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	04/15/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on interview, record review, and other pertinent facility documents, it was determined that the facility failed to ensure that residents received appropriate pain management and that pain medication was administered in accordance with the physician's orders for pain level parameters. This deficient practice was identified for 1 of 5 residents (Resident #2) reviewed for unnecessary medications and was evidenced by the following:On 4/10/2026 at 8:53 AM, the surveyor observed Resident #2 lying on the bed watching television. Resident #2 was pleasant and cooperative and alerted the surveyor that they were hard of hearing. No resident behaviors, or distress were observed.On 4/10/2026 at 9:52 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #2.A review of the admission Record revealed that Resident #2 was admitted with the following but not limited to diagnoses: Chronic pain syndrome, atherosclerotic heart disease, morbid obesity, neuralgia (intense, stabbing, or burning pain caused by damaged , irritated, or compressed nerves) and neuritis (the inflammation of one or more peripheral nerves, often causing pain, tenderness, numbness, tingling, and diminished reflexes or loss of function), cervicalgia (pain in the neck region, ranging from mild discomfort to severe stiffness or muscle spasms, often caused by muscle strain, poor posture, or injury), paranoid schizophrenia, and low back pain.A review of Resident #2's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/14/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was cognitively intact. Section D of the MDS indicated that the resident had no mood indicators and section E of the MDS revealed that the resident did not have any behaviors during the observation period. According to Section J, the resident had pain that was occasional and was moderate in intensity. Section N indicated that the resident received opioid daily.A review of Resident #2's individual comprehensive care plan (ICCP) included a Focus area, date initiated: 8/3/2022 and revision on: 1/26/2026, [resident name] is at risk for pain r/t (related to) chronic pain. [resident name] is on drugs designed to relieve pain without opioid medication for pain management. Interventions included: Administer analgesics (drugs designed to relieve pain without causing loss of consciousness) as scheduled and as per MD (medical doctor) orders. Assess pain level with appropriate pain assessment scale and document as indicated. Complete pain assessments as per facility policy and ongoing observation and assessment for pain utilizing 0-10 pain scale as indicated.A review of the Order Summary Report (OSR), dated as of 4/14/2026, included the following physician orders (PO):A PO, dated 7/27/2022, for pain scale q (every) shift 0-10 every shift.A PO, dated 9/21/2022, for Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 4 hours as needed for Mild pain 2 tabs = 650 MG Do not give over 4000mg daily.A PO, dated 4/3/2026, for Oxycodone HCL (hydrochloric acid) Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain (6-10).A PO, dated 4/14/2026, for Oxycodone HCL Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Severe pain (7-10).On 4/13/2026 at 9:51 AM, the surveyor reviewed Resident #2 for unnecessary medications. The surveyor reviewed the past six months of the consultant pharmacist (CP) medication regimen review (MRR).On 10/27/2025, the CP made the following recommendation:Documented pain level of 0 (zero) does not match PRN (as necessary) oxycodone indication of moderate to severe. Please follow specific order. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	See 10/1 at 1026, 10/10 at 0402, 10/15 at 0649, and 10/22 at 2330. The surveyor reviewed the Medication Administration Record (MAR) for October 2025 and it was revealed that Resident #2 was provided Oxycodone (HCl) Oral Tablet 5MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain (6-10) on 10/1 at 1026 (10:26 AM) for a pain level of 0 (zero), on 10/10 at 0402 (4:02 AM) for a pain level of 0 (zero), on 10/15 at 0649 (6:49 AM) for a pain level of 0 (zero) and on 10/22 at 2330 (11:30 PM) for a pain level of 0 (zero).On 12/31/2025, the CP made the following recommendation: Documented pain level of 0 (zero) and 5 does not match PRN Oxycodone indication of moderate to severe (6-10). Please follow specific order. Review of December 2025 MAR revealed the following: On 12/12/2025 at 1229 (12:29 PM) Resident #2 was administered Oxycodone HCL oral tablet 5MG for a documented pain level of 0. On 12/15/2025 at 0112 (1:12 AM) Resident #2 was administered Oxycodone HCl tablet 5MG for a documented pain level of 5. On 2/25/2026, the CP made the following recommendations: Documented pain level of 0 (zero) and 4 does not match PRN Oxycodone indication of moderate to severe (6-10). Please follow specific order. The surveyor reviewed the February 2026 MAR. The MAR revealed that Resident #2 was administered Oxycodone HCl 5MG for moderate to severe pain (6-10) on 2/5/2026 for a pain level of 0 (zero). On 3/25/2026, the CP made the following recommendation: Documented pain level of 0 does not match PRN Oxycodone indication of moderate to severe (6-10). Please follow specific order. Review of the March 2026 MAR revealed that Resident #2 was administered Oxycodone HCl Oral Tablet 5 MG on 3/16/2026 at 0810 (8:10 AM) for a documented pain level of 0 (zero). Resident #2 was administered Oxycodone HCl Oral Tablet 5 MG on 3/17/2026 at 1016 (10:16 AM) for a documented pain level of 0 (zero). Resident #2 was administered Oxycodone HCl Oral Tablet 5 MG on 3/17/2026 at 2224 (10:24 PM) for a documented pain level of 0 (zero). On 04/14/2026 at 8:28 AM the surveyor asked Resident #2 if he/she experienced pain regularly. Resident #2 stated, I have pain. He/she then told the surveyor I have pain when I sit down. I had five major back surgeries. I get pain in my neck, back and down my leg. The dosage of Oxycodone is too low. On 4/14/2026 at 8:35 AM, the surveyor conducted an interview with the Licensed Practical Nurse (LPN#1) assigned to Resident #2 on that shift. The surveyor asked LPN#1 if Resident #2 dealt with pain. LPN#1 responded, Yes. The way he/she described it, I would say it was chronic. The surveyor then asked if the facility had a pain scale in place. LPN#1 responded we have a pain scale, yes. The pain scale is 1-10. Usually, the Tylenol is for mild to moderate pain (1-5). If they described the pain as 6 or above, then we would use the medication that was prescribed for that pain level. The surveyor then asked LPN#1 if she would prescribe Oxycodone HCl Oral Tablet 5 MG for a resident who reported their pain scale as zero to five (5). LPN #1 stated, if a resident told me their pain level was zero, no, I would not administer Oxycodone. They had no pain. I probably would not administer Oxycodone for a pain level of 1-5, I would administer what was ordered for that pain level by the physician.On 4/14/2026 at 8:45 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM#2) of the wing in which Resident #2 resided. The surveyor asked LPN/UM#2 if the facility utilized a pain scale. LPN/UM #2 responded, Yes. She stated we have a pain scale that we utilized at the facility. The pain scale is 0-10. Mild is 0-3, moderate is 4-6 and severe is 7-10. The surveyor then asked LPN/UM #2 if a resident described a pain level of 0, would you administer Oxycodone HCl Oral Tablet 5 MG. LPN/UM#2 replied, No. She further explained that you want to try first to manage the pain with a lighter drug and see how that worked first. You do not want to jump right to the opioid. The surveyor then asked LPN/UM#2 if the pain scale utilized by the facility indicated administering Oxycodone HCl Oral Table 5 MG for a pain level of 0-5. LPN/UM #2 stated the pain scale that we utilized would not indicate the Oxycodone be administered for a pain level of 0-5. The facility Director of Nursing (DON) has in-serviced us continuously on this matter. She further stated that this has been a problem with Resident #2.On 4/14/2026 at 9:00 AM, the surveyor conducted an interview with the facility Licensed Nursing Home Administrator (LNHA) and the facility DON. The surveyor asked the DON if Resident #2 should have been administered Oxycodone HCl Oral Tablet 5 MG for a pain level that ranged from 0-5. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON responded that the facility pain scale was mild pain is 0-3, moderate pain is 4-6 and severe pain is 7-10. She then stated that Oxycodone should not have been administered for a pain level of 0-5. A review of the facility provided document titled, Numeric Rating Scale, undated, included the following: One frequently used pain scale is the Numeric Rating Scale (NRS). With the NRS, nurses ask the clients to rate the intensity of their pain on a scale from 0 to 10, with 0 being no pain and 10 being the worst pain the client can imagine. Scores are interpreted as follows: 0 is no pain, 1 to 3 is mild pain, 4 to 6 is moderate pain, and 7 to 10 is severe pain.A review of the untitled/undated facility provided document revealed the following under Pain Management by Level:Mild Pain (0-3): Use non-opioid analgesics like acetaminophen (a medication used to treat pain and fever reduction) or NSAIDS (Non-steroidal anti-inflammatory drugs).Moderate Pain (4-6): Consider weak opioids like codeine or Tramadol, possibly combined with non-opioids.Severe Pain (7-10): Strong opioids like morphine or oxycodone are typical, possibly using a multimodal approach for better relief. The surveyor reviewed the facility provided Pain Management, policy, date reviewed/revised: 5/6/25, which included: The following was observed under Policy: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, goals and preferences. The following was revealed under Policy Explanation and Compliance Guidelines: The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain.NJAC 8:39-27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 4/14/2026 at 10:03 AM the surveyor, accompanied by the Director of Dietary (DOD), observed the following in the kitchen:A standup mixer was observed to be bagged and not in use on a metal countertop, The DOD confirmed to the surveyor that the mixer was cleaned and sanitized and was bagged when not in use. The surveyor and DOD removed the plastic bag to observe the mixer. Upon removal of the bag the surveyor observed a yellowish, oily/greasy substance on the upper attachment area. The surveyor used their finger to swipe the area, and a greasy, unidentified substance was observed on the surveyor's finger. In addition, there was unidentified, dried debris on the base arm of the mixer. When interviewed, the DOD agreed that the mixer needed cleaning and immediately cleaned the affected areas in the surveyor's presence.A review of the facility Kitchen Equipment Cleaning Policy, review date: 5/6/25, included: The following was observed under Policy: The facility maintains all kitchen equipment, utensils, and food preparation surfaces in a clean condition to support safe food handling practices. Cleaning of equipment is performed as needed based on use and operational needs. The following were revealed under Policy Explanation and Compliance Guidelines:General requirementsAll kitchen equipment shall be kept clean and free of food debris and residue.Cleaning shall occur at routine intervals and when equipment becomes soiled.Cleaning FrequencyEquipment and utensils used in food preparation shall be cleaned after use. NJAC 8:39-17.2(g)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and review of facility documents, it was determined that the facility failed to maintain the resident's environment in a safe, sanitary, and homelike manner by ensuring that damaged flooring was repaired in a timely manner. This deficient practice was identified on 1 of 2 units (West Unit) and 1 of 1 dining rooms and was evidenced by the following: 1.) On 4/13/2026 at 10:42 AM, while conducting an observation in the dining room, the surveyor observed a loose floor tile near the main doors. On 4/13/2026 at 10:48 AM, the surveyor and the Director of Maintenance (DM) returned to the dining room. He confirmed the surveyor's findings. At that time, the surveyor interviewed the DM who stated, it should not be popped up like that. I will address it right away because it is a tripping hazard. He added that normally they checked the floors once per week and they have a maintenance log on each unit for staff to report any issues. He added that most times they just told him verbally if there were any concerns. On 4/13/2026 at 10:54 AM, near the [NAME] -B hall, the surveyor noted uneven flooring secured by black tape. At that time, a family member of an unsampled resident stated, I thought it was decorations, but that looks like break your neck tape to me, as they walked by and looked at the flooring. On 4/13/2026 at 11:23 AM, during a further tour of the facility, located on the [NAME] Unit, near the soiled utility room, the surveyor noted a loose cracked floor tile. On 4/14/2026 at 9:41 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that they were renovating the hallways. He added that he would be conducting an audit and would have them fixed if they were not intact, as someone could trip. On 4/14/2026 at 9:45 AM, the surveyor, accompanied by the LNHA, toured the [NAME] Unit. He pointed to a caution sign that was placed near the uneven flooring after the surveyor's inquiry. He also confirmed the findings of the loose floor tiles. He added that during the renovations, the floor tiles should be maintained in a manner that they did not pose a fall risk to the residents. A review of the facility's Environment of Care: Safety and Maintenance Policy undated policy, included, The facility shall maintain a safe, clean, and functional environment for residents, staff, and visitors.The facility environment shall be kept in a condition that promotes safety, cleanliness, and accessibility. NJAC 8:39-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to: a.) accurately identify when a medication administered via a patch was applied and removed, b.) ensure an incomplete physician's order was clarified c.) accurately transcribe and implement a diet order in accordance with the Dietician's recommendations. This deficient practice was identified for 1 of 1 resident, (Resident #86) reviewed for Pain and for 1 of 1 resident (Resident #87), reviewed for meal tray accuracy. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1.)On 4/9/2026 at 10:15 AM, the surveyor observed Resident #86 in bed, wearing a sling on their left arm. On 4/9/2026 at 1:14 PM, the surveyor reviewed the medical record for Resident #86. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: pain in left hand, muscle weakness, pain in left shoulder, and a displaced fracture of the left humerus. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 4/13/2026, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident occasionally experienced moderate pain. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 4/6/2026, that the resident was on a pain management regimen. Interventions included: Administer medications as ordered. Monitor for side effects and effectiveness, and attempt non-pharmacological pain interventions when not contraindicated: massage, repositioning, peaceful environment, aroma therapy, music, etc. A review of the Order Summary Report (OSR), dated as of 4/14/2026, included the following physician orders (PO): A PO, dated 4/6/2026 at 10:21 AM, for Lidoderm external patch 5 %, to be applied to the left shoulder in the evening and to be removed in the morning. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO, dated 4/6/2026, for Voltaren external gel 1 %, apply to the upper arm, two times per day for pain. The physician's order did not include the location where the Voltaren gel should be applied. A review of the April 2026 MAR revealed that the Lidoderm patch should be applied at 6:00 PM. Check marks and nurse initials were noted for April 6 through April 13, 2026, which indicated that the medication was administered 8 (eight) times. There was no designated time slot for the nurse to sign that the Lidoderm patch was removed. On 4/14/2026 at 10:17 AM, the surveyor made a follow-up visit with Resident #86 who stated that they did not like to consume too many medications. They added that they have never used the Lidoderm patch since they came to the facility. On 4/14/2026 at 10:21 AM, the surveyor interviewed the Registered Nurse (RN) who stated that Resident #86 was on a pain management regimen for their left arm pain. She added that the resident had a Lidoderm patch ordered to be applied in the evening, and she was not sure if they used it because it was applied during the evening hours. She also stated that she has not seen it on Resident #86 and therefore she has not removed it. She further stated that typically, the Medication Administration Record (MAR) would reflect the time that it should be administered and removed, then the nurse would initial accordingly. RN #1 further stated that she would be made aware of the time that the patch needed to be removed by the designated time when the order was noted. On 4/14/2026 at 10:36 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that the MAR should reflect the time that the Lidoderm patch should be applied and removed, and the nurse should initial to indicate that it was done. On 4/14/2026 at 10:43 AM, the surveyor interviewed the Director of Nursing (DON) who stated that there should have been a designated time when the PO was entered into the system. She further stated that depending on the PO, it would populate on the MAR or TAR for the nurse to carry out the PO during the med pass. At that time, the DON added that the provider entered the order for the Lidoderm, and she was not sure if they needed education on when something needed to be removed, it also needed to be timed. On 4/14/2026 at 11:03 AM, the surveyor and RN #1 checked the medication cart. There was a package labeled with Resident #86's name on it that contained Lidoderm 5% patch. The plastic package indicated that 14 Lidoderm patches were delivered. There were 11 of 14 Lidoderm patches present, which indicated that only 3 (three) were removed. On 4/14/2026 at 4/15/2026 at 11:38 AM, the surveyor conducted a follow-up interview with the DON who stated that she was still investigating why there were only 3 patches removed from the box, and there were initials on the MAR which indicated that that Lidoderm 5% Patch was administered 8 (eight) times. She further stated that the Voltaren gel order should have been clarified to indicate where it should be applied. 2.) On 4/10/2026 at 11:17 AM, the surveyor observed Resident #87 seated in a wheelchair at the bedside with their meal tray on an overbed table in front of them. The surveyor noted that the resident had a single chicken drumstick on their plate. The resident stated that the Dietician had visited him/her and stated that she would recommend double portions of protein, and a protein supplement, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as the resident had a wound that needed protein for wound healing. The resident stated that they had yet to receive double portions of protein. The surveyor reviewed the electronic medical record (EMR) for Resident #87. A review of the admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; morbid (severe) obesity due to excess calories, mild protein-calorie nutrition, difficulty in walking, not elsewhere classified, and acute respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues). A review of the comprehensive Minimum Data Set (MDS), (an assessment tool) dated 4/6/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS included that the resident was at risk for Pressure Ulcers/Injuries and was admitted to the facility with 1 (one) unstageable pressure ulcer due to coverage of the wound bed by slough (a layer of dead skin) and/or eschar (dead tissue that forms over a wound). A review of the Individualized Comprehensive Care Plan (ICCP) revealed that the resident had a Focus area initiated on 4/8/2026, with a revision date of 4/15/2026, for Nutritional Status: Resident #87, .I am on a Therapeutic diet and at nutritional & hydration risk related to morbid obesity .receive double protein per RD (Registered Dietician) recommendation. Interventions included: .Registered Dietician to evaluate and make diet/supplement change recommendations as needed (4/8/2026).Provide and serve diet as ordered Therapeutic diet (Double protein) (Revision on 4/15/2026). A review of the Order Summary Report, included the following Physician's Orders (PO): A PO, dated 4/3/2026, for NAS (No added Salt) diet, Regular texture, Thin Consistency. Fruit cup at HS. Juice with meals. Hot tea with meals and 4 (four) oz (ounces) of milk with meal for diet. A PO, dated 4/4/2026, for Give 4 Oz of Pudding with lunch and record the amount consumed. In the afternoon for supplement give 4 oz of pudding po (by mouth) with lunch and record amount consumed. A PO, dated 4/3/2026, for Protein Oral Liquid (Protein) Give 30 ml (milliliters) by mouth in the evening for supplement. Give 30 cc (cubic centimeters) by mouth in the evening for supplement. Give 30 cc po daily and record amount consumed. A review of a Nutritional Risk Evaluation with an Effective date of 3/26/2026 at 9:04 PM, revealed: Albumin (the most abundant protein in human blood plasma, produced by the liver) less than 30 g/L (grams per liter), 3-5 other nutrition-related labs abnormal. Assessment and Plans included: Resident is on a low-fat cholesterol diet. Likes fruit and pudding and juice. We discussed the importance of more protein. PAB (pre-albumin) 18 and alb (albumin) 3.3. Has a wound and is on MVI (multivitamin) with minerals, vit c and vit d. Rec (recommend) double meat and pudding or fruit cup at HS (hours of sleep). Monitor intake, weight and labs. On 4/14/2026 at 11:51 AM, the surveyor observed resident seated in a wheelchair at the bedside. The resident stated that he/she had still not received double portions of protein at meals, but he/she did receive a protein supplement with his/her medications and his family brought in an oral protein drink from home. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/2026 at 12:04 PM, the surveyor observed the resident's meal tray in the presence of Certified Nursing Assistant (CNA #1) who confirmed that the resident's meal ticket included one 2 (two) Oz (ounce) Baked Herb Chicken drumstick, a small house salad, Italian [NAME] Beans 4 Oz. and did not include double portions of protein as recommended by the RD. On 4/14/2026 at 12:07 PM, the surveyor interviewed Registered Nurse (RN #1) who stated that when the RD made a recommendation an order was placed in the computer for the diet type, and we filled out a diet slip that went to the kitchen. RN #1 stated that the RD would have to tell us about the recommendation in order for the order to be placed into the computer. RN #1 stated that there was an order for the resident to receive pudding, and she had been giving the resident that. At that time, the surveyor returned to the resident's room and confirmed that the resident had received both a container of pudding and fruit juice as described by RN #1, but the resident still had not received double portions of protein as recommended by the RD. On 4/15/2026 at 9:41 AM, the surveyor interviewed the Director of Nursing (DON) who sated that the RD wanted Resident #87 to receive double protein and that the order was clarified and updated in the diet orders after surveyor inquiry. The DON stated that the RD communicated her recommendations to the facility via email and she did receive an email with the RD's recommendations for Resident #87 on 4/3/2026. The DON stated that the Unit Manager (UM) also received it and took off the order, but the double order of protein was missed. The DON stated that she would have expected that the RD's recommendations to have been followed. The DON further stated that there were also orders for oral protein supplements now after surveyor inquiry. On 4/15/2026 at 10:30 AM, the DON provided the surveyor with an email dated 4/3/2026 at 8:00 AM, with a Subject of Diet Recommendations. The diet recommendations that were made by the RD for Resident #87 included: Rec double meats, Provide fruit cup at HS (hours of sleep), Rec juice with meals, Wants hot tea with meals and wants 4 (four) ounce milk with meals (requesting iced tea), Provide pudding with lunch, Rec to liberalize diet D/C (discontinue) low fat low cholesterol diet to be Regular NAS (No added Salt), Rec 30 ml liquid protein 1 (one) time a day. On 4/15/2026 at 10:47 AM, the surveyor interviewed the Registered Dietician (RD) via telephone who confirmed that she worked at the facility one day per week. The RD stated that she completed a Nutritional Risk Assessment for Resident #87 on 3/26/26 and confirmed that she emailed the facility on 4/3/2026 with Diet Recommendations for the resident. The RD stated that she recalled the resident and believed that he/she wanted more foods rather than supplements, so she recommended double portions of protein and pudding. The RD stated that if the resident was at higher risk she would have checked the orders to confirm implementation of her recommendations, but the UM was usually right on it, so she was surprised that the resident did not get double portions because he/she really needed that. A review of the facility's Physician Orders Policy reviewed 5/6/2025, included: It is the policy of the facility to ensure that all physician orders are obtained, documented, communicated, and implemented accurately and in a timely manner to support safe and effective resident care. Physician orders must be complete, legible, and authenticated in accordance with applicable regulatory and professional standards. .All new orders must be reviewed for: Completeness.The nurse must clarify questionable orders with (continued on next page)

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	04/15/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the prescribing practitioner prior to implementation. A review of the facility's Documentation in Medical Record reviewed 5/6/2025 included, Licensed staff . shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. A review of the facility Nutritional Management policy, dated 7/9/2025, included: .Nutritional recommendations may be made by the dietician based on the resident's preferences, goals, clinical condition or other factors and followed up with the physician/practitioner for orders as per facility policy, if indicated. NJAC 8:39-27.1(a)