STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974**

(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 #s: NJ174676 Survey Dates: 09/09/2024 through 09/12/2024 Census: 38 Sample Size: 12 + 3 closed records A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		10/11/24

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

Electronically Signed | 10/02/2024

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

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F 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan (CP) that included the use NJ Exec Order 26.4b1 [redacted]); a CP that included the use of NJ Exec Order 26.4b1), and a CP that included NJ Exec Order 26.4b1. This deficient practice was identified for 5 of 15 residents (Resident #3, #5, #17, #11, and #29) reviewed for comprehensive person-centered CP.	F 656	1.The Assistant Director of Nursing has since updated the comprehensive care plan for NJ Exec Order 2 for Resident #3 and #5, use of NJ Exec Order 26.4b1) for Resident #17 and #11, and NJ Exec Order 26.4b1 for resident #29. 2.The facility acknowledges that all residents have the potential of being affected by the deficient practice. The Director of Nursing (DON) or designee has completed an 100% audit of the last	

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F 656	Continued From page 2 This deficient practice was evidenced by the following: 1. On 9/9/24 at 09:28 AM, the surveyor observed Resident #3 awake in bed. The surveyor also observed the resident had a NJ Exec Order 26.4b1 [redacted] Resident #3 stated they wear a NJ Exec Order in the evening and the NJ Exec Order is removed in the morning. The surveyor reviewed Resident #3's medical records, which revealed that the resident was admitted to the facility with diagnoses that included but not limited to NJ Exec Order 26.4b1 [redacted] The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order revealed a Brief Interview for Mental Status (BIMS) that could not be completed at the time of interview. The Quarterly MDS further revealed Resident #3 had been using a NJ Exec Order A review of the NJ Ex Order 26.4(b)(1) Physician Order Sheet revealed a Physician's Order (PO) dated NJ Exec Order, for 'NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted] A review of the CP titled Holistic Care Plan/Continuing Services with a start date of NJ Exec Order and a last reviewed date of NJ Exec Order did not reflect the resident's use of the NJ Exec Order 26.4b1 [redacted] On 9/10/24 at 9:55 AM, the surveyor conducted an interview with Licensed Practical Nursing	F 656	quarter of all residents to identify who currently uses splints, are prescribed AC, and those who have pressure ulcer care to ensure all items are correctly reflected in the care plan. Any discrepancies were corrected promptly. 3.The Director of Nursing has provided education on the facility policy "Care/Service Plans" to the entire interdisciplinary (IDCP) team, with an emphasizes of updating hand-written additions to the care plan located in the residents room to include use of splints, anticoagulant medication and those with pressure ulcer. The DON or designee will review all new admissions who are using splints, are on AC medication, and have pressure ulcer care during clinical meeting to ensure care plans are accurate . Any discrepancies will be corrected promptly. 4.The Director of Nursing or designee will complete an audit of 20% of current residents, to include new admissions, who use splints, are on AC medication, or have pressure ulcer care weekly for one month and monthly for three months until 2/1/2025. The audit will review the comprehensive care plans to ensure updates are reflected correctly for those residents who use splints, are on AC medication, or have pressure ulcer care. Any discrepancies will be corrected promptly. Audit findings will be reposted to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review until 2/1/25. Additional audits and education may be determined based	

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F 656	Continued From page 3 (LPN#1) who stated the residents CP are kept in a separate notebook inside the resident's room. LPN #1 added that the use of [redacted] must be addressed in the resident's CP. LPN #1 was not able to locate a CP for Resident #3's use of [redacted] and could provide any information as to why there was no care plan initiated. 2. On 9/9/24 at 10:47 AM, the surveyor observed Resident #17 in their room with eyes closed in bed. The surveyor reviewed Resident #17's medical records which revealed that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the Quarterly MDS, dated [redacted] revealed a BIMS score of [redacted] out of 15, which indicated that the resident had [redacted] The MDS further revealed under Section N. "Medications" that Resident #17 was taking an [redacted] medication. A review of the [redacted] POS revealed a PO dated [redacted] "[redacted]" A review of Resident #17's CP which reflected a review date of [redacted] revealed under the medication's portion which did not reflect the resident's use of [redacted] medication. 3. On 09/09/24 at 9:59 AM, the surveyor observed the resident who was seated in a	F 656	on audit findings.	

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F 656	Continued From page 4 wheelchair in the dining room, eating breakfast with other residents. The surveyor reviewed Resident #5's medical records, which revealed that the resident was admitted to the facility with diagnoses that included but not limited to NJ Exec Order 26.4b1 [redacted]. A review of the Admission MDS dated NJ Exec Order 26.4b reflected the resident had a BIMS score of NJ Ex out of 15, indicating the resident was NJ Exec Order 26.4b1 [redacted] A review of the NJ Ex Order 26.4(b)(1) POS revealed a PO dated NJ Exec Order 26 for NJ Exec Order 26.4b1 [redacted] The NJ Exec Order 26.4b1 POS also reflected that Resident #5 had a PO dated NJ Exec Order 2 for NJ Exec Order 26.4b1 to be NJ Exec Order 26.4b1 [redacted] A review of the comprehensive person-centered CP for Resident #5 did not reflect the resident's use of NJ Exec Order 26.4b1 [redacted]. On 9/11/24 at 11:15 AM, the surveyor requested documentation for Resident #5 from the U.S. FOIA (b)(6)	F 656		

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F 656	Continued From page 5	F 656		

U.S. FOIA (b)(6) The surveyor informed the U.S. FOIA (b) that the resident's NJ Exec Order 26.4b1 did not reflect in the resident's CP. The U.S. FOIA (b) told the surveyor that she was aware of the concern.

4. On 09/10/24 at 11:54 AM, the surveyor observed Resident #29 in bed with a family member present at bed side. The resident was NJ Ex Orde and stated that they had NJ Exec Order 26.4b1.

The surveyor reviewed Resident #29's medical records, which revealed that the resident was admitted to the facility with diagnoses that included but not limited to NJ Exec Order 26.4b1 .

A review of the Quarterly MDS, dated NJ Exec Order 26.4b1 revealed that the resident had a BIMS score of NJ out of 15, indicating NJ Exec Order 26.4b1 Further review of the MDS revealed the resident had a NJ Exec Order 26.4b1) and NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 POS revealed a PO dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Ex Order 26.4 with an indication for the NJ Exec Order 26.4b1 to NJ Ex Order 26.4(b) with NJ Ex Order 26.4 , apply the NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 water then cover with a NJ Exec Order 26.4b1.

Further review of the NJ Ex Order 26.4(b)(1) POS revealed a PO dated for NJ Ex Order 26.4(b)(1) with an indication for the NJ Exec Order 26.4b1 to cleanse with NJ Exec Order 26.4b1 apply NJ Exec Order 26.4b1

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F 656	Continued From page 6	F 656		

NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 water then cover with a NJ Exec Order 26.4b1 NJ Ex Order 26.4b1.

A review of Resident #29's CP titled "Holistic Care Plan" did not reflect a CP that addressed the resident's NJ Exec Order 26.4b1.

On 09/12/24 at 09:56 AM, the surveyor interviewed and reviewed the CP's that were provided by the U.S. FOIA (b), who stated to the surveyor the CP's that were provided were the residents CP's and there were no CP's for the NJ Exec Order 26.4b NJ Exec Order 26.2 that had developed.

A review of the facility's policy titled "Skin Integrity Program" dated 01/24 revealed that if a new NJ Exec Order 2 is identified during skin checks the care/service plan will address approaches for NJ Exec Order 2 care.

5. On 9/09/24 at 10:13 AM, the surveyor observed Resident #11 seated in their wheelchair inside the main dining room. The resident was NJ Ex Order 26.4 answer the surveyor's inquiry and stated they were not in any NJ Exec Or

The surveyor reviewed Resident #11's medical records, which revealed that the resident was admitted to the facility with diagnoses that included but not limited to

A review of the Quarterly MDS, dated NJ Ex Order 26.4(, revealed that the resident had a BIMS score of NJ out of 15, indicating NJ Exec Order 26.4b1. Further review of the MDS under "Section N. Medications" indicated that the resident was taking NJ Exec O

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F 656	Continued From page 7 A review of the form titled, '[NJ Exec Order 26.4b1] Medications" for Resident #11 reflected a PO for '[NJ Exec Order 26.4b1] oral two times daily started on [NJ Ex Order 26.4(b)] A review of Resident #11's CP which reflected an initiated date of [NJ Ex Order 26], revealed under the medication's portion which did not reflect the resident's use of [redacted] medication. On 9/10/24 at 9:59 AM, the survey team interviewed the [NJ Exec Orde], who stated holistic assessment included the CP. The [NJ Exec Orde] further stated that the CP were kept in a notebook inside each resident's room. The [U.S. FOIA (b)] added that the CP's were updated as needed and for "any immediacy on the CP's would be handwritten." The [U.S. FOIA (b)(6)] agreed that the [NJ Exec Order 26.4b1]; use of AC medications; [NJ Ex Orde] and [NJ Ex Order 26.4(b)(1)] devices must be addressed in the CP. The [U.S. FOIA (b)] did not provide any further information as to why the above concerns were not reflected in each of the resident's CP's. On 9/10/24 at 11:30 AM, the [NJ Exec Orde] provided the survey team with a facility policy, Care/Service Plans with a revision date of 5/2021. Under the procedure section of the policy it states, "1. Guest/residents admitted to Post Acute/Long Term Care will have ...b, The interim care plan will reflect the resident's goals and include interventions that address his or her current needs ...c. The interim care plan will include healthcare information necessary to care for resident including, but not limited to...ii. Physician orders (list of medications)..4. Any changes identified in the comprehensive care plan in the resident's goals, physical, mental, or psychosocial	F 656		

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F 656	Continued From page 8 function, that was not identified in the interim care plan will be provided in to the resident and/or responsible party ...8. Care plans will be reviewed, revised if applicable, on an ongoing basis by the interdisciplinary team with any changes in condition and after each assessment, including both comprehensive and quarterly review assessments." On 9/11/24 at 2:00 PM, the survey team met with the U.S. FOIA (b)(6) [redacted]. There were no further information provided.	F 656		
F 658 SS=D	NJAC 8:39-11.2(e)(2) thru (i); 27.1(a), (d) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain the nursing professional standard of clinical practices by not accurately 1. documenting the pain management assessment and 2. Documenting the time and use of each as-needed NJ Exec Order 26.4b1 for 1 of 12 residents (Resident #11) reviewed for unnecessary medications. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse	F 658	1. The facility initiated a "[redacted] Assessment Scale for [redacted]" that will be used for residents who are unable to identify [redacted]. Resident #11 had a NJ Exec Order 26.4b1 done and physical monitors are now in place for PRN [redacted]. 2. The facility acknowledges that all residents have the potential to be affected by the deficient practice. Nursing Leadership completed a 100% audit of all	10/11/24

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F 658	Continued From page 9 Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; 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." The deficient practice was evidenced by the following: On 9/09/24, at 10:13 AM, the surveyor observed Resident #11 seated in their wheelchair in the main dining room. The resident was able to answer the surveyor's inquiry and stated that they were not in [redacted] On 9/11/24, at 10:42 AM, the surveyor reviewed Resident #11's electronic medical record and revealed the following information: According to the Admission Record (an admission summary), Resident #11 was admitted to the facility with diagnoses that included but were not limited to [redacted] The Quarterly Minimum Data Set (MDS), dated [redacted], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored [redacted] out of 15, which indicates that resident had [redacted]. Further review of the MDS under "Section J. [redacted] Management" [redacted] Presence was answered as [redacted]	F 658	current residents who are unable to identify a pain scale who are receiving PRN pain medication to ensure physical monitors are in place and assessment is completed prior to administration. Discrepancies were corrected promptly. All residents with PRN pain medications who are unable to identify a pain scale now have a physical monitor in place. 3. The Director of Nursing (DON) or designee educated all nursing staff and clinical leadership on the facility's policy "Pain Management" emphasizing physical monitors and use of the "Pain Assessment Scale for Advanced Dementia" for residents who are unable to identify pain scale. This education has been added to orientation for all newly hired nurses. All new admissions will be reviewed during morning clinical meetings to validate that physical monitor is in place in the Electronic Medical Record. Any discrepancies will be corrected promptly. 4. The Director of Nursing or designee will complete weekly audits of 20% of new admissions and long term care residents who are receiving PRN pain medication and are unable to identify pain scale for one month and monthly for three months until 2/1/25, to validate that physical monitor is in place in EMR and assessment has been completed prior to administration and after administration of the PRN pain medication. Discrepancies will be corrected promptly to include re-education of staff if needed. Audit findings will be reported to the Quality	

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F 658	Continued From page 10 A review of Resident #11's '[redacted] Medications" revealed the following Physician Orders: '[redacted] (2 tablets = [redacted] oral PRN every 6 (six) hours. Notes: Indication: [redacted]' with an order date of [redacted] 'NJ Exec Order 26.4b1 [redacted]. Notes: Indication: NJ Exec Order 26.4b1 Give (1) tablet PO BID (twice daily)." with an order date of [redacted]. Further review of the form titled '[redacted] Medications" reflected a medication with an order date of NJ Exec Order 26.4b1 [redacted] 1 tablet as needed every six hours that were administered on the following dates: [redacted] The surveyor could not locate in the medical records regarding any [redacted] assessment documentation before and after the [redacted] medication was administered to the resident. A further review of the clinical notes from [redacted] through NJ Ex Order 26.4(b)(1), did not reflect any documented [redacted] assessment; the time when the medication was administered and the indication of use for NJ Exec Order 26.4b1 [redacted]. A review of the form titled "Holistic Care Plan" initiated on [redacted] revealed under [redacted]," under "Goal(s)," which revealed to, "Please	F 658	Assurance/Performance Improvement Committee (QAPI) monthly for review until 2/1/2025. Additional audits and education may be determined based on audit findings	

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F 658	Continued From page 11 monitor for action and NJ Ex Order 26.4(b)(1) as well as asked." On 09/11/24, at 09:35 AM, the surveyor interviewed the Certified Nursing Assistant who stated that when the resident NJ Exec Order 26.4b1, they would report it to the nurse. On 09/11/24 at 9:45 AM, the surveyor interviewed the NJ Exec Order 26.4b1 who stated that Resident #11's medical record had no NJ Ex Ord assessment monitoring that was ordered by the Physician. On 9/11/24 at 01:50 PM, the survey team met with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)). The U.S. FOIA (b stated that the nursing staff does not complete any NJ Ex Ord assessment documentation. A review of the policy titled "Pain Management," updated in May 2021 under "Procedure:" revealed that "3. Nurse uses the numerical Pain Intensity Scale and/or physical observations to identify the presence of pain, 5. Nurse will notify provider of existing pain and/or history of pain presently relieved or not relieved by medications and non-medicinal approaches, and 7. Pain level will be assessed before and after administration of analgesic and documented in the Physical Monitors in the eMAR." There were no further information provided by the U.S. FOIA (b)(6) regarding the concern above.	F 658		
F 812 SS=F	NJAC 8:39-27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary	F 812		10/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974**

(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 812	Continued From page 12 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: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 9/9/24 at 8:29 AM, the surveyor in the presence of the U.S. FOIA (b) (6) observed the following during the kitchen tour: 1. In the walk-in refrigerator, the surveyor observed a 2 gallon container with Béchamel	F 812	1. No residents were affected by the deficient practice. The day of observation, the General Manager of Dining (GM) disposed of the Béchamel sauce, bacon, pan of shrimp, unidentified white liquid, raw asparagus, bag of sourdough bread, pasta, and Worcestershire sauce. The GM moved all items that were stored higher than 18 inches in the walk in freezer. The GM ensured the two door standing ovens were cleaned. The Dining Associate discarded the cranberry juice in the dining room. 2.The facility acknowledges that all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974**

(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 812	Continued From page 13 sauce with a use by date of 9/8/24, cooked bacon with a use by date of 9/7/24, a full tray pan of shrimp defrosting not covered or labeled, a 1 gallon tub of an unidentified white liquid with no date, and a full sheet pan of raw asparagus not labeled. The [U.S. FOIA (b) (6)] stated all items were past the "use by" date and should have been discarded by the evening supervisor. The [U.S. FOIA (b) (6)] also confirmed that all items need to be labeled with prepared date and use by dates. 2. In the walk-in freezer, the surveyor observed multiple items stored higher than 18 inches from the ceiling. 3. In the dry storage area, the surveyor observed an open bag of sourdough bread with a use by date 9/7/24, an open bag of 160 ounce (oz) pasta not properly wrapped or labeled, and a 1 gallon container Worcestershire 8/14/24 use by date. The [U.S. FOIA (b) (6)] stated all items were past the "use by" date and should have been discarded by the evening supervisor and all items need to be labeled with open and use by dates. 4. In the cooking area of the kitchen, the surveyor observed the two, two door standing ovens. The inside of oven #2 had black colored cooked on debris and oven #1 had a sticky white colored substance on lower oven door handles. On 9/9/24 at 9:12 AM, the surveyor while on dining observations observed the following: 5. Surveyor observed an open container of cranberry juice labeled with a use by date of 9/8/24. The dietary aide (DA#1) stated that the cranberry juice should have been discarded. DA#1 could not provide any information on how	F 812	residents have the potential of being affected by the deficient practice. The GM completed an audit of all items located in the kitchen, pantry, and freezer to ensure proper labeling, cleaning and storage of all items. 3. The [U.S. FOI] was re-educated on facility policies, Food/Non Food Storage, Labeling and Dating, and Cleaning/Sanitizing Major Cooking Equipment. The GM or designee will in-service all dining staff on the policies Food/Non Food Storage, Labeling and Dating, and Cleaning. 4.The GM or designee will complete daily audits for one month and monthly for three months to ensure cleaning and sanitation, labeling, and storage are all in accordance with regulation within the dining program. Any concerns found will be addressed promptly. All documentation will be provided to the administrator. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly until 2/1/2025. Additional audits and education may be determined based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974**

(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 812	Continued From page 14 the cranberry juice was in the dining room. On 9/10/24 at 9:50 AM, the U.S. FOIA (b) (6) provided the surveyor with three facility policies: Labeling and Dating with a revised date of 4/2024, Cleaning and Sanitizing Major Cooking Equipment with a revised date of 1/2024, and Food/Non-Food Storage with a revised date of 4/2024. The labeling and dating policy states under the procedure section, "2. All items will have a received date. 3. All opened items or items not in original containers will be covered, clearly and properly labeled. 4. Leftover food will be in appropriate containers or wrapped and dated. Leftover food is checked daily to determine its usage. If it cannot be used within 72 hours of production, it is labeled, dated, and frozen for future use." The cleaning and sanitizing major cooking equipment policy states under the procedure section, "1. All Food Service Equipment and preparation Equipment will be cleaned and sanitized after each use and maintained in a clean and sanitized condition." The food/non-food storage policy states under its procedure section, "3. All food and supplies will be stored six (6) inches above the floor, and 18 inches from the ceiling." On 9/10/24 at 1:49 PM, the survey team met with the U.S. FOIA (b)(6) to discuss the above concerns. There were no further information provided. NJAC 8:39-17.2(g)	F 812		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20016	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

(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 the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.	S 560	1.No residents were affected by the deficient practice 2. The facility acknowledges that all residents have the potential of being affected by the deficient practice. The administrator has reviewed the staffing for 2 weeks to validate that the facility meets the minimum staffing requirement of certified nursing assistants. 3.The administrator or designee will provide education regarding the required direct care staff to resident ratios to the clinical leadership staff and scheduler. The facility has job postings and has advertised for all open certified nurse aide positions. The administrator or designee	10/11/24

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

Electronically Signed | 10/02/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20016	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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S 560	Continued From page 1 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of	S 560	will pursue securing direct care staffing services from staffing agencies and will utilize floating staff from our Assisted Living with short notice vacancies. 4.The administrator or designee will review the certified nurse aide staffing and resident census to ensure compliance with the required direct care staff to resident ratios daily for one month and then weekly for two months. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly until 1/1/2025. Additional audits and education may be determined based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20016	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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S 560	Continued From page 2 required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week staffing prior to survey beginning 08/25/2024 and ending 09/12/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 2 of 14 day shifts as follows: -08/25/24 had 4 CNAs for 40 residents on the day shift, required at least 5 CNAs. -08/30/24 had 4 CNAs for 39 residents on the day shift, required at least 5 CNAs. On 9/12/2024 at 10:20 AM, the surveyor met with the Licensed Nursing Home Administrator and the Director of Nursing regarding the above concern.There was no additional information provided by the facility.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20016	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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S2120	Continued From page 3	S2120		
S2120	8:39-31.1(c) Mandatory Physical Environment (c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, P.O. Box 809, Trenton, New Jersey 08625-0809. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 09/09/2024 and 09/10/2024, it was determined that the facility failed to ensure that quarterly Uniform Fire Safety Code inspections were conducted in accordance with N.J.A.C 5:70. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview on 09/09/24 at 9:00 AM during the Life Safety Code entrance conference, the surveyor requested that the Back of House (BOH) and Front of House (FOH) provide Uniform Fire	S2120	1. No residents were affected by the deficient practice. The facilities fire vendor provided the documentation for the quarterly uniform fire code inspection. The vendor also performed the quarterly uniform fire code inspection for 9/2024. 2. The facility acknowledges that all residents have the potential to be affected by the deficient practice. 3. The General Services Director (GSD) or	10/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20016	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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S2120	Continued From page 4 Safety Code inspections for 2023 and 2024. A record review at 10:30 AM, revealed that quarterly inspections were provided for 09/18/23, 12/15/23 and 3/27/24. In an interview at 3:00 PM the surveyor made a request for the missing Uniform Fire Safety Code inspections for review the following morning. No additional information was provided. The facility's Administrator was notified of the deficient practice at the Life Safety Code exit conference on 09/10/24.	S2120	designee will be educated that inspections for uniform fire code are to be done on a quarterly basis. The GSD will educate the general services leadership team that inspections for uniform fire code are to be done on a quarterly basis in accordance with NJAC 5:70. 4. The GSD or designee will coordinate with the vendor to ensure that inspections for the uniform fire code will be completed on a quarterly basis until 1/1/2026. All documentation will be provided to the administrator. Findings will be reposted to the Quality Assurance/Performance Improvement (QAPI) quarterly until 1/1/2026 for review. Additional audits and education may be determined based on audit findings.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315523	A. Building B. Wing	10/28/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 10/11/2024	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 10/11/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 10/14/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
20016 Y1	A. Building B. Wing Y2	10/28/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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 10/11/2024	ID Prefix S2120 Reg. # 8:39-31.1(c) LSC	Correction Completed 10/04/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 9/12/2024	☐ 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
	315523	A. BUILDING **01** B. WING _____	**09/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(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
E 000	Initial Comments Continuing Care At Lantern Hill 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		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/10/24 and Continuing Care at Lantern Hill was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancy. Continuing Care at Lantern Hill is an eight-story building that was built in 2016. Skilled nursing is located on the fourth floor. It is composed of Type II (222) protected construction. The facility is divided into two - smoke zones. The generator does 100 % of the building as per the Senior Facilities Manager.	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced	K 271		10/18/24

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

Electronically Signed | 10/02/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING 01 B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 271	Continued From page 1 by: Based on observations and interview on 09/09/2024 in the presence of the U.S. FOIA (b) (6) [redacted] it was determined that the facility failed to ensure that exits terminated directly at a public way and that exit discharge was arranged and marked to make clear the direction of egress travel from the exit discharge to a public way in accordance with NFPA 101:2012 Edition, Sections 7.7.1 and 7.7.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 2:13 PM, revealed that the exit access pathway from the stairway enclosure led to the back of the boiler room outside of the building. There was an approximate 6-foot-wide separation between the exit access pathway from the stairway enclosure and the exit access pathway. Additionally, there were no markings or signs making clear the direction of egress travel to a public way. In an interview at the time of the observation, the U.S. FOIA [redacted] confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/10/24 at 3:00 PM. N.J.A.C 8:39-31.2(e)	K 271	1.No residents were affected by the deficient practice. The facilities vendor added a concrete slab to connect the exit access pathway from the exit access pathway to the stairway. Additionally, the vendor installed an exit sign to make clear the direction of egress travel to the public way. 2.The facility acknowledges all residents have the potential to be affected by the deficient practice. The General Services Director (GSD) or designee completed an audit of all exit pathways to ensure there is a clear direction of egress travel to the public way. All discrepancies will be corrected promptly. 3.The U.S. FOIA [redacted] was educated on ensuring all exits should be terminated at a public way and exit discharges are marked and made clear to the direction of egress travel in accordance with NFPA 101. The GSD or designee will provide the same education to the general services leadership to ensure that all egress exits are terminated directly and clear to the public way. 4.The GSD or designee will complete an audit on all egress access points to ensure all signage and exits terminated at the public way monthly for one month and quarterly thereafter until 5/1/2025. Any discrepancies will be corrected promptly. Reports will be given to the facility Administrator or designee. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) for review monthly for one month and quarterly until 5/1/2025. Additional audits and education may be	

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	315523	A. BUILDING **01** B. WING _____	**09/12/2024**

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K 271	Continued From page 2	K 271	determined based on audit findings.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 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) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/10/2024 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that	K 321	1.No residents were affected by the deficient practice. The General Services Director (GSD) or designee installed a closing arm on the second floor boiler	10/18/24

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K 321	Continued From page 3 hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 18.3.2.1, 7.2.1.8, 9.7, 8.4 and NFPA 13. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:00 AM, revealed that the boiler room (hot water room) door on the second floor did not self-close and latch. An observation at 9:10 AM, revealed that a sprinkler head in the main plant first floor boiler room had a cover on it. In interviews at the time of the observations, the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2(e) NFPA 13	K 321	room door. The facility's vendor came out and removed the sprinkler cover in the main plant first floor boiler room. 2.The facility acknowledges all residents have the potential to be affected by the deficient practice. The GSD or designee will conduct a 100% audit on all hazardous doors to ensure there is a self-closing latch. An 100% audit will be completed on all sprinklers to ensure the cover is removed. All discrepancies will be corrected promptly. 3.The U.S. FOIA (b) (6) or designee was educated that doors in hazardous areas must self-close and latch in accordance with NFPA 101. The GSD or designee will educate the GS leadership team that all sprinkler covers need to be removed in accordance with NFPA 13. 4.The GSD or designee will complete an audit on all hazardous doors to ensure the self-closing and positive latching monthly for one month and quarterly thereafter until 5/1/2025. The GSD or designee will coordinate with the facility's vendor to ensure all covers are removed from sprinkler heads during the quarterly fire sprinkler inspections for the facility on a quarterly basis. All documentation will be provided to the Administrator. Findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) for review monthly for one month and quarterly until 5/1/2025. Additional audits and education may be determined based on audit findings.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101	K 324		10/18/24

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K 324	Continued From page 4 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/10/2024 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the cooking equipment was protected and maintained in accordance with NFPA 101: 2012 Edition, Sections 19.3.2.5.1, NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, and NFPA 17 A, Chapter 4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:21 AM, revealed that the	K 324	1.No residents were affected by the deficient practice. The blow-off caps have been installed and attached on the affected discharge nozzles. The 1 discharge nozzle have been cleaned. 2.The facility acknowledges all residents have the potential to be affected by the deficient practice. 3.The U.S. FOIA (b) (6)) was educated that the blow-off caps must be installed and are cleaned on the hood units in accordance with NFPA 96 and 17A. The DSD will educate the dining services leadership team that the blow-off	

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K 324	Continued From page 5 kitchen suppression system contained 7 discharge nozzles. Five of the 7 discharge nozzles were unprotected, 3 of 7 discharge nozzles had blow off covers (caps) but they were not attached, 2 of 7 discharge nozzles were not provided with blow off covers (caps) and 1 of the unprotected discharge nozzles was observed to have heavy grease buildup. In an interview at the time, the [redacted] confirmed the observation. The [redacted] informed the [redacted]. The facility's [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 09/10/24 at 3:00 PM. N.J.A.C 8:39-31.2(e) NFPA 17A, 96	K 324	caps must be installed and are cleaned on the hood units in accordance with NFPA 96 and 17A. 4.The DSD or designee will complete an audit on to ensure the blow-off caps are protected and installed and are cleaned on the hood units daily for one month and monthly for three months. All documentation will be provided to the Administrator. Findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) for review monthly until 2/1/2025. Additional audits and education may be determined based on audit findings.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/09/2024 in the presence of the [redacted], it was determined that the facility failed to ensure that semi-annual fire alarm	K 345	1. No residents were affected by the deficient practice. The facilities fire vendor came out and completed the fire alarm inspection, testing, and maintenance	10/18/24

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K 345	Continued From page 6 system inspections, testing and maintenance (ITM) and smoke detector sensitivity testing were conducted in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview on 09/09/2024 at 10:00 AM during the Life Safety Code entrance conference, the surveyor requested fire alarm system ITM from the U.S. FOIA (b) Documentation review at 10:30 AM revealed that a fire alarm inspection was conducted on 5/14/2024. There was no documentation indicating that a fire alarm inspection was conducted for the second half of 2023. In an interview at the time of documentation review, the U.S. FOIA (stated that they only perform an annual inspections of the fire alarm system and that they would get back to me regarding the sensitivity testing. No further documentation was provided regarding the semi-annual fire alarm inspections or smoke detector sensitivity testing. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/10/24 at 3:00 PM. N.J.A.C 8:39-31.2(e) NFPA 70, 72	K 345	(ITM). The facilities fire vendor came out and completed the sensitivity training for all smoke detectors. 2.The facility acknowledges all residents have the potential to be affected by the deficient practice. 3.The U.S. FOIA (b) (6)) or designee was educated that fire alarm ITM is to be done on a semiannual basis and smoke detector sensitivity testing shall be completed as outlined in NFPA 72, Section 14.4.4.3. The GSD or designee will provide education to the general services leadership team that fire alarm ITM is to be done on a semiannual basis and smoke detector sensitivity testing is to be completed in accordance with NFPA 70 and 72. 4.The GSD or designee will coordinate with the vendor to ensure fire alarm ITM is completed on a semi-annual basis as well as smoke detector sensitivity training. All documentation of completion will be provided to the administrator on a semi-annual basis until 1/1/2026. Findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) for review semi-annually until 1/1/2026. Additional audits and education may be determined based on audit findings.	
K 353 SS=F	Sprinkler System - Maintenance and Testing	K 353		10/18/24

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K 353	Continued From page 7 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/10/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that sprinkler system gauges were replaced or recalibrated every 5 years in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:07 PM, revealed that the 4 of 4 water pressure gauges on the sprinkler system were dated 2015. In an interview at the time of the observation, the U.S. FOIA [redacted] confirmed the findings.	K 353	1.No residents were affected by the deficient practice. The facility's fire vendor came out and replaced and recalibrated the sprinkler gauges. 2.The facility acknowledges all residents have the potential to be affected by the deficient practice. The facilities fire vendor will audit all sprinkler gauges to ensure they are replaced and recalibrated. 3.The U.S. FOIA (b) (6) [redacted]) or designee was educated that sprinkler gauges must be replaced and recalibrated every five years in accordance with NFPA 25. The GSD or designee will educate the general services leadership team that sprinkler gauges must be replaced and	

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K 353	Continued From page 8 The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference at 3:00 PM. N.J.A.C 8:39-31.2(e) NFPA 25	K 353	recalibrated every five years in accordance with NFPA 25. 4.The GSD or designee will conduct an audit to ensure all sprinkler gauges are replaced and recalibrated within the five year requirement annually until 1/1/2026. All documentation will be provided to the administrator. Findings will be reposted to the Quality Assurance/Performance Improvement Committee (QAPI) annually for review until 1/1/2026. Additional audits and education may be determined based on audit findings.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/09/2024 and 09/10/2024 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) , it was determined that the facility failed to ensure that portable fire extinguishers were provided and installed in accordance with NFPA 101:2012 Edition, Sections 9.7.5, NFPA 10:2010 Edition, Sections 5.4.2, 5.5.5.3, A 5.5.5.3, 6.1.3.3.2, 6.1.3.10.2, 6.1.3.8, A 5.4.2.2 and NFPA 96, This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 09/09/2024 between 1:40 PM	K 355	1.No residents were affected by the deficient practice. The portable fire extinguishers outside the nurse's station and rooms 444,428, and 447 were all re-installed so they are lower than 60 inches from the floor. An ABC fire extinguisher has been obtained and placed in the kitchen along with proper signage indicating its location. A placard was obtained and attached to the Class K fire extinguisher. 2.The facility acknowledges all residents have the potential to be affected by the deficient practice. The General Services	10/18/24

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K 355	Continued From page 9 and 3:05 PM, revealed that the portable fire extinguisher outside of the nurse's station and outside of rooms 444, 428 and 447 were installed at a height of 63-inches above the floor. Observations on 09/10/2024 at 9:21 AM, revealed the following in the kitchen: 1. There was no ABC type fire extinguisher privided in the area. 2. There was no placard stating the fire protection system shall be actuated prior to using the Class K fire extinguisher. 3. There was no sign indicating the location of the fire extinguishers. In interviews at the time of the observations, the U.S. FOIA (b) and U.S. FOIA (b) confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/10/24 at 3:00 PM. N.J.A.C 8:39-31.2(e) NFPA 10, 96	K 355	Director (GSD) completed an audit on all portable fire extinguishers in the facility to ensure they met the height of under 60 inches. All discrepancies were correctly promptly. 3.The U.S. FOIA (b) or designee will be educated on the height of portable fire extinguishers, to include having an ABC type fire extinguisher, having proper signage, and having placards for Class K extinguishers in accordance with NFPA 10 and 96. The GSD will educate the general services leadership team on the height of portable fire extinguishers, to include having an ABC type fire extinguisher, having proper signage, and having placards for Class K extinguishers in accordance with NFPA 10 and 96. 4.The GSD will conduct an audit to ensure the portable fire extinguishers are under the 60 inch height requirement, that an ABC fire extinguisher is located in the kitchen with proper signage, and a placard is attached to the wall adjacent to the Class K fire extinguisher stating that the fire protection system shall be activated prior to using the fire extinguisher . Staff education will be monthly for one month and quarterly until 5/1/2025. All documentation will be provided to the administrator. Findings will be reposted to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for one month and quarterly thereafter until 5/1/2025 for review. Additional audits and education may be determined based on audit findings.	

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K 761	Continued From page 10	K 761		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review, observations and interviews on 09/09/2024 and 09/10/2024 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview during the Life Safety Code entrance conference, the surveyor requested the fire door assembly inspection, testing and maintenance (ITM) to the U.S. FOIA (b and U.S. FOIA (b) A review revealed that documentation was provided for the inspection of two doors. "Door ID# 4th. FL. MC" and "Door ID# 4th FL. Skilled".	K 761	1.No residents were affected by the deficient practice. The facility performed an inspection on the fire door near room 415, the door near room 432, and the door near room 404. 2.The facility acknowledges all residents have the potential to be affected by the deficient practice. The General Services Director or designee completed a 100% audit on all fire assembly doors and completed an inspection in accordance with NFPA 80. 3.The U.S. FOIA (or designee was educated that all fire door assemblies must be inspected on an annual basis in accordance with NFPA 80. The GSD will educate the general services leadership team that all fire door assemblies must be inspected on an annual basis in	10/18/24

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CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 11 An observation at 1:45 PM, revealed that the stairway enclosure near room 415 had a fire door assembly. An observation at 2:00 PM, revealed that the stairway enclosure near room 432 had a fire door assembly. An observation at 2:40 PM, revealed that the stairway enclosure near room 404 had a fire door assembly. No further documentation was provided regarding these 3 fire door assemblies ITM. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24 at 3:00 PM. N.J.A.C 8:39-31.2(e)	K 761	accordance with NFPA 80. 4.The GSD will complete an audit of all fire door assemblies monthly for one month and annually thereafter until 1/1/2026. All documentation will be provided to the administrator. Findings will be reposted to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for one month and annually thereafter until 1/1/2026 for review. Additional audits and education may be determined based on audit findings.	

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
315523 Y1	A. Building 01 - CONTINUING CARE AT LANTERN HILL B. Wing Y2	10/28/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0271	10/18/2024	LSC K0321	10/18/2024	LSC K0324	10/18/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	10/18/2024	LSC K0353	10/18/2024	LSC K0355	10/18/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0761	10/18/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
9/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO