STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD WHITING, NJ 08759**

(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 Complaints # NJ 168306, 173740, 176087 Survey dates: 9/3/2024-9/6/2024 Census: 50 Sample Size: 14+ 3 Closed Records 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. A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		10/25/24

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

Electronically Signed | 09/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to treat a resident with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life specifically by not providing a NJ Ex Order 26.4(b)(1) for a NJ Ex Order 26.4(b)(1). The deficient practice was identified for 2 of 2 (Residents # 29, # 31) residents reviewed for Dignity. The deficient practice was evidenced by the following:	F 550	Corrective Action: Residents #29 and #31 were provided NJ Ex Order 26.4(b)(1) for their NJ Ex Order 26.4(b)(1) An audit was conducted to identify that any resident using a NJ Ex Order 26.4(b)(1) has a NJ Ex Order 26.4(b)(1) to protect their dignity and Resident Rights. Disposable privacy bags were ordered for NJ Ex Order 26.4(b)(1).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 550	Continued From page 2 On 09/03/2024 at 09:24 AM during the initial tour of the facility, the surveyor observed Resident # 29 in bed. At that time, the surveyor observed a NJ Ex Order 26.4(b)(1) attached to the bed. There was no NJ Ex Order 26.4(b)(1). There was NJ Ex Order 26.4(b)(1) visible in the bag. On 09/03/2024 at 09:28 AM during the initial tour of the facility, the surveyor observed Resident # 31 in his/her wheelchair. At that time, the surveyor observed a U.S. FOIA (b) (6) on the side of the wheelchair. There was no NJ Ex Order 26.4(b)(1). On 09/05/2024 at 08:50 AM, the surveyor observed Resident # 31 in his/her wheelchair. At that time, the surveyor observed a NJ Ex Order 26 on the side of the wheelchair. There was no NJ Ex Order 26.4(b)(1). On 09/05/2024 at 08:53 AM, the surveyor observed Resident # 29 in bed. At that time, the surveyor observed a NJ Ex Order 26.4(b)(1) attached to the bed. There was no NJ Ex Order 26. A review of Resident # 29's Physician's Orders located in the Electronic Medical Record (EMR) revealed he/she had an order for NJ Ex Order 26.4(care every shift. A review of Resident # 31's Physician's Orders located in the EMR revealed he/she had an order for NJ Ex Order 26.4(care twice daily. A review of Resident # 29's Quarterly Minimum Data Set (MDS; An assessment tool) dated NJ Ex Order 26.4(b)(1) revealed under section, " NJ Ex that he/she had an NJ Ex Order 26.4(b)(1).	F 550	Identification of at-Risk Residents: Any resident with a urinary catheter drainage bag has the potential to be affected. Systemic Change: The Unit Manager Nurse/Director of Nursing(DON)/Social Worker, provided education on Resident Rights/Dignity to all staff and the importance of providing a privacy bag for any resident with a urinary catheter drainage bag when inside or outside their room. Daily observation audits will be conducted by the Unit Manger Nurse/Designee to ensure residents have a privacy bag for their urinary catheter drainage bag. A declining Inventory Supply Checklist was implemented in the central supply room for the staff to utilize to address declining supplies for the purchaser to ensure timely reordering of supplies. Staff were educated on the Inventory Supply Checklist and of its importance to ensure the Residents have in stock at all times the appropriate supplies, including but not limited to privacy bags for urinary catheter drainage bags. Direct Care Staff Assignment Sheets were revised to address the use of a privacy bag (when inside/outside their room) for any resident that has a urinary catheter drainage bag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 550	Continued From page 3 A review of Resident # 31's Quarterly MDS dated [NJ Ex Order 26.4(b)(1)] revealed under section, "[NJ E]" that he/she had an NJ Ex Order 26.4(b)(1). On 09/05/2024 during an interview with the U.S. FOIA (b) (6) the Surveyor asked if residents are in bed who have a [NJ Ex Order 26.4(b)(1)], should the [NJ Ex Order 26.4(b)(1)] have a [NJ Ex Order 26.4(b)(1)]. The [U.S.] replied, "Yes, they should." On the same date at 12:40 PM during an interview with the U.S. FOIA (b) (6) the Surveyor asked should residents with NJ Ex Order 26.4(b)(1) have [NJ Ex Order 26.4(b)(1)] for the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)] replied, "Yes." Further, the [U.S. FOIA (b)] stated, "Its a dignity issue. It could be a room mate's visitor that is there. Its a dignity issue." A review of the facility policy titled, "Quality of Life - Dignity" with a revised date of 1/24/24 revealed that, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality." The policy also revealed that, "10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." Lastly, "11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident keep urinary catheter bags covered..."	F 550	Quality Assurance: Monthly for 3 months the Unit Manager Nurse/Designee will review and report to the Administrator/DON/QAPI Committee compliance with the the use of privacy bags for residents that have a urinary catheter drainage bag.	
F 812 SS=F	NJAC § 8:39-27.1 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 4 §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, interviews, and review of facility documentation it was determined that the facility failed to a.) properly label, date and store potentially hazardous foods in a manner that is intended to prevent the development of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was evidenced by the following: On 09/03/24 at 08:30 AM, the surveyor conducted a kitchen tour with the U.S. FOIA (b) (6) and the facility U.S. FOIA (b) (6) The surveyor observed the following: The Preparation Box refrigerator contained a 1	F 812	Corrective Action: The Food Service Director (FSD) conducted an audit of all food items/condiments/cooking ingredients in the Dry Storage/Refrigerator/Freezer that did not have dates/labels or had expired dates, all items were immediately discarded that did not meet the requirement/compliance for proper labeling/dating. The flour in the plastic container was discarded, the scooper and container were removed and properly cleaned. A clean container and scooper were provided for the flour and a sign on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 5 (one) gallon container of thousand island dressing and a 1-gallon container of tartar sauce with no opening date or use by date. The U.S. FOIA was interviewed at this time and stated that the importance of having an opening date and a use by date was to ensure that the product "freshness" was maintained. The surveyor inspected the dry storage closet that contained a 15-pound container of dry liquid thickener with a use by date of 08/15/24. The U.S. FOIA was interviewed at this time and stated that it was important to ensure that all products had an opening date and a use by date to ensure that the product was fresh and did not go stale. He stated that he would discard the thickener because it was past the use by date. The produce refrigerator contained a large hotel container filled with whole peppers with a use by date of 08/24/24 and 9 (nine) 16-ounce bags of carrots with a use by date of 08/16/24. There was also a large cardboard box of kale with no received date or use by date labeled on the box. The U.S. FO was present at this time and stated that the produce was past the used by date and would have to be discarded. The surveyor observed a large plastic container of flour with the scooper left inside the container. The U.S. FOIA stated that the scooper should not be left inside of the container as it could potentially contaminate the flour. The commercial can opener was observed with sticky brown substances on the shaft and pointed blade that inserted into the can. The U.S. FO stated at this time, that the can opener was usually cleaned daily. When the surveyor asked the U.S. FO for the	F 812	flour container with instructions that the scooper is not to be left in the flour container, and the scooper after each use goes to the dishwasher. The can opener, gas oven, fryer, and flat top were cleaned. Identification of at-Risk Residents: All residents have the potential to be affected. Systematic Change: The "Dry Storage Life of Foods" Policy was reviewed and revised to include clarification of the labeling and dating of the dry foods. A Master Cleaning Schedule was implemented for all equipment and appliances. All kitchen Staff were educated by the FSD/Designee on Policies for Labeling and Dating for all food items/condiments/cooking ingredients Dry/Refrigerator/Freezer, and on the Master Cleaning Schedule and Infection Prevention and Sanitation in the kitchen to avoid cross contamination (i.e. but not limited to, the scoop in the flour container). Quality Assurance: The FSD/Designee will conduct daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 6 Master Cleaning Schedule for equipment or who verified that the equipment was clean, the chef stated that they did not have a Master Cleaning Schedule but were in the process of creating one. The surveyor observed that outside of the gas oven and fryer were splattered with grease and food particles. The inside glass of the oven door was covered with burnt brown material. The flat top stove was observed with burnt food particles located on the inside and behind the controls of the flat top. The U.S. FOIA stated that they would have to clean the inside with a vacuum. The surveyor observed an uncovered, unlabeled, undated silver hotel pan full of spice located under a preparation table. The U.S. FO identified the spice as a salt and pepper cooking mixture and indicated that it should be covered and labeled with a "use by date". Next to the salt and pepper mixture was a large 10-pound bag of dry elbow macaroni covered with plastic wrapping. The macaroni had no opening date or use by date. The U.S. FOIA indicated that it should be dated when it was opened and a date that indicated how long it was good for. He stated that both the salt and pepper mixture and the dry elbow macaroni would be discarded. The surveyor observed a large 1-gallon container of vegetable oil with no use by date and a 16 oz of box of powdered sugar with a use by date of 08/30/24. The U.S. FO indicated that the vegetable oil should be dated, and the powdered sugar needed to be discarded as it was past the used by date. There were 7(seven) three-gallon containers of ice cream located in the ice cream freezer with no	F 812	audits on the compliance with food labeling and dating for all food items/condiments/cooking ingredients for Dry Storage/Refrigerator/Freezer, and compliance with the use and storage of scoops (i.e. but not limited to the flour scoop) and weekly audits on the compliance with the cleaning schedule for appliances and equipment. The FSD/Designee monthly for 6 months will review and report the results of all the above mentioned audits to the Administrator/QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD WHITING, NJ 08759**

(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 7	F 812		

opening or use by dates. The U.S. FOIA stated that he did not date them because they were usually gone within a couple days.

The surveyor observed 3 (three) silver hotel pans covered with plastic which contained almonds, walnuts, and pecans with use by dates of 08/29/24. The U.S. FOIA indicated that the nuts would be discarded as they were past the use by dates.

The surveyor observed 1-silver hotel pan covered with plastic which contained ice cream sprinkles with a use by date of 08/29/24. The U.S. FOIA indicated that the sprinkles would be discarded as they were past the use by date.

The surveyor observed a silver hotel pan which contained sliced canned cranberry sauce stored with other toppings used for ice cream. The cranberry sauce was covered with plastic but did not contain a date when opened or a use by date and a 4 (four) pound jar of maraschino cherries with no opening date or used by date. The U.S. FOIA stated that the cranberry sauce and the cherries would need to be discarded.

The surveyor entered the freezer with the U.S. FOIA and U.S. FOIA and observed 2 (two) large trays of premade turkey meatloaf covered with plastic wrap with a use by date of 08/26/24 and large zip lock bag of scallops with a use by date of 01/13/24. The U.S. FOIA explained to the surveyor that these items needed to be decarded because they were past the use by date and should not have been in the freezer.

On 09/03/24 09:34 AM, the surveyor interviewed the U.S. FOIA who had been employed in the facility for NJ Ex Order 26.4b1 graduate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 8	F 812		

with an NJ Ex Order 26.4b1. The U.S. FOIA indicated that he was also a NJ Ex Order 26.4b1. The U.S. FOIA and the U.S. FOIA both agreed that the items listed should have had use by dates to assure that the food was fresh. The U.S. FOIA stated that if the items were not stamped with an opening date or a used by date then you would not know how long the food item was good for.

The U.S. FOIA provided the surveyor with the following policies.

The facility policy titled, "Dry Storage Life of Foods" dated January 2023, indicated that the facility used the manufacturers expiration date for product storage. The policy also reflected a list of food items that it if delivered with no expiration dates, the staff were to utilize the policies guidelines for dating and labeling of dry foods. The food item should be labeled with the date that the food was received and discarded when the quality of the product was deemed unacceptable.

On 09/06/24 at 12:30 PM, the surveyor interviewed the U.S. FOIA (b) (6) who reviewed the dry food storage policy with the surveyor. The U.S. FOIA (b) admitted that the policy was not specific for the labeling and dating of the dry foods and indicated that the current policy was "up for interpretation". She stated that dry food must be labeled with the received date and use by date.

The facility policy titled; "Frozen Storage Life of Foods" dated January 2023, indicated that the facility utilized the expiration date for products however do not exceed 1(one) year. If there was no expiration date on the package the facility was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD WHITING, NJ 08759**

(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 9	F 812		

to add the time listed to the date the food was received. In the case of food is partially used and the remaining food was exposed to air relabel the product "opened" to use within 3-months.

The facility policy titled, "Cleaning Frequency and Schedules" dated 10/01/2022, indicated that contact surfaces shall be cleaned before each use and any time contamination may have occurred. Non-food contact surfaces shall be cleaned at a frequency necessary to prevent the accumulation of soil. The policy also indicated that cleaning task, including procedures must be assigned to appropriate associates in accordance with the usual job or duty performed. The facility was to create the cleaning schedule worksheet, Master Cleaning Schedule" and Individual Area Cleaning Schedule sheets for the entire operation that included what needed to be cleaned, who was responsible for cleaning it and when it was to be cleaned. The policy indicated that the facility was to verify cleaning was being done properly and at the correct frequency by signing off the "Individual Area Cleaning Schedule". These cleaning worksheets and schedules were to be retained for a period of 30 days.

NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061533	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 is 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 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. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: 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 established minimum staffing requirements in	S 560	Corrective Action: The Administrator/Director of Nursing (DON)/Staffing Scheduler/Designee will review direct care to resident ratios for compliance with mandatory staffing requirements. Bi-weekly the Human Resource Director(HR)/Administrator/DON/Staffing Scheduler will meet (Recruitment and Retention Meeting) to review open positions/staffing needs/recruitment and retention efforts and resumes. Direct Care staff open positions will be	10/25/24

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

Electronically Signed | 09/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061533	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 560	Continued From page 1 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 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 two weeks of staffing prior to survey from 08/18/2024 to 08/31/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: The facility was deficient in CNAs for resident care on 2 of 14 day shifts as follows: -08/20/2024 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/23/2024 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. A review of the facility policy titled, "Skilled Nursing Facility Staffing (New Jersey)" revised 08/11/2021 revealed under, "Policy:" that, "Our facility provides adequate staffing to meet needed care and services for our resident population." Further, the policy revealed under, "Procedure"	S 560	advertised in multiple venues, but not limited to, Organization's Website, social media, Online Recruitment companies, local Vocational Tech and C.N.A training schools. Identification of at-Risk Residents: All residents have the potential to be affected. Systemic Change: The Staffing Scheduler/Designee/DON/Administrator, were educated by the HR Director on the Company's new Payroll System Recruitment features. When there are open direct care staff shifts, all efforts will be made to meet compliance with the direct care staff to resident ratios. The Staffing Scheduler/Designee will contact all available direct care staff to offer incentive pay to those individuals coming in to work an additional shift(s). Additionally, all contracted Staffing Agencies will be contacted to assist in staffing to meet mandatory staffing levels. The Administrator/DON/HR will conduct a survey for direct care staff wages/benefits/sign on and referrals bonuses, with local facilities and Staffing Agencies, to identify opportunities to recruit and retain direct care staff. Daily the Staffing Scheduler/Designee/DON/Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061533	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 560	Continued From page 2 that, "3. [The Facility] will make judicious efforts to enforce the minimum caregiver-to-resident ratios and follow all the other staffing guidelines and specifics as outlined on NJ Act S2712."	S 560	will review the next day's direct care staff staffing levels to ensure compliance with direct care to resident ratios. Quality Assurance: Monthly for 3 months the results of the daily staffing levels for direct care staff will be reviewed and reported by the DON/Designee to the Administrator/QAPI Committee. Any staffing level discrepancies that are identified will be immediately addressed with the appropriate corrective action. Monthly for 3 months the HR Director/Designee will review and report the results of the Recruitment and Retention Meetings to the Administrator/DON/QAPI Committee.	
S2230	8:39-31.6(b) Mandatory Physical Environment (b) Fire drills shall be conducted a total of 12 times per year, with at least one drill on each shift and one drill on a weekend. The facility shall attempt to have the local fire department participate in at least one fire drill per year. An actual alarm shall be considered a drill if it is documented. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 09/04/2024 in the presence of the Director of	S2230	Corrective Action:	10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061533	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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
S2230	Continued From page 3 Plant and Environmental Services (DPES), it was determined that the facility failed to conduct weekend fire drills Annually. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's fire drill documentation for the previous 12-months, revealed that there were no documented fore drills conducted on a weekend. In an interview, at 01:30 PM, the DPES confirmed the findings. The facility's Administrator was informed of the deficient practice at the Life Safety Code exit conference on 09/05/2024 at 01:15 PM.	S2230	A weekend Fire Drill was conducted on the Long-Term Care Unit (LTC) on 9/14/2024 by the Facility's Contracted Vendor. Identification of at-Risk Residents: All residents have the potential to be affected. Systematic Change: The Director of Plant and Environmental Services/Security/Designee were educated by the Administrator on the importance of conducting 12 Fire Drills/month that include at least one drill on each shift, and a weekend shift. A checklist/notification system was implemented to track 12 months of Fire Drills to ensure they will be conducted for all shifts including a weekend shift. Quality Assurance: Monthly for 12 months the Director of Security/Designee will review and report to the Administrator/QAPI Committee the results of the Fire Drills being conducted in to ensure compliance with meeting requirement for conducting Fire Drills for each shift including a weekend shift in a 12 month period.	

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)
315298	A. Building B. Wing	11/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

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 F0550 Reg. # 483.10(a)(1)(2)(b)(1)(2) LSC	Correction Completed 10/25/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 10/25/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 9/6/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061533		11/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

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 10/25/2024	ID Prefix S2230 Reg. # 8:39-31.6(b) LSC	Correction Completed 10/25/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/6/2024	☐ 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
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 Crestwood Manor was found to be 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 09/04/24 and 09/05/24. Crestwood was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Crestwood Manor is a one-story building that was built in the January 1989. It is Type II protected construction. The facility is divided into five (5) smoke compartments and has a Diesel generator. The facility has 64 licensed beds and the census was 50.	K 000		
K 132 SS=F	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated	K 132		10/25/24

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

Electronically Signed | 09/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 132	Continued From page 1 by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/05/2024 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that penetrations through fire barriers provided a 2-hour fire resistance rating between occupancies in accordance with NFPA 101:2012 Edition, Section 19.1.3.4.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:15 AM, revealed the fire barrier wall above the doors by the employee entrance had wire and pipe penetrations that were sealed with a yellow non-rated expansion foam. The seam where the roof deck met the barrier wall was also filled with the same non-rated product. This barrier was required to meet a 2-hour fire resistance rating. Continued observation revealed that one of the 2 doors in the barrier assembly did not have an identification plate required in a fire barrier assembly. In an interview at the time of observation, the U.S. FOIA (b) and U.S. FOIA (b) confirmed the findings.	K 132	Corrective Action: The fire barrier wall (wire and pipe penetrations) above the doors by the employee entrance and the seam where the roof deck meets the barrier wall, were assessed and repaired by a Contracted Vendor, with the appropriate 2-hour fire resistance rating material to ensure compliance in accordance with NFPA 101:2012 Edition, 19.1.3.4.1 See attached photo. The 2 doors in the fire barrier assembly were replaced, and with an identification plate intact. See attached photo. Identifications of at-Risk Residents: All residents have the potential to affected. Systemic Change: The Facility's Contracted Vendor completed an assessment of the Healthcare Center to ensure that penetrations through fire barriers provide a 2-hour fire resistance rating between	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 132	Continued From page 2 The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 01:15 PM. NJAC 8:39-31.2(e)	K 132	occupancies in accordance with NFPA 101:2012 Edition, 19.1.3.4.1, with the areas identified as not meeting compliance were repaired with the appropriate 2-hour fire resistance rating material. An audit was conducted for all fire/smoke barrier doors to ensure they have identification plates intact. Maintenance Staff were educated on the fire/smoke barrier door audit, and the importance of maintaining the identification plate on the door. Quality Assurance: Monthly for 1 month only the Maintenance Director/Designee will review and report the results of the status of compliance with having the appropriate 2-hour fire resistance rating material for fire barrier walls/penetrations to the Administrator/QAPI Committee. Monthly and ongoing for 12 months the Maintenance Director/Designee report to the Administrator/QAPI Committee the results of the fire/smoke door audits to ensure the doors in the barrier assembly have an identification plate.	
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	K 321		10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 321	Continued From page 3 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) 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 observations and interviews on 09/04/2024 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 hazardous areas were protected with self-closing doors in accordance with NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.5.9 and 8.4. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 321	Corrective Action: The Facility's Door Vendor assessed the main Laundry room door next to the commercial dryers. The Vendor installed a part/hardware that allows the door to self close in its frame in accordance with NFPA 101: 2012 Edition, Sections 19.3.5.9 and 8.4. See attached photo	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 321	Continued From page 4 An observation at 01:00 PM, revealed the door to the main laundry room by the commercial dryers was not closed in the frame. A closure test performed by the U.S. FOIA (b) revealed the door did not close to the frame from the fully open position. This test was repeated 2 additional times with the same results. In an interview at the time, the U.S. FOIA (b) and U.S. FOIA (b) (6) stated the self-closing device was recently replaced. An observation at 01:10 PM, revealed the set of double doors to the large storage room/mechanical/generator control room were not closed to the frame. Further observation revealed there was a cylindrical magnet on the meeting edge of one door, preventing the 2nd door from closing to the frame. In an interview at the time, the U.S. FOIA (b) and U.S. FOIA (b) confirmed the findings. The facilty's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 01:15 PM. NJAC 8:39-31.2(e)	K 321	The Maintenance Director removed the cylindrical magnet from the meeting edge of the set of double doors to the large storage room/mechanical/generator control room. Once the cylindrical magnet was removed the set of double doors self closed in its frame. See attached photo Identification of at-Risk Residents: All residents have the potential to be affected. Systemic Change: The Maintenance Director/Designee will conduct daily door inspections for 4 weeks, and thereafter, ongoing weekly inspections. An audit checklist was implemented to ensure compliance that hazardous areas are protected with self-closing doors that self close in their frame. The Maintenance/Housekeeping/Laundry staff were educated by the Administrator/Maintenance Director on the requirement to have hazardous areas protected by self closing doors, and the importance of communicating to the Maintenance Director/Housekeeping Director/Administrator/Designee when a door protecting a hazardous area doesn't self close in its frame. Quality Assurance:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 321	Continued From page 5	K 321	Monthly, and ongoing for 12 months the Maintenance Director/Designee will review and report to the Administrator/QAPI Committee the audit results/compliance of the hazardous areas that are protected with self closing doors that they close in their frame.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 324		10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 324	Continued From page 6 Based on observations, documentation review, and interviews on 09/5/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) , it was determined that the facility failed to a) ensure semi-annual inspections were conducted on the range-hood fire suppression system in accordance with NFPA 96 and b) provide the required instructional signage, above the Class K portable fire extinguisher to ensure all portable fire extinguishers were ready for use in accordance with the requirements of NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1, and NFPA 10: 2010 Edition. These deficient practices had the potential to affect all residents and were evidenced by the following: a) A review of the facility's inspection documentation on 09/04/2024, revealed the last documented inspection of the range-hood fire suppression system was dated 12/12/2023 nearly 9 months ago. Observations on 09/04/2024 at 12:45 PM, revealed the inspection tags on the kitchen system was dated 12/12/2023. b) A continued observation in the kitchen, revealed a K-type fire extinguisher that did not have the required instructional placard indicating: "Warning in case of appliance fire, use this extinguisher only after fixed suppression system has been activated". In an interview at the time, the U.S. FOIA (b) and U.S. FOIA (b) confirmed the finding. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit	K 324	Corrective Action: The Kitchen Range-Hood Fire Suppression System was inspected in accordance with NFPA 96, and instructional signage was placed above the Class K portable fire extinguisher in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12,9.7.4.1, and NFPA 10:2010 Edition, informing staff on when to use the the Class K portable fire extinguisher (only after fixed suppression system has been activated). See attached photo Identification of at-Risk Residents: All residents have the potential to be affected. Systematic Change: The Food Service Director (FSD)/Maintenance Director implemented a system to ensure that semi-annually the Range-Hood Fire Suppression System is inspected. The FSD/Maintenance Director/Designee conduct monthly audits of all fire extinguishers including the Class K portable fire extinguisher to ensure that the signage for the Class K portable fire extinguisher has the instructions with it, informing staff of when to use it. Kitchen Staff were educated by the FSD, on where the Class K portable fire extinguisher is located and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 324	Continued From page 7 conference on 09/05/24 at 01:15 PM. NJAC 8:39-31.2(e) NFPA 10, 96	K 324	instructions (signage next to the Class K portable fire extinguisher) on when to use. Quality Assurance: Monthly and for 3 months the FSD/Maintenance Director/Designee will review and report to the Administrator/QAPI Committee on the status of the presence of the instructional signage for the Class K portable Fire Extinguisher and the kitchen's staff knowledge of its location and its instructions. Semi-Annually and ongoing for 12 months the FSD/Maintenance Director/Designee will review and report to the Administrator/QAPI Committee the status on the Inspection of the Kitchen Range-Hood Fire Suppression System.	
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, 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	K 341		11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 341	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/05/24, in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), it was determined that the facility failed to install supervised smoke/heat detection in accordance with NFPA 101: 2012 Edition, Section 19.3.4.1, 9.6.1.8, NFPA 70: 2011 Edition and NFPA 72: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 09:35 AM, revealed there was no smoke detection provided in the Long-Term Care main entrance foyer enclosure. The area was climate controlled and had electrical lighting. In an interview at the time, the U.S. FOIA (b) and U.S. FOIA (confirmed the observation. The U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 01:15 PM. NJAC 8:39 -31.2 (c), 31.2(e) NFPA 72	K 341	Corrective Action: The Facility's Contracted Vendor installed in the Long-Term Care (LTC) main entrance foyer enclosure, a supervised smoke/heat detection device in accordance with NFPA 101: 2012 Edition, Section 19.3.4.1.9.6.1.8, NFPA 70: 2011 Edition and NFPA 72: 2010 Edition. (see separate email sent to the DOH for photo) Identification of at-Risk Residents: All residents have the potential to be affected. Systematic Change: The Administrator educated the US FOIA (b)(6) on the requirement and importance of having smoke detectors in all resident areas throughout the LTC Unit. The Maintenance Director/Designee audited the LTC unit to ensure compliance in all areas for NFPA 101: 2012 Edition, Section 19.3.4.1.9.6.1.8, NFPA 70: 2011 Edition and NFPA 72: 2010 Edition. Quality Assurance:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 341	Continued From page 9	K 341	Monthly for 1 month only the Maintenance Director/Designee will review and report the results of the above audit to the Administrator/QAPI Committee.	
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 09/04/2024 and 09/05/2024 in the presence of the U.S. FOIA (b) (6) [redacted] it was determined that the facility failed to a) ensure that semi-annual fire alarm system inspections, testing and maintenance (ITM) and b) sensitivity testing of smoke detectors 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: a) Documentation review on 09/04/2024, revealed that the last semi-annual fire alarm system inspection was conducted on 01/19/2024, nearly 8 months ago. b) Documentation review also revealed there was documentation of any sensitivity testing for smoke	K 345	Corrective Action: The Facility's Contracted Vendor conducted a fire alarm system inspection, testing, and maintenance sensitivity testing for all the smoke detectors on the Long-Term Care Unit (LTC). Identification of at-Risk Residents: All Residents have the potential to be affected. Systemic Change: The Administrator educated the U.S. FOIA (b) (6) [redacted] Services/Designee on the requirement to conduct Semi-Annual Fire Alarm System Inspections, testing and Maintenance.	11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 345	Continued From page 10 detectors. In an interview on 09/05/2024 at 09:30 AM, the U.S. FOIA (b) stated the facility was unable to provide any documentation of a more recent inspection of the fire alarm system or any sensitivity testing of smoke detectors. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 09/05/24 at 01:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	A checklist was implemented to track compliance with the semi-annual fire alarm system inspections, testing and maintenance, and sensitivity testing for all smoke detectors in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, and NFPA 72. The DPES will monitor though electronic notifications and manually check list. To ensure compliance for the due date for the semi-annually smoke detector sensitivity testing. Quality Assurance: For 1 month, and thereafter semi-annually, the DPES/Designee will monitor compliance with the semi-annually sensitivity testing. DPES/Designee will report the results/compliance of the fire alarm system inspections testing and maintenance, and sensitivity testing for all smoke detectors to the Administrator/QAPI Committee monthly. (See inspection report will be sent to DOH)	
K 355 SS=C	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	K 355		10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 355	Continued From page 11 by: Based on observation and document review on 09/05/2024 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it was determined the facility failed to inspect portable fire extinguishers in 30 day intervals in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12 and NFPA 10: 2010 Edition, Section 4.3.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations beginning at 09:35 AM, revealed the facility had 5 portable fire extinguishers located in the Long-Term Care unit. A review of the tags on the extinguishers, revealed the facility inspected them monthly but did not inspect them in 30 day intervals for 2 of the monthly inspections. The inspections were dated 05/01/2024 and then 06/16/2024 and 07/03/2024 and then 08/19/2024. Each of the two interval were 47 days between inspection, in excess of the 30 day interval. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 01:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	Corrective Action: The Maintenance Director/Designee audited all the Long-Term Care (LTC) portable fire extinguishers to ensure they were inspected in 30 day intervals in accordance with NFPA 101:2012 Edition, Section 19.3.5.12, and NFPA 10: 2010 Edition, Section 4.3.1. Identification of at-Risk Residents: All residents have the potential to be affected. Systemic Change: A tracking system was implemented to notify the Maintenance Director/Designee of the inspection dates for the portable fire extinguishers in 30 day intervals in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12 and NFPA 10 Edition, Section 2.3.1 Maintenance Staff/designee were educated by the Administrator/Maintenance Director on the importance and regulation to inspect portable fire extinguishers in 30 day intervals. Quality Assurance: Monthly and ongoing the Maintenance Director/Designee will review and report the results/compliance of the 30 day interval inspections for the portable fire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 355	Continued From page 12	K 355	extinguisher inspections to the Administrator/QAPI Committee.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/05/2024 in the presence of th U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of smoke and maintaining the fire rating of the wall in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105: 2010 Edition, and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:25 AM, revealed the smoke barrier assembly near room N166 had unsealed wire/pipe penetrations through the wall above the	K 372	Corrective Action: The Facility's Contracted Vendor repaired the smoke barrier assembly (near room 166) above the double doors and the seam than runs up where the roof deck meets the barrier wall with appropriate 2-hour fire resistance rating material for the smoke barrier assembly (near room 166) above the double smoke barrier doors and the seam that ran up where the roof deck met the barrier wall. (see attached photo) Identification of at-Risk Residents: All residents have the potential to be	10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 372	Continued From page 13 smoke barrier doors. Continued observation revealed insulation stuffed into the seam where the roof deck met the barrier wall. This insulation is rated by compaction ratios that could not be verified. In an interview at the times of observation, the U.S. FOIA (b) and U.S. FOIA (confirmed the findings. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 01:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80, 105	K 372	affected. Systemic Change: The Administrator educated the U.S. FOIA (b) (6) on the requirement and importance of ensuring the appropriate 2-hour fire resistance rating material be used for the smoke barrier assembly areas. The facility's Contracted Vendor completed an audit of the Long-Term Care Facility (LTC) to ensure that penetrations through the smoke/fire barriers are protected by materials restricting the transfer of smoke and maintaining the fire rating of the wall in accordance with NFPA 101: 2012 Edition, Section 8.5.6, 8.3.5, NFPA 105: 2010 Edition, and NFPA 80 2010 Edition. Quality Assurance: For 1 month only (on the completion of the above repair for the smoke barrier assembly area) the Maintenance Director/Designee will report the results of the above audit to the Administrator/QAPI Committee.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that	K 374		10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 14 resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/05/24 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 smoke barrier doors closed into their door frame to resist the passage of smoke when released from their hold open devices in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.6.3.3 to 19.3.6.3.17, 8.5.4 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:00 AM, revealed the smoke barrier doors located by room U.S. FOIA (b) did not close to the frame when released from the hold-open device. One of the double doors remained open leaving a 1-inch gap between the meeting edges. An observation at 10:05 AM, revealed the smoke/fire barrier doors located by the employee entrance did not close to the frame when released from the hold-open device. One of the 2 doors was in contact with the floor and did not close at all. When pulled beyond the contact with the floor, the door still did not close to the frame. This set of doors was the fire rated separation	K 374	Corrective Action: The Facility's Contracted Vendor assessed and repaired the smoke barrier double doors next to room N132 and between the Independent Living and Long-Term Care occupancies to meet compliance with NFPA 101: 2012 Edition, Section 19.3.6.3, 19.3.6.3.3 to 19.3.6.3.17, 8.5.4 and NFPA 80: 2010 Edition, to ensure that the smoke/fire barrier doors closed completely in its frame. see attached photos Identification of at-Risk Residents: All residents have the potential to be affected. Systematic Change: An audit/checklist was implemented to track inspections for smoke/fire barrier doors and to immediately address any issues that prevent the doors from self closing in their frame.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 15 between the Independent Living and Long-Term Care occupancies. In an interview at the time of observations, the U.S. FOIA (b) and U.S. FOIA (b) confirmed the findings. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference at 01:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 374	The Maintenance Director/Designee educated the Maintenance staff on the new audit/checklist, and how to perform inspections for the smoke/fire barrier doors to ensure they self closes in its frame, and the importance of communicating the results immediately to the Maintenance Director/Designee/Administrator. The Maintenance Director/Designee will conduct daily for 4 weeks, and thereafter, ongoing weekly, smoke/fire barrier door audits/inspections to ensure they self close in their door frame. Quality Assurance: Monthly and ongoing for 12 months, the Maintenance Director/Designee will review and report to the Administrator/QAPI Committee the results/compliance of the smoke barrier doors self closing in their door frame.	
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	K 761		10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 16 that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/04/24 and 09/05/2024 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 fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101: 2012 Edition, Section 7.2.1.15 and NFPA 80: 2010 Edition, Section 5.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: A document review at on 09/04/2024, revealed there were no documented annual fire door inspections provided by the facility. In an interview on 09/05/2024 at 09:30 AM, the U.S. FOIA (b) stated that the facility had no documented inspections of the fire doors in the previous year. An observation on 09/05/2024 at 10:05 AM in the presence of the U.S. FOIA (b) and U.S. FOIA (b revealed there was a fire door assembly located near the employee entrance that served as a separation between the Long-Term Care and Independent Living licensure. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 09/05/2024 at 01:15 PM.	K 761	Corrective Action: he Facility's contracted Door Vendor completed an Inspection of all the Smoke/Fire barrier doors in the Long-Term Care Unit (LTC), The Commercial Washer/Dryer rooms and the Mechanical Room and the Smoke/Fire barrier double doors separating the Independent Living and the LTC occupancies to ensure compliance with NFPA 101: 2012 Edition, Section 7.2.1.15 and NFPA 80: 2010 Edition, Sections 5.2.1 Identification of at-Risk Residents: All residents have the potential to be affected. Systematic Change: The Administrator educated the U.S. FOIA (b) (6) on the requirement and the importance of Annual Fire/Smoke Door inspections. The Maintenance Director has implemented a tracking system to ensure compliance is met with Annual Fire/Smoke Door inspections by CM Door Vendor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 17 NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	The Maintenance Director/Designee will provide to the Administrator the dates for the Annual Smoke/Fire Door inspections. Quality Assurance: Monthly for 1 month for the initial audit inspection, and on the 12th month for the annual inspection, the Maintenance Director/Designee will review and report the results of the Annual Smoke/Fire Door Inspection conducted by the Facility's contracted Door Vendor to the Administrator/QAPI Committee.	
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	K 918		10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 918	Continued From page 18 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the 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 documentation review and interviews on 09/04/2024 and 09/05/2024 in the presence of the U.S. FOIA (b) (6) it was determined that ht e facility failed to a) exercise the emergency generator under full load 12 times per year on a 20 to 40 day interval, b) exercise the emergency generator under load for 4 continuous hours every 36 months, c) conduct a load bank test on the emergency generator annually where the generator uses less than 30% of the rating, and d) ensure the emergency generator assumed the building load within 10 seconds of a power failure in accordance with NFPA 101: 2012 Edition, NFPA 99: 2012 Edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 Edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7. These deficient practices had the potential to affect all residents and were evidenced by the following: a) A review of the the facility's emergency generator log on 09/04/2024, revealed the facility exercised the generator under load monthly but 1	K 918	Corrective Action: The Facility's contracted Generator Vendor conducted a continuous load test, and load bank test for the emergency generator. CM Generator Vendor assessed the emergency generator to ensure compliance with the timeliness to assume the load of the building on transfer. Identification of at-Risk Residents: All residents have the potential to be affected. Systemic Change: The Administrator provided education to the Maintenance Director/Maintenance staff on the requirement and importance of the "emergency generator full load test 12 times on 20 to 40 day intervals and to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(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 918	Continued From page 19 of the 12 tests was performed greater than 40 days from the previous. One test was performed on 01/09/2024 and then on 02/29/2024, 51 days later. b) A continued review of the emergency generator log on 09/04/2024, revealed the facility had no documentation of a continuous load test of the generator over the last 36 months. c) A continues review of the emergency generator log on 09/04/2024, revealed the facility had no documentation of an annual load bank test. The facility provided follow-up documentation from the inspection vendor on 09/05/2024 stating the building only used 12% of the generator's capability, requiring this load bank test. d) A continued review of the emergency generator log on 09/04/2024, revealed 4 of the 12 monthly load tests documented the generator took more than 10 seconds to assume the load of the building on transfer. In an interview on 09/05/2023 at 09:30 AM, the U.S. FOIA (b) confirmed the findings. The facility's U.S. FOIA (b) (6) was informed of the deficient practices at the Life Safety Code exit conference on 09/05/2024 at 01:15 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	exercise the generator under 4 continuous hours every 36 months and to conduct a load bank test on the emergency generator annually where the generator uses less than 30% of the rating and ensure the emergency generator assumed the building load within 10 seconds of a power failure". A checklist/notification system was implemented to ensure dates are met for the emergency generator load bank test every 12 months, the continuous load test every 36 months, and monthly full load tests (on a 20 to 40 day interval). The Maintenance Director/Designee will inform CM's Generator Vendor/Administrator immediately of any delays (more than 5 seconds) when conducting the generator load tests to assume the load of the building on transfer. Quality Assurance: Monthly for 12 months the Maintenance Director/Designee will review and report to the Administrator/QAPI Committee the results/compliance of the generator load load bank test, and the monthly full load test.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance	K 921		10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 20 Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 09/04/2024 and 09/05/2024 in the presence of the U.S. FOIA (b) (6) [redacted] it was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) intervals were established with policies and protocols for Patient Care Related Electrical Equipment (PCREE) in	K 921	Corrective Action: The Facility's Contracted Vendor conducted an inspection and testing for the maintenance of the Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1 and 10.3.5.4.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD** **WHITING, NJ 08759**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 21 accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1 and 10.3.5.4. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's maintenance records on 09/04/2024, revealed there was no documentation regarding ITM for PCREE. In an interview on 09/05/2024 at 9:30 AM, the U.S. FOIA (b) stated there was no ITM documentation for PCREE that included patient beds, air mattresses, oxygen concentrators, nebulizer and similar items that were used for patient care. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 09/05/2024 at 01:15 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	Identification of at-Risk Residents: All residents have the potential to be affected. Systematic Change: CM implemented a policy for the Testing and Maintenance of Patient Care Related Electrical Equipment (PCREE). A checklist/audit was implemented to track the testing and maintenance of PCREE. The Maintenance Director/Designee educated the Maintenance staff on the PCREE policy and the checklist/audit. Quality Assurance: The Maintenance Director/Designee for 1 month and thereafter semi-annually, will review and report the results of the PCREE inspection/testing to the Administrator/QAPI Committee.	

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
315298 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

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 K0132	10/25/2024	LSC K0321	10/25/2024	LSC K0324	10/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0341	11/08/2024	LSC K0345	11/08/2024	LSC K0355	10/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	10/25/2024	LSC K0374	10/25/2024	LSC K0761	10/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	10/25/2024	LSC K0921	10/25/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/6/2024	☐ YES ☐ NO