STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING ______ B. WING ______	06/13/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY 06/13/19 CENSUS: 107 SAMPLE: 23 + 32 + 3 CLOSED RECORDS The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 636 SS=D	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. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		7/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 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	Continued From page 1 (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 the Annual Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient	F 636	1) The MDS for residents #13, #19, and #21 were completed. 2) All residents have the potential to be affected by the deficient practice.	

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F 636	Continued From page 2 practice was identified for 3 of 55 residents (Resident #13, 19, and 21) reviewed for comprehensive assessments and was evidenced by the following: The Centers For Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. At a minimum, facilities are required to complete a comprehensive assessment for each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident, where 12 months refers to a period within 366 days. 1. The electronic health record (EHR) identified that an Annual Minimum Data Set (MDS), an assessment tool for evaluating the status of a resident with an assesssment reference date (ARD) of [redacted], was due to be completed by [redacted] for Resident #19. When reviewed, the EHR reflected that the Annual MDS had not been completed until [redacted] 2. The EHR identified that an Annual MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #13. When reviewed, the EHR reflected that the Annual MDS had not been completed until [redacted]. 3. The EHR identified that an Annual MDS, with an ARD of [redacted] was due to be completed by	F 636	3) The MDS coordinator was in-serviced on required time frames for completing MDS assessments. The MDS coordinator will submit a monthly calendar to DON for assessments due routinely. DON and MDS coordinator will meet weekly to: 1) Review status of assessments and communicate any additional assessment added to calendar; 2) Review MDS assessments for completeness in the Sigmacare system. DON and MDS coordinator will date and initial calendar next to each assessment due after verifying that it was completed. 4) The DON will review the MDS calendar and Sigmacare dashboard with the Administrator every 2 weeks for three months to ensure assessments are completed timely. The calendar with the ARD dates along with the completion dates for MDS assessments will be reviewed quarterly at the Quality Assurance Meeting for 2 quarters.	

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F 636	Continued From page 3 [redacted] for Resident #21. When reviewed, the EHR reflected that the Annual MDS had not been completed until [redacted]. NJAC 8:39-11.1	F 636		
F 638 SS=E	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 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 the Quarterly Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the specified timeframe as required. This deficient practice was identified for 29 of 55 residents (Residents #13, #21, #8, #17, #50, #34, #15, #53, #16, #36, #33, #1, #26, #9, #35, #25, #10, #18, #27, #6, #29, #19, #14, #28, #7, #12, #4, #20, and #30), whose MDS assessments were reviewed and were evidenced by the following: The Centers For Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date	F 638	1) MDS for residents #13, #21, #8, #17, #50, #34, #15, , #53, #16, #36, #33, #1, #26, #9, #35, #25, #10, #18, #27, #6, #29, #19, #28, #7, #12, #4, #20, and #30 were completed. Resident #14 was discharged 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 currently up to date. 3) The MDS coordinator was in-serviced on required time frames for completing quarterly MDS. The MDS coordinator will submit monthly calendar to DON for assessment due routinely. DON and MDS coordinator will meet weekly to: 1) Review status of assessments and communicate any additional assessment	7/5/19

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F 638	Continued From page 4 (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1). The Assessment Reference Date (ARD) of the Quarterly MDS was within 92 days after the ARD of the previous MDS and; 2). the completion date was no later than 14 days after the ARD. On 6/13/19 11:49 AM the surveyors reviewed the following: 1. The Electronic Health Record (EHR) identified that a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted] was due to be completed by [redacted] for Resident #8. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 2. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #17. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 3. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #50. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 4. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #34. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 5. The EHR identified that a Quarterly MDS, with	F 638	added to the calendar; 2) Review MDS assessments for completeness in the Sigmacare system; 3) Review that discharged residents are removed from the Sigmacare system. DON and MDS coordinator will date and initial on the calendar next to each assessment due after verifying that it was completed. 4) The DON will review the MDS calendar and Sigmacare dashboard with the Administrator every 2 weeks for three months to check assessments are completed timely. The calendar with the ARD dates along with the completion dates for MDS assessments will be reviewed quarterly at the Quality Assurance Meeting for 2 quarters.	

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F 638	Continued From page 5 an ARD of [redacted], was due to be completed by [redacted] for Resident #15. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 6. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #53. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 7. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #16. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 8. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #36. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 9. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #33. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 10. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #1. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted] 11. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #26. When reviewed, the EHR reflected that the Quarterly MDS had not	F 638		

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F 638	Continued From page 6 been completed until [redacted]. 12. The EHR identified that a modified Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #9. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 13. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #35. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 14. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #25. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 15. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #10. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted] 16. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #18. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted] 17. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #27. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. 18. The EHR identified that a Quarterly MDS, with	F 638		

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F 638	Continued From page 7 an ARD of [redacted] was due to be completed by [redacted] for Resident #6. When reviewed, the EHR reflected that the Quarterly MDS had not yet been completed until [redacted] 19. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #29. When reviewed, the EHR reflected that the Quarterly MDS had not yet been completed until [redacted]. 20. The EHR identified that a Quarterly MDS, with an ARD of [redacted] had no completion for Resident #14. When reviewed, the EHR reflected that the Quarterly MDS had not yet been completed as of [redacted]. 21. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #28. When reviewed, the EHR reflected that the Quarterly MDS had not yet been completed until [redacted] 22. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #7. When reviewed, the EHR reflected that the Quarterly MDS had not yet been completed until [redacted]. 23. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #12. When reviewed, the EHR reflected that the Quarterly MDS had not yet been completed until [redacted]. 24. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #4. When reviewed, the EHR reflected that the Quarterly MDS had not yet	F 638		

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F 638	Continued From page 8 been completed until [redacted]. 25. The EHR identified that a Quarterly MDS, with an ARD of [redacted] due to be completed by [redacted] for Resident #20. When reviewed, the EHR reflected that the Quarterly MDS had not yet been completed until [redacted]. 26. The EHR identified that a Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #30. When reviewed, the EHR reflected that the Quarterly MDS had not yet been completed until [redacted]. In an interview on 6/13/19 at 1:06 PM, the MDS Coordinator stated that the MDS assessments "got behind" due to an absence from work. When she returned she wasn't able to catch up. The MDS Coordinator also stated that she had been having difficulty transmitting them recently as well. In a follow-up interview on 6/13/19 at 1:19 PM, the Director of Nursing stated that she was responsible signing off on every assessment, attesting that each was complete, however, offered no explanation as to why they were not completed. NJAC 8:39-11.1	F 638		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for	F 640		7/5/19

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F 640	Continued From page 9	F 640		

each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must

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F 640	Continued From page 10 transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to electronically transmit the Minimum Data Set (MDS) a periodic and federally mandated, standardized assessment tool, as required. This deficient practice was identified for 21 of 55 residents (Residents #13, ##21, #8, #17, #50, #34, #15, #53, #16, #36, #26, #35, #25, #10, #18, #27, #19, #14, #12, #4, and #20), whose MDS assessments were reviewed and were evidenced by the following: The Centers For Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1). The Assessment Reference Date (ARD) of the Quarterly MDS was within 92 days after the ARD of the previous MDS and; 2). the completion date was no later than 14 days after the ARD. The Manual also specified that MDS assessments were required to be electronically transmitted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System within 14 days of the final completion date.	F 640	1) MDS for residents #13, #21, #8, #17, #50, #34, #15, #53, #16, #36, #26, #35, #25, #10, #18, #27, #19, #12, #4, and #20 were completed and submitted. Resident #14 was discharged from the facility on [redacted]. 2) All residents have the potential to be affected by the deficient practice. An audit was done and all MDS were completed and submitted. 3) The MDS coordinator was in-serviced on required time frames for MDS encoding/transmissions. The MDS coordinator will submit monthly calendar to DON for assessments due routinely. DON and MDS coordinator will meet weekly to review status of assessments and communicate any additional assessments added to the calendar. MDS assessments will be reviewed for timely transmission of assessments in the Sigmacare system. Sigmacare will be updated to reflect discharged residents. 4) The DON will review the MDS calendar and Sigmacare dashboard with the Administrator every 2 weeks for three months to check for accuracy and to ensure assessments are encoded/transmitted timely. The calendar with the ARD dates along with the	

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OCEANA REHABILITATION AND NC	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

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F 640	Continued From page 11 On 6/13/19 11:49 AM the surveyors reviewed the following: 1. The Electronic Health Record (EHR) identified that a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [redacted] was due to be completed by [redacted] for Resident #8. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 2. The EHR identified that a Quarterly MDS with an ARD of [redacted] was due to be completed by [redacted] for Resident #17. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 3. The EHR identified that a Quarterly MDS with an ARD of [redacted] was due to be completed by [redacted] for Resident #50. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 4. The EHR identified that a Quarterly MDS with an Assessment Reference Date (ARD) of [redacted] was due to be completed by [redacted] for Resident #34. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate	F 640	completion dates of transmission for MDS assessments will be reviewed quarterly at the Quality Assurance Meeting for two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING ______ B. WING ______	06/13/2019

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

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F 640	Continued From page 12 government authorities as required. 5. The Electronic Health Record (EHR) identified that an Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [redacted] was due to be completed by [redacted] for Resident #13. When reviewed, the EHR reflected that the Annual MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 6. The EHR identified that an Annual MDS with an ARD of [redacted] was due to be completed by [redacted] for Resident #21. When reviewed, the EHR reflected that the Annual MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 7. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #15. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 8. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #53. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required.	F 640		

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	315193	A. BUILDING ______ B. WING ______	06/13/2019

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

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F 640	Continued From page 13 9. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #16. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 10. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #36. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 11. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #26. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 12. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by [redacted] for Resident #35. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted] In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 13. The EHR identified that a Quarterly MDS, with an ARD of [redacted], was due to be completed by	F 640		

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	315193	A. BUILDING ______ B. WING ______	06/13/2019

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OCEANA REHABILITATION AND NC	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

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F 640	Continued From page 14	F 640		

[REDACTED] for Resident #25. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [REDACTED]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required.

14. The EHR identified that a Quarterly MDS, with an ARD of [REDACTED] was due to be completed by [REDACTED] for Resident #10. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [REDACTED]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required.

15. The EHR identified that a Quarterly MDS, with an ARD of [REDACTED] was due to be completed by [REDACTED] for Resident #18. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [REDACTED]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required.

16. The EHR identified that a Quarterly MDS, with an ARD of [REDACTED], was due to be completed by [REDACTED] for Resident #27. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [REDACTED]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required.

17. The EHR identified that the Annual MDS, with an ARD of [REDACTED] was due to be completed by [REDACTED] for Resident #19. When reviewed, the EHR reflected that the Annual MDS had not been

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	315193	A. BUILDING ______ B. WING ______	06/13/2019

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OCEANA REHABILITATION AND NC	**502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210**

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F 640	Continued From page 15 completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 18. The EHR identified that the Quarterly MDS, with an ARD of [redacted] had no completion date for Resident #14. When reviewed, the EHR reflected that the Quarterly MDS had not been completed as of [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 19. The EHR identified that the Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #12. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 20. The EHR identified that the Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #4. When reviewed, the EHR reflected that the Quarterly MDS had not been completed until [redacted] In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. 21. The EHR identified that the Quarterly MDS, with an ARD of [redacted] was due to be completed by [redacted] for Resident #20. When reviewed,	F 640		

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OCEANA REHABILITATION AND NC	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

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F 640	Continued From page 16 the EHR reflected that the Quarterly MDS had not been completed until [redacted]. In addition, the EHR revealed that the MDS had not been submitted to the appropriate government authorities as required. In an interview on 6/13/19 at 1:06 PM, the MDS Coordinator stated that the MDS assessments "got behind" due to an absence from work. When she returned she wasn't able to catch up. The MDS Coordinator also stated that she had been having difficulty transmitting the assessments recently as well. NJAC 8:39-11.2(e)(3)	F 640		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide evidence that the required hours of annual education for Certified Nursing Assistants were met. This deficient practice was identified for 3 of 5 Certified Nursing Aides reviewed and was evidenced by the following: On 06/12/19 at 2:25 PM, the Assistant Director of	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 at this biannual mark. 2) All residents have the potential to be affected by the deficient practice. 3) The ADON was in-serviced on the	7/5/19

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OCEANA REHABILITATION AND NC	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

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F 730	Continued From page 17 Nursing (ADON) stated that nursing education training credits were tracked by calendar year, in the presence of the Director of Nursing (DON) and Corporate Clinical Coordinator, where a calendar year was considered to begin on January 1 and end on December 31 in a given year. On 06/13/19 at 10:35 AM, the surveyor reviewed the educational training records for five randomly selected Certified Nursing Aides (CNA) for 2018. A CNA is a caregiver to a resident in a long-term care facility and often acts as an intermediary between the resident and nurse. The surveyor's review of the records revealed that three of five CNA staff members did not have the minimum 12 hours of annual education required by federal regulations. The surveyor interviewed the ADON and DON, in the presence of the Corporate Clinical Coordinator at this time. The ADON acknowledged that the minimum education requirement for each CNA was 12 hours and that some of the hours may have been missed. The DON stated that she could have done better in tracking the hours. Both the ADON and DON stated that they were in the process of trying to develop a better accounting system for CNA educational requirements. NJAC 8:39-13.4(b)	F 730	required hours of annual education mandated for Certified Nursing Aides within the calendar year. 4) The DON or designee will audit 5 CNA education records monthly for six months to ensure the 12 hour requirement is being met. The audit will be reviewed quarterly at the Quality Assurance Meeting for two quarters.	

New Jersey Department of Health

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	060503	A. BUILDING: ____ B. WING ____	06/13/2019

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

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITTH 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 ENFORCMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S1145	8:39-13.4(b) Mandatory Communication (b) Each service shall provide education or training for all employees in the service at least four times per year and in response to resident care problems, implementation of new procedures, technological developments, changes in regulatory standards, and staff member suggestions. All staff members shall receive training at least two times per year about the facility's infection control procedures, including handwashing and personal hygiene requirements. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide evidence that at least two training sessions related to handwashing for Certified Nursing Assistants were provided. This occurred for 5 of 5 Certified Nursing Aides reviewed and this deficient practice was evidenced by the following:	S1145	1) All CNAs have completed hand washing education at least one time for 2019. 2) All residents have the potential to be affected by the deficient practice.	7/5/19

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

Electronically Signed | | 06/26/19

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060503	A. BUILDING: ______ B. WING ______	06/13/2019

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S1145	Continued From page 1 On 06/12/19 at 2:25 PM, the Assistant Director of Nursing (ADON) stated that nursing education training credits were tracked by calendar year, in the presence of the Director of Nursing (DON) and Corporate Clinical Coordinator, where a calendar year wass considered to begin on January 1 and end on December 31 in a given year. On 06/13/19 at 10:35 AM, the surveyor reviewed the educational training records for five randomly selected Certified Nursing Aides (CNA) for 2018. A CNA is a caregiver to a resident in a long-term care facility and often acts as an intermediary between the resident and nurse. The surveyor's review of the records revealed that four of five CNA staff members did not have at least two training sessions related to hand washing and that one of five CNA staff members did not have any training sessions related to hand washing. The surveyor interviewed the DON, in the presence of the ADON and Corporate Clinical Coordinator at this time. The DON confirmed that the training related to hand washing was not met. Both the ADON and DON stated that they were in the process of trying to develop a better accounting system for CNA educational requirements.	S1145	3) The ADON was in-serviced on the mandatory requirements of hand washing education at least two times a year for CNAs. 4) The DON or designee will audit 5 CNA education records monthly for six months 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.	
S1166	8:39-13.4(c)(5) Mandatory Communication (c) At least one education training program each year shall be held for all employees on each of the following topics: 5. Pharmacy (for all direct care staff).	S1166		7/5/19

New Jersey Department of Health

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S1166	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide evidence that at least one training program related to pharmacy for Certified Nursing Assistants was provided. This occurred for 5 of 5 Certified Nursing Aides reviewed and this deficient practice was evidenced by the following: On 6/12/19 at 2:25 PM, the Assistant Director of Nursing (ADON) stated that nursing education training credits were tracked by calendar year, in the presence of the Director of Nursing (DON) and Corporate Clinical Coordinator, where a calendar year was considered to begin on January 1 and end on December 31 in a given year. On 6/13/19 at 10:35 AM, the surveyor reviewed the educational training records for five randomly selected Certified Nursing Aides (CNA) for 2018. A CNA is a caregiver to a resident in a long-term care facility and often acts as an intermediary between the resident and nurse. The surveyor's review of the records revealed that five of five CNA staff members did not have at least one training program for the year related to pharmacy. The surveyor interviewed the DON, in the presence of the ADON and Corporate Clinical Coordinator at this time. The DON confirmed that the training related pharmacy was not met. Both the ADON and DON stated that they were in the process of trying to develop a better accounting system for CNA educational requirements.	S1166	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 one training program related to pharmacy for Certified Nursing Assistants. 4) The DON or designee will audit 5 CNA education records monthly for six months 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.	