

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Fountainview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by not ensuring a.) a system to ensure discrepancies of controlled substances were documented and rectified for four controlled substances, Ambien, Klonopin, Percocet, and Ultram and, b.) accurately account for and document the administration of a controlled medication, liquid morphine sulfate. This deficient practice was identified for 4 medications stored in the Automated Dispensing System (ADS) and on 1 of 4 medication carts reviewed and was evidenced by the following: 1. On 7/9/26 at 11:30 AM, the surveyor requested a copy of the discrepancy report for the ADS from the Assistant Director of Nursing (ADON). The report was provided and included Ambien, Klonopin, Percocet, and Ultram; however, no dates of when the discrepancies occurred or resident names were included. On 7/14/26 at 12:31 PM, the surveyor interviewed the Director of Nursing (DON) regarding the discrepancy report. She explained that any discrepancies flag on the screen when someone went to use the ADS. She stated that the report she provided was printed by the vendor of the machine, adding that she was unable to print the reports herself. The surveyor requested a report that included the dates of the discrepancies. On 7/15/26 at 8:20 AM, the DON provided a discrepancy report that included dates, which reflected the following discrepancies: Ambien 5 mg: 5/6/26 (minus 1) Ambien 5 mg: 5/7/26 (minus 1) Klonopin 0.25 mg: 5/8/26 (minus 1) Klonopin 0.5 mg: 5/8/26 (minus 19) Percocet 5 mg/325 mg: 5/24/26 (plus 4) Percocet 5 mg/325 mg: 5/27/26 (minus 4) Ultram 50 mg: 5/25/26 (plus 10) (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ultram 50 mg: 5/26/26 (minus 1) Ultram 50 mg: 5/27/26 (minus 11) Ultram 50 mg: 5/28/26 (minus 1) Ultram 50 mg: 5/31/26 (minus 1) On 7/15/26 at 9:10 AM, the surveyor interviewed the DON, who stated she spoke with the nurses and determined the discrepancies were due to a misunderstanding regarding how count numbers were entered into the machine. She stated the actual counts were correct, but the nurses misunderstood how to input the numbers, putting them in twice. She further stated that she provided individual education as each incident occurred and then conducted widespread education on 6/2/26. The surveyor requested the records of the individual education as well as the investigation for each discrepancy to rule out diversion. On 7/15/26 at 10:17 AM, the DON explained that if a discrepancy occurred, it flagged in red at the top of the screen displaying the quantity, which must be addressed before anyone could access the machine. She further stated that it could not be bypassed. She explained that she educated and questioned the nurses involved in the discrepancies and noted that the machine requires two nurses to sign out a controlled substance. She also stated she reviewed which resident each medication was dispensed for, as every medication was signed out for a specific resident. On 7/15/26 at 10:24 AM, the surveyor interviewed the DON and asked if a daily count was completed for controlled substances. She repeated that education was completed for each nurse involved and that she would provide it to the surveyor. She stated that two nurses were involved in each discrepancy, and that she reviewed the medication and resident involved. She stated the machine does not provide a printout of discrepancies, re-emphasizing that nurses were entering incorrect numbers: It's silliness that they're doing. They're doing it backwards. They are punching in numbers and not doing it accurately. On 7/15/26 at 10:59 AM, the surveyor called the representative for the ADS. He stated that the discrepancies for May were resolved and that he would send the report to the DON. On 7/15/26 at 11:22 AM, the DON provided a report (Resolved Discrepancies, C3) sent to her from the ADS representative, which included (Date range: 4/15/26 &ndash; 7/15/26): Ambien 5 mg (5/6/26, minus 1): Resolved 5/8/26; reason: general typo during prior transaction. Ambien 5 mg (5/7/26, minus 1): Resolved 5/8/26; reason: general typo during prior transaction. Klonopin 0.25 mg (5/8/26, minus 1): Resolved 5/8/26; reason: prior user removed less than requested. Klonopin 0.5 mg (5/8/26, minus 19): Resolved 5/8/26; reason: count back error; pulled and replaced (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wrong bin. Percocet 5 mg/325 mg (5/24/26, plus 4): Resolved 6/4/26; reason: count back error. Percocet 5 mg/325 mg (5/27/26, minus 4): Resolved 6/4/26; reason: count back error. Ultram 50 mg (5/25/26, plus 10): Resolved 6/4/26; reason: count back error. Ultram 50 mg (5/26/26, minus 1): Resolved 6/4/26; reason: count back error. Ultram 50 mg (5/27/26, minus 11): Resolved 6/4/26; reason: count back error. Ultram 50 mg (5/28/26, minus 1): Resolved 6/4/26; reason: count back error. Ultram 50 mg (5/31/26, minus 1): Resolved 6/4/26; reason: count back error. On 7/15/26 at 1:08 PM, the ADON provided a Transaction by Patient report from the ADS. On 7/15/26 at 2:04 PM, the survey team met with the DON, Licensed Nursing Home Administrator (LNHA), and Regional LNHA to inform them of the above concerns. The DON stated she would print everything out that evening, adding that the printing process was very tedious. On 7/16/26 at 9:19 AM, the Consultant Pharmacist (CP) met with the survey team and stated he was unaware of any controlled substance discrepancies. The team shared the discrepancy report with the CP, who reiterated that he had not been notified of any ADS discrepancies. On 7/16/26 at 9:59 AM, the facility provided an undated policy titled Controlled Substances, which included: Policy: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Policy Interpretation and Implementation: 12. The Director of Nursing Services (DNS) shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties and shall give the Administrator a written report of such findings On 7/16/26 at 10:06 AM, the survey team met with the DON, LNHA, and Regional LNHA. The DON stated that she went through the discrepancies one by one, that there was no diversion, and that staff were printing the records out piece by piece, adding, the paperwork of it is tedious. She stated that education was completed, that she reviewed the system daily, and that education was given individually. She again stated these were clerical errors. The surveyor reviewed Item #12 of the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Controlled Substances policy and requested the DON's written findings for the discrepancies in question. On 7/16/26 at 11:19 AM, the survey team again requested documentation regarding the discrepancy investigations. On 7/16/26 at 11:32 AM, the DON provided investigations, which included: Ambien 5 mg (5/4/26): Ambien was pulled for a resident and the ADS froze; staff were unable to enter the amount found. Klonopin (4/28/26): 20 tablets of Klonopin 0.25 mg were delivered. 4/29/26: Klonopin 0.25 mg was inaccurately placed in the bin assigned to Klonopin 0.5 mg. 5/7/26: Staff attempted to pull Klonopin 0.25 mg for a resident, but the box was empty. Staff noted the 0.25 mg tablets were in the 0.5 mg box. 5/8/26: The DON and ADON placed the Klonopin 0.25 mg tablets into the correct box. Ultram (5/25/26): Staff attempted to withdraw 1 Ultram and inadvertently documented that they placed 10 Ultram tablets into the bin. Percocet: Documentation provided without a written conclusion. On 7/16/26 at 11:53 AM, the DON stated the investigations were completed yesterday and today (following the surveyor's inquiry). 2. On 7/15/26 at 9:56 AM, the surveyor and Licensed Practical Nurse (LPN) #1 conducted a medication storage audit on the two medication carts located on the [NAME] Unit. The Low Side medication cart was checked, and no concerns were noted. During the High Side medication cart audit, the surveyor observed that a bottle of Morphine Sulphate liquid appeared to have been opened, but no administration record for Unsamped Resident #14 was noted. LPN #1 removed the twist-off lid from the Morphine Sulphate, and there was no foil observed, which was normally present to seal the bottle. At that time, LPN #1 stated that when the medication came from the pharmacy, the box was closed and two nurses would sign, which indicated that they had received the medication from the pharmacy. She then stated that the medication would only be opened when it was time to administer the medication to a resident. When asked if new bottles were delivered with a seal under the cap, LPN #1 stated she thought so but was unsure, and that an example of a new bottle would be in their locked medication storage room. LPN #1 stated that she would need another nurse to access the example. LPN #1 reviewed with the surveyor Unsamped Resident #14's Individual Patient's Controlled Drug Record (a form nurses use to track how much medicine is received, given, and left over during each work shift, commonly referred to as a 'declining sheet') showing that the medication was never given to the resident for whom it was prescribed. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/26 at 10:25 AM, the surveyor, accompanied by LPN #1 and the Assistant Director of Nursing (ADON), entered the medication storage room. LPN #1 and the ADON removed a new bottle of Morphine Sulphate liquid from the medication storage machine and, after removing it from its box, opened the lid. The surveyor, LPN #1, and ADON observed that the bottle was sealed with a silver-colored foil underneath the lid. On 7/15/26 at 11:01 AM, LPN #2 was interviewed by the surveyor. LPN #2 stated that if the declining sheet was blank, the medication had not been given and should not be opened. LPN #2 further stated that two nurses checked and counted the controlled medications at the beginning and end of every shift against the declining sheet to make sure they agreed. If there was a discrepancy, it would be reported to the Unit Manager (UM). On 7/15/26 at 11:20 AM, the UM/LPN was interviewed by the surveyor. She stated that medication bottles should be labeled with the date they were opened to ensure they would be used before their expiration date. The UM/LPN and LPN #2 checked the bottle again in the presence of the surveyor; no date indicating when it had been opened was noted on the bottle or the box containing it. On 7/16/26 at 9:19 AM, the Consultant Pharmacist (CP) for the facility spoke to the survey team. The CP stated to surveyors that the manufacturer of the morphine sulfate places a foil seal to cover the medication under the cap, and that it would not be broken unless the medication had been opened to be administered. He stated that the nursing rights of medication administration were meant to negate accidental opening and administering of medications meant for other residents. The CP stated that pharmacy consultants would be informed of any suspicion of diversion, and that they had not been contacted. Policy: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Policy Interpretation and Implementation: The Director of Nursing Services (DNS) shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties, and shall give the Administrator a written report of such finding N.J.A.C. 8:39-29.7(c)		

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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 review of facility provided documents, it was determined that the facility failed to maintain proper kitchen sanitation practices to prevent the development of food borne illness. The deficient practice was evidenced by the following: On 7/9/26 at 10:47 AM, during the kitchen tour with the Food Service Director (FSD), the surveyor observed a utility rack with stacked pans on each shelf, all turned upside down. The FSD identified this as the dried pot and pan storage rack. The surveyor observed seven pans stacked together on the third shelf from the top. The FSD identified these as 4-inch deep full-size pans. The FSD separated all seven pans, and the 1st, 2nd, 3rd, and 4th pans in the stack revealed a clear, thin liquid dripping onto the floor. The pans were visibly wet on the inside and outside surfaces. The FSD acknowledged the pans should not be stacked together while wet, and acknowledged they were improperly wet-nested (the practice of stacking or storing recently washed dishes or kitchenware while still wet, creating a moist environment that promotes bacterial growth). The FSD also acknowledged that the wetness could cause bacterial growth. The FSD stated that staff should have stored the pans on the drying rack until completely dry before placing them on the clean storage rack. On 7/14/26 at 12:11 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who acknowledged that wet nesting should not occur because bacteria could grow, and stated that it was not allowed. The LNHA further stated staff should have ensured that all pans were dry on the drying rack before placing them on the clean storage rack. On 7/15/26 at 2:05 PM, the survey team met with the Regional Licensed Nursing Home Administrator (RLNHA), the LNHA, and the Director of Nursing (DON). The surveyor made facility administration aware of the above-mentioned concerns. A review of the facility-provided FSD Job Description, under Purpose of Your Job Position, revealed: The primary purpose of your job position is planning, organizing, implementing, and directing the overall operation of the Dietary Department in accordance with current Federal, State, and local standards, guidelines and regulations governing our facility, and as may be directed by the Administrator, to assure that quality nutritional services are provided on a daily basis and that the dietary department is maintained in a clean, safe, and sanitary manner. Under Safety and Sanitation: Ensure that all food storage rooms, preparation areas etc., are maintained in a clean, safe, and sanitary manner. A review of an undated and unlabeled facility kitchen policy, provided by the DON, revealed under 5. Equipment: a.) All food service equipment should be cleaned, sanitized, dried and reassembled after each use. N.J.A.C. 8:39-17.2(g)		

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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. Complaint # 3091573Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to report an allegation of verbal abuse to the New Jersey Department of Health (NJDOH) within 2 hours for one of one resident (Resident # 19) reviewed for abuse. This deficient practice was evidenced by the following:A review of the admission Record (an admission summary) for Resident #19 revealed the resident was admitted to the facility with diagnoses which included but were not limited to; major depressive disorder, recurrent, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily activities), anxiety disorder, unspecified (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life) and alcohol abuse with intoxication, uncomplicated.A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 4/28/2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact.A review of the Individual Comprehensive Care Plan (ICCP) revealed a focus area indicating the resident was at times verbally and physically aggressive toward staff related to poor impulse control and alcohol intoxication, and would make false statements against staff which would be immediately rescinded (Date Initiated: 09/11/2025; Revision Date: 07/10/2026). Further review of the ICCP revealed an intervention stating that when the resident became agitated, staff were to: intervene before agitation escalated; guide the resident away from the source of distress; engage calmly in conversation; and, if the response was aggressive, walk calmly away and approach later (Date Initiated: 09/11/2025).A review of the facility's Reportable Event Record/Report dated 7/13/2026 revealed the event occurred on 7/10/2026 at 11:00 AM and was reported to the NJDOH on 7/10/2026 at 4:20 PM. Further review revealed the resident told the Social Worker (SW) the Licensed Nursing Home Administrator (LNHA) had called them names.On 7/14/2026 at 11:05 AM, the surveyor interviewed the Director of Nursing (DON), who stated Resident #19 emailed the SW on 7/9/2026 after 5:00 PM stating that something had happened with the administrator. The DON stated the SW had already left for the day but returned to the facility after seeing the email. The DON stated the SW made her aware of the event at that time. The DON stated the event occurred when the LNHA observed Resident #19 attempting to enter the nourishment room. She stated residents were not allowed in the nourishment room due to infection control concerns. The DON stated Resident #19 had previously been told that staff would assist them with whatever they needed from the nourishment room. She stated Resident #19 became irritated when the LNHA questioned them about attempting to enter the room. The DON stated she attempted to interview the resident on 7/9/2026, but the resident told her to leave them alone. The DON stated she did not report the incident to the NJDOH at that time because the resident was care planned for making false statements against staff. She stated that an allegation of verbal abuse should be reported to the NJDOH within two hours, adding that they did not report it initially because the resident rescinded what was said.On 7/14/2026 at 12:05 PM, the surveyor interviewed the SW, who stated she received an email on Thursday evening, 7/9/2026, after 5:00 PM from Resident #19 regarding an incident in which the LNHA allegedly called them names. The SW stated she immediately notified the LNHA, the DON, and the Assistant DON (ADON) about the allegations. She stated she returned to the facility and interviewed Resident #19. Resident #19 stated the event happened Wednesday morning (7/8/2026) when the LNHA questioned them about attempting to enter the nourishment room. She stated the resident alleged the LNHA pushed into their room and called them names. The SW asked the resident (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what names the LNHA had called them, at which point the resident stated it had not happened. The SW stated the LNHA was not in the building at the time of the interview. The SW stated she updated the DON, who then took over the investigation. On 7/14/2026 at 12:40 PM, during a follow-up interview with the DON, she stated she tried to interview the resident again on Friday morning (7/10/2026), but the resident did not want to speak to her. She stated she tried again Friday afternoon, but the resident asked to be left alone. Due to the resident's response, the DON stated she advised reporting it because the resident was not cooperating and it did not appear the matter was resolved. The DON provided the surveyor with a completed investigation which concluded the facility was unable to substantiate the allegation. On 7/14/2026 at 1:27 PM, the surveyor interviewed the LNHA, who stated that if an allegation of abuse was made, the first steps were to ensure the resident was safe and report the event to the NJDOH within two hours. The LNHA stated the DON advised him to report it when the SW first made him aware of the email, but he did not do so at that time. On 7/16/2026 at 10:06 AM, during a meeting with the survey team, the DON, and the regional administrator, the LNHA acknowledged that the allegation should have been reported within two hours. A review of the facility's policy Abuse Prevention initiated January 2018, revealed Policy: The facility will not tolerate any form of resident abuse, neglect, or exploitation by staff members. The facility will have an abuse prevention program that protects residents from physical and mental abuse, in compliance with State and Federal regulations and the mission and philosophy of this facility. Verbal abuse: any use of oral, written, or gestured language which is threatening, profane, degrading, loud and/or using nicknames when the resident does not approve of them. 7. Report/Respond: The facility must assure that any incidents of substantiated abuse and neglect are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State or Federal Laws. NJAC 8:39-4.1(a)(5), 9.4(f)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on observations, interviews, and review of medical records and other facility documentation, it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) using the Resident Assessment Instrument (RAI) process on a resident who elected hospice benefits in the appropriate time frame. This deficient practice was identified for 1 of 2 residents reviewed for hospice (Resident # 11). This deficient practice was evidenced by the following: On 7/09/2026 at 10:23 AM, the surveyor observed Resident #11 in a wheelchair. The resident stated hospice was going well. The surveyor reviewed the resident's electronic medical record (EMR), which revealed an admission Record that reflected Resident #11 had medical diagnoses which included, but were not limited to, cancer. A review of the progress notes dated 2/20/26 indicated the resident was admitted on to hospice effective 2/20/26. A review of the resident's Minimum Data Set (MDS), an assessment tool, revealed that the SCSA dated 3/4/26 was completed on 3/10/26, which was not within 14 calendar days from the resident's hospice election as required (should have been completed by 3/6/26). On 7/14/2026 at 10:39 AM, the surveyor interviewed the MDS Coordinator (MDSC), who stated a significant change for hospice should be done within 14 days of going on hospice, and this resident's MDS was dated 3/4/26. She further stated that it was scheduled for 3/4/26, and she did not know it had to be completed within 14 days. On 7/14/2026 at 12:36 PM, the surveyor interviewed the Director of Nursing (DON), who stated she believed they had 2 weeks to complete a significant change for hospice. On 7/15/2026 at 2:04 PM, the survey team met with the DON, Licensed Nursing Home Administrator (LNHA), and Regional LNHA and notified them of the above concern. On 7/16/2026 at 10:06 AM, the survey team met with the DON, LNHA, and the Regional LNHA. The Regional LNHA stated the MDSC misinterpreted the guidelines for opening an MDS versus completion of the MDS. A review of the facility-provided, undated policy titled MDS Completion and Submission Timeframes included the MDS completion date as the 14th calendar day after determination of significant change in status. NJAC 8:39-11.2(i)		

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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. Based on observation, interview, record review and review facility documents, it was determined that the facility failed to obtain a physician's order for oxygen therapy for 1 of 2 residents (Resident #5) reviewed for respiratory care. The deficient practice was evidenced by the following: On 7/9/26 at 10:40 AM, during the initial tour, the surveyor observed Resident #5 sitting in a wheelchair in their room. The surveyor observed an oxygen concentrator (a device that generates oxygen) located near the resident's bed, with a nasal cannula (tubing that delivers the oxygen from the concentrator to the nose) placed on the oxygen concentrator. The resident stated that they wear oxygen while in bed at night. The surveyor reviewed the electronic medical record (EMR) for Resident #5. A review of the admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included, but were not limited to: chronic obstructive pulmonary disease, unspecified (COPD: incurable lung disease that causes restricted airflow and breathing difficulties) and morbid (severe) obesity due to excess calories (more of the calories consumed will be stored as fat). A review of the annual Minimum Data Set, an assessment tool dated 4/1/26, indicated the resident had a Brief Interview for Mental Status score of 15 out of 15, indicating the resident was cognitively intact. A review of the individualized comprehensive care plan (ICCP) included a focus area with a revision date of 12/20/23, stating the resident was at risk for respiratory distress due to a diagnosis of COPD, pulmonary edema (too much fluid in the lungs), asthma (inflammatory disease of the airways), congestive heart failure (heart muscle doesn't pump blood as well as it should), history of sleep apnea (repeated stops and starts in breathing during sleep), and obesity. The ICCP interventions included: administer medications per physician orders, assist resident to a position of comfort when experiencing difficulty breathing, provide oxygen therapy as per physician order, and provide inhalation or nebulizer treatments per physician order. A further review of the ICCP included a focus area with a revision date of 3/13/25, stating the resident required the use of oxygen due to episodes of shortness of breath related to COPD and shortness of breath when lying flat. The ICCP interventions included providing oxygen as ordered by the physician and pulse oximetry (a test that measures blood oxygen saturation) as ordered by the physician, and reporting levels below normal limits to the physician. A review of the Order Summary Report included the following physician orders (PO): A PO dated 8/4/25: Oxygen: obtain SPO2 (oxygen saturation) every shift for shortness of breath (SOB). A review of the July 2026 PO did not include any orders for oxygen therapy. On 7/10/26 at 11:31 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the resident uses oxygen at 2 liters per minute (lpm) as needed (PRN) at nighttime. She further stated that there should be a physician's order for oxygen. The surveyor and LPN reviewed the physician's orders in the EMR, and the LPN confirmed there was no physician's order for PRN oxygen. On 7/10/26 at 11:47 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN), who stated that Resident #5 wears oxygen PRN at night only. She further stated that there should be a physician's order for PRN oxygen. The UM/LPN confirmed that there were no physician orders for oxygen PRN at night. She stated that the importance of having a physician's order for oxygen was to ensure the resident received the oxygen as needed. She further stated, I do not see any current physician orders for oxygen. On 7/15/26 at 9:28 AM, the surveyor interviewed the Director of Nursing, who stated that if a resident used oxygen, there should be a physician's order. She stated that the purpose of having physician's orders was to ensure nurses are following physician directions. A review of the facility's Oxygen Administration Policy, revised 6/19/24, included, Purpose: the purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Fountainview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident .N.J.A.C. 8:39-27.1(a)		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility Medical Director (MD) failed to attend mandatory quarterly Quality Assurance and Performance Improvement (QAPI) meetings for two out of five quarterly meetings. This deficient practice was evidenced by the following: On 07/09/26 at 10:05 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) during the Entrance Conference. The surveyor requested a copy of all quarterly QAPI sign-in sheets since the last survey, a list of QAPI Committee Members, and the QAPI policies and procedures. A review of the list of QAPI Committee Members revealed that the Medical Director was listed as a member. A review of the facility-provided QAPI sign-in sheets revealed the following: QAPI 2025 4th Quarter (dated 12/31/25): Did not include a signature for the Medical Director. QAPI 2026 2nd Quarter (dated 06/30/26): Did not include a signature for the Medical Director. On 07/16/26 at 11:00 AM, the surveyor interviewed the LNHA, who acknowledged that there was no Medical Director signature on either the 2025 4th quarter QAPI meeting sign-in sheet (dated 12/31/25) or the 2026 2nd quarter QAPI meeting sign-in sheet (dated 06/30/26). The LNHA was unable to provide evidence that the Medical Director attended either meeting, and acknowledged that the Medical Director was a key member of the QAPI committee. A review of the facility's undated QAPI policy, provided by the LNHA, revealed the following: Under the QAPI Committee members they included each Department Head, but Medical Director was not listed as a QAPI Committee member. N.J.A.C. 8:39-23.1, 2, 3		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure contracted hospice staff utilized proper personal protective equipment (PPE: clothing or gear worn to protect both those providing and receiving care from potential harm) during care of a resident on enhanced barrier precautions (EBP: infection control measures using gowns and gloves during high-contact care to prevent the spread of multidrug-resistant organisms). The deficient practice was identified for 1 of 1 resident (Resident #22) reviewed for infection control and was evidenced by the following: On 7/9/26 at 10:05 AM, the surveyor observed an EBP sign on the resident's door with the letter B written in black ink on it and a PPE bin outside of the room. The resident was observed in Bed B receiving care from an individual who was not wearing a gown. The electronic medical record was reviewed for Resident #22. A review of the admission Record, an admission summary, revealed diagnoses that included, but were not limited to: Alzheimer's disease (a progressive disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia), anemia (a condition in which the body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and right heart failure, unspecified (the right side of the heart cannot pump blood effectively to the lungs, causing blood to back up into the body's veins and leading to fluid accumulation). A review of the resident's most recent Minimum Data Set (MDS), an assessment tool dated 7/5/26, revealed the resident had a Brief Interview for Mental Status score of 2 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident was dependent on staff for most self-care and mobility tasks, and the resident had an indwelling urinary catheter (a tube is inserted into the bladder to drain urine). A review of the Individual Comprehensive Care Plan (ICCP) revealed a focus area dated 7/6/26: Enhanced barrier precautions related to a suprapubic catheter, with interventions including: apply isolation equipment when providing direct care, maintain contact precautions during direct care, isolation cart outside of room, and place precaution signage at the resident's room entrance. A review of the Order Summary Report (OSR) revealed the following physician's orders (PO): A PO dated 7/6/26: Hospice. A PO dated 7/6/26: Enhanced barrier precautions every shift for infection related to suprapubic catheter. On 7/10/26 at 10:36 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated a hospice aide came daily for about an hour to wash, change, and support the resident. The LPN/UM also stated the resident was on EBP because of the suprapubic catheter, and the hospice aides were educated on EBP. On 7/14/26 at 9:32 AM, the surveyor interviewed a Certified Nursing Assistant (CNA), who stated she was not assigned to the resident that day and was not sure if there were precautions, but she could check the sign on the door. The CNA confirmed the resident was on EBP and that staff should gown and glove when giving care. On 7/14/26 at 10:12 AM, the surveyor conducted a telephone interview with the clinical director of the hospice provider, who stated the hospice aides were educated on EBP yearly and were notified by facility staff when a resident was on EBP. The clinical director stated that the expectation of hospice staff when caring for a resident on EBP was to maintain proper facility protocols, wear PPE, use proper hand hygiene, practice infection prevention, and notify the nurse of changes. On 7/15/26 at 9:34 AM, the surveyor interviewed the Director of Nursing (DON), who stated the purpose of EBP was to keep the resident safe with no spread of infection or harm to the patient. The DON confirmed that if a resident was on EBP, signage was posted on the door and everyone should follow the signage, not just in-house staff. The DON stated that if a hospice aide was not following EBP, it was the expectation of the entire building staff, not (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	just nursing, to address it immediately. On 7/15/26, the above concerns were presented to the Licensed Nursing Home Administrator, the DON, and the Regional Administrator. A review of the facility-provided Isolation policy, updated 12/2/25, revealed: Policy Interpretation and Implementation . 2 . Enhanced Barrier Precautions- In addition to Standard Precautions, implement EBP during high-contact resident care activities: such as dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, for residents with indwelling devices . A. Examples of when EBP will be required: 4. Residents with a urinary catheter . C. Gown (1) . wear a gown (clean, nonsterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. N.J.A.C. 8:39-27.1(a)		