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 _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey 11/26/2024 Census: 103 Sample Size: 26 + 2 closed records C/O # NJ 166369, 166726, 167867, 176216 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, it was determined that the facility failed to complete the Quarterly Minimum Data Set (MDS) assessments, a resident assessment tool used to facilitate the management of care, in a timely manner for 46 of 49 residents reviewed for system selected MDS over 120 days for late submissions., (Residents #49, #24, #29, #55, #32, #33, #48, #13, #8, #51, #11, #22, #27, #3, #50, #72, #18, #19, #9, #54, #57, #64, #70, #58, #37, #36, #45, #337, #187, 336, #21, #5, #4, #20, #69, #34, #16, #28, #66, #15, #25, #30, #17, #38, #42, #67). This deficient practice was evidenced by the following:	F 638	The following assessments where completed and submitted: Resident #49 completed [redacted] submitted to CMS [redacted] Resident #24 completed [redacted] submitted to CMS [redacted] Resident #29 completed [redacted] submitted to CMS [redacted] Resident #55 completed [redacted] submitted to CMS [redacted] Resident #32 completed [redacted] submitted to CMS [redacted] Resident #33 completed [redacted] submitted to CMS [redacted] Resident #48 completed [redacted] submitted to CMS [redacted] Resident #13 completed [redacted] submitted to CMS [redacted] Resident #8 completed [redacted]	12/31/24

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

Electronically Signed | 12/13/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 638	Continued From page 1 Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. The Quarterly Assessment was considered timely if 1) The Assessment Reference Date (ARD) of the Quarterly MDS (QMDS) was within 92 days after the ARD of the previous MDS and 2) the completion date was no later than 14 days after the ARD. 1. Resident #49's Quarterly MDS (QMDS) ARD was NJ ex order 26.4b1, the Quarterly Assessment (QA) had not been completed as of NJ ex order 26.4b1 and NJ ex ord 2. Resident #24's QMDS ARD was NJ ex order 26.4b1, the QA had not been completed as of NJ ex order 26.4b1 and NJ ex order 26.4b1 . 3. Resident #29's QMDS ARD was NJ ex order 26.4b1, the QA had not been completed as of NJ ex order 26.4b1 and NJ ex order 26.4b1 . 4. Resident #55's QMDS ARD was NJ ex order 26.4b1, the QA had not been completed as of NJ ex order 26.4b1 and NJ ex order 26.4b1 . 5. Resident #32's QMDS ARD was NJ ex order 26.4b1, the QA had not been completed as of NJ ex order 26.4b1 and was 61 days overdue. 6. Resident #33's QMDS ARD was NJ ex order 26.4b1, the QA had not been completed as of NJ ex order 26.4b1 and NJ ex order 26.4b1 . 7. Resident #48's QMDS ARD was NJ ex order 26.4b1, the QA had not been completed as of NJ ex order 26.4b1 and NJ ex order 26.4b1 . 8. Resident #13's QMDS ARD was 09/11/24, the	F 638	submitted to CMS NJ ex order 26.4b1 Resident #51completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #11 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #22 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #27 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #3 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #50 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #72 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #18 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #19 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #9 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #54 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #57 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #64 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #70 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #58 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #37 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #36 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #45 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1 Resident #337 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1	

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F 638	Continued From page 2	F 638		

NJ ex order 26.4b1 and NJ ex order 26.4b1

9. Resident #8's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

10.Resident #51's QMDS ARD was NJ ex order 26.4b1 the NJ ex order 26.4b1 and NJ ex order 26.4b1.

11.Resident #11's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1

12.Resident #22's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

13.Resident #27's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

14.Resident #3's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1

15.Resident #50's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

16.Resident #72's QMDS ARD was NJ ex order 26.4b1 the NJ ex order 26.4b1 and NJ ex order 26.4b1

17.Resident #18's QMDS ARD was NJ ex order 26.4b1 the NJ ex order 26.4b1 and NJ ex order 26.4b1.

18.Resident #19's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

19.Resident #9's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

20.Resident #54's QMDS ARD was NJ ex order 26.4b1, the QA NJ ex order 26.4b1 and NJ ex order 26.4b1

21.Resident #57's QMDS ARD was NJ ex order 26.4b1, the

Resident #187 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #336 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #21 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #5 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #4 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #20 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #69 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #67 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #34 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #16 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #28 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #66 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #15 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #25 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #30 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #17 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #38 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #42 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

Resident #67 completed NJ ex order 26.4b1 submitted to CMS NJ ex order 26.4b1

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F 638	Continued From page 3 QA NJ ex order 26.4b1 and NJ ex order 26.4b1 22.Resident #64's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1 23.Resident #70's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1 24.Resident #58's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1 25.Resident #37's QMDS ARD was NJ ex order 26.4b1 the NJ ex order 26.4b1 and NJ ex order 26.4b1 26.Resident #36's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1 . 27.Resident #45's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1 . 28.Resident #337's QMDS ARD was NJ ex order 26.4b1, NJ ex order 26.4b1 and NJ ex order 26.4b1 29.Resident #187's QMDS ARD was NJ ex order 26.4b1 the QA NJ ex order 26.4b1 and NJ ex order 26.4b1 30.Resident #336's QMDS ARD was NJ ex order 26.4b1 the NJ ex order 26.4b1 and NJ ex order 26.4b1 . 31.Resident #21's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1 . 32.Resident #5's QMDS ARD was NJ ex order 26.4b1 the NJ ex order 26.4b1 and NJ ex order 26.4b1 . 33.Resident #4's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1 . 34.Resident #20's QMDS ARD was NJ ex order 26.4b1, the	F 638	All residents have the potential to be affected by the deficient practice. A complete audit for all active residents was conducted on 11/25/2204 by the MDS coordinator to determine the number of incomplete comprehensive assessments that were flagging as late to determine immediate action for compliance. It was determined that all incomplete assessments would be completed by 12/31/2024. The Administrator, DON and/or designee will conduct weekly audits starting on 11/25/204 to ensure the timeliness of all comprehensive assessments for the next 60 days, then twice a month for the next 2 months and monthly thereafter for 2 additional months. The Administrator provided re-education on 11/25/2024 to the US FOIA (B) (6) regarding the timeliness for completing the comprehensive assessments and his expectations for timely compliance. All audits will be reviewed by the Administrator, DON and/or designee to ensure timely compliance per the audit timeframes beginning on 11/25/2024. These audits will be reviewed at the next three quarterly QA meetings for recommendations and/or feedback. The Administrator and DON will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024	

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F 638	Continued From page 4	F 638		

NJ ex order 26.4b1 and NJ ex order 26.4b1

35.Resident #69's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

36.Resident #34's QMDS ARD was NJ ex order 26.4b1 the NJ ex order 26.4b1 and NJ ex order 26.4b1.

37.Resident #16's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

38.Resident #28's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

39.Resident #66's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

40.Resident #15's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

41.Resident #25's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

42.Resident #30's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

43.Resident #17's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and US FOIA (B) (6).

44.Resident #38's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

45.Resident #42's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

46.Resident #67's QMDS ARD was NJ ex order 26.4b1, the NJ ex order 26.4b1 and NJ ex order 26.4b1.

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F 638	Continued From page 5 On 11/25/24 at 11:00 AM, the survey team interviewed the US FOIA (B) (6)). The US FOIA (B) (6) stated that she had worked as the US FOIA (B) (6) in the facility for 3 years. The US FOIA (B) (6) stated that she was doing the US FOIA (B) in 2 buildings at this time. The US FOIA (B) (6) said she knew things were behind and she had to help the other building. The US FOIA (B) (6) acknowledged that US FOIA (B) were behind. A review of the facility policy entitled MDS 3.0 Completion with an implemented date of 10/15/24 under Types of OBRA Assessments: 2.e. Quarterly Assessment - completed using an ARD no > (greater than) 92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD).	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		12/31/24

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F 656	Continued From page 6 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to develop and implement a comprehensive person-centered care plan specifically for a resident NJ ex order 26.4b1 and NJ ex order 26.4b1 This deficient practice was identified for 1 of 26 sampled residents, (Resident #1) and was evidenced by the following:	F 656	The deficiency occurred when the facility staff failed to implement a care plan for a NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 NJ ex order 26.4b1 for resident #1 NJ ex order 26.4b1 The care plan was updated on NJ ex order 26.4b1, to reflect the current goals and interventions for resident #1. On the same day, the US FOIA (B) (6) provided education to the US FOIA (B) (6), the US FOIA (B) (6), the US FOIA (B) (6), and	

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F 656	Continued From page 7 On 11/20/2024 at 10:43 AM, during the initial tour, Resident #1 NJ ex order 26.4b1 Resident #1 NJ ex order 26.4b1 A review of the Electronic Medial Record for Resident #1 revealed the following: A review of Resident #1's Admission Record revealed that he/she had diagnoses that included NJ ex order 26.4b1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ ex order 26.4b1, under Section NJ ex order 26.4b1 under Section Medications: NJ ex order 26.4b1 : Use and Indication: indicated that Resident #1 NJ ex order 26.4b1 . A review of the Physician Orders on NJ ex order 26.4b1 at 09:29 AM, revealed the following: -NJ ex order 26.4b1 -NJ ex order 26.4b1 . -NJ ex order 26.4b1 NJ ex order 26.4b1 . -NJ ex order 26.4b1	F 656	the US FOIA (b)(6) regarding the facility policy on developing and implementing comprehensive care plans. Additionally, the DON conducted a thorough audit for all residents on November 25, 2024, to determine if comprehensive care plans had been developed, implemented, and aligned with each patient's current goals and interventions, as well as to verify adherence to the facility's policy on comprehensive care plans. All residents have the potential to be affected by the deficient practice. On 11/25/2024 the US FOIA (B) re-educated the nurse managers, US FOIA (B) (6), social worker, and infection preventionist on the facility policy for comprehensive care plans to ensure they are patient-centered and that the goals and interventions are appropriate. The DON, or designee, will continue to audit all residents with a comprehensive care plan beginning on November 25, 2024. These audits will take place weekly for four weeks, then twice a month for two months, and monthly for three months. All audit results will be reviewed by the Administrator, DON, and/or their designees to ensure timely compliance according to the specified audit schedule. Additionally, these audits will be discussed at the quarterly Quality Assurance (QA)	

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F 656	Continued From page 8 -[redacted], monitor site every shift for signs and symptoms of [redacted] every shift. -[redacted] every shift with 1[redacted] every shift. -[redacted] on admission. -[redacted], before & after [redacted] medication one time a day for [redacted]. -[redacted] Weekly & as needed every day shift every Thursday AND as needed. A review of Resident #1's Care Plan dated [redacted] did not include focus areas that addressed that the resident had a [redacted] and a [redacted] During an interview with the surveyor on 11/25/2024 at 01:55 PM, the [redacted] when asked what the expectations for a comprehensive person-centered Care Plan to include, agreed that a [redacted] and [redacted] should be included in the residents Care Plan. A review of a facility policy on titled, "Comprehensive Care Plans," implemented date of 01/10/2024, objectives include, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." NJAC 8:39-11.2(f)	F 656	meetings for recommendations and feedback from the QA Committee. The Administrator and DON will oversee the implementation of this corrective action plan, with a completion date of December 31, 2024	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		12/31/24

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 _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

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F 695	Continued From page 9 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to implement infection control measures for the handling and storage of NJ Exec Order 26.4b1 equipment for 1 of 2 residents reviewed for NJ ex order 26.4b1 (Resident # 7) and was evidenced by the following: During the initial tour on 11/20/2024 at 10:20 AM, Resident #7 was observed sitting in the dayroom with a NJ ex order 26.4b1 The surveyor observed the NJ ex order 26.4b1 [redacted]. The NJ ex order 26.4b1 [redacted]. Resident #7 NJ ex order 26.4b [redacted] NJ ex order 26.4b1. Resident #7 said he/she was waiting for his/her ride to the Dr. as he/she NJ ex orde [redacted] Resident #7 NJ ex order 26.4b1 [redacted]. On 11/20/2024 at 11:04 AM, Resident #7 was observed on the NJ ex order 26.4b1 [redacted]	F 695	Resident #7□s NJ ex order 26.4b1 [redacted]. The NJ ex order 26.4b1 [redacted], and NJ ex order 26.4b1 [redacted] After the NJ ex order 26.4b1, the resident□s NJ ex order 26.4b1 [redacted] The LPN charge nurse measured the resident's NJ ex order 26 [redacted], recording a NJ ex order 26.4b1 [redacted]. Education on the facility□s NJ Exec Order 26.4 Administration policy and infection control□specifically addressing NJ Exec Order 26 NJ Exec Order 26 proper storage, and replacement of the NJ Exec Order 26.4b1 after care□was provided to the nursing staff by the US FOIA (B) (6) [redacted] on NJ ex order 26.4b1 [redacted] All residents have the potential to be affected by the deficient practice. An audit for all active residents with a physician's order for oxygen was	

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F 695	Continued From page 10 On 11/21/2024 at 09:14 AM, a review of the EMR revealed the following: According to the Admission Record Resident #7 NJ ex order 26.4b1 . A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b1, Resident #7 has a Brief Interview for Mental Status score of NJ ex order 26 indicating Resident #7 NJ ex order 26.4b1. Section NJ indicated Resident #7 NJ ex order 26.4b1 . Section NJ E revealed Resident #7 NJ ex order 26.4b1 . A review of the Order summary Report with active orders as of NJ ex order 26.4b1, NJ ex order 26.4b1 A review of Resident #7's care plan revealed a focus area with date initiated of NJ ex order 26.4b1 [resident name] NJ ex order 26.4b1 , and NJ ex Under the Goal section the resident will NJ Exec Order 26.4b1 daily through review date. Interventions included but were not limited to: NJ ex order 26.4b1 . There was no documentation to indicate the resident NJ Exec Order 26.4b1. During an interview with the surveyor on 11/25/2024 at 09:56 AM, the Registered	F 695	conducted by the DON on November 20, 2024, to ensure that oxygen tubing was dated and stored in clear plastic bags. Any unbagged tubing was discarded, and new tubing was applied, dated, and bagged. The audit also verified that physician's orders were accurate, that the facility's Oxygen policy was followed, and that oxygen was administered correctly. On November 25, 2024, the DON re-educated the nursing staff on infection control concerning the proper storage of oxygen tubing, dating the tubing, and placing it in bags when not in use. This education also included adhering to the facility's Oxygen policy and administering oxygen as ordered by the attending physician. Ongoing audits will commence on November 25, 2024, conducted by the DON or an assigned designee, focusing on all residents with physician orders for oxygen. These audits will occur weekly for four weeks, twice a month for two months, and then monthly for three months. The results of all audits will be reviewed by the Administrator, DON, and/or their designee to ensure compliance according to the schedule outlined above starting November 25, 2024. These audits will also be discussed at the next two quarterly Quality Assurance (QA) meetings for recommendations and feedback from the QA Committee. The Administrator and DON will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024.	

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F 695	Continued From page 11	F 695		

Nurse/Unit Manager RN/UM #1 was asked what the facility policy regarding oxygen use is. RN/UM #1 responded I would have to check with US FOIA (B) US FOIA (B) (6) about the policy to confirm what the policy is. The surveyor questioned what the procedure was for storage of NJ Exec Order 26.4b1 equipment. RN/UM #1 said we put it NJ Exec Order 26.4b in a bag, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and bags every week and as needed. When asked what the expectation is for wearing NJ Exec Order 26 if there is a physician order for NJ Exec Order 26.4b1 RN/UM #1 responded, "It should always be on if ordered NJ Exec Order 26.4b1 If the resident NJ Exec Order 26 to wear NJ Exec Order 26.4b we document it in EMR and notify US FOIA (b)(6)) and family and we put that on the care plan.

During an interview with the surveyor on 11/25/2024 at 01:56 PM, when asked what the facility policy regarding NJ Exec Order 26 use the US FOIA (B) replied, "We get a physician order and put it in the EMR. We also put on the care plan and with changes we update the care plan. We change NJ Exec Order 2 weekly and as needed and verify NJ Exec Order 26 settings. The surveyor then asked the US FOIA (B) what the facility policy was regarding the storage of NJ Exec Order 26.4b1 equipment when not in use. The US FOIA (B) said if package (NJ Exec Order 26 is sealed, we keep it in the package. Once opened the NJ Exec Order 2 is dated and labeled. Then we would continue to make sure to change on the weekly schedule and NJ Exec Order 26.4b1 stored in the bag when not in use. When questioned what the expectation was if the order for NJ Exec Order 26 was NJ Exec Order 26.4b1 the US FOIA (B) said, "If the resident is NJ Exec O and NJ Exec Order 26.4b and will remove the NJ Exec Order 26.4 we care plan it." The US FOIA (B) further stated we (nursing) provide education. The US FOIA (B) then confirmed to the surveyor that if it's not on (NJ Exec Order 26.4b the care plan as refusing, the

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F 695	Continued From page 12 [redacted] should have been on. On 11/26/2024 at 09:30 AM, the [redacted] brought in an employee statement from the nurse who had this resident on [redacted]. The nurse confirmed with the [redacted] that the resident's [redacted], and the [redacted] The surveyor reviewed the evidence of the [redacted] positions with the [redacted] who confirmed Resident #7 [redacted] where it was observed by the surveyor as it [redacted]. On 11/25/2024 at 11:49 AM, a review a facility policy titled Oxygen Administration with date implemented of 10/10/24 revealed under the Policy section: Oxygen is administered to residents who need it, consistent with professional standards of practice, the person-centered care plans, and the resident's goals and preferences. The following was revealed under Policy Explanation and Compliance Guidelines section 5. Other infection control measures include: e. Keep delivery devices covered in plastic bag when not in use.	F 695		
F 812 SS=F	NJAC 8:39-27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		12/31/24

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F 812	Continued From page 13 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 11/20/24 at 09:21 AM, the surveyor, accompanied by the US FOIA (B) (6) US FOIA (B) (6), observed the following in the kitchen: 1. In the dry storage room on a middle shelf a previously opened bag of macaroni pasta was wrapped in plastic wrap. The pasta had no open or use by date. 2. On a middle rack of the spice shelf a stack of four (4) plastic NJ Exec Order 26.4 containers were stacked on top of each other. The surveyor removed the top NJ Exec Order 26.4 container and observed a clear watery substance on the bottom of the container below and a clear watery substance on the interior of the NJ Exec Order 26.4 container that was on the top. In addition, a second stack of two (2) NJ Exec Order 26.4 containers was also observed to be wet with a clear liquid substance, a practice known as	F 812	The pasta, soft pretzels, bacon and chorizo were discarded. The food service director removed the affected Cambro containers and pans to be rewashed and properly air dried. A new thermometer was placed in the freezer. All residents have the potential to be affected by the deficient practice. On November 20, 2024, the Food Service Director inspected all kitchen food areas to ensure proper labeling and dating of food items. The Director also educated the dietary staff on the importance of accurately labeling and dating food. A new thermometer was placed inside the walk-in freezer, and the dietary staff where in serviced on the requirement that refrigerators and freezers always have a thermometer in place. The macaroni pasta, frozen soft pretzels, box of bacon and chorizo were discarded immediately	

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F 812	Continued From page 14 wet nesting (the practice of stacking wet dishes, pots, or pans together, which prevents them from drying and can lead to bacteria growth.). On interview the [US FOIA (B)] stated that they ([NJ Exec Order 26.4b1] should be air dried prior to stacking to prevent wet nesting. The [US FOIA (B)] removed the affected [NJ Exec Order 26.4b] containers to be re- cleaned, sanitized, and air dried. 3. On the pot/pan storage rack next to the steamer on an upper shelf two (2) deep third pans were stacked on top of each other. The surveyor removed the top third pan and observed a clear, wet liquid on the bottom of the third pan below (wet nesting). The [US FOIA (B)] removed the two (2) third pans to be re-cleaned, sanitized, and air dried before stacking. 4. During the observation of the walk-in freezer the surveyor observed the temperature log prior to entering the walk-in freezer. The temperature log was observed to be up to date and the temperatures were within acceptable parameters for frozen storage. Upon entering the walk-in freezer, the surveyor, [US FOIA (B)] and cook could not find an internal thermometer used to monitor the freezer temperature. The cook stated, "We're gonna grab another one." 5. On a middle shelf in the walk-in freezer a previously opened bag of contained frozen soft pretzels. The bag had no dates. In addition, on a middle shelf closest to the door of the walk-in freezer, a previously opened box of bacon was partially covered with plastic wrap. One half of the box of bacon was exposed to the air because the plastic wrap did not fully cover the bacon. The bacon was dry on visual appearance. The cook removed the bacon to the garbage. Adjacent to	F 812	on 11/20/2024. The Food Service Director conducted a training session with her dietary staff on wet nesting, emphasizing the necessity of re-cleaning, sanitizing, and air-drying pots and pans before stacking them. On November 25, 2024, dietary staff received further education on food storage practices and labeling and dating, ensuring that all food items are adequately covered and protected from exposure to the air. The Food Service Director will conduct daily audits for two weeks, followed by weekly audits for four weeks, and monthly audits for three months. The Administrator and/or designee will review the results of all audits to ensure compliance according to the schedule outlined above starting November 25, 2024. These audits will also be discussed at quarterly Quality Assurance (QA) meetings for recommendations and feedback from the QA Committee. The Administrator and DON will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024	

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F 812	Continued From page 15	F 812		

the bacon, a box wrapped in manufacturers plastic contained Fresh Chorizo (a spiced pork sausage). The plastic on the top of the box was torn leaving the frozen chorizo exposed to the air. The box also had no received date. The cook removed the chorizo to the garbage in the presence of the surveyor.

The surveyor reviewed the facility policy titled Date Marking for Food Safety, date implemented: 6/1/2024. The following was revealed under POLICY: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. In addition, the following was revealed under Policy Explanation and Compliance Guidelines for Staffing:

2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.

3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared.

4. The marking system shall consist of a label, the day/date of opening, and the day/date the item must be consumed or discarded.

6. The US FOIA (b)(6), or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly.

7. The US FOIA (b)(6) , or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed.

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F 812	Continued From page 16 The surveyor reviewed the facility policy titled Cleaning Dishes/Dish Machine, 2021. The following was revealed under Procedure: Staff will follow these procedures for washing dishes: 9. Dishes should be air dried on the dish racks, not dried with towels. 10. Inspect for cleanliness and dryness and put dishes away if clean (be sure hands are clean). Dishes should not be nested unless they are completely dry. NJAC 8:39-17.2(g)	F 812		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315193 Y1	A. Building B. Wing Y2	1/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0638	Correction	ID Prefix F0656	Correction	ID Prefix F0695	Correction
Reg. # 483.20(c)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(i)	Completed
LSC	12/31/2024	LSC	12/31/2024	LSC	12/31/2024
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/31/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/26/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 11/22/24, the facility is NOT in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness	E 004		12/31/24

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

Electronically Signed | 12/13/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

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E 004	Continued From page 1 requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 11/22/24 in the presence of the Director of Maintenance (DM), the facility failed to establish and maintain a comprehensive Emergency Preparedness Program, that was updated at least annually to include the date of the review and any updates made to the emergency plan based on the review in accordance with Appendix Z, CFR 483.73(a): Emergency Plan. This deficient practice had the potential to affect 103 residents and was evidenced by the following: A documentation review of the facilities Emergency Preparedness Plan at 9 AM, revealed no sign in sheet or documentation for annual facility review and any updates made to the Emergency Preparedness Plan based on the previous review for 2024, 2023, 2022 or 2021. The last documentation of a facility review was	E 004	The Maintenance Director and staff completed a review of the Emergency Preparedness Program Plan for annual review on 11/26/2024. All residents have the potential to be affected by the deficient practice. The US FOIA (B) (6), US FOIA (B) (6) and staff were in-serviced on 11/26/2024 on the Emergency Preparedness Program. A continued review of the EPP will be conducted by the Administrator,Maintenance Director and facility staff at least annually. The Maintenance Director/designee will conduct a monthly audit for 3 months.The audit will be reviewed by the	

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	315193	A. BUILDING 01 B. WING _____	11/26/2024

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FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

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E 004	Continued From page 2 only the US FOIA (B) (6) stating he read it, understood it and approved it in 2020 and it was not signed in the sign spot below the Administrators name for the Administrators signature. The Hazard Vulnerability Analysis (HVA) that shall be updated annually as part of the annual review was dated 2021. The US FOIA (B) (6) and US FOIA (B) (6) confirmed the document review at the time. The US FOIA (b)(6) were made aware of the deficient practice at the Life Safety Code exit conference at 1:17 PM. NJAC 8:39-31.2(e), 31.6(i)1	E 004	Administrator/designee, and monitored. This audit will be reviewed at two quarterly QAPI meetings for recommendations and/or feedback, with a completion date set for December 31,2024	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/20/24, 11/21/24 and 11/22/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Fountain Springs at Cape May is a 1-story building that was built in 1972, It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does 100% of the building as per the Maintenance Director. The current occupied beds are 103 of 116.	K 000		
K 300	Protection - Other	K 300		12/31/24

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K 300 SS=F	Continued From page 3 CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/21/24 in the presence of the [US FOIA (B) (6)] [redacted], it was determined the facility failed to ensure penetrations in smoke and fire barriers were protected to limit the spread of fire and restrict the movement of smoke from one side of the barrier to the other in accordance with NFPA 101 2012 Edition, Section 8.3.4, 8.3.5, 8.4.4, 8.5, 8.5.6 and 19.3. These deficient practices had the potential to affect 103 residents and were evidenced by the following: An observation at 12:50 PM of the fire barrier above the drop ceiling at the double smoke doors by the conference room, revealed penetrations through the cinder block wall to the other side of the wall. There was a 5-inch diameter hole with a 2-inch copper pipe going through and two other areas with copper pipe and wires going through that had yellow foam material around pipes. On the resident [NJ ex order 28.4b] side of the double doors, the two areas were with copper pipe and wires were passing through an 8-inch by 8-inch opening in the cinder block. The facility did not have	K 300	The Maintenance Director filled all holes with block and concrete. The smaller cracks were filled with fire barrier sealant All residents have the potential to be affected by the deficient practice. The Maintenance Director/designee will conduct an audit to ensure there are no penetrations in smoke and fire barriers. All holes will be filled with block and concrete, and for smaller cracks and/or holes they will be filled with fire barrier sealant by 12/31/2024. The Maintenance Director/designee will conduct a monthly audit for 3 months. This audit will be reviewed at the next two quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will oversee the	

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K 300	Continued From page 4 documentation of the fire or smoke protection rating of the yellow foam material. In an interview at the time, the [US FOIA] confirmed the observations. An observation at 1:05 PM of the fire barrier above the drop ceiling at the double smoke doors by social services, revealed penetrations through the cinder block wall to the other side of the wall. There was a 5-inch by 3-inch hole with 2 black plastic pipes and the hole went all the way through to the other side. There was another penetration with two copper pipes of 2-inch and 1-1/2 inch diameter penetrating through a 8-inch by 5-inch hole through the cinder block. In an interview at the time, the [US FOIA] confirmed the observations. An observation at 1:25 PM of the fire barrier above the drop ceiling at the double smoke doors by east wing shower room, revealed penetrations through the cinder block wall to the other side of the wall. There was a 5-inch by 2-1/2 inch hole with multiple wires running through the cinder block wall to the other side unprotected. There were also penetrations through the corridor wall going into the shower room where pipes and HVAC duct penetrated the sheet rock side corridor wall at the same location. In an interview at the time, the [US FOIA] confirmed the observations. The [US FOIA (b)(6)] and [US FOIA] were informed of the deficient practice on 11/22/24 at 1:17 PM during the Life Safety Code exit conference.	K 300	implementation of this corrective action plan, with a completion date set for December 31,2024	

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K 300	Continued From page 5	K 300		
K 324 SS=F	N.J.A.C. 8:39-31.2(e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/21/2024 in the presence of the US FOIA (B) (6) [redacted], it was a determined that the facility failed to perform monthly inspections of the range-hood fire suppression system wet	K 324	The Maintenance Director immediately inspected and signed the tag. All residents have the potential to be	12/31/24

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K 324	Continued From page 6 chemical cylinder in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect 103 residents and was evidenced by the following: An observation at 11:35 AM of the kitchen range-hood fire suppression system wet chemical tank inspection tag, revealed the semi-annual inspection was performed in September of 2024 and the monthly inspection documentation spaces on the back of the tags were blank indicating the monthly inspection had not been performed for the month of October 2024. There was no documentation of the monthly inspections being performed for the months of August, July, June, May, April, March, February, and January of 2024 and December and November of 2023. No further documentation was provided. In an interview at the time, the [redacted] confirmed the observation. The [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 11/22/24 at 1:17 PM. NJAC 8:39-31.2(e) NFPA 17 A, 96	K 324	affected by the deficient practice. The facility's Maintenance Director/designee will ensure monthly inspections will be performed and documented beginning 11/21/2024. The Administrator/designee will conduct a monthly audit for 4 months. This audit will be reviewed at the next two quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		12/31/24

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K 353	Continued From page 7 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/21/24 in the presence of the US FOIA (B) (6) [redacted] it was determined the facility failed ensure fire system sprinkler heads were maintained and ceiling smoke barriers were maintained in accordance with NFPA 101: 2012 edition, Sections 9.7.5, 19.3.5.1, and NFPA 25: 2011 edition. These deficient practices had the potential to affect 103 residents and were evidenced by the following: Observations during a tour of the facility between 9:45 AM and 1:35 PM revealed the following: 1. Throughout the facility, 30 sprinkler head escutcheon plates had spaces or holes next to the escutcheon plate that penetrated through the drop ceiling. 2. Throughout the facility, 7 sprinkler head escutcheon plates were coming down away from the ceiling greater that 1/2-inch exposing a space around the sprinkler head pipe that went through	K 353	The Maintenance Director/designee repaired the gaps around the sprinkler head system with new escutcheon plates, tracks and ceiling tiles. All residents have the potential to be affected by the deficient practice. The facility's Maintenance Director/designee will conduct an audit of all sprinkler heads in the facility to ensure there are no gaps around the sprinkler head system. The Administrator/designee will conduct a monthly audit for 3 months. This audit will be reviewed at the next two quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will oversee the implementation of this corrective action	

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K 353	Continued From page 8 the drop ceiling. 3. Sprinkler heads in the kitchen storage room, resident room #43, the purchasing office, and the east wing medication storage room were missing their escutcheon plates. 4. Smoke barrier drop ceiling tiles were missing or had holes penetrating through them in the following locations: a. The front desk closet had one 2-foot by 4-foot ceiling tile half opened and one 2-foot by 4-foot ceiling tile missing with a sprinkler head in the open space. b. In the west wing med room, there was a water bleeder faucet coming through a 5- 1/2 by 2-3/4 inch opening in the drop ceiling. c. In the west wing closet behind the nurses station, there was a record book case support rod going through the drop ceiling and that had a 3/4-inch by 9-inch slit through the drop ceiling running from the rod to the wall. d. In the east wing storage area, there were penetrations with wires above the electrical box, a 4-inch by 4-inch hole, and 2 conduit wires above timer boxes going through the drop ceiling. The openings would allow smoke and hot gases to flow into the space above preventing the sprinklers from being activated at their designed activation temperature. In an interview at the time, the [redacted] confirmed the observations.	K 353	plan, with a completion date set for December 31,2024	

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K 353	Continued From page 9 The US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code survey exit conference on 11/22/24 at 1:17 PM. N.J.A.C 8:39-31.2(e) NFPA 13, 25	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no	K 363		12/31/24

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K 363	Continued From page 10 restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/21/2024 in the presence of the [redacted] it was determined that the facility failed to ensure that doors in the corridor could resist the passage of smoke, had positive latching hardware and were not held open by devices other than those that release when the door is pushed or pulled for 6 of 13 doors observed in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3 and 19.3.6.3.10. This deficient practice had the potential to affect 103 residents and was evidenced by the following: An observation at 10:10 AM revealed the door to resident room 30 did not shut to positive latch because the strike plate was bent and the bottom screw was coming out, preventing the door from closing. An observation at 10:15 AM revealed the linen closet door by west wing nurses station did not positive latch because it had tape over the door strike plate hole and the strike hole was stuffed with material. An observation at 10:45 AM revealed the door to resident room 12 did not positive latch when shut and bounced back open when closed. The test was repeated 2 times by the [redacted] with the same	K 363	The facility repaired the doors with new latching hardware, strike plates, removed the blocked latches and adjusted the doors in the frame on 11/21/2024. All residents have the potential to be affected by the deficient practice. The maintenance director/designee will conduct an audit to ensure all doors in the facility are functioning and working properly. The Administrator/designee will conduct a monthly audit for 4 months. This audit will be reviewed at the next two quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024	

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K 363	Continued From page 11 results. An observation at 11:35 AM revealed the corridor kitchen entrance door was 1-inch opened. When the door was opened to 90 degrees and released it stopped at the strike plate and did not close to latch. An observation at 12:05 PM revealed the door to resident room 49 did not close to latch without force applied because it was tight in the frame. The test was repeated 2 times with the same results. An observation at 12:20 PM revealed the east wing corridor medication room door did not positive latch when closed because the strike was stuck inside the door body. In interviews at the time, the [US FOIA] confirmed the observations. The [US FOIA (B) (6)] was made aware of the deficient practices at the Life Safety Code survey exit conference on 11/22/2024 at 1:17 PM.	K 363		
K 374 SS=F	N.J.A.C 8:39-31.2 (e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window	K 374		12/31/24

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K 374	Continued From page 12 assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 11/21/24 in the presence of the US FOIA (B) (6) [redacted], it was determined that the facility failed to ensure smoke barrier doors closed into their door frame when released from their hold open devices or closed leaving only the minimum clearance necessary for proper operation to resist the passage of smoke for 2 of 5 smoke barrier doors observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.7 to 19.3.7.9, 8.5.4, 8.5.4.1 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect 103 residents and was evidenced by the following: An observation at 11:04 AM revealed the service hall smoke barrier single door by central supply room did not close all the way into its frame when released from the fully open position. The door leaf hit the door frame on the top and did not close all the way leaving a 3/4-inch space 35-inches up from the door bottom diminishing to 1/2-inch space for 16 additional inches measured with a standard tape measure. The test was repeated 2 times with the same result. An observation at 11:50 AM revealed the double smoke barrier doors by social services had a 1-1/16 inch space between the bottom of the door leaf and the floor for the door leaf on room 33 side of the corridor. The space was measured	K 374	The Maintenance Director adjusted and repaired the door with an extender by central supply room and the double smoke barrier doors by the social services office. All residents have the potential to be affected by the deficient practice. The facility's Maintenance Director/designee will conduct a quarterly inspection of all doors. The Administrator/designee will conduct a monthly audit for 3 months. This audit will be reviewed at the next two quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024	

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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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 13 with a standard tape measure. In an interview at the time, the [US FOIA] confirmed the observations. The [US FOIA (B) (6)] was informed of the deficient practice at the Life Safety Code survey exit conference on 11/22/24 at 1:17 PM. NJAC 8:39-31.2 (e) NFPA 80	K 374		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/21/24 in the presence of the [US FOIA (B) (6)] it was determined the facility failed to install metal electrical boxes and guard live electrical parts in accordance with NFPA 99: Section 6.3, 2012 Edition and NFPA 70: 2011 Edition. The deficient practice had the potential to affect 2 residents and was evidenced by the following: An observation at 10:45 AM of resident [NJ ex order 26.4b1] revealed a live 4-inch by 4-inch square steel electrical outlet box with a single 208 volt receptacle mounted on the surface of the drywall next to the Packaged Thermal Air Conditioner	K 911	The facility's Maintenance Director on 11/21/2024 removed the electrical box from the outside of the dry wall and reinstalled the electrical box into the wall. All residents have the potential to be affected by the deficient practice. The Maintenance Director/designee will conduct an audit to ensure no other resident rooms or areas have exposed electrical boxes.	12/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING 01 B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 14 (PTAC) unit. The box was not secured firmly and moved when touched. The PTAC unit was plugged into the electrical box and operational. The box and receptacle were in-wall installation type not designed for surface mounting. In an interview at the time, the [redacted] confirmed the observation. The [redacted] was informed of the deficient practice at the Life safety Code exit conference on 11/22/24 at 1:17 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	The Administrator/designee will conduct a monthly audit for 3 months. This audit will be reviewed at the next two quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		12/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING 01 B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 15 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 11/20/24 and 11/21/24 in the presence of the US FOIA (B) (6) it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, blade tension and physical integrity in accordance with NFPA 99: 2012 Edition, Section 6.3, and 6.3.3.2, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect 103 residents and was evidenced by the following: In an interview with the US FOIA and observations on 11/21/24 confirmed that the facility had non-hospital grade outlets installed in resident rooms. A documentation review on 11/20/24 at 09:00 AM revealed there were room inspection check lists which included a row for outlets. This documentation did not indicate all the required inspection and tests were performed or any result values. The room inspection checklist had the year recorded in the date box for only 6 of 61 rooms and the last recorded full date with the year on it was 7/28/2023, 15 months prior to survey. In an interview at the time, the US FOIA confirmed the documentation review. The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code exit conference on 11/22/2024 at 1:17 PM.	K 914	The Maintenance Director/designee inspected all the outlets in the resident's room documenting it on a form indicating the status of the results. All residents have the potential to be affected by the deficient practice. The facility's Maintenance Director/designee will ensure an annual inspection of all outlets in residents' rooms will be performed for grounding, polarity, and blade tension. The Administrator/designee will conduct a monthly audit for 3 months. This audit will be reviewed at the next two quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING **01** B. WING _____	**11/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	**502 ROUTE 9 NORTH** **CAPE MAY COURT HOUSE, NJ 08210**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 16 NJAC 8:39-31.2(e) NFPA 99	K 914		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by:	K 921		12/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315193	A. BUILDING 01 B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 17 Based on document review and interview on 11/20/24 in the presence of the US FOIA (B) (6) [redacted], it was determined that the facility did not provide policies and protocols for patient care related electrical equipment (PCREE), and conduct maintenance of electrical equipment and maintain a record log of all required testing, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. The deficient practice had the potential to affect 103 residents and was evidenced by the following: Documentation review between 9 AM and 1:45 PM revealed there was no documentation of PCREE testing, inspection and maintenance. In an interview at 9:30 AM the US FOIA [redacted] stated that there were no policies, protocols or inspection reports for patient care related electrical equipment for the facility at this time. The US FOIA (B) (6) [redacted] was informed of the findings at the Life Safety Code exit conference on 11/22/24 at 1:17 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	The Maintenance Director inspected and tested all electrical equipment. The facility implemented a new policy, protocol and inspection log for PCREE testing on 11/22/2024. All residents have the potential to be affected by the deficient practice. The Administrator and Maintenance Director implemented policies on 11/22/2024 on physical electrical equipment and electrical safety and trained the maintenance staff on ensuring proper compliance of facility protocols on maintenance of electrical equipment and maintenance of record logs of all required testing. The Administrator/designee will conduct a monthly audit for 3 months. This audit will be reviewed at the next two quarterly QAPI meetings for recommendations and/or feedback. The Administrator/designee will oversee the implementation of this corrective action plan, with a completion date set for December 31,2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315193 Y1	A. Building B. Wing Y2	1/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0004 Reg. # 483.73(a) LSC	Correction Completed 12/31/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315193	A. Building 01 - OCEANA REHABILITATION CENTER B. Wing	1/2/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS AT CAPE MAY NURSING & REHAB CENTE	502 ROUTE 9 NORTH CAPE MAY COURT HOUSE, NJ 08210

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix Reg. # NFPA 101 LSC K0300	Correction Completed 12/31/2024	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 12/31/2024	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 12/31/2024
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 12/31/2024	ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 12/31/2024	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 12/31/2024
ID Prefix Reg. # NFPA 101 LSC K0914	Correction Completed 12/31/2024	ID Prefix Reg. # NFPA 101 LSC K0921	Correction Completed 12/31/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO