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	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Springs at Cape May Nursing & Rehab Cente	502 Route 9 North Cape May Court House, NJ 08210

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 34423 51337 Based on interview, record review and review of other facility documentation and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, it was determined that the facility failed to complete the Quarterly Minimum Data Set (MDS) assessments, a resident assessment tool used to facilitate the management of care, in a timely manner for 46 of 49 residents reviewed for system selected MDS over 120 days for late submissions., (Residents #49, #24, #29, #55, #32, #33, #48, #13, #8, #51, #11, #22, #27, #3, #50, #72, #18, #19, #9, #54, #57, #64, #70, #58, #37, #36, #45, #337, #187, 336, #21, #5, #4, #20, #69, #34, #16, #28, #66, #15, #25, #30, #17, #38, #42, #67). This deficient practice was evidenced by the following: Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3. 0 Manual classified the Observation (Look Back) Period as the time 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 (QMDS) 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. 1. Resident #49's Quarterly MDS (QMDS) ARD was 10/10/24, the Quarterly Assessment (QA) had not been completed as of 11/25/24 and was 32 days overdue. 2. Resident #24's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. 3. Resident #29's QMDS ARD was 09/26/24, the QA had not been completed as of 11/25/24 and was 46 days overdue. 4. Resident #55's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. 5. Resident #32's QMDS ARD was 09/11/24, the QA had not been completed as of 11/25/24 and was 61 days overdue. (continued on next page)

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.

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

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Resident #33's QMDS ARD was 10/10//24, the QA had not been completed as of 11/25/24 and was 32 days overdue. 7. Resident #48's QMDS ARD was 10/02/24, the QA had not been completed as of 11/25/24 and was 40 days overdue. 8. Resident #13's QMDS ARD was 09/11/24, the QA had not been completed as of 11/25/24 and was 61 days overdue. 9. Resident #8's QMDS ARD was 10/10/24, the QA had not been completed as of 11/25/24 and was 32 days overdue. 10.Resident #51's QMDS ARD was 09/12/24, the QA had not been completed as of 11/25/24 and was 60 days overdue. 11.Resident #11's QMDS ARD was 09/18/24, the QA had not been completed as of 11/25/24 and was 54 days overdue. 12.Resident #22's QMDS ARD was 09/12/24, the QA had not been completed as of 11/25/24 and was 60 days overdue. 13.Resident #27's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. 14.Resident #3's QMDS ARD was 10/10/24, the QA had not been completed as of 11/25/24 and was 32 days overdue. 15.Resident #50's QMDS ARD was 09/19/24, the QA had not been completed as of 11/25/24 and was 53 days overdue. 16.Resident #72's QMDS ARD was 09/03/24, the QA had not been completed as of 11/25/24 and was 69 days overdue 17.Resident #18's QMDS ARD was 09/17/24, the QA had not been completed as of 11/25/24 and was 55 days overdue. 18.Resident #19's QMDS ARD was 09/11/24, the QA had not been completed as of 11/25/24 and was 61 days overdue. 19.Resident #9's QMDS ARD was 10/02/24, the QA had not been completed as of 11/25/24 and was 40 days overdue. 20.Resident #54's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. 21.Resident #57's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	22.Resident #64's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. 23.Resident #70's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue 24.Resident #58's QMDS ARD was 09/26/24, the QA had not been completed as of 11/25/24 and was 46 days overdue. 25.Resident #37's QMDS ARD was 09/5/24, the QA had not been completed as of 11/25/24 and was 67 days overdue. 26.Resident #36's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. 27.Resident #45's QMDS ARD was 09/19/24, the QA had not been completed as of 11/25/24 and was 53 days overdue. 28.Resident #337's QMDS ARD was 08/16/24, the QA had not been completed as of 11/25/24 and was 87 days overdue. 29.Resident #187's QMDS ARD was 07/25/24, the QA had not been completed as of 11/25/24 and was 109 days overdue. 30.Resident #336's QMDS ARD was 07/17/24, the QA had not been completed as of 11/25/24 and was 117 days overdue. 31.Resident #21's QMDS ARD was 09/19/24, the QA had not been completed as of 11/25/24 and was 53 days overdue. 32.Resident #5's QMDS ARD was 09/12/24, the QA had not been completed as of 11/25/24 and was 60 days overdue. 33.Resident #4's QMDS ARD was 09/04/24, the QA had not been completed as of 11/25/24 and was 68 days overdue. 34.Resident #20's QMDS ARD was 09/18/24, the QA had not been completed as of 11/25/24 and was 54 days overdue. 35.Resident #69's QMDS ARD was 09/21/24, the QA had not been completed as of 11/25/24 and was 51 days overdue. 36.Resident #34's QMDS ARD was 08/29/24, the QA had not been completed as of 11/25/24 and was 74 days overdue. 37.Resident #16's QMDS ARD was 10/3/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38.Resident #28's QMDS ARD was 09/26/24, the QA had not been completed as of 11/25/24 and was 46 days overdue. 39.Resident #66's QMDS ARD was 09/07/24, the QA had not been completed as of 11/25/24 and was 65 days overdue. 40.Resident #15's QMDS ARD was 09/05/24, the QA had not been completed as of 11/25/24 and was 67 days overdue. 41.Resident #25's QMDS ARD was 08/01/24, the QA had not been completed as of 11/25/24 and was 102 days overdue. 42.Resident #30's QMDS ARD was 09/12/24, the QA had not been completed as of 11/25/24 and was 60 days overdue. 43.Resident #17's QMDS ARD was 10/03/24, the QA had not been completed as of 11/25/24 and was 39 days overdue. 44.Resident #38's QMDS ARD was 09/11/24, the QA had not been completed as of 11/25/24 and was 61 days overdue. 45.Resident #42's QMDS ARD was 09/05/24, the QA had not been completed as of 11/25/24 and was 67 days overdue. 46.Resident #67's QMDS ARD was 09/03/24, the QA had not been completed as of 11/25/24 and was 66 days overdue. On 11/25/24 at 11:00 AM, the survey team interviewed the MDS Coordinator (MDSC). The MDSC stated that she had worked as the MDSC in the facility for 3 years. The MDSC stated that she was doing the MDS in 2 buildings at this time. The MDSC said she knew things were behind and she had to help the other building. The MDSC acknowledged that MDS were behind. A review of the facility policy entitled MDS 3.0 Completion with an implemented date of 10/15/24 under Types of OBRA Assessments: 2.e. Quarterly Assessment - completed using an ARD no > (greater than) 92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41442 Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to develop and implement a comprehensive person-centered care plan specifically for a resident who required a Foley Catheter and a Peripherally Inserted Central Catheter (PICC) used to deliver the antibiotic. This deficient practice was identified for 1 of 26 sampled residents, (Resident #1) and was evidenced by the following: On 11/20/2024 at 10:43 AM, during the initial tour, Resident #1 was observed as having a left upper arm Peripherally Inserted Central Catheter (PICC), (used for administration of an Intravenous Medication or fluids). Resident #1 was also noted to have a Foley Catheter (a thin, flexible tube that drains urine from the bladder into a collection bag outside the body), hanging to the left side of the bed in a privacy bag. A review of the Electronic Medial Record for Resident #1 revealed the following: A review of Resident #1's Admission Record revealed that he/she had diagnoses that included but not limited to, infected sacral wound with wound botulism and possible osteomyelitis, complicated Urinary Tract Infection, Dementia. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 10/31/2024, under Section H: Indwelling Catheter, under Section N: Medications: High-Risk Drug Classes: Use and Indication: indicated that Resident #1 is taking an Antibiotic; Under Section O: Special Treatments, Procedures, and Programs: IV Access-Central. A review of the Physician Orders on 11/21/2024 at 09:29 AM, revealed the following: -Maintain Enhanced Barrier Precautions related to Foley/wound/PICC line. -Foley Catheter Care every shift and as needed. -Foley Catheter indwelling 15 French. -Change Foley Catheter collection bag as needed. -Double Lumen PICC to Right Upper Arm (RUA). -PICC line, monitor site every shift for signs and symptoms of infection every shift. -PICC line flush every shift with 10 millimeters (ml) to maintain line every shift. -PICC line measure 32 centimeters on admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PICC line flush with 10 ml Normal Saline, before & after INTERMITTENT medication one time a day for Bacteremia/Fungemia. -PICC line change transparent dressing Weekly & as needed every day shift every Thursday AND as needed. A review of Resident #1's Care Plan dated 10/3/2024, did not include focus areas that addressed that the resident had a PICC line and a Foley Catheter. During an interview with the surveyor on 11/25/2024 at 01:55 PM, the Director of Nursing when asked what the expectations for a comprehensive person-centered Care Plan to include, agreed that a PICC line and Foley Catheter should be included in the residents Care Plan. A review of a facility policy on titled, Comprehensive Care Plans, implemented date of 01/10/2024, objectives include, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. NJAC 8:39-11.2(f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34423 Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to implement infection control measures for the handling and storage of respiratory equipment for 1 of 2 residents reviewed for respiratory care, (Resident # 7) and was evidenced by the following: During the initial tour on 11/20/2024 at 10:20 AM, Resident #7 was observed sitting in the dayroom with a high back wheelchair. The surveyor observed the oxygen tubing draped on top of the concentrator uncovered and exposed. The concentrator was turned off. Resident #7 also had an e cylinder (portable oxygen tank) secured on the back of the wheelchair with oxygen tubing draped over the strap used to secure the cylinder to the wheelchair. Resident #7 said he/she was waiting for his/her ride to the Dr. as he/she had lung cancer and was going for a follow-up. Resident #7 was not currently using oxygen. On 11/20/2024 at 11:04 AM, Resident #7 was observed on the unit self-propelling his/her wheelchair with no oxygen in use. On 11/21/2024 at 09:14 AM, a review of the EMR revealed the following: According to the Admission Record Resident #7 was admitted with diagnoses including but not limited to: Heart Failure, Chronic Obstructive Pulmonary Disease. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated 10/29/2024, Resident #7 has a Brief Interview for Mental Status score of 12/15 indicating Resident #7 had intact cognition. Section J indicated Resident #7 had shortness of breath when lying flat and with exertion. Section O revealed Resident #7 used oxygen upon admission and while a resident. A review of the Order summary Report with active orders as of 11/25/2024, showed a physician order for oxygen at 2 liters via n/c (nasal cannula) continuous, every shift. A review of Resident #7's care plan revealed a focus area with date initiated of 10/25/2024, [resident name] has a potential at risk for altered respiratory status. CHF (congestive heart failure), dysphagia, hx (history) of pulmonary tuberculosis, chronic airway obstruction, and hx of smoking. Under the Goal section the resident will display optimal breathing pattern daily through review date. Interventions included but were not limited to: oxygen administered as per MD (physician) order. There was no documentation to indicate the resident refused oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 11/25/2024 at 09:56 AM, the Registered Nurse/Unit Manager RN/UM #1 was asked what the facility policy regarding oxygen use is. RN/UM #1 responded I would have to check with DON (Director of Nursing) about the policy to confirm what the policy is. The surveyor questioned what the procedure was for storage of respiratory equipment. RN/UM #1 said we put it (oxygen tubing) in a bag, label tubing and change tubing and bags every week and as needed. When asked what the expectation is for wearing oxygen if there is a physician order for continuous use RN/UM #1 responded, It should always be on if ordered continuously. If the resident refuses to wear oxygen, we document it in EMR and notify NP (Nurse Practitioner) and family and we put that on the care plan. During an interview with the surveyor on 11/25/2024 at 01:56 PM, when asked what the facility policy regarding oxygen use the DON replied, We get a physician order and put it in the EMR. We also put on the care plan and with changes we update the care plan. We change tubing weekly and as needed and verify oxygen settings. The surveyor then asked the DON what the facility policy was regarding the storage of respiratory equipment when not in use. The DON said if package (tubing) is sealed, we keep it in the package. Once opened the tubing is dated and labeled. Then we would continue to make sure to change on the weekly schedule and oxygen tubing stored in the bag when not in use. When questioned what the expectation was if the order for oxygen was continuous the DON said, If the resident is alert and oriented and will remove the oxygen, we care plan it. The DON further stated we (nursing) provide education. The DON then confirmed to the surveyor that if it's not on (oxygen) the care plan as refusing, the oxygen should have been on. On 11/26/2024 at 09:30 AM, the DON brought in an employee statement from the nurse who had this resident on 11/20/2024. The nurse confirmed with the DON that the resident's oxygen tubing was not covered, and the oxygen was not on. The surveyor reviewed the evidence of the tubing positions with the DON who confirmed Resident #7 could not have physically placed the oxygen tubing where it was observed by the surveyor as it was on the concentrator of the e cylinder. On 11/25/2024 at 11:49 AM, a review a facility policy titled Oxygen Administration with date implemented of 10/10/24 revealed under the Policy section: Oxygen is administered to residents who need it, consistent with professional standards of practice, the person-centered care plans, and the resident's goals and preferences. The following was revealed under Policy Explanation and Compliance Guidelines section 5. Other infection control measures include: e. Keep delivery devices covered in plastic bag when not in use. NJAC 8:39-27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40039 Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 11/20/24 at 09:21 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. In the dry storage room on a middle shelf a previously opened bag of macaroni pasta was wrapped in plastic wrap. The pasta had no open or use by date. 2. On a middle rack of the spice shelf a stack of four (4) plastic Cambro containers were stacked on top of each other. The surveyor removed the top Cambro container and observed a clear watery substance on the bottom of the container below and a clear watery substance on the interior of the Cambro container that was on the top. In addition, a second stack of two (2) Cambro containers was also observed to be wet with a clear liquid substance, a practice known as wet nesting (the practice of stacking wet dishes, pots, or pans together, which prevents them from drying and can lead to bacteria growth.). On interview the FSD stated that they (Cambro's) should be air dried prior to stacking to prevent wet nesting. The FSD removed the affected Cambro containers to be re- cleaned, sanitized, and air dried. 3. On the pot/pan storage rack next to the steamer on an upper shelf two (2) deep third pans were stacked on top of each other. The surveyor removed the top third pan and observed a clear, wet liquid on the bottom of the third pan below (wet nesting). The FSD removed the two (2) third pans to be re-cleaned, sanitized, and air dried before stacking. 4. During the observation of the walk-in freezer the surveyor observed the temperature log prior to entering the walk-in freezer. The temperature log was observed to be up to date and the temperatures were within acceptable parameters for frozen storage. Upon entering the walk-in freezer, the surveyor, FSD and cook could not find an internal thermometer used to monitor the freezer temperature. The cook stated, We're gonna grab another one. 5. On a middle shelf in the walk-in freezer a previously opened bag of contained frozen soft pretzels. The bag had no dates. In addition, on a middle shelf closest to the door of the walk-in freezer, a previously opened box of bacon was partially covered with plastic wrap. One half of the box of bacon was exposed to the air because the plastic wrap did not fully cover the bacon. The bacon was dry on visual appearance. The cook removed the bacon to the garbage. Adjacent to the bacon, a box wrapped in manufacturers plastic contained Fresh Chorizo (a spiced pork sausage). The plastic on the top of the box was torn leaving the frozen chorizo exposed to the air. The box also had no received date. The cook removed the chorizo to the garbage in the presence of the surveyor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor reviewed the facility policy titled Date Marking for Food Safety, date implemented: 6/1/2024. The following was revealed under POLICY: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. In addition, the following was revealed under Policy Explanation and Compliance Guidelines for Staffing: 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a label, the day/date of opening, and the day/date the item must be consumed or discarded. 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. 7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed. The surveyor reviewed the facility policy titled Cleaning Dishes/Dish Machine, 2021. The following was revealed under Procedure: Staff will follow these procedures for washing dishes: 9. Dishes should be air dried on the dish racks, not dried with towels. 10. Inspect for cleanliness and dryness and put dishes away if clean (be sure hands are clean). Dishes should not be nested unless they are completely dry. NJAC 8:39-17.2(g)