STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061536	A. BUILDING: _____ B. WING _____	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	527 RIVER AVENUE LAKEWOOD, NJ 08701

(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) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident 10 of 14 days shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. No residents were identified to be negatively affected not meeting the staffing levels mandated by State of New Jersey. The cause for the deficiency was difficulty in recruiting nurses and aides. Facility has increased amount of ads to recruit potential staff applications. All responses are being followed up on daily. 2. All residents have the potential to be affected, all residents were noted though not to be affected by staffing levels noted during survey. 3. The facility has implemented a significant above market rate of pay for C.N.A. Facility conducts job fairs, offers	2/27/23

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

Electronically Signed | 03/06/23

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 01/29/2023-02/04/2023 and 02/05/2023-02/11/2023, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA (Certified Nurses Aide) to 8 residents for the day shift are documented below: -01/29/23 had 12 CNAs for 102 residents on the day shift, required 13 CNAs. -02/02/23 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -02/03/23 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -02/04/23 had 9 CNAs for 100 residents on the day shift, required 12 CNAs.	S 560	referral, sign on bonuses and expediate oriented process for new hires. If there are call outs bonuses and OT are being offered. Director of Nursing or designee will review any C.N.A call outs daily and proactively make every effort to replace. C.NA call out policy will be reviewed with all C.N.As 4. The Director of nursing/designee will monitor C.N.A staffing ratios daily and report weekly to x 4 weeks then monthly. The audit will be presented to the Administrator. Administrator will share findings quarterly for the next year with QAPI committee.	

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S 560	Continued From page 2 -02/05/23 had 9 CNAs for 100 residents on the day shift, required 12 CNAs. -02/06/23 had 8 CNAs for 100 residents on the day shift, required 12 CNAs. -02/07/23 had 10 CNAs for 100 residents on the day shift, required 12 CNAs. -02/08/23 had 12 CNAs for 101 residents on the day shift, required 13 CNAs. -02/10/23 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -02/11/23 had 10 CNAs for 98 residents on the day shift, required 12 CNAs. On 02/23/2023 at 9:51 AM, during an interview with the surveyor, the Staffing Coordinator replied, "Yes. I know that currently we are not meeting the minimum. I am meeting them as close as possible" when asked if she is aware of the state-mandated minimum staffing requirements. On the same date at 1:02 PM, during an interview with the surveyor, the Infection Preventionist replied, "Yes" when asked if the facility is aware of the state mandate regarding CNA staffing. During the same interview, the Licensed Nursing Home Administrator replied, "No, we're not" when asked if the facility is meeting those requirements.	S 560		

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E 000	Initial Comments This facility is 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		
F 000	INITIAL COMMENTS Standard Survey 2/24/2023 Census: 100 Sample Size: 29 + 2 closed records 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to maintain the call device within reach for 1 of 29 sampled residents, (Resident #67). This deficient practice was evidenced by the following: On 2/17/2023 at 8:46 AM the surveyor observed Resident #67 lying in bed. The surveyor observed that Resident #67's call device was on the floor at the foot of the bed. The call device was between	F 558	F558 1. The call bell for resident # 67 was secured immediately and placed within reach and was given [redacted] also. 2. All residents have the potential to be affected by the deficient practice. 3. All nursing staff were re-in serviced to check for placement of residents Call	3/17/23

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F 558	Continued From page 1 the wall and bed. The call device was not accessible to the Resident #67. According to the Resident Face Sheet, Resident #67 was admitted to the facility with the following but not limited to diagnoses: [redacted] A review of the quarterly Resident Assessment Instrument Minimum Data Set, an assessment tool, dated [redacted] revealed that Resident #67 had a Brief Interview for Mental Status score of [redacted], indicating severe cognitive impairment. According to [redacted] Resident #67 required supervision/limited assist with activities of daily living. [redacted] revealed that Resident #67 was frequently incontinent of both [redacted] and [redacted] revealed Resident #67 had a [redacted]. According to [redacted] Resident #67 had no[redacted] and [redacted] A review of Resident #67's Care Plan Activity Report revealed a care plan with a "Focus" for [redacted]. It revealed Resident #67 was a risk for falls due to poor safety awareness, [redacted] The following was observed under Interventions: "Keep call bell within reach while in room," Effective [redacted]. On 2/23/2023 at 8:31 AM, the surveyor observed Resident #67 lying in bed with the bed pushed against the wall. The call light device cord was observed to extend from the outlet on the wall and extend down onto the floor between the bed and wall. The call device was not within reach of	F 558	bells were secured within reach of each resident when unattended. All center personnel who provide care to residents were re-educated as to the process for call bell securement and accessibility to each resident when unattended. 4. Unit managers and shift supervisors will do weekly audits x 4 weeks and monthly x 3 months of the process for adherence to call bell securement and accessibility to all residents when unattended and report their findings to DON/ADON monthly x 3 months. The report will be presented monthly by DON at Quality Assurance and Improvement meeting. This will occur monthly x 3 months.	

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F 558	Continued From page 2	F 558		

Resident #67.

On 2/23/2023 at 10:07 AM, the surveyor observed Resident #67 seated in their wheelchair, in their room, eating breakfast. The bed was made for the day. The call device was still observed between the wall and bed and lying on the floor at the foot end of the bed, as seen previously that morning. The surveyor interviewed Licensed Practical Nurse (LPN #2) and Certified Nursing Assistant (CNA #1) assigned to Resident #67 that shift. CNA #1, when interviewed, agreed that she is responsible to make sure that resident call devices are within reach of the resident and that she is to monitor for placement of the call light during the shift. LPN #2 agreed that call lights are to be within reach of the resident. The surveyor questioned LPN #2 if he/she had already provided Resident #67 their medication this AM. LPN #2 said that he/she had already provided medication to Resident #67 this morning but had not noticed the call device being on the floor.

On 2/23/2023 at 1:09 PM, the surveyor met with the facility administrative staff. The surveyor asked the facility Director of Nursing (DON) what their expectation was for placement of facility call devices. The DON responded, "My expectation is that all resident call lights are within reach of the resident." When asked who in the facility is responsible for ensuring that call lights are resident accessible the DON stated, "All staff are responsible to ensure that resident call devices are within reach. Any staff could do that, housekeeping, nursing, activities."

The surveyor reviewed the facility provided policy titled Call Lights, undated. The policy had the

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F 558	Continued From page 3 following Purpose: "To use a light and/or sound system to alert staff to patient needs." The following was revealed under Procedure: 5. "Always position call light conveniently for use and within the reach of the resident." 7. "Check lights when providing care to ensure that cord length is appropriate and that the light is in working order. Report defective call lights promptly to maintenance for immediate repair and arranges for alternate call system or change patient's room and frequent checks on resident." N.J.A.C. 8:39-31.8(c)(9)	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		2/27/23

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F 584	Continued From page 4 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean and safe environment for 1 of 3 units, [redacted]. This deficient practice was evidenced by the following: On 2/17/2023 at 12:37 PM, Surveyor #1 observed the following on [redacted] unit: *While walking in the hallway your feet were partially sticking to the floor. *The floor in the unit dayroom/Dining room had [redacted] and a large dried stain by the partitioned part of the wall when entering the room to the left. On 2/17/2023 at 12:42 PM, Surveyor #1 observed	F 584	POC for Tag 0584 1) Floor of [redacted] hallway which was sticky was cleaned. Floor of the [redacted] that had stains was cleaned and the wall too. Stains in hallway were cleaned. Threshold was placed for [redacted]. Flooring placed in hall by [redacted] and opposite [redacted] Corners of baseboards and doors were cleaned. Wallpaper repaired in [redacted] doors and door frames touched up and walls repaired as needed. Overhead table in [redacted] has been replaced. In [redacted] he rust around PTAC was sanded down and re-painted , the wall has been repainted and the corkboard has been straightened.	

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F 584	Continued From page 5 the following: *Dark stains along the baseboard of the hallway on the entire unit *There was no doorway threshold for room [redacted] *Outside room [redacted] pieces of the hallway flooring were missing across from room [redacted] *The corners of the baseboard and doors had black colored debris and dust balls for all doors on the unit On 2/21/2023 at 8:56 AM, Surveyor #1 observed the following: *Wallpaper in bathroom of room [redacted] has peeling wallpaper in the corner. * Chipped paint on door frames and doors, wallpaper buckled and peeling On 2/16/2023 at 11:08 AM surveyor #2 observed the following in room [redacted]. The surveyor observed the[redacted] over the bed table. The table had an unidentified white substance surrounding the outer edge of the table. The top of the over-there -bed table appeared to be delaminating and also had an unidentified white substance on the table top and other unidentified darker stains on the table top. On 2/23/2023 surveyor #2 made the following observations in room[redacted] bed[redacted] The metal frame that surrounds the [redacted] unit was observed to be rusted around the top edge of the metal frame. The wall adjacent to the resident's bed is painted blue. Multiple scrapes	F 584	Near room [redacted] residue buildup on the radiator has been cleaned. Hole in the wall in the [redacted] near television has been repaired. Brownish residue on bedframe and bedrail ion [redacted] has been cleaned. Peeling Wallpaper in [redacted] has been repaired. Molding in [redacted] has been repaired. Pillow in[redacted] has been replaced. 2)All residents have the potential to be affected by the deficient practice. 3) An audit was completed throughout the facility to ensure the floors were clean and no tiles missing, thresholds in place by all doors, walls are not stained, baseboards, radiators and molding were clean, doors, door frames and walls are touched up with paint, cork board are straight, wallpaper is not ripped or peeling, walls are in good condition, PTAC frames are not rusted, moldings were in place, overbed tables were clean and not peeled and pillows were not ripped. Housekeeping staff and maintenance staff were in-serviced regarding proper cleaning procedures. Housekeeping director and Maintenance Director were in-serviced regarding making appropriate rounds to observe the appropriate cleaning and repair measures are taken by staff. 4) Administrator or designee will make weekly rounds for the next 6 months of the resident rooms and common areas to	

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F 584	Continued From page 6 are observed in the paint which shown through the blue paint and are white in color. The cork board on the wall above the head of the resident's bed is crooked. On 2/17/2023 at 09:32 AM, Surveyor #3 observed the following on the [redacted] unit: *Residue buildup on the radiator near room [redacted] *Hole in the wall in the dayroom/lounge near the television *Brownish residue buildup on the bedrail and bedframe in room [redacted] *Brownish residue buildup noted on the bedframe in room [redacted] * Peeling wallpaper in room [redacted] *Rubber moulding hanging off the wall under the radiator in room [redacted] *Multiple rips in a pillow located in room [redacted] On 2/22/23 at 10:15 AM, five days after the initial observation, the bedframe in room [redacted] and [redacted] still had the residue buildup. During an interview with Surveyor #3 on 02/22/2023 at 10:47 AM, the Housekeeper (HK) stated that all rooms are cleaned daily and if the housekeepers are gone for the day porters are always available. During an interview with Surveyor #3 on 2/22/2023 at 11:05 AM, the Assistant Director of Housekeeping (ADOH) replied, "daily" when	F 584	ensure the areas are clean and all repairs noted are addressed in a timely fashion. Administrator will share his findings quarterly with QAPI committee.	

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F 584	Continued From page 7 asked how often the rooms are cleaned. The ADOH further stated "the housekeeper is expected to clean the spot, if they are unable to then they will call a porter, if the porter can't get it, then they call me." when asked what is expected of the housekeeper if there is a residue buildup on the bedframe or handrail. In addition, the ADOH stated the hallway is swept and mopped 3 times per day when asked how often the hallway is swept and mopped. During an interview with Surveyor #3 on 2/22/2023 at 11:05 AM, the Director of Nutritional Services (DONS) replied "yes, as needed" when asked are the beds wiped down. On 02/22/2023 at 11:26 AM Surveyor #3 requested the ADOH accompany Surveyor #3 to room [redacted] and the hallway of the [redacted] Unit. The ADOH confirmed the bedframes in room [redacted] were not clean and stated "yes, that should have been cleaned, sometimes I get in here myself." Attention was brought to the radiator in the hallway near room [redacted] the ADOH stated he "didn't get a chance to get to it yet, it should be cleaned immediately, as soon as you see it." A review of the Housekeeping Operations Manual revised on 3/2020 revealed, "Cleaning Specifics RESIDENT ROOMS Beds (headboard, footboard, hand-rails) Daily ...Radiators (dust & check inside for debris Daily ...CORRIDORS and LOBBIES Resilient Tile Floor (dust mop, damp mop, spot mop) Daily Resilient Tile Floor (buff & burnish) Daily Daily Procedures for Cleaning a Resident Room ...5. Clean resident bed- wipe down headboard, footboard, and handrails"	F 584		

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F 584	Continued From page 8 A review of the facility policy titled The Maintenance and cleaning of PTAC (Packaged Terminal Air Conditioner)/Radiator units revealed, "PROCEDURE: Maintenance Department will inspect and clean PTACS and Radiators quarterly. This includes cleaning of the filters and the coils. This can be done either through washing the filters and/or by using forced air. Maintenance Department will keep a log to the facility Administrator."	F 584		
F 695 SS=D	N.J.A.C. 8:39-31.4(a)(c)(f) Respiratory/Tracheostomy Care and Suctioning 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, record review and review of other facility documentation, it was determined that the facility failed to follow physician orders in accordance with professional standards for the care of [redacted] for 2 of 3 residents reviewed for [redacted] use (Resident # 30 and Resident # 68). This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title	F 695	F695 1. Resident # 30 and # 68 both were given new [redacted] □s with current dates. 2. All residents have the potential to be affected by this deficient practice therefore an audit was done of all residents on [redacted]. All residents on [redacted] were given new	3/17/23

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FOUNTAIN VIEW CARE CENTER	527 RIVER AVENUE LAKEWOOD, NJ 08701

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F 695	Continued From page 9 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." During the initial tour of Buckingham unit on 2/16/2023 at 11:29 AM, Resident #30 was observed lying in bed. Surveyor #1 observed an [redacted] at the bed side, turned off, with [redacted] that has residents last name and [redacted] on it. The [redacted] is draped over the [redacted] and exposed and in contact with [redacted] r. Surveyor #1 also observed an [redacted], turned off, at the bed side with a [redacted] with [redacted] with residents last name and [redacted] and draped over the concentrator uncovered and exposed and in contact with the machine. Resident# 30 said he/she uses [redacted]	F 695	tubing□s with current date. 3. All nurses were re-in serviced on [redacted] □s dating and storage 4. [redacted] policy updated to include storage when not in used and changing [redacted] weekly. 5. Unit Manager and/shift supervisors will conduct audits of all resident on oxygen weekly x 4 weeks and monthly x 3 months to determine that all resident□s [redacted] are dated and stored correctly. They will submit the audit report to DON. Monthly report by DON will be submitted to the QI Committee and the Administrator. This will occur for 3 months.	

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F 695	Continued From page 10 all day. On 2/17/2023 at 9:06 AM, Surveyor #1 observed Resident #30 in his/her room. Both the [redacted] were turned off and the [redacted] is uncovered and exposed. The [redacted] still had the tape with [redacted] them and were draped over and in contact with the [redacted] and concentrator. According to the Resident Face Sheet, Resident #30 was admitted to the facility with diagnoses including but not limited to: [redacted] or [redacted]. A review of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate resident care, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) of [redacted] indicating Resident #30 had [redacted]. A further review of the MDS indicated under [redacted] Resident #30 used [redacted] n while a resident. A review of the Physician's Orders indicated [redacted] Device: nasal cannula Rate: [redacted] with start date of [redacted] The Physician's Orders further indicated an order dated [redacted] Change [redacted] weekly. A review of the Treatment Administration Record (TAR) for [redacted] revealed that the [redacted] tubing was signed by the nurse as having been changed on [redacted]	F 695		

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F 695	Continued From page 11 A review of Resident # 30's care plan revealed a Focus area [redacted]. Interventions included but were not limited to "change [redacted] as ordered with an effective date of [redacted]." During an interview with Surveyor #1 on 2/17/2023 at 1:07 PM, the surveyor requested Unit Manger Licensed Practical Nurse (UM/LPN) to accompany surveyor to room [redacted]. UM/LPN confirmed both the [redacted] and [redacted] were dated [redacted] UM/LPN said [redacted] should be stored in plastic bag when not in use and he/she isn't using [redacted] but that is no excuse. On 2/16/2023 at 10:45 AM, Surveyor #2 observed Resident #68 in his/her room sitting in chair, with the [redacted] connected to an [redacted]. An [redacted] and cart were also present at the bedside, the [redacted] was uncovered and draped over the [redacted]. Both [redacted] contained a piece of [redacted] with [redacted] written on it. On 02/17/2023 at 9:54 AM, Surveyor #2 observed Resident # 68 was observed sitting in his/her room with the oxygen [redacted] in use. Both [redacted] still contained a piece of tape with [redacted] handwritten on it. A review of the Resident Face Sheet revealed that Resident #68 was admitted with diagnoses including but not limited to: [redacted]. A review of the most annual MDS dated [redacted], revealed BIMS of [redacted] indicating	F 695		

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F 695	Continued From page 12 Resident #68' cognition [redacted]. A further review of the MDS indicated under [redacted] Resident #68 used [redacted] while a resident. A review of the Physician's Orders indicated, [redacted] with start date/time [redacted] 9:02 PM. An additional Physician's Order dated [redacted] 9:02 PM indicated, [redacted] Change [redacted] weekly Schedule: Every Week on [redacted] at 11:00 PM- 7:00 AM A review of the TAR for [redacted] revealed that the [redacted] was signed by the nurse as having been changed on [redacted] and [redacted] During an interview with Surveyor #2 on 2/17/2023 at 1:11 PM, the surveyor requested UM/LPN to accompany the surveyor to Resident #68's room. UM/LPN confirmed both the nasal [redacted] connected to the [redacted] and [redacted] connected to the concentrator were dated [redacted] and the [redacted] connected to the [redacted] was uncovered. UM/LPN replied, "They cover it with plastic when not in use," when asked how the [redacted] should be stored when not in use. The UM/LPN further stated that the 11-7 nurse changes the [redacted] weekly. During an interview with the surveyor on 2/23/2023 at 1:02 PM, the Director of Nursing said the process for [redacted] changes is tubing's are to be changed weekly on the 11-7 shift. This automatically populated on MAR/TAR. The DON stated that the Unit Mangers are responsible to check to make sure [redacted] are changed on their rounds. The nurse	F 695		

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F 695	Continued From page 13 is responsible because she is signing for it. The Infection Preventionist also checks as part of infection control rounds. The DON said her expectations are to be in compliance and that is why there is order so the nurses don't miss it. When asked how the [redacted] is to be stored when not in use, the DON replied it is to be stored in a bag. A review of a facility policy titled [redacted] Administration did not include documentation of when [redacted] is to be changed.	F 695		
F 812 SS=E	NJAC: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 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:	F 812		2/27/23

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F 812	Continued From page 14 Based on observation, interview, and review of other facility documentation, 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 2/16/2023 from 9:30 AM to 10:18 AM the surveyor, accompanied by the Director of Nutrition Services (DONS), observed the following in the kitchen: 1. In the dry storage room on an upper shelf 3 individual, opened cardboard boxes, contained plastic knives, forks, and spoons. The boxes were open to the air and the utensils were exposed to contamination. 2. On an upper rack of a wheeled and multi-tiered can storage rack, a can of applesauce unsweetened had a significant dent on the upper seam. The DONS removed the can to the designated dented can area. 3. Prior to observing the high temperature dish machine the surveyor requested that the DONS provide the surveyor the high temperature dish machine temperature log for review. The log revealed the following recorded temperatures for the breakfast period on 2/16/2023: Wash: 160 F (Fahrenheit) Rinse: 180 F. According to the Dish Machine Temperature Documentation sheet, dated February 2023, the following minimum temperature standards were "Wash Temp> 160 degrees and Rinse Temp>180 degrees. The document further revealed, "Any out-of-range temps/ppm (parts per million) must be reported to supervisor." The surveyor and DONS then went to observe the wash and rinse temperatures on	F 812	1. New flatware was obtained to replace those that were in cardboard box opened to the air. Can of applesauce with significant dent was removed. Items in dish machine at 120F were sanitized and dish machine vendor came to service the machine. All noted items that were not dated or were expired have been disposed of. Empty packages of cereal in [redacted] nourishment room were removed and all drawers have been cleaned. Food labeled with resident name and room number but not dated was removed and disposed of. The turkey from previous day was discarded. Meat slicer was cleaned, sanitized and covered. 2) All residents have the potential to be affected by the deficient practice. 3) Dietary staff in-serviced on the appropriate storage of dry goods, including utensils and to note when cans are dented. Dietary staff in-serviced regarding appropriate storage and labeling of food items in a refrigerator. Dietary staff in-serviced on the appropriate temperatures of the dish	

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F 812	Continued From page 15 the dish machine while facility staff were actively washing dishes after the breakfast meal service. On the first observation the surveyor and DONS observed a wash temperature of 120 F and a rinse temperature of 196 F. The surveyor then questioned the dishwasher at what time the dish machine temperatures were recorded. The dishwasher responded, "I had 160 F this morning when I recorded the temperature." The surveyor then questioned the dishwasher at what time did he record the wash and rinse temperature of the dish machine. The dishwasher responded, "I wrote on the log around 7 AM." The surveyor further questioned the dishwasher if he monitored the dish machine wash and rinse temperatures throughout the dishwashing process. The dishwasher replied, "I monitor the temperatures periodically, but I didn't today." At this point the DONS instructed the dishwasher to shut the high temperature dish machine down and was placing a call to have the dish machine serviced. 4. On an upper shelf of the walk-in refrigerator, a plastic milk crate contained 3 lemons in a plastic bag dated 1/19/2022. An orange was also in the crate, open to the air and uncovered. The orange was wilted and was covered in a white fungus like growth on the outer surface. The DONS removed the orange to the trash. On another upper shelf, an opened bag of Low Moisture Mozzarella Cheeses was not completely sealed and was exposed to the air. The bag also had no open or use by date, as per facility policy. The DONS threw the cheese in the trash. On 2/22/2023 from 10:27 to 10:39 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN #2), observed the following on the Medici unit pantry/nourishment room:	F 812	machine and to report any issues to the director. Dietary staff in-serviced regarding the proper sanitation and storage of equipment when not in use. Dietary and nursing staff in-serviced regarding the appropriate storage and cleanliness of the nourishment rooms. Dietary and nursing staff in-serviced regarding the appropriate labeling of items in nourishment room refrigerators. 4) Administrator or designee will audit the kitchen and nourishment rooms weekly for the next 6 months to ensure proper procedures are being adhered to for storage of dry good, refrigerated food, storing of equipment and the functionality of the dish machine. Administrator will share his findings quarterly for the next year with the QAPI committee.	

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F 812	Continued From page 16	F 812		

1. On an upper shelf of a snack storage cabinet the surveyor observed a face shield that was used by staff for PPE (personal protective equipment). The face shield was stored in the same cabinet that is used to store snacks for the facility residents.

2. In a drawer next to the refrigerator, the surveyor observed (2) empty portion control packages of breakfast cereal. The packages were opened and only crumbs were visible in the containers.

3. The surveyor observed a white plastic bag in the pantry refrigerator. A paper bag was within the white plastic bag and appeared to contain Asian style takeout food. The bag was labeled with a name and room number. The bag did not have a date. According to LPN #2, "I will take out the food." LPN #2 further stated, "Yes, all food should be dated and discarded after 72 hours. I will remove everything, when asked by the surveyor if foods are to be dated when placed in the refrigerator.

On 2/23/2023 from 10:43 to 11:04 AM, the surveyor, accompanied by the DONS, observed the following in the kitchen:

1. In the walk-in refrigerator, on a lower rack of a multi-tiered wheeled cart, a 1/2 pan placed on top of a sheet pan contained 2 white plastic bags of ground turkey to be defrosted. The bags had a "pull date" of 2/20/23 and a "discard/use" by date of 2/22/2023. The DONS stated, "That should have been used yesterday." The ground turkey was discarded.

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2. In the cook's prep area a cleaned and sanitized meat slicer was on top of the cook's prep table. The slicer had no cover and was exposed. The surveyor asked the cook and DONS if the meat slicer had been used since the beginning of operations that day. The cook nodded no, and the DONS stated that the meat slicer was cleaned and sanitized and should be covered when not in use. The surveyor and DONS observed unidentified food debris on the base of the slicer under the slicing wheel.

The surveyor reviewed the facility policy titled Dented Can Policy, Rev 8.2021. The following was revealed under POLICY: Kitchen will receive quality acceptable canned goods. Unacceptable, dented canned goods will be reported and returned/discarded in a timely manner." The following was revealed under the heading PROCEDURE:

1. "Identify an acceptable/unacceptable dented can. Unacceptable: Any dent, crease, bulge, swelling, or rust."

2. "Upon discovery, place dented can in the designated "Dented Can" area."

The surveyor reviewed that facility policy titled RECEIVABLE AND STORAGE POLICY, Revised 7.2022. The following was revealed under the heading PROCEDURE:

8. "Ensure that all foods are securely covered, dated, and labeled."

The surveyor reviewed the facility policy titled DISWASHING POLICY, Revised 7.2020. The following was revealed under the heading

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F 812	Continued From page 18	F 812		

PROCEDURE:

9. "Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitation."

10. "High Temp (Wash 150 degrees F (Fahrenheit), Rinse 180 degrees F)."

12. FSD (Food Service Director) or designee will spot check clean dishes and dish machine log temperature and PPM (part per million) reading prior to each usage."

The surveyor reviewed the facility policy titled RECEIVING and STORAGE, dated 2.2020. The following was revealed under the heading Purpose: "To receive, store, and issue efficiently foods, nonfood items, and supplies; to establish receiving methods that assure that all items ordered are received, and to control issue so that no items are lost, stolen, or allowed to deteriorate." The policy further revealed the following:

vii "Produce that shows insect infestation, mold, cuts, wilting, discoloration, or unpleasant odor."

The surveyor reviewed the facility policy regarding food brought in by family and visitors, undated. The following was revealed under the heading Policy Interpretation and Implementation:

6. "Once food is delivered to the resident, the food or any leftover food that the resident did not finish, will be bagged, labeled, dated and placed in resident's own fridge or nourishment room fridge on the unit for the resident."

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F 812	Continued From page 19 7. "Leftover food is only allowed to stay in the nourishment fridge for up to 72 hours only." 11. "After 72 hours kitchen staff upon their daily inspection of the nourishment fridge, will discard any food left in the fridge." The surveyor reviewed the facility policy titled Food Service Equipment Sanitation Policy; date reviewed/revised: 5/08/21. The following was revealed under the heading POLICY: "All slicers, Buffalo Choppers, Blenders and Mixers will be cleaned and sanitized before and after every use." In addition, the following was revealed under PROCEDURE: "Only bag clean equipment once completely cleaned, sanitized, air dried and not in use." N.J.A.C. 8:39-17.2(g)	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to maintain garbage off the ground surrounding 2 of 2 garbage dumpster's. This deficient practice was evidenced by the following: On 2/16/2023 at approximately 10:10 AM, the surveyor and the facility Director of Nutrition Services (DONS) went outside the facility to	F 814	1. All paper cups, disposable gloves, plastic wrappers, cigarette butts, leaves, cardboard boxes, and any other unidentified debris outside area of dumpsters were immediately disposed of. 2. All residents and visitors to facility have the potential to be affected by the deficient practice.	2/27/23

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F 814	Continued From page 20 inspect the designated facility garbage area. Upon arriving to the designated garbage area, the surveyor observed 2 green dumpster's with lids open and staff actively dumping garbage. The DONS identified these 2 dumpster's as "garbage dumpster's." A third dumpster with its lids closed was determined to be a "recycling" only dumpster, per the DONS. Upon observation of the ground surrounding the dumpster's the surveyor observed an empty Reese's candy wrapper, plastic beverage lids, papers, plastic wrappers, an empty portion control ketchup packet, and old rusty grocery shopping cart, plastic straws, cigarette butts, leaves, pieces of white, plastic garbage bags, disposable gloves, surgical style masks, paper cups, empty 4 ounce plastic juice containers, cardboard boxes, and empty Black and Mild cigar box, an empty plastic gallon jug with top half of the jug removed, empty snack type bags, as well as other pieces of unidentified debris and garbage. When interviewed as to who had the responsibility of maintaining the facility garbage area the DONS responded, "The garbage area should be cleaned and monitored daily. We do it daily. My staff and our housekeeping staff will get it cleaned up." The surveyor reviewed the facility policy titled GARBAGE AND DUMPSTER AREA POLICY, Date: Reviewed/Revised 5/08/21. The following was revealed under Policy: "To maintain at all times the dumpster area is clean and organized." In addition, the following was also revealed: 3. "IF ANY TRASH BLOWS OUT OF THE TRASH CAN OR YOU DROP ANY TRASH ON THE GROUND OR AROUND THE DUMPSTER,	F 814	3.An audit was completed outside all facility dumpsters to ensure no paper cups, disposable gloves, plastic wrappers, cigarette butts, leaves, cardboard boxes and any other unidentified debris was on the ground surrounding the dumpsters. Dietary staff was in-serviced regarding proper sanitary environment for residents and staff and to ensure no garbage and debris was on the ground surrounding dumpsters. DONS was in-serviced regarding making appropriate rounds to observe staff properly disposing garbage. 4. Administrator or designee will make weekly rounds for the next 6 months of areas outside garbage dumpsters to ensure no garbage or debris on the ground. Administrator will share his findings quarterly with QAPI committee.	

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F 814	Continued From page 21 YOU ARE RESPONSIBLE TO PICK IT UP (tie up the bags first). IF YOU MAKE A MESS BY THE DUMPSTER WHEN THROWING OUT GARBAGE, YOU MUST CLEAN IT UP." 5. "DO NOT THROW BOXES OUT BY THE BACK DOOR ONTO THE GROUND." N.J.A.C 8:39-19.3(c)	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING _____ B. WING _____	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	527 RIVER AVENUE LAKEWOOD, NJ 08701

(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 880	Continued From page 22 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 23 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to a) implement infection control measures for the handling and storage of [redacted] equipment for 2 of 2 residents reviewed for [redacted] use, (Resident # 30 and Resident # 68) and b) failed to ensure staff wore the appropriate personal protective equipment (PPE) required to enter a resident's room that required transmission-based precautions during wound care. The deficient practice was observed for 1 of 2 residents investigated for [redacted] (Resident #97). This deficient practice was evidenced by the following: 1.) During the initial tour of [redacted] unit on 2/16/2023 at 11:29 AM, Resident #30 was observed lying in bed. Surveyor #1 observed an [redacted] at the bed side, turned off, with [redacted] that has residents last name and [redacted] on it. The [redacted] is draped over the [redacted] uncovered and exposed and in contact with [redacted]. Surveyor #1 also observed an [redacted], turned off, at the bed side with a [redacted] with tape with residents last name and [redacted] and draped over the [redacted] uncovered and exposed and in contact with the machine. Resident# 30 said he/she uses [redacted] all day. On 2/17/2023 at 9:06 AM, Surveyor #1 observed Resident #30 in his/her room. Both the [redacted] cylinder and concentrator were turned off and the [redacted] is uncovered and exposed. The [redacted] still had the tape with [redacted] on them and were draped over and in contact with the [redacted]	F 880	F880 1. Resident # 30 and # 68 both were given new [redacted] □s with current dates. The [redacted] were not used by either resident and were not negatively affected by the mishaps. 2. All residents have the potential to be affected by this deficient practice therefore an audit was done of all residents on [redacted] All residents on [redacted] were given new tubing□s with current date. 3. All nurses were re-in serviced on [redacted] □s dating and storage 4. [redacted] policy updated to include storage when not in used and changing [redacted] s weekly. 5. Unit Manager and/shift supervisors will conduct audits of all resident on [redacted] weekly x 4 weeks and monthly x 3 months to determine that all resident□s [redacted] are dated and stored correctly. They will submit the audit report to DON. Monthly report by DON will be submitted to the QI Committee and the Administrator. This will occur for 3 months. F880 1. Resident was not negatively affected by nurse not using correct PPE when giving care. Nurse was re-education on "Enhanced Barriers Precautions" completed on 2/27/23 and completed competency test.	

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	315327	A. BUILDING _____ B. WING _____	02/24/2023

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F 880	Continued From page 24 and [redacted]. On 2/17/2023 at 9:06 AM, Surveyor #1 observed Resident #30 in his/her room. Both the [redacted] r and [redacted] were turned off and the [redacted] is uncovered and exposed. The [redacted] still had the tape with [redacted] on them and were draped over and in contact with the [redacted] and [redacted]. During an interview with the surveyor on 2/17/2023 at 1:07 PM, the surveyor requested Unit Manger Licensed Practical Nurse (UM/LPN) to accompany surveyor to room [redacted]. UM/LPN said [redacted] should be stored in plastic bag when not in use and he/she isn't using [redacted] but that is no excuse. 2.) On 2/16/2023 at 10:45 AM, Surveyor #2 observed Resident #68 in his/her room sitting in a chair, with the [redacted] connected to an [redacted]. An [redacted] and cart were also present at the bedside, the [redacted] was uncovered and draped over the [redacted]. Both [redacted] contained a piece of tape with [redacted] written on it. On 02/17/2023 at 9:54 AM, Surveyor #2 observed Resident # 68 was observed sitting in his/her room with the [redacted] in use. Both [redacted] tubings still contained a piece of tape with [redacted] handwritten on it. A review of the Resident Face Sheet revealed that Resident #68 was admitted with diagnoses including but not limited to: [redacted]	F 880	2. All residents have the potential to be affected by this deficient practice therefore all staff were re-educated about Enhanced Barriers Precautions. 3. All nursing staff were re-in serviced on “Enhanced Barrier Precautions” IP Nurse/ unit managers will conduct random weekly Enhanced Barrier Precaution competency tests of care givers weekly x 4 weeks and then monthly x 3 months. IP Nurse/DON will monthly submit report to the QI Committee and the Administrator. This will occur x 3 months.	

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F 880	Continued From page 25 [redacted].	F 880		

A review of the most annual Minimum Data Set (MDS; an assessment tool) dated [redacted] revealed a Brief Interview for Mental Status score of [redacted] indicating Resident #68' cognition was [redacted]. A further review of the MDS indicated under [redacted] Resident #68 used [redacted] while a resident.

A review of the Physician's Orders indicated, [redacted] Device: [redacted] with start date/time [redacted] 9:02 PM. An additional Physician's Order dated [redacted] 9:02 PM indicated, [redacted] - Change [redacted] weekly Schedule: Every Week on [redacted] at 11:00 PM- 7:00 AM.

A review of the Treatment Administration Record for [redacted] revealed that the [redacted] was signed by the nurse as having been changed on [redacted].

During an interview with Surveyor #2 on 2/17/2023 at 1:11 PM, the surveyor requested UM/LPN to accompany surveyor to Resident #68's room. UM/LPN confirmed both the cylinder [redacted] and [redacted] were dated [redacted] and the [redacted] connected to the [redacted] was uncovered. UM/LPN replied, "They cover it with plastic when not in use" when asked how the [redacted] should be stored when not in use. The UM/LPN further stated that the 11-7 nurse changes the [redacted] weekly.

During an interview with the surveyors on 2/23/2023 at 1:07 PM, the Director of Nurisng (DON) said, when asked how the [redacted] is to be stored when not in use, the DON replied it

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	315327	A. BUILDING _____ B. WING _____	02/24/2023

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F 880	Continued From page 26	F 880		

is to be stored in the bag.

The facility was unable to provide a policy regarding storage of [redacted] when not in use.

3.) On 2/17/2023 at 12:21 PM, Surveyor #3 observed a sign on Resident #97's room door that read, " [redacted] : Wear gloves and a gown for the following [redacted] Resident Care Activities." The Resident Care Activities listed on the sign included, [redacted] Care: any [redacted] requiring a dressing."

On the same date and time, Surveyor #3 observed [redacted] care performed by Licensed Practical Nurse (LPN) #1 on Resident #97. Prior to entering the room and during the procedure, LPN #1 did not wear a gown.

A review of Resident #97's Physician's Orders located in the Electronic Medical Record (EMR) revealed an order for [redacted] " scheduled for every day during all shifts. The order was renewed on [redacted]

A review of Resident #97's Care Plan Activity Report located in the EMR, revealed a care plan titled, '[redacted] " with an effective date of [redacted] In the care plan, there was an intervention that revealed staff must apply isolation equipment upon entry to the room.

On the same date at 12:32 PM, during an interview with Surveyor #3, LPN #1 replied, "Yes,

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F 880	Continued From page 27	F 880		

yes I am." when asked if she was supposed to wear a gown.

On 2/23/23 at 1:02 PM, during an interview with Surveyor #3, the Infection Preventionist replied, "Yes" when asked if during [redacted] care on a resident in an enhanced barrier precaution room, should the nurse doing the procedure, wear a gown.

A review of the undated facility policy titled, "Isolation-Categories of transmission-based precautions" under section, "Policy and Interpretation and Implementation" number "2." revealed, "[redacted]: In addition to Standard Precautions, implement [redacted] 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 [redacted]s..." Further, the policy revealed under "c." that, "Gown (1) In addition to wearing a gown as outlined under Standard Precautions, 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. 8:39-19.4(a)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061536		4/3/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	527 RIVER AVENUE LAKEWOOD, NJ 08701

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/27/2023	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
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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	
2/24/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315327 Y1	A. Building B. Wing Y2	4/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	527 RIVER AVENUE LAKEWOOD, NJ 08701

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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0695	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(i)	Completed
LSC	03/17/2023	LSC	02/27/2023	LSC	03/17/2023
ID Prefix F0812	Correction	ID Prefix F0814	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	02/27/2023	LSC	03/06/2023	LSC	03/17/2023
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	
2/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING **01** B. WING _____	**02/24/2023**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 90's with no current major renovations or noted additions. It is a one- story building Type II (000) unprotected construction with no basement and is fully sprinklered. The inside 54 KW natural gas generator does approximately 60% of the building. The building has 7-smoke zones and an updated fire alarm system. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 123 certified beds. At the time of the survey the census was 100. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222	Egress Doors	K 222		2/27/23

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

Electronically Signed | 03/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222 SS=F	Continued From page 1 CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222		

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K 222	Continued From page 2 permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/23/2023, it was determined that the facility failed to ensure that exit doors locked with a delayed egress device were provided with instructional signage as per the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was identified in 5 of 5 egress doors and evidenced by the following: From approximately 9:30 AM to 1:45 PM, the Surveyor and Maintenance Director (MD), observed that 5 of 5 the exit/egress fire door's in the facility were not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's opened in 15-seconds	K 222	1. All exit/egress doors now have visible signs reading "Push until the alarm sounds, door can be opened in 15 seconds" posted. 2. An audit was completed with all exit/egress doors in the facility to ensure proper visible signs with the correct verbiage are posted by each door. All residents have the potential to be affected by the deficient practice. Maintenance Director was in-serviced regarding proper visible signs and verbiage by all exit/egress doors in facility. 3. Administrator or designee will make	

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K 222	Continued From page 3 and the MD indicated the doors opened with the activation of the fire alarm. The Maintenance Director, confirmed the findings at the time of the observations. The Administrator was informed of these findings during the Life Safety Code survey exit conference on 02/23/2023. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222	weekly rounds for the next 6 months to ensure correct signs are posted by all exit/egress doors. Administrator will share his findings quarterly with QAPI committee.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		3/29/23

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K 321	Continued From page 4 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/23/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 6 of 18 hazardous area storage room doors and was evidenced by the following: 1). At 1:40 PM, the Personal Protective Equipment storage room was observed to have approximately 100 plus combustible cardboard boxes, greater than 50 square feet in size and requires an auto close device installed on the door. 2). At 11:49 AM, the kitchen door was observed with a 90 minute fire rating label, but the wooden door was compromised with two 1/2" holes through the door. 3). At 11:54 AM, the right-side kitchen door was observed with a rated 45 minute fire rating label, but the top of the wooden door was compromised with four 1/4" holes through the door and when the door was opened, it remained open due to the	K 321	K321 1.Auto close device was installed on PPE room door. Holes on kitchen door were filled with fire barrier caulk. Kitchen and storage room Door no longer stick to the floor as obstruction underneath was removed. Hardware(door knob assembly) has been added to the wooden laundry door. Door actuator in service corridor wooden doors has been fixed and doors have been replaced so doors can close properly. 2. An audit was completed throughout the facility to ensure all doors have the required fire resistance rating, are free from any holes and close properly. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding required fire resistance ratings for all doors, to be free of holes and close properly.	

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K 321	Continued From page 5 door sticking to the floor. 4). At 11:58 AM, the general storage room was observed to have 2-doors, 1 of the 2 doors remained open due to the door sticking to the floor. 5). At 12:04 PM, the wooden laundry room door was missing hardware (door knob assembly) leaving an approximately 4" opening through the door. 6). At 12:10 PM, the service corridor set of wooden doors would not close properly, due to the door actuator (the component in any machine that enables movement) not functioning properly. The Maintenance Director confirmed the finding's during the observations. The Administrator was informed of the finding's at the Life Safety exit conference on 02/23/2023. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321	4. Administrator or designee will make weekly rounds for the next 6 months to ensure all doors have correct fire resistance rating, are free of holes and close properly. Administrator will share his findings quarterly with QAPI committee.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders,	K 341		3/31/23

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K 341	Continued From page 6 and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/23/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 3 of 3 enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: From approximately 9:30 AM. to 1:30 PM. the surveyor and the MD, observed in the enclosed courtyards, no evidence of a fire alarm notification (horn/strobe) device in the following enclosed courtyards: 1). Buckingham 2). Fountain 3). Fireside An interview was conducted during the observation's and the surveyor asked the MD, if there was a horn/strobe, tied into the fire alarm system within court yard's: (Buckingham, Fountain and Fireside). The MD confirmed that currently there are no horn/strobe devices tied	K 341	1. Horn/Strobes for all 3 enclosed courtyards have been ordered and to be installed by March 31. 2. An audit was completed in all 3 enclosed courtyards to ensure proper fire alarm notification devices are placed there. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding the requirement of proper fire alarm notification devices in all enclosed courtyards. 4. Administrator or designee will make weekly rounds of all 3 enclosed courtyards for the next 6 months to ensure fire alarm notification devices are properly installed and working. Administrator will share his findings quarterly with QAPI committee.	

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K 341	Continued From page 7 into the fire alarm system in the enclosed courtyard's observed. The Administrator was notified of the findings at the Life Safety Code exit conference on 02/23/2023. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and document review on 02/22/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to conduct in-house fire drills with varying activation types and specific simulation of emergency fire conditions and predictable times, in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced by the following:	K 712	1. Fire drill was conducted to specify the simulation of the emergency fire conditions. 2. An audit was conducted to note that nature of emergencies are specified and that times of emergency drills vary according to the regulation. All residents have the potential to be affected by the deficient practice.	3/22/23

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K 712	Continued From page 8 The facility fire drill reports revealed method for the simulation of emergency fire conditions for 6 of 12 drills, were not documented: Date: Type of alarm transmission: Pull, Smoke or Page Shift: 7-3 3-11 11-7 - 02/13/23 Type: N/A 04:52 PM - 01/16/23 Type: pull 12:49 PM - 12/05/22 Type: N/A 12:58 AM - 11/21/22 Type: pull 07:55 PM - 10/18/22 Type: smoke 01:09 PM - 09/14/22 Type: N/A 02:01 AM - 08/28/22 Type: smoke 04:55 PM - 07/12/22 Type: smoke 01:10 PM - 06/09/22 Type: N/A 01:44 AM - 05/06/22 Type: pull 04:42 PM - 04/14/22 Type: N/A 11:10 AM - 03/07/22 Type: N/A 02:20 AM 7-3 shift 3 of 4 drills within 1-hour 3-11 shift 3 of 4 drills within 1-hour 11-7 shift 3 of 4 drills within 1-hour The fire drills had identified locations, but were not specific as to what caused the simulation of emergency fire conditions. The MD confirmed the time's were to close for 3 of 3 shifts completed and indicated the simulation of emergency fire conditions were not specific in the identified areas on the reports.	K 712	3. In service conducted with Maintenance Director to ensure emergency drills occur at the appropriate times, frequencies and conditions to be included and noted for each drill. Contracted fire safety vendor notified to ensure to include these considerations when scheduling and conducting future drills. 4. On a quarterly basis, Administrator or designee will review the fire drills to ensure the times of the drill are appropriate and the conditions are specified. Administrator will share his findings quarterly with the QAPI committee.	

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K 712	Continued From page 9 The Administrator was informed of the finding at the Life Safety Code exit conference on 02/23/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by:	K 741		2/27/23

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K 741	Continued From page 10 Based on observation and interview on 2/23/2023, in the presence of the Maintenance Director (MD) and Administrator (ADM), the facility failed to maintain smoking areas in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. This deficient practice was identified for 2 of 2 smoking areas observed and was evidenced by the following: 1). From approximately 9:30 AM. to1:45 PM., the Surveyor and Maintenance Director observed in the Buckingham smoking enclosed courtyard that 100 plus cigarette butts were in dried leaves and mulch. The area included 1-approved astray for the disposal of cigarette butts. There was no approved self-closing covered metal container in the area for the disposal of cigarette butts and ashes from the approved astray. A plastic composite garbage can was observed to have combustible paper cups, paper plates and various combustible items, including many cigarette butts. 2). From approximately 9:30 AM. to 1:45 PM., the Surveyor and Maintenance Director observed in the Fireside smoking enclosed courtyard that 100 plus cigarette butts were in dried leaves and mulch. The area included 1-approved astray for the disposal of cigarette butts. There was no approved self-closing covered metal container in the area for the disposal of cigarette butts and ashes from the approved astray. A plastic composite garbage can was observed to have combustible paper cups, paper plates and various combustible items, including many cigarette butts. The MD confirmed the finding's during the observations. No further documentation was provided.	K 741	1.All cigarette butts have been cleared and disposed of. A self closing metal container is in every courtyard now. 2. An audit was completed in all courtyards to ensure no cigarette butts are in leaves or mulch and that there are self closing metal containers in all courtyards. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding need to have all courtyards clean of cigarette butts and self closing metal containers to be placed in each courtyard. 4. Administrator or designee will make weekly rounds for the next 6 months to ensure all courtyards are clean from cigarette butts and that self closing metal containers are present. Administrator will share his findings quarterly with QAPI committee.	

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K 741	Continued From page 11 The Administrator was informed of the finding's at the Life Safety Code exit conference on 2/23/2023. NJAC 8:39-31.2(e)	K 741		
K 911 SS=E	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, interview, and review of facility documentation on 2/23/2023, in the presence of the Maintenance Director (MD), the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for 1 of 1 generator's. This deficient practice was evidenced by the following: On 2/23/2023 at 12:05 PM, the surveyor and MD reviewed all the facility's generator documentation. The facility currently has an interior 54 KW (kilowatt) natural gas generator. The MD could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the	K 911	1. Gas company will provide us a copy of documented reliability letter. 2. An audit was done to ensure there is a documented reliability letter from the natural gas provider for the natural gas generator. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding need for documented reliability letter from the natural gas provider for the natural gas generator. 4. Administrator or designee will inspect quarterly for the next year to ensure documented reliability letter from natural gas provider is in Life Safety binder. Administrator will share his findings quarterly with QAPI committee.	3/28/23

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K 911	Continued From page 12 following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The MD confirmed there was no reliability letter available from the natural gas provider for the 54 KW natural gas generator for the facility to present to the surveyor. No additional information was received. The Administrator was informed of the findings at the Life Safety Code exit conference on 2/23/2023. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911		
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	K 914		3/31/23

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K 914	Continued From page 13 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 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 2/23/2023, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 32 of 32 resident rooms and observed by the following: From approximately 9:30 AM, to 1:30 PM, the surveyor and MD observed that the resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The last annual electrical inspection by the facility's electrical vendor was dated 05/18/22. The inspection report indicated: "electrical systems & wiring were safe and in well maintained condition" and did not indicate specific functionally test of electrical receptacles in residents' rooms annually for grounding, polarity,	K 914	1. Electrical inspection of all outlets in resident rooms has been done. 2. An audit was completed throughout the facility for all electrical receptacles that are not hospital grade to ensure annual electrical inspection is done. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced regarding the need for all electrical receptacles that are not hospital grade to get an annual electrical inspection. 4. Administrator or designee will review Life Safety binder for the next year to ensure all electrical receptacles in the facility that are not hospital grade received an annual electrical inspection. Administrator will share his findings quarterly with QAPI committee.	

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K 914	Continued From page 14 and blade tension in accordance with NFPA 99. The MD indicated he was not aware of any non-hospital grade outlet testing procedures that had to be preformed annually. The Administrator was informed of the findings at the Life Safety Code exit conference on 2/23/2023. NJAC 8:39-31.2(e) NFPA 99	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		3/30/23

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FOUNTAIN VIEW CARE CENTER	**527 RIVER AVENUE** **LAKEWOOD, NJ 08701**

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K 918	Continued From page 15 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/23/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure a remote manual stop station for one of one generators and installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the surveyor and MD observed the interior 54 KW (kilowatt) natural gas generator. There was no remote manual stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the MD, who confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code exit conference on	K 918	1. Manual stop station was installed outside area of generator location. 2. An audit will be done to ensure manual stop station is installed and working properly. All residents have the potential to be affected by the deficient practice. 3. Maintenance Director was in-serviced about need to have manual stop station outside generator area. 4. Administrator or designee will do quarterly rounds to ensure manual stop station is installed and working properly. Administrator will share his findings quarterly with QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315327	A. BUILDING **01** B. WING _____	**02/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	**527 RIVER AVENUE** **LAKEWOOD, NJ 08701**

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K 918	Continued From page 16 2/23/2023. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315327 Y1	A. Building B. Wing Y2	4/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VIEW CARE CENTER	527 RIVER AVENUE LAKEWOOD, NJ 08701

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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0695	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(i)	Completed
LSC	03/17/2023	LSC	02/27/2023	LSC	03/17/2023
ID Prefix F0812	Correction	ID Prefix F0814	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	02/27/2023	LSC	03/06/2023	LSC	03/17/2023
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	
2/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO