EHR reflected that the been completed until  13. The EHR identified an ARD of graph of grap	ed that a modified Quarterly , was due to be for Resident #9. When effected that the Quarterly completed until  ed that a Quarterly MDS, with as due to be completed by #35. When reviewed, the e Quarterly MDS had not  ed that a Quarterly MDS, with as due to be completed by #25. When reviewed, the e Quarterly MDS had not  ed that a Quarterly MDS, with as due to be completed by 10. When reviewed, the e Quarterly MDS had not  ed that a Quarterly MDS, with as due to be completed by 18. When reviewed, the e Quarterly MDS had not  ed that a Quarterly MDS, with as due to be completed by 18. When reviewed, the e Quarterly MDS had not  ed that a Quarterly MDS, with as due to be completed by 18. When reviewed, the e Quarterly MDS had not  ed that a Quarterly MDS, with as due to be completed by #27. When reviewed, the e Quarterly MDS had not	F 6	38		

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F 638	an ARD of ware for Resident and ARD of for Resident for R	ed that a Quarterly MDS, with was due to be completed by the ed that a Quarterly MDS had not yet been the ed that a Quarterly MDS had not yet the ed that a Quarterly MDS, with was due to be completed by the ed that a Quarterly MDS, with was due to be completed by the ed that a Quarterly MDS, with was due to be completed by the ed that a Quarterly MDS, with was due to be completed by the ed that a Quarterly MDS had not yet the ed that a Quarterly MDS, with was due to be completed by the ed that a Quarterly MDS, with the ed that a Quarterly MDS, with the ed that a Quarterly MDS, with each to be completed by the ed that a Quarterly MDS had not yet	F 63	8		

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F 638	an ARD of for Resident; EHR reflected that the been completed until 26. The EHR identifies an ARD of for Resident; FHR reflected that the been completed until In an interview on 6/1 Coordinator stated the "got behind" due to as she returned she was MDS Coordinator also having difficulty transitivell.	d that a Quarterly MDS, with le to be completed by #20. When reviewed, the e Quarterly MDS had not yet  d that a Quarterly MDS, with less due to be completed by #30. When reviewed, the e Quarterly MDS had not yet	F	338			
	attesting that each wa	g stated that she was ff on every assessment, as complete, however, n as to why they were not					
F 640 SS=E	NJAC 8:39-11.1 Encoding/Transmitting CFR(s): 483.20(f)(1)-	g Resident Assessments (4)	F	640			7/5/19
	a facility completes a	d data processing  ng data. Within 7 days after resident's assessment, a he following information for					

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F 640	(iv) Quarterly reviews (v) A subset of items reentry, discharge, and (vi) Background (face is no admission asses §483.20(f)(2) Transmafter a facility comple a facility must be caped CMS System information contained in the MDS standard record layout and that passes standard record layout and the State.  §483.20(f)(3) Transmart days after a facility encoded, accurate, at the CMS System, incompletely contained in the CMS system, incompletely significant correct (v) Significant correct (v) Significant correct assessment.  (vi) Quarterly review.  (vii) A subset of items reentry, discharge, and (viii) Background (faccinitial transmission of does not have an administration.	ment. Int updates. Int updates. Int updates. Int updates. Int updates. Int updates. Int upon a resident's transfer, Ind death. Interessment. I	F 64			

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F 640	Continued From page	÷ 10	F 64	0			
	transmit data in the for a State which has by CMS, in the forma approved by CMS. This REQUIREMENT by: Based on interview a determined that the fatransmit the Minimum and federally mandat assessment tool, as respectively.	ormat specified by CMS or, an alternate RAI approved to specified by the State and is not met as evidenced and record review it was acility failed to electronically a Data Set (MDS) a periodic ed, standardized equired.		1) MDS for residents #13, #21 #50, #34, #15, #53, #16, #36, # #25, #10, #18, #27, #19, #12, # were completed and submitted #14 was discharged from the fa	#26, #35, #4, and #20 I. Resident		
	residents (Residents #34, #15, #53, #16, # #27, #19, #14, #12, #	e was identified for 21 of 55 #13, ##21, #8, #17, #50, 36, #26, #35, #25, #10, #18, 4, and #20), whose MDS viewed and were evidenced		2) All residents have the poten affected by the deficient practic audit was done and all MDS we completed and submitted.  3) The MDS coordinator was in	ce. An ere		
	Resident Assessment 3.0 Manual classified Back) Period as the tiresident's condition of by the MDS. The Asses (ARD) referred to the (or "look back") period covered for the resident assessment was consumed assessment Reference Quarterly MDS was word the previous MDS.	sidered timely if 1). The ce Date (ARD) of the vithin 92 days after the ARD and; 2). the completion date		on required time frames for MD encoding/transmissions. The Note coordinator will submit monthly to DON for assessments due not DON and MDS coordinator will weekly to review status of assessand communicate any addition assessments added to the cale MDS assessments will be reviet timely transmission of assessments Sigmacare system. Sigmacare updated to reflect discharged remaining transmission of assessments will be reviet timely transmission of assessments.	OS MDS recalendar outinely. I meet essments al endar. ewed for nents in the e will be essidents.		
	Manual also specified were required to be ethe Quality Improvem	days after the ARD. The I that MDS assessments I tectronically transmitted to ent Evaluation System Submission and Processing In 14 days of the final		4) The DON will review the MD and Sigmacare dashboard with Administrator every 2 weeks for months to check for accuracy a ensure assessments are encoded/transmitted timely. To with the ARD dates along with	n the or three and to he calendar		

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F 640	1. The Electronic Heathat a Quarterly Minin Assessment Referendue to be completed When reviewed, the Quarterly MDS had regular and ARD of Some of the Resident EHR reflected that the been completed until EHR revealed that the submitted to the appropriate and ARD of Some of the Resident EHR reflected that the submitted to the appropriate and ARD of Some of the Resident EHR reflected that the submitted to the appropriate and ARD of Some of the Resident EHR reflected that the submitted to the appropriate and ARD of Some of the Resident EHR revealed that the submitted to the appropriate and Assessment Reference of the Reflected that the submitted to the appropriate and Assessment Reference of the Reflected that the submitted to the appropriate and Assessment Reference of the Referen	At the surveyors reviewed the alth Record (EHR) identified mum Data Set (MDS) with an ace Date (ARD) of was by for Resident #8.  EHR reflected that the not been completed until the EHR revealed that the ubmitted to the appropriate es as required.  In addition, the le MDS had not been repriate government ed.  In addition, the le Quarterly MDS with as due to be completed by #17. When reviewed, the le Quarterly MDS had not le MDS had not been repriate government ed.  In addition, the le Quarterly MDS with as due to be completed by #50. When reviewed, the le Quarterly MDS had not le MDS had not been repriate government ed.	F6	completion dates of transrassessments will be review the Quality Assurance Mediguarters.	wed quarterly at		

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F 640	that an Annual Minin Assessment Referer was due to be comp #13. When reviewed Annual MDS had no In addition, MDS had not been s government authorit  6. The EHR identifie ARD of was for Resident EHR reflected that th completed until revealed that the MD	ries as required.  realth Record (EHR) identified for the proof of the	F 64	0				
	an ARD of for Resident at EHR reflected that the been completed until EHR revealed that the submitted to the approximation and ARD of for Resident EHR reflected that the been completed until EHR revealed that the	ed that a Quarterly MDS, with as due to be completed by #53. When reviewed, the ne Quarterly MDS had not I I I I I I I I I I I I I I I I I I I						

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		315193	B. WING _			06/13/2019		
NAME OF PROVIDER OR SUPPLIER  OCEANA REHABILITATION AND NC				STREET ADDRESS, CITY, STATE, ZIP C 502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ	ODE	1 33.10.20.10		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 640	an ARD of for Resident # EHR reflected that the been completed until EHR revealed that the submitted to the appropriate and ARD of for Resident EHR reflected that the submitted to the appropriate and ARD of for Resident EHR reflected that the been completed until EHR revealed that the been completed until EHR reflected that the been completed until EHR revealed that the been completed until EHR revealed that the been completed until EHR revealed that the submitted to the appropriate and ARD of for Resident EHR reflected that the been completed until EHR revealed that the submitted to the appropriate authorities as required authorities as requ	d that a Quarterly MDS, with ras due to be completed by 16. When reviewed, the e Quarterly MDS had not In addition, the e MDS had not been opriate government d.  ed that a Quarterly MDS, , was due to be completed ent #36. When reviewed, the e Quarterly MDS had not In addition, the e MDS had not been opriate government d.  ed that a Quarterly MDS, with ras due to be completed by #26. When reviewed, the e Quarterly MDS had not In addition, the e MDS had not been opriate government d.  ed that a Quarterly MDS, with ras due to be completed by #35. When reviewed, the e Quarterly MDS had not In addition, the e MDS had not been opriate government d.  ed that a Quarterly MDS, with as due to be completed by #35. When reviewed, the e Quarterly MDS had not In addition, the e MDS had not been opriate government d.	F6	540				
		ed that a Quarterly MDS, with vas due to be completed by						

		IDENTIFICATION NUMBER		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		315193	B. WING _			06/13/2019		
NAME OF PROVIDER OR SUPPLIER  OCEANA REHABILITATION AND NC			,	STREET ADDRESS, CITY, STATE, ZIP CO 502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 0	DDE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 640	EHR reflected that the been completed until EHR revealed that the submitted to the appropriate and ARD of for Resident for	#25. When reviewed, the ne Quarterly MDS had not I In addition, the ne MDS had not been ropriate government ed.  ed that a Quarterly MDS, with was due to be completed by #10. When reviewed, the ne Quarterly MDS had not I In addition, the ne MDS had not been ropriate government ed.  ed that a Quarterly MDS, with was due to be completed by #18. When reviewed, the ne Quarterly MDS had not I In addition, the ne MDS had not been ropriate government ed.  ed that a Quarterly MDS, with was due to be completed by #27. When reviewed, the ne Quarterly MDS had not I In addition, the ne MDS had not been ropriate government ed.  ed that a Quarterly MDS, with was due to be completed by In addition, the ne MDS had not been ropriate government ed.	F6	540				
		#19. When reviewed, the ne Annual MDS had not been						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315193	B. WING		06/13/2019		
	NAME OF PROVIDER OR SUPPLIER  OCEANA REHABILITATION AND NC			STREET ADDRESS, CITY, STATE, ZIP CODE 502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLETION		
F 640	revealed that the MI	ge 15  In addition, the EHR  OS had not been submitted to ernment authorities as	F 640				
	with an ARD of for Resident #14. W reflected that the Qu completed as of revealed that the MI	had no completion date had no completion date hen reviewed, the EHR harterly MDS had not been had not been had not been submitted to had not been submitted to					
	with an ARD of by for Resid the EHR reflected the been completed unt EHR revealed that the state of the state	lent #12. When reviewed, nat the Quarterly MDS had not il . In addition, the he MDS had not been propriate government					
	with an ARD of by for Residence of the total been completed unto the EHR revealed that the total been completed unto the transfer of the total been completed unto the transfer of the transfe	he MDS had not been propriate government					
	with an ARD of	ied that the Quarterly MDS, was due to be completed lent #20. When reviewed,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315193	B. WING			06/	13/2019
NAME OF PROVIDER OR SUPPLIER  OCEANA REHABILITATION AND NC				50	TREET ADDRESS, CITY, STATE, ZIP CODE 02 ROUTE 9 NORTH APE MAY COURT HOUSE, NJ 08210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 640	been completed until EHR revealed that the submitted to the approauthorities as require.  In an interview on 6/1 Coordinator stated the "got behind" due to a she returned she was MDS Coordinator also having difficulty trans recently as well.	at the Quarterly MDS had not . In addition, the e MDS had not been ropriate government d.  3/19 at 1:06 PM, the MDS at the MDS assessments n absence from work. When sn't able to catch up. The o stated that she had been mitting the assessments	F	640			
F 730 SS=E	CFR(s): 483.35(d)(7) §483.35(d)(7) Regula The facility must com of every nurse aide a months, and must pro education based on t reviews. In-service tr requirements of §483 This REQUIREMENT by: Based on interview a determined that the fa evidence that the req education for Certified met.  This deficient practice Certified Nursing Aide evidenced by the follow	ar in-service education. plete a performance review t least once every 12 ovide regular in-service he outcome of these raining must comply with the 6.95(g). T is not met as evidenced and record review, it was acility failed to provide uired hours of annual d Nursing Assistants were e was identified for 3 of 5 es reviewed and was	F	730	1) All education records of CNAs who are actively employed were reviewed to ensure they are in the process of receiving at least 6 hours of education this biannual mark.  2) All residents have the potential to be affected by the deficient practice.  3) The ADON was in-serviced on the	o at	7/5/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315193	B. WING _			06/	/13/2019	
	NAME OF PROVIDER OR SUPPLIER  OCEANA REHABILITATION AND NC			STREET ADDRESS, CITY, STATE, ZIP CODE  502 ROUTE 9 NORTH  CAPE MAY COURT HOUSE, NJ 08210				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 730	Nursing (ADON) state training credits were to the presence of the D and Corporate Clinical calendar year was conjuncted and and any ear.  On 06/13/19 at 10:35 the educational training selected Certified Nural A CNA is a caregiver care facility and often between the resident review of the records CNA staff members of the corporations. The surveyor interview the presence of the C Coordinator at this time acknowledged that the requirement for each some of the hours made tracking the hours. But stated that they were	ed that nursing education racked by calendar year, in irector of Nursing (DON) all Coordinator, where a nsidered to begin on a December 31 in a given  AM, the surveyor reviewed and records for five randomly raing Aides (CNA) for 2018. It is a resident in a long-term acts as an intermediary and nurse. The surveyor's revealed that three of five id not have the minimum 12 action required by federal wed the ADON and DON, in corporate Clinical ine. The ADON e minimum education CNA was 12 hours and that any have been missed. The could have done better in both the ADON and DON in the process of trying to counting system for CNA	F 7	730	required hours of annual education mandated for Certified Nursing Aides within the calendar year.  4) The DON or designee will audit 5 C education records monthly for six monto ensure the 12 hour requirement is being met. The audit will be reviewed quarterly at the Quality Assurance Mee for two quarters.	ths		

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
060503		B. WING		06/13/2019		
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
OCEANA F	REHABILITATION AND N	C	TE 9 NORTH Y COURT HOU	ISF N.I 08210		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
S 000	Initial Comments		S 000			
	WITTH THE STANDA JERSEY ADMINISTR 8:39, STANDARDS F TERM CARE FACILI' SUBMIT A PLAN OF INCLUDING A COMP DEFICIENCY AND EI IMPLEMENTED. FAII DEFICIENCIES MAY ENFORCMENT ACTI WITH THE PROVISIO	CATIVE CODE, CHAPTER OR LICENSURE OF LONG TIES. THE FACILITY MUST CORRECTION, PLETION DATE, FOR EACH NSURE THAT THE PLAN IS LURE TO CORRECT RESULT IN ON IN ACCORDANCE DNS OF THE NEW RATIVE CODE, TITLE 8, ORCEMENT OF				
S1145	8:39-13.4(b) Mandato	ory Communication	S1145			7/5/19
	training for all employ four times per year ar care problems, impler procedures, technolog changes in regulatory member suggestions, receive training at lea the facility's infection	gical developments, standards, and staff All staff members shall st two times per year about				
	by: Based on interview at determined that the fa evidence that at least related to handwashir Assistants were providentified Nursing Aide	is not met as evidenced  and record review, it was acility failed to provide two training sessions and for Certified Nursing ded. This occurred for 5 of 5 as reviewed and this a evidenced by the following:		1) All CNAs have completed hand washing education at least one time f 2019.  2) All residents have the potential to be affected by the deficient practice.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

06/26/19

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New Jersey Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		060503	B. WING		06/13/	/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
OCEANA	REHABILITATION AND N	С	TE 9 NORTH Y COURT HOU	SE, NJ 08210		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S1145	Continued From page	÷ 1	S1145			
	On 06/12/19 at 2:25 F Nursing (ADON) state training credits were to the presence of the Dound Corporate Clinical calendar year wass of January 1 and end or year.  On 06/13/19 at 10:35 the educational training selected Certified Nur A CNA is a caregiver care facility and often between the resident review of the records CNA staff members of training sessions related that one of five CNA seany training sessions	PM, the Assistant Director of ed that nursing education racked by calendar year, in irector of Nursing (DON) al Coordinator, where a considered to begin on a December 31 in a given  AM, the surveyor reviewed and records for five randomly raing Aides (CNA) for 2018. It is a resident in a long-term acts as an intermediary and nurse. The surveyor's revealed that four of five id not have at least two ted to hand washing and staff members did not have related to hand washing.		3) The ADON was in-serviced on the mandatory requirements of hand was education at least two times a year fo CNAs.  4) The DON or designee will audit 5 (education records monthly for six more to ensure hand washing education was provided at least two times a year. The audit will be reviewed quarterly at the Quality Assurance Meeting for two quarters.	CNA on this as	
	presence of the ADOI Coordinator at this tim the training related to	N and Corporate Clinical ne. The DON confirmed that hand washing was not met. DON stated that they were in to develop a better				
S1166		ation training program each	S1166		7	7/5/19
	the following topics:	all employees on each of				
	5. Pharmacy (for	all direct care staff).				

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New Jersey Department of Health							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BOILDING.				
060503		B. WING		06/1	3/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	NTE, ZIP CODE			
OCEANA	DELLA DIL ITATIONI AND A	502 ROUT	E 9 NORTH				
UCEANA	REHABILITATION AND N	CAPE MA	Y COURT HOU	SE, NJ 08210			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
S1166	Continued From page	⊋ 2	S1166				
	by: Based on interview and determined that the fare evidence that at least related to pharmacy for Assistants was provide Certified Nursing Aided deficient practice was On 6/12/19 at 2:25 PI Nursing (ADON) state training credits were to the presence of the Dougland Corporate Clinical calendar year was consulted and Corporate Clinical calendar year was consulted by the educational training selected Certified Nursing A CNA is a caregiver care facility and often between the resident review of the records CNA staff members do training program for the surveyor interview presence of the ADON Coordinator at this ting the ADON and DON states.	ded. This occurred for 5 of 5 es reviewed and this is evidenced by the following:  M, the Assistant Director of ed that nursing education tracked by calendar year, in Director of Nursing (DON) all Coordinator, where a considered to begin on in December 31 in a given  AM, the surveyor reviewed ing records for five randomly ring Aides (CNA) for 2018. To a resident in a long-term in acts as an intermediary and nurse. The surveyor's revealed that five of five did not have at least one the year related to pharmacy.  Wed the DON, in the N and Corporate Clinical ine. The DON confirmed that harmacy was not met. Both stated that they were in the evelop a better accounting		1) All CNAs are in the process of receiving a pharmacy in-service.  2) All residents have the potential to be affected by the deficient practice.  3) The ADON was in-serviced on the mandatory requirements of at least or training program related to pharmacy Certified Nursing Assistants.  4) The DON or designee will audit 5 Ceducation records monthly for six mor to ensure at least one training program related to pharmacy was provided. The audit will be reviewed quarterly at the Quality Assurance Meeting for two quarters.	ne for CNA nths m		