STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountainview Care Center	527 River Avenue Lakewood, NJ 08701

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40902 Complaint #: NJ162242 Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident's rights were protected when a staff member video recorded the resident without the resident or their representative's consent. This deficient practice was identified for 1 of 1 resident reviewed for resident rights (Resident #239). Findings include: A review of Resident #239's Admission Record face sheet (an admission summary) indicated that the resident was admitted to the facility with diagnoses which included but not limited to; bipolar disorder, schizoaffective disorder, and anxiety disorder. A review of Resident #239's comprehensive Minimum Data Set (MDS), an assessment tool dated 01/27/23, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15; which indicated a severely impaired cognition. The surveyor observed on 03/04/25 at 3:10 PM, a video recording taken on 03/07/23 at 1:38 PM, of the outside entrance and reception area of the Ear, Nose, and Throat (ENT) doctor's office, revealed that Housekeeping Aide (HA #1) was video recording Resident #239 with a cell phone. Resident #239 appeared upset and was confused and the resident stated that they believed they had been kidnapped by HA #1. Further review revealed that the transport driver from the transportation company took HA #1's cell phone and assisted HA #1 with continuing to video recording the resident on the same cell phone. During a telephone interview on 03/04/25 at 2:59 PM, with the ENT staff (ENT #1), who stated that she was notified by her staff on 03/07/23, that HA #1 was inappropriate with Resident #239 and they asked her to come to the reception area. ENT #1 stated that she observed HA #1 yelling and belittling Resident #239 while video recording the resident. During a telephone interview on 03/04/25 at 3:05 PM, ENT #2 stated that HA #1 was video recording Resident #239 who seemed agitated and confused. ENT #2 stated the staff were videotaping the resident during the incident. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/25 at 8:59 AM, the Director of Nursing (DON) stated that she was contacted by ENT #1 who reported that HA #1 was videotaping Resident #239 who upset and then she passed the phone to the transport driver who continued to video tape Resident #239. The DON stated that staff were prohibited from recoding residents, and they had been trained regarding that expectation. NJAC 8:39-4.1(a)12

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 52126 Based on observation, interview, and policy review, it was determined that the facility failed to respect the right to confidentiality of medical records during medication pass. This deficient practice was identified for 2 of 8 residents observed during medication pass (Resident #38 and Resident #290). Findings include: Observation on 03/05/25 at 11:27 AM, Registered Nurse (RN #1) administered medications to resident Resident #290 in the resident's room. RN #1 left Resident #290's electronic medical records (EMR) open which contained confidential and private medical information visible to any resident or visitor in the hallway outside of the dining room. During an interview on 03/05/25 at 11:40 AM, RN #1 stated, I'm nervous, I don't normally leave the computer screen open. Observation on 03/05/25 at 1:02 PM, Licensed Practical Nurse (LPN #1) administered medications to Resident #38 in the resident's room. LPN #1 left Resident #38's EMR open which contained confidential and private medical information visible to any resident or visitor in the hallway outside of the dining room. During an interview on 03/05/25 at 1:05 PM, LPN #1 stated, someone could see the resident's information if the screen of the computer is left open. During an interview on 03/06/25 12:09 PM, the Director of Nursing (DON) stated, It's expected for the computer screen to be closed so that people cannot see resident information. It would be a HIPPA [Health Insurance Portability and Accountability Act] violation and a violation of resident rights to privacy and confidentiality. A review of the facility's undated Resident Rights policy includedFederal and state laws guarantee certain basic rights to all residents in this facility. These rights include the resident's right to: . t. privacy and confidentiality. NJAC 8:39-4.1(a); 35.2(i)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40902 Complaint #: NJ162242 Based on observation, interview, record review, and review of the facility's policy, the facility failed to implement their abuse policies and procedures by ensuring a resident (Resident #239) was free from verbal abuse. This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #239). Resident #239, who had diagnoses of bipolar, schizoaffective disorder, and anxiety, was observed by staff at an Ear, Nose, and Throat (ENT) doctor's office appointment being verbally abused and exploited by their facility escort, Housekeeping Aide (HA #1), who recorded the resident with their cell phone while they verbally abused the resident. The ENT staff who witnessed the incident reported that HA #1 was belittling and yelling at the resident. Observation of the ENT's surveillance video showed the entrance to the ENT's office with HA #1 yelling and cursing at Resident #239 who was observed visibly upset and verbalized that they thought HA #1 was kidnapping them. HA #1 continued to record and yell at the resident; never once reassuring the resident of their safety. The ENT's office had to request that HA #1 leave their office and a new escort be brought from the facility for Resident #239. The facility's failure to implement their abuse policy to ensure all residents were free from verbal abuse and exploitation posed the likelihood of serious harm to all residents. This resulted in an Immediate Jeopardy (IJ) situation. The IJ was Past Non-Compliance (PNC). The IJ was identified from 3/7/23 at 1:38 PM, when HA #1 began verbally abusing Resident #239 and exploiting them by videotaping it. The facility's Administration were notified of the IJ on 3/6/25 at 4:50 PM. The facility submitted an acceptable Removal Plan (RP) on 3/6/25 at 10:41 PM. The facility was back in compliance when the facility addressed the situation by: HA #1 was terminated; Resident #239 received a psychosocial evaluation; and all staff were in-serviced on the facility's abuse prevention and reporting policies by the Assistant Director of Nursing (ADON). The survey team verified the completion of the RP was 3/7/23, during an on-site survey on 3/6/25 at 11:13 PM, and determined the IJ was PNC. Findings include: A review of the facility's Abuse Prevention policy initiated January 2018, included the facility will not tolerate any form of resident abuse, neglect, or exploitation by staff members, volunteers, visitor, or family members or by another resident . The surveyor reviewed the closed medical record for Resident #239. A review of the Admission Record face sheet (admission summary) revealed that the resident was admitted to the facility with diagnoses which included but not limited to; bipolar disorder, schizoaffective disorder, and anxiety disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 1/27/23, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated a severely impaired cognition. A review of the individualized comprehensive care plan (ICCP) included a focus area initiated 1/22/23, that the resident had a cognitive deficit. Interventions included: to be able to verbalize safety rules for specific tasks; engage in appropriate social conversation with facility staff; and consistent caregivers. A review of a Social Progress Note dated 3/7/23, indicated that the Social Worker (SW) documented that they followed-up with Resident #239 upon their return from the doctor's office. The resident appeared calm and in no emotional distress. The resident reported they could not recall if there was an incident while they were at the doctors and does not know what may have happened . A review of the Individual Psychotherapy Progress Note dated 3/8/23, included that the resident was initially tense, worried, and irritated because [the resident] was going to attend a meeting with staff. [The resident] was able to speak calmly once [they] were settled and assured [they] would be alright . A review of the facility's undated Investigation included an overview that on 3/7/23, at approximately 1:40 PM, the Director of Nursing (DON) received a phone call from the ENT's office that Resident #239 was observed with their escort, HA #1, who was observed having inappropriate aggressive behaviors towards the resident which included yelling, cursing, and videotaping Resident #239. That caused Resident #239 to become more agitated, that they fear for the resident safety with staff member, that [HA #1's] were so disruptive to the office that they asked her to step out of the office. The DON advised the office to call the police, to have HA #1 removed, and the facility would immediately send a new staff member to assist the resident. The investigation further indicated that HA #1 returned to the facility, they were interviewed, and the facility reviewed HA #1's cell phone video and then had them delete the video. The facility concluded that based on their investigation, the alleged allegation of abuse was substantiated. HA #1 was witnessed yelling, cursing, and videotaping the resident; actual videos of the resident were taken without their consent. HA #1 was asked and deleted all videos, and HA #1 was terminated. On 3/4/25 at 3:10 PM, the surveyor observed the video recording taken and provided by the ENT's office on 3/7/23 at 1:38 PM. The video showed the outside entrance and reception area of the ENT's office with HA #1 yelling loudly and cursing towards Resident #239 while videotaping the resident with a cell phone. Resident #239 appeared upset and was confused and the resident stated that they believed they had been kidnapped by HA #1 who never reassured the resident of their safety, but only yelled at the resident. Further review revealed that at no time did the transport driver for the facility's contracted transportation company intervene on behalf of the resident, but instead assisted HA #1 with the videotaping of the resident on the same cell phone. During a telephone interview on 3/4/25 at 2:59 PM, ENT staff (ENT #1) stated that she was notified by her staff on 3/7/23, that HA #1 was inappropriate with Resident #239 and staff asked her to come to the reception area. ENT #1 also stated that she observed HA #1 yelling and belittling Resident #239. ENT #1 stated her staff asked HA #1 to step outside and they contacted the facility to make them aware and they requested that another staff member come to supervise Resident #239 for the remainder of the appointment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a telephone interview on 3/4/25 at 3:05 PM, ENT #2 revealed that the aide [HA #1] was very nasty to Resident #239. ENT #2 stated HA #1 was yelling at the resident a lot and videotaping the resident who seemed agitated and confused. ENT #2 reported that Resident #239 thought they were being kidnapped, but the aide [HA #1] did not assure the resident that they were safe and just yelled at them. During an interview on 3/6/25 at 8:59 AM, the DON stated she was contacted by ENT #1 at the ENT's office on 3/7/23, who reported that she had witnessed HA #1 being abusive towards Resident #239. The DON stated HA #1 was terminated, and that the facility substantiated that abuse occurred. The DON stated when she reviewed the abuse video, she was visibly shocked and upset. The DON stated the abuse Resident #239 sustained was terrible. The acceptable Removal Plan (RR) on 3/6/25 at 10:41 PM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including; HA #1 was terminated, Resident #239 received a psychosocial evaluation, and all staff were in-serviced on the facility's abuse prevention and reporting policies by the ADON. The facility self-corrected the deficient practice and it was determined that the IJ was Past Non-Compliance (PNC); that the facility corrected their non-compliance on 3/7/23. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 3/6/25 at 11:13 PM. NJAC 8:39-4.1(5); 33.2(c)12

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 40902 Complaint #: NJ162242 Based on observation, interview, record review, and review of the facility's policy, it was determined that the facility failed to ensure residents were free from physical restraints. This deficient practice was identified for 1 of 1 resident reviewed for restraints (Resident #239). Findings include: A review of Resident #239's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; bipolar disorder, schizoaffective disorder, and anxiety disorder. A review of Resident #239's comprehensive Minimum Data Set (MDS), an assessment tool dated 01/27/23, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15; which indicated a severely impaired cognition. A review of Resident #239's individualized comprehensive care plan 02/13/23, did not include the resident had a restraint or used a wheelchair seatbelt. A review of Resident #239's Physician Orders dated 03/05/23, did not include an order for restraints. Observation on 03/04/25 at 3:10 PM, of video recording taken on 03/07/23 at 1:38 PM, of the outside entrance and reception area of an Ear, Nose, and Throat (ENT) doctor's office, revealed Resident #239 was seated in their wheelchair with a lap seatbelt applied. Several times in the video, Resident #239 was observed grabbing the front of the reception desk and attempting to stand up from their wheelchair, but the wheelchair's lap seatbelt prevented the resident from independently standing up from their wheelchair. During a telephone interview on 03/04/25 at 2:59 PM, ENT staff (ENT #1) stated that she observed Resident #239 in the reception area of their office in a wheelchair. ENT #1 stated Resident #239 was strapped in their wheelchair and they were unable to release the seatbelt and stand up. During an interview on 03/05/25 at 2:29 PM, the Staffing Coordinator (SC) stated she was the staff who went to the ENT office on 03/07/23, to remain with Resident #239 and she accompanied the resident back to the facility. The SC stated she believed Resident #239 had a seatbelt on. The SC also stated that when residents were transported, the transport driver put a seat belt on the residents. The SC stated if a resident had a strap or lap seatbelt on while they were in their wheelchair, and it restricted their freedom of movement and it would be a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/25 at 8:59 AM, the Director of Nursing (DON) stated that she reviewed the abuse video and observed Resident #239 in a wheelchair with a lap seatbelt in use. The DON stated that the use of the wheelchair's lap seatbelt was a restraint. The DON stated that the transport driver was the person who put the strap on the resident and was the one who should have released it; it was not her staff that did that. A review of the facility's undated Restraints Policy and Procedure policy included restraints can only be applied with a physician's written order specifying type, medical justification, duration, and condition for use . NJAC 8:39-4.1(a)5, 6 NJAC 8:39-27.1(a)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52126 Complaint #: NJ172235 Based on interviews, record review, and facility policy review, it was determined that the facility failed to implement policies and procedures to report an allegation of staff-to-resident sexual abuse to the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #289). Findings include: A review of Resident #289's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; anxiety disorder, dementia with agitation, social phobia, and cognitive communication deficit. The resident expired on [DATE]. A review of Resident #289's BIMS Evaluation dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) score of 4 out of 15; which indicated a severely impaired cognition. A review of Resident #289's individualized comprehensive care plan (ICCP) revealed that the resident had impaired decision [making] and a diagnosis of cognitive communication deficit dated [DATE]. Further review of the ICCP revealed that the resident exhibited socially inappropriate behavior as evidenced by false accusations that included; yelled out was kicked, thrown to floor, pushed around with no specific details, nor timeframe then will forget saying those comments dated [DATE], with an intervention for a two-staff assistance with care, refer for psychiatric consult as needed, and social service evaluation and follow-up. The resident exhibited physically aggressive behavior toward staff/other dated [DATE]. The resident had a diagnosis of social anxiety disorder and social phobia dated [DATE]. The resident was at high risk for skin breakdown related to decreased mobility, anemia, history of wounds, actual wounds, incontinence or diabetes and bed bound status dated [DATE]. A review of the facility provided investigative documentation dated [DATE], revealed the facility was notified by the ombudsman on [DATE], that a complaint was received that Resident #289 was sexually assaulted by an unidentified staff member approximately two weeks before the resident's death on [DATE]. During a telephone interview on [DATE] at 3:22 PM, the Resident's Representative (RR #1) stated that they had not been notified of the allegation. During an interview on [DATE] at 4:05 PM, the Director of Nursing (DON) stated, No, it was not reported to the NJDOH or police. The DON stated that the ombudsman came in and investigated the allegation and closed the case. I didn't think I needed to report it, since the ombudsman came in. I just investigated the allegation and kept a soft file just in case and educated the staff on abuse. I'm responsible for reporting abuse allegations to the [NJDOH] and police. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Abuse Prevention policy revised [DATE], included The facility will not tolerate any form of resident abuse, neglect, or exploitation by staff members, volunteers, visitors, or family members, or by another resident .All occurrences of abuse, neglect, mistreatment, exploitation, injuries of unknown origin, theft or misappropriation of resident's property, and other grievances or complaints will be reported .The facility has procedures to report all alleged violations and substantiated incidents to the [State Agency] and to all other agencies, as required, and to take actions depending on the results of the investigation .The Administrator or designee will notify the following agencies of the allegations: the office of the ombudsman . New Jersey Department of Health and Senior Services must be called immediately .the secretary of the US Department of Health and Human Services must be notified immediately and in no event later than 2 hours after forming the suspicion of a crime resulting in serious bodily injury to a resident .If the suspected crime does not result in serious bodily injury, the report must be made no later than 24 hours after forming the suspicion .the local police department will be notified of any suspected crime resulting but not limited to theft, physical abuse, sexual abuse or extreme verbal abuse threatening bodily harm. NJAC 8:,d+[DATE].4(f)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. 40902 Complaint #: NJ162242 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate an allegation of staff to resident verbal abuse and exploitation by a Housekeeping Aide (HA #1) who was observed being verbally abusive and videotaping the incident. This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #239). Resident #239, who had diagnoses of bipolar, schizoaffective disorder, and anxiety, was observed by staff at an Ear, Nose, and Throat (ENT) doctor's office appointment being verbally abused and exploited by their facility escort, HA #1, who recorded the resident with their cell phone while they verbally abused the resident. The ENT staff who witnessed the incident reported that HA #1 was belittling and yelling at the resident. Observation of the ENT's surveillance video showed the entrance to the ENT's office with HA #1 yelling and cursing at Resident #239 who was observed visibly upset and verbalized that they thought HA #1 was kidnapping them. HA #1 continued to record and yell at the resident; never once reassuring the resident of their safety. The ENT's office had to request that HA #1 leave their office and a new escort be brought from the facility for Resident #239. During the facility's investigation, the facility failed to thoroughly investigate by obtaining statements from all witnesses including other residents who were escorted by HA #1 to their appointments. The facility's failure to implement their abuse policy by immediately conducting a thorough investigation to ensure all residents were free from abuse posed a likelihood of serious harm to all residents. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 3/7/23 at 1:38 PM, when HA #1 began verbally abusing Resident #239 and exploiting them by videotaping it. The facility's Administration were notified of the IJ on 3/6/25 at 4:50 PM. The facility submitted an acceptable Removal Plan (RP) on 3/6/25 at 10:41 PM. The survey team verified the implementation of the RP on-site 3/6/25 at 11:13 PM. Findings include: A review of the facility's Abuse Prevention policy initiated January 2018, included all reports of alleged or suspected abuse, neglect, and injuries of unknown origin shall be promptly and thoroughly investigated by the facility's Administrator. Immediate Investigation: the Nurse Supervisor will immediately initiate and investigation and will: .interview those staff members or other persons present to determine a cause/effect relationship for the injury/incident .the person conducting the interview will: .interview all witnesses and staff in the immediate area; interview the resident when appropriate . The surveyor reviewed the closed medical record for Resident #239. A review of the Admission Record face sheet (admission summary) revealed that the resident was admitted to the facility with diagnoses which included but not limited to; bipolar disorder, schizoaffective disorder, and anxiety disorder. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 1/27/23, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated a severely impaired cognition. A review of a Social Progress Note dated 3/7/23, indicated that the Social Worker (SW) documented that they followed-up with Resident #239 upon their return from the doctor's office. The resident appeared calm and in no emotional distress. The resident reported they could not recall if there was an incident while they were at the doctors and does not know what may have happened . A review of the Individual Psychotherapy Progress Note dated 3/8/23, included that the resident was initially tense, worried, and irritated because [the resident] was going to attend a meeting with staff. [The resident] was able to speak calmly once [they] were settled and assured [they] would be alright . A review of the facility's undated Investigation signed by the Director of Nursing (DON), included an overview that on 3/7/23, at approximately 1:40 PM, the DON received a phone call from the ENT's office that Resident #239 was observed with their escort, HA #1, who was observed having inappropriate aggressive behaviors towards the resident which included yelling, cursing, and videotaping Resident #239. That caused Resident #239 to become more agitated, that they fear for the resident safety with staff member, that [HA #1's] was so disruptive to the office that they asked her to step out of the office. The DON advised the office to call the police, to have HA #1 removed, and the facility would immediately send a new staff member to assist the resident. The investigation further indicated that HA #1 returned to the facility, they were interviewed, and the facility reviewed HA #1's cell phone video and then had them delete the video. The resident returned to the facility and a skin assessment was conducted with no injuries found. The facility concluded that based on their investigation, the alleged allegation of abuse was substantiated. HA #1 was witnessed yelling, cursing, and videotaping the resident; actual videos of the resident were taken without their consent. HA #1 was asked and deleted all videos, and HA #1 was terminated. The statements obtained were from the Unit Manager, DON, and HA #1. There were no interviews with the driver of the contracted transportation company, the ENT staff, HA #1's supervisor, Resident #239, or other residents. There was no evidence during the course of the facility's investigation if any other residents were identified and interviewed who had been escorted to appointments by HA #1. On 3/4/25 at 3:10 PM, the surveyor observed the video recording taken provided by the ENT's office on 3/7/23 at 1:38 PM. The video showed the outside entrance and reception area of the ENT's office with HA #1 yelling loudly and cursing towards Resident #239 while videotaping the resident with a cell phone. Resident #239 appeared upset and was confused and the resident stated that they believed they had been kidnapped by HA #1 who never reassured the resident of their safety, but only yelled at the resident. Further review revealed that at no time did the transport driver for the facility's contracted transportation company intervene on behalf of the resident, but instead, he took HA #1's cell phone and continued to record the resident. During a telephone interview on 3/4/25 at 2:59 PM, ENT staff (ENT #1) stated that she reported the incident to the facility; however, there were no follow-up interviews conducted with her by the facility. During a telephone interview on 3/4/25 at 3:05 PM, ENT #2 stated that she was not interviewed by anyone from the facility about the incident. (continued on next page)

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	315327	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountainview Care Center	527 River Avenue Lakewood, NJ 08701

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 3/6/25 at 8:35 AM, the Social Services Director (SSD) stated during an abuse investigation, she interviewed the resident involved and other residents. The SSD stated during that investigation, she did not interview any residents. During an interview on 3/6/25 at 8:59 AM, the DON stated the ENT staff did not make her aware of the driver being involved in the incident, but she did not ask. The DON also stated that she did not interview all the ENT staff who witnessed the incident; she did not know that she could. The DON further stated that she did not interview the Scheduling Coordinator at that time or attempt to identify and interview other residents who had been escorted by HA #1 during appointments. The acceptable Removal Plan (RR) on 3/6/25 at 10:41 PM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including; a complete investigation was initiated; the Licensed Nursing Home Administrator (LNHA) and DON were educated by the Regional Administrator on the facility's abuse policy, customer service, professionalism, and complete and thorough investigations; the SSD was in-serviced on proper investigation of abuse including interviews of other residents; and all staff were in-serviced on abuse. The survey team verified the implementation of the Removal Plan on-site on 3/6/25 at 11:13 PM. NJAC 8:39-4.1(a)5

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 40902 Based on observation, interview, and record review, it was determined that the facility failed to ensure residents received alternative measures prior to installation of bedrails. This deficient practice was identified for 1 of 1 resident reviewed for bedrails (Resident 78). Findings include: A review of Resident #78's Admission Record face sheet (an admission summary) reflected the resident was readmitted to the facility with diagnoses which included but not limited to ; hemiplegia and hemiparesis. A review of Resident #78's quarterly Minimum Data Set (MDS), and assessment tool dated 12/01/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated a fully intact cognition. A review of Resident #78's individualized comprehensive care plan dated 05/29/24, included the resident required left bedrail for mobility and safety. Interventions in place were left sided bedrails as ordered. A review of Resident #78's Bed Rail Evaluation dated 05/29/24, revealed no alternatives were attempted prior to the placement of the bedrails. During an observation on 03/04/25 at 11:18 AM, Resident #78 was lying in the bed with the head of the bed upright and a bedrail on the left side in place. During an interview on 03/05/25 at 5:01 PM, the Licensed Practical Nurse (LPN #3) stated that the nursing staff completed the bedrail assessment for Resident #78, but they did not explore alternative options prior implementing the use of the bedrail. During an interview on 03/06/25 at 6:09 PM, the Director of Nursing (DON) stated the facility did not explore alternative options prior to the use of bedrails, and the facility allowed a resident to use them when they requested to do so. NJAC 8:39-27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 52126 Based on observation and interview, it was determined that the facility failed to properly store medications safely and securely during medication administration. The deficient practice was identified for 2 of 8 residents observed during medication pass. Findings include: Observation on 03/05/25 at 11:27 AM, of Resident #290's medication administration, the Registered Nurse (RN #1) left the medication cart unlocked in the hallway outside of the dining room and left a vial of insulin on top of the medication cart unsecured. The cart was not visualized by RN #1 during medication administration. During an interview on 03/05/25 at 11:40 AM, RN #1 stated, I'm nervous, I don't normally leave the cart unlocked or leave insulin on top of the cart. Observation on 03/05/25 at 1:02 PM, of Resident 38's medication administration, the Licensed Practical Nurse (LPN #1) left the medication cart unlocked in the hallway. The cart was not visualized by LPN #1 during medication administration. During an interview on 03/05/25 at 1:05 PM, LPN #1 stated, someone could get into the medications if the cart is left unlocked. During an interview on 03/06/25 12:09 PM, the Director of Nursing (DON) stated it was expected that if the medication cart was not within eyesight during medication administration, the nurse was required to lock the cart. The DON continued if the medication cart was left unlocked, someone could have gotten into the cart and took medications. The DON confirmed insulin vials were expected to be secured in the cart when the nurse was not present. A review of the facility's Medication Administration policy dated March 2017, included During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. NJAC 8:39-29.4(h)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on record review and interview, it was determined that the facility failed to ensure a resident's medical record was maintained complete, accurately documented, and readily accessible. This deficient practice was identified for 1 of 30 sampled residents (Resident #87). Findings include: A review of Resident #87's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included; atherosclerosis of native arteries of bilateral legs, restless leg syndrome (RLS), and nerve pain. A review of Resident's #87's Progress Notes included a Nurses Note dated [DATE], included .At 3:05 PM, [Resident #87] found in bed with eyes closed .no respirations/no pulse. 3:10 PM code blue called, cardiopulmonary resuscitation (CPR) initiated at 3:13 PM .3:30 PM call placed to power of attorney (POA) . During conversation, POA states that [Resident #87] should have been a do not resuscitate (DNR). She stated she had signed practitioner orders for life sustaining treatment (POLST) stating same. Explanations given that [name of the facility] did not have a copy of POLST and that with no POLST, [Resident #87] had to be considered a full code so CPR initiated. A review of the Progress Notes included no documented evidence from the Social Worker regarding talking to the resident POA about the POLST. During an interview on [DATE] at 9:15 AM, the Social Service Director (SSD) confirmed she kept a soft file on Resident #87 and had all the documentation in that file. The SSD confirmed that she educated the POA that either she would need to sign a new POLST, or the facility would need to get a copy of the existing POLST, and that Resident #87 would remain a full code until a POLST was obtained. The SSD stated that the only thing that she placed in the medical record was quarterly assessments and care conferences, otherwise she kept everything else in her office in a soft file. The SSD was not aware that the medical records were to remain complete, accurately documented, and readily accessible for each resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy titled, Medical Records and Accuracy Policy, indicated, To ensure that all medical records are accurately maintained, easily accessible, and compliant with applicable laws and regulations, including those set by the State of [name of state], the Centers for Medicare and Medicaid Services (CMS), and the Health Insurance Portability and Accountability Act (HIPAA) .Policy: 1. Accurate Documentation: All medical records must reflect accurate, current, and complete information regarding the resident's medical condition, care plan, treatments, medications, and progress .2. Completeness of Records: Each medical record must contain, at a minimum, the following .treatment plans, care plan, and interdisciplinary progress notes .3. Timeliness of Documentation: Documentation should be completed in a timely manner, ideally immediately following a resident's visit or procedure. All entries should reflect the most up-to-date information.Review of the facility's undated policy titled, Medical Records and Accuracy Policy, indicated, To ensure that all medical records are accurately maintained, easily accessible, and compliant with applicable laws and regulations, including those set by the State of [name of state], the Centers for Medicare and Medicaid Services (CMS), and the Health Insurance Portability and Accountability Act (HIPAA) .Policy: 1. Accurate Documentation: All medical records must reflect accurate, current, and complete information regarding the resident's medical condition, care plan, treatments, medications, and progress .2. Completeness of Records: Each medical record must contain, at a minimum, the following .treatment plans, care plan, and interdisciplinary progress notes .3. Timeliness of Documentation: Documentation should be completed in a timely manner, ideally immediately following a resident's visit or procedure. All entries should reflect the most up-to-date information. NJAC 8:,d+[DATE].1(a)18 NJAC 8:,d+[DATE].2