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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINVIEW 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 000	INITIAL COMMENTS Complaint #: NJ00174037 Census: 88 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		6/28/24

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

Electronically Signed | 06/21/2024

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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	315327	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 842	Continued From page 1	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 2 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint# NJ00174037 Based on interviews, record review, and review of other pertinent facility documentation on 05/30/24, it was determined that the facility failed to maintain a complete Medical Record (MR) which contained the New Jersey Universal Transfer Form (NJUTF) for a resident who was sent out for an emergent hospitalization. This deficient practice was identified for Resident #4, 1 of 5 sampled residents, and was evidenced by the following: According to the Admission Record, Resident #4 was admitted to the facility with diagnoses which included but were not limited to: [redacted] A review of the Resident #4's Progress Notes (PN) revealed that on [redacted] at 09:45, Licensed Practical Nurse (LPN) #1 documented "Resident was noted yelling "I can't breathe, I can't breathe. Bp-[redacted], R-[redacted] T-[redacted] SpO2-[redacted] on [redacted] of [redacted], [redacted] noted to [redacted] upon auscultation. Call place to [physician] n/o [new order] received to send resident to ER [emergency room] for eval [evaluation] and treat [treatment] ...Call place to 911 EMTs [emergency medical technicians] arrived stat [immediately] resident transported to MMSC [hospital] ..." A further review of the Resident #4's PN, dated [redacted] at 14:20 and documented by LPN #1,	F 842	1.Resident # 4 was not negatively affected by the NJUTF, and resident #4 no longer resides in the facility. 2.All residents have the potential to be affected and an audit was done to ensure all NJUTF are preserved in the residents MR. 3.Facility's Emergency Transfer discharge policy was updated to include steps of completing and uploading the NJ Transfer Discharge Form into the resident medical record. All nurses were in-serviced by the Director of Nursing/designee on the NJ Universal Transfer Form, correct completion of the form and uploading a copy in the medical record. 4.The DON or designee will audit NJ Universal Transfer Form for residents that are transferred to the hospital monthly for three months. The DON will share the outcome of the audits at the quarterly QAPI for action and recommendations.	

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	315327	A. BUILDING _____ B. WING _____	C 05/30/2024

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FOUNTAINVIEW CARE CENTER	**527 RIVER AVENUE LAKEWOOD, NJ 08701**

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F 842	Continued From page 3	F 842		

revealed as follows: "Call place to MMSC-ER [hospital-ER] for status on resident ...spoke with RN [nurse] made aware resident being admitted dx: [redacted]. Call place to [physician] and [redacted] [resident's [redacted]] to make aware ...".

A review of Resident #4's MR revealed no NJUTF for the [redacted] transfer to the hospital.

During an interview with the surveyor on 05/30/24 at 2:57 p.m. and at 4:57 p.m., the Director of Nursing (DON) stated she was unable to locate the [redacted] NJUTF for Resident #4. The DON further stated she/he did not see the Resident when he was transferred out. At which point, the DON affirmed that Resident #4's NJUTF was not made.

A review of the facility policy titled, "Transfer or Discharge, Emergency", revealed under the "Policy Interpretation and Implementation" #2 Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: ...c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident ...".

NJAC 8:39-35.2 (d) 12

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 _____	C 05/30/2024

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

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S 000	Initial Comments Complaint #: NJ00174037 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency 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 facility document review on 5/30/2024, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 7 of 14 day shifts. This 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,	S 560	1) No residents were identified on the 2567 as having been affected by the deficient practice. 2) This deficient practice has the potential to affect all residents. 3) Staffing Coordinator was educated by the Administrator regarding the Mandatory Staffing Ratios and instructed to update the contact information of all current licensed personnel, so staff can be called in to meet staffing needs in case of call-outs. 4) Staffing ratios will be monitored daily by Administrator or designee for thirty days to ensure compliance. Administrator will	6/28/24

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

Electronically Signed | 06/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (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 certified nurse aide 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. The surveyor requested staffing for the weeks of 05/05/24 to 05/11/24 and 05/12/24 to 05/18/24. The facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -05/05/24 had 7 CNAs for 85 residents on the day shift, required at least 11 CNAs. -05/06/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -05/08/24 had 9 CNAs for 85 residents on the day shift, required at least 11 CNAs. -05/11/24 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -05/12/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -05/13/24 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs. -05/18/24 had 9 CNAs for 86 residents on the day	S 560	audit staffing reports monthly for three months. Results will be reported to the quarterly QAPI meeting.	

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S 560	Continued From page 2 shift, required at least 11 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061536 Y1	A. Building B. Wing Y2	6/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINVIEW 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 06/28/2024	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
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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	
5/30/2024	☐ 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 A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315327		6/30/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINVIEW 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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 06/28/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 5/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			