STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315457	A. BUILDING _____ B. WING _____	C 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SOCIAL MINISTRIES CRANES MILL	**459 PASSAIC AVENUE WEST CALDWELL, NJ 07006**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #s NJ 164566, 165341, 182642 STANDARD SURVEY: 3/7- 3/12/25 CENSUS: 37 SAMPLE SIZE: 12+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		4/5/25

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

Electronically Signed | 04/01/2025

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

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F 583	Continued From page 1 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide physical privacy during a NJ Exec Order 26.4b1 treatment for 1 (Resident #21) of 9 residents reviewed for privacy and dignity. The deficient practice was evidenced by the following. On 3/7/25 at 10:42 AM the surveyor observed Resident #21 NJ Exec Order 2 and NJ Exec O in bed. The resident had a NJ Exec Order 26.4b1 seated at the bedside. A review of the electronic medical record revealed the following information. The 1/27/25 Admission Minimum Data Set (MDS) assessment tool indicated the resident had NJ Exec Order 26.4b1 and was admitted with a NJ Exec Order 26.4b1 . The Resident Medical Profile included a NJ Exec Order 26. physician's order for nursing to NJ Exec Order 26.4 the NJ Exec O with NJ Exec Order 26.4b1, NJ Exec Ord with NJ Exec Order 26.4b1 , NJ Exec Orde with NJ Exec Order 26.4b1 and	F 583	F583- Privacy: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. The Director of Nursing provided initial in-service training to the nurse providing care to resident #21 on NJ Exec Order 26.4b1 regarding personal privacy while providing treatment care to residents. Additional training was provided to the nurse on 3/14/2025, including competency checks regarding treatment observation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; B. On 3/28/2025, a 100% questionnaire audit of the 3 alert and oriented residents that receive wound care treatment, ensuring they have received privacy during their treatment. Director of Social Worker completed audit 3/28/2025.	

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F 583	Continued From page 2 NJ Exec Order 26.4b1 once daily. The surveyor approached Resident #21's room on 3/11/25 at 1:08 PM to observe the resident's NJ Exec Order 26.4b1 which had been prearranged with the US FOIA (b)(6) who would perform the treatment. The surveyor knocked on the closed door. The US FOIA (b) came out and left the door open. The resident was visible from the doorway. The resident was NJ Exec Order 26.4b1 on their NJ Exec Order 26.4 facing the window. The resident's NJ Exec Order 2 were pulled down past their NJ Exec Order 26.4b1 . The US FOIA (b) prepared for the NJ Exec Order 26.4b1 treatment for 10 minutes while the resident remained NJ Exec Order 26.4b and NJ Exec Order 2 from the hallway. At 1:19 PM the US FOIA (b) approached the resident's bedside to begin the treatment. At that time the surveyor asked the US FOIA (b) to speak with her near the doorway. The surveyor asked the US FOIA (b) if privacy should be afforded to the resident and the US FOIA (b) replied privacy should be provided and pulled the privacy curtain. The surveyor spoke with the US FOIA (b)(6) on 3/11/25 at 2:00 PM regarding the US FOIA (b)(6) failure to provide the resident with physical privacy during the NJ Exec Order 26.4b1 treatment. The surveyor reviewed the 4/6/17 policy and procedure for providing a NJ Exec Order 26.4b1 . The second step of the procedure, after identifying the resident, was to provide privacy. NJAC 8:39-4.1(a)16	F 583	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; C. On 3/14/2025, the Director of Nursing provided in-service training to all nurses regarding personal privacy while providing treatment to residents. All in-services were completed by 4/4/2025 D. 3/14/2025, the Director of Nursing completed competency checks on all nurses regarding treatment care to residents. All competencies were completed by 4/4/2025 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and E.Starting 3/31/2025, Director of Nursing or designee will audit 2 nurses providing treatment care to residents to observe to ensure treatment care was provided according to the SNF policy weekly times for 4 weeks, monthly times for 1 month, and quarterly thereafter. Director of Nursing will report audit findings monthly to the QAPI team for review until 100% compliance times three months. F.Starting 3/31/2025, Social Worker will interview 2 residents who receive treatment, ensuring they receive privacy during treatment care, weekly times for 4 weeks, monthly times for 1 month, and quarterly thereafter. The Director Social Worker will report audit findings monthly to the QAPI team for review until 100% compliance times three months.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		4/5/25

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F 755	Continued From page 3 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with	F 755	F755- Pharmacy services/Pharmacist/Records: Narcotic Medication Inspection	

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F 755	Continued From page 4 professional standards to ensure a.) stored [NJ Exec Order 26.4b] medication was maintained with the safety tamper resistant seal (Resident #4), identified for 1 of 1 medication cart inspected, b.) ensure an accurate ordering and receiving of [NJ Exec Order 26.4b] medications on the required Federal [NJ Exec Order 26.4b] acquisition forms (DEA Form-222) were completed with sufficient detail to enable accurate reconciliation, identified for 7 of 9 provided DEA Form-222, and c.) medication was properly disposed after falling onto the bed, observed during medication pass observation. The deficient practice was evidenced by the following: 1.) On 3/11/25 at 9:29 AM, the surveyor and the [US FOIA (b)(6)] began the [NJ Ex Order 26.4(b] medication inspection, which was stored in a mounted, double locked portion of the medication cart ([NJ Ex Order 26.4(b] box), assigned to the 2500 hall. At 9:32 AM, in the presence of [US FOIA (b)] the surveyor reviewed the accountability record (a shift-to-shift log; count/sign in sheet, used to account for the [NJ Exec Order 26.4b] medications within the medication cart) was signed daily until the day shift of 3/11/25. The [US FOIA (b)] stated that there were no discrepancies found that day. At 9:35 AM, the surveyor and the [US FOIA (b)] reviewed the [NJ Exec Order 26.4b1] utilization record [NJ Exec Order 26.4b1] log that details the following: when the [NJ Ex Order 26.4(b] was received, starting quantity, the [NJ Exec Ord] time, the dose removed from inventory, nurse administering, quantity remaining , wasted amount when pertinent and who checked the log) of Resident	F 755	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. The [NJ Exec Order 26.4b1] was not given to resident #4, and [NJ Exec Order 26.4b1] to the resident. On [NJ Exec Order 26] the unsealed [NJ Exec Order 26.4b1] was destroyed by DON and LPN, and the hospice nurse re-ordered the medication. The Director of Nursing verified that the medication was available in the backup medication storage system, should the resident require morphine before the arrival of the new delivery. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; B. All residents that receive liquid narcotics have the potential to be affected. On 3/11/25 an audit was conducted by the Director of Nursing on the seals of unopened medications, as a result no other seals were identified as open. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; c. The Director of Nursing collaborated with the Pharmacy to identify a root cause, and a process was put in place on 3/11/2025. Going forward, the facility will not accept unsealed narcotics. On 3/25/25, the Controlled Substances policy was updated to include verifying that tamper resistant seals are in place upon arrival at the facility. An in-service was initiated on 3/11/25, educating nurses to check for the seal upon delivery and	

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F 755	Continued From page 5 #4's NJ Exec Order 26.4b1 [redacted] The NJ Exec Order 26 [redacted] did not reflect the medication was used from the time it was received on NJ Exec Order 26.4b1 [redacted] At that time, the surveyor and the US FOIA (b [redacted] observed the safety tamper resistant seal (provides visual evidence of any attempt to open or manipulate the packaged medication) was missing for Resident # 4's NJ Exec Order 26.4b1 [redacted] bottle. The NJ Exec Order 26.4b1 [redacted] had a pharmacy label dated NJ Exec Order 26.4 [redacted], and the contents reflected approximately NJ Exec Order 2 [redacted] At that time, the LPN #1 stated she did not break the seal for Resident #4's NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted] and that she had received the NJ Exec Order 26.4b1 [redacted] that way from the beginning of her shift that day. The US FOIA (b [redacted] stated she did not inform the US FOIA (b)(6) [redacted] about the missing tamper resistant seal. At 10:19 AM, the surveyor informed the US FOIA (b) [redacted] of the concern regarding the missing tamper resistant seal for Resident #4's NJ Exec Order 26.4b1 [redacted]. At 10:40 AM, during a follow-up meeting with the surveyor, the US FOIA (b) [redacted] acknowledged that all nurses on duty were responsible to ensure that bottled narcotic medications delivered from the pharmacy, had the tamper resistant seal and was stored in a manner that the tamper resistant seal was kept intact. 2.) On 3/11/25 at 11:50 AM, the surveyor and the US FOIA (b) [redacted] reviewed the facility's DEA Form-222 which revealed that the facility did not complete Part 5, the number of packages received or the date the medication was received as instructed to on the	F 755	ensure its presence when signing off on counts at shift sign-off. They have been instructed to notify the Director of Nursing if there is a missing seal upon arrival or if they notice a missing seal on a full bottle during narcotic counts at shift change. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and D. Starting 3/31/2025, the Director of Nursing or designee will audit the medication carts and refrigerators to ensure there are no missing seals on any unopened bottles of narcotics weekly for four (4) weeks, monthly for one (1) month, and quarterly thereafter. The Director of Nursing will report audit findings monthly to the QAPI team for review, until compliance is maintained consistently for three (3) months. The LNHA is responsible for ensuring overall compliance. F-755Lack of completion of section 5 of DEA 222 form: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. There were no specific residents that were identified Address how the facility will identify other residents having the potential to be affected by the same deficient practice; B. All residents that receive narcotics have the potential to be affected. On 3/12/25, the Director of Nursing reconciled the medications, and identified that no	

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F 755	Continued From page 6 reverse of the DEA Form-222. The insufficient details were as follows: Order Form: #[NJ Exec Order 26.4b1] No number received, no date received. #[NJ Exec Order 26.4b1] No number received, no date received. #[NJ Exec Order 26.4b1] No number received, no date received. #[NJ Exec Order 26.4b1] No number received, no date received. #[NJ Exec Order 26.4b1] No number received, no date received. #[NJ Exec Order 26.4b1] No number received, no date received. #[NJ Exec Order 26.4b1] No number received, no date received. Additionally, the surveyor observed the DEA Form-222 did not have the associated invoice to show that upon receipt of the [NJ Exec Order 26.4b] the items received were reconciled against the DEA Form-222 as evidenced by the missing documentation on Part 5. On 3/11/25 at 1:22 PM, during a meeting with two surveyors, the [US FOIA (b)] acknowledged that the process for receiving [NJ Exec Order 26.4b1] and the reconciliation process could be streamlined. The [US FOIA (b)] stated that she would retrieve the invoices from the nurses or the pharmacy. On 3/12/25 at 8:58 AM, during a follow-up meeting with the surveyor, the [US FOIA (b)] stated that they were unable to determine when the tamper resistant seal went missing. The [US FOIA (b)] also stated that the policy would be updated to include	F 755	residents were identified as being affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; C. On 3/12/25 the pharmacy consultant educated the US FOIA (b)(6) on the process of the final step (Section 5) in the completion of the DEA Form- 222-instructions on the back of the DEA 222 form. Section 5 indicates that once medications are received at the facility, they need to be reported on the 222-form copy. On 3/12/25 the process for receiving and documenting scheduled medication deliveries was revised so that the Director of Nursing completes all portions of the DEA 222-form. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and D. Starting 3/31/2025, the LNHA will audit the completion of the DEA 222-form and report audit findings monthly to the QAPI team for review, until compliance is maintained consistently for 3 months. The LNHA is responsible for ensuring overall compliance. F-755 Incorrect disposal method of unused medication: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. There was no harm to the unsampled resident. On 3/11/25, the DON provided a	

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F 755	Continued From page 7 verification of the tamper resistant seal was intact along with the accuracy of the inventory count, this was to ensure the integrity of the medication. A review of the provided facility policy, Controlled Substances, dated 4/30/19, revision undated, included under record keeping did not include a process to ensure narcotic medications with tamper resistant seal were received, maintained and tracked. A review of the provided facility policy, Storage of Medications, dated 6/8/15, revision undated, included that the facility shall store all drugs and biologicals in a safe, secure and orderly manner. A review of the instructions for DEA Form-222 under Part 5, Controlled Substance Receipt included the following: 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item ... 3. The surveyor observed the [redacted] administer medications to an unsampled resident on [redacted] at 8:16 AM. While administering the medications one pill dropped on to the resident's bed. The medication was [redacted]., an [redacted] medication. The [redacted] disposed of the pill in the open trash receptable affixed to the side of the medication cart located in the unit hallway. When questioned by the surveyor, [redacted] stated she should have used the "Drug Buster," a receptacle used for the safe disposal of medications.	F 755	1:1 re-education about the correct medication destruction process with the nurse who caused the deficient practice. The nurse was assessed for competency and was able to successfully demonstrate the proper protocol on 3/14/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; B. All residents that receive medication have the potential to be affected. On 3/14/2025, the Director of Nursing provided in-service training to all nurses regarding the disposal of unused medications to ensure no other residents are impacted. All in-services were completed by 4/4/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; C. A systematic change will be made beginning on April 1st, 2025, Medication pass competencies will be changed from once annually to twice annually on all nurses that pass medications in the SNF by the DON/Designee Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and D. Starting 3/31/2025, the DON/Designee will audit medication pass for 2 nurses weekly and report the findings monthly to the QAPI team for review, until compliance is maintained consistently for three (3) months. The LNHA is responsible for ensuring overall compliance.	

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F 755	Continued From page 8 The surveyor interviewed the US FOIA (b)(6) [redacted] on 3/11/25 at 2:00 PM. The [redacted] stated the nurse should have used the Drug Buster which is located in each medication cart.	F 755		
F 880 SS=D	NJAC 8:39- 29.2(a)(d); 29.4(i)(k); 29.7(c) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		4/1/25

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F 880	Continued From page 9 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to	F 880	F 880-Infection Control: Address how corrective action will be	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 follow appropriate infection control practices to prevent or reduce the NJ Exec Order 26.4b1 during a NJ Exec Order 26.4b1 treatment for 1 (Resident #21) of 2 residents reviewed for NJ Exec Order 26.4b1. The deficient practice was evidenced by the following. The surveyor observed Resident #21 NJ Exec Order 2 and NJ Exec O in bed on NJ Exec Order 2 at 10:42 AM . The resident had a NJ Exec Order 26.4b1 seated at the bedside. A review of the electronic medical record revealed the following information. The NJ Exec Order 26.4 Admission Minimum Data Set (MDS) assessment tool indicated the resident had NJ Exec Order 26.4b1 and was admitted with a NJ Exec Order 26.4b1. The Resident Medical Profile included a NJ Exec Order 26. physician's order for nursing to NJ Exec Order 26.4 the NJ Exec O with NJ Exec Order 26.4b1, NJ Exec Orde with NJ Exec Order 26.4b1 , NJ Exec Orde with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 once daily. The surveyor observed the resident's NJ Exec Order 26.4b1 treatment on NJ Exec Order 26 at 1:08 PM. The US FOIA (b)(6) sanitized the over bed table, applied a NJ Exec Order 26.4b1 to the table, and assembled the needed supplies for the treatment. A glass jar of NJ Exec Order 26.4b1 was taken from the treatment cart. The entire jar was brought into the resident's room and placed on the over bed table at the resident's bedside. At the completion of the treatment at 1:36 PM the US FOIA (b) returned the jar to the drawer of the treatment cart without sanitizing it. When	F 880	accomplished for those residents found to have been affected by the deficient practice; A. The Director of Nursing provided initial in-service training to the nurse providing care to resident #21 on NJ Exec Order 26.4b1 regarding infection control while providing treatment care to residents. Additional training was provided to the nurse on 3/14/2025, including competency checks regarding treatment observation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; B. On 3/14/2025, the Director of Nursing provided in-service training to all nurses regarding infection control while providing treatment care to residents to ensure no other residents are impacted. All in-services were completed by 4/4/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; C. On 3/14/2025, the Director of Nursing completed competency checks on all nurses regarding infection control while providing treatment care to residents. All competencies were completed by 4/4/2025 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and D. Starting 3/31/2025, Director of Nursing or designee will audit 2 nurses providing treatment care to residents to observe to ensure treatment care was provided according to your policy weekly times for 4 weeks, monthly times for 1 month, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315457	A. BUILDING _____ B. WING _____	C 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SOCIAL MINISTRIES CRANES MILL	**459 PASSAIC AVENUE WEST CALDWELL, NJ 07006**

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F 880	Continued From page 11 questioned by the surveyor, the [US FOIA (b)] stated she should have sanitized the jar first. At that same time, the surveyor asked the [US FOIA (b)] if she was done with the treatment pass. She replied she was. The surveyor noted the trash containing the [NJ Exec Order 26.4b1] and the [NJ Exec Order] were left in the room at the resident's bedside in the resident's trash can. The [US FOIA (b)] stated she would remove the trash from the resident's room to the dirty utility room. The surveyor spoke with the [US FOIA (b)(6)] and the [US FOIA (b)(6)]) on [NJ Exec Order 26.] at 2:00 PM regarding the [US FOIA (b)(6)] failure to follow standard infection control. The [US FOIA (b)] confirmed the jar should not have been replaced into the treatment cart without sanitizing it. The [US FOIA (b)] stated soiled dressings are to be removed from the resident's room upon completion of the treatment. The surveyor reviewed the 4/6/17 policy and procedure for providing a clean dressing change. The third step of the procedure was to place a plastic bag on the over bed table or in close proximity of the resident. The policy and procedure did not address removing trash from the room or returning unsanitized items back into the treatment cart. NJAC 8:39-19.1; 8:39-27.1(e)	F 880	quarterly thereafter. Director of Nursing will report audit findings monthly to the QAPI team for review until 100% compliance times three months.	

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
315457 Y1	A. Building B. Wing Y2	4/7/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SOCIAL MINISTRIES CRANES MILL	459 PASSAIC AVENUE WEST CALDWELL, NJ 07006

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 F0583 Reg. # 483.10(h)(1)-(3)(i)(ii) LSC	Correction Completed 04/05/2025	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 04/05/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/01/2025
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	
3/14/2025	☐ 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
	315457	A. BUILDING **01** B. WING _____	**03/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SOCIAL MINISTRIES CRANES MILL	**459 PASSAIC AVENUE** **WEST CALDWELL, NJ 07006**

(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 An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 3/13/25, and 3/14/25. The facility was found to be in compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 42 CFR 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 3/13/25 and 3/14/25 and the facility was found to be in non-compliance 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. Lutheran Social Ministries at Crane's Mill is a two - story building built in 1998. It is composed of Type II protected construction. The facility is divided into four - smoke zones. The generator powers approximately 100 % of the building per the Maintenance Director. The current occupied beds are 37 of 56.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 291		3/25/25

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

Electronically Signed | 04/01/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315457	A. BUILDING 01 B. WING _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SOCIAL MINISTRIES CRANES MILL	459 PASSAIC AVENUE WEST CALDWELL, NJ 07006

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K 291	Continued From page 1 Based on observation and interview on 3/14/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to maintain a battery back-up emergency light above the interior emergency generator transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 1 of 1 interior transfer switches, had the potential to affect all residents and was evidenced by the following: An observation at 10:49 AM with the US FOIA (b)(6) [redacted] revealed in the generator transfer switch room, that the transfer switch was not equipped with battery backed-up emergency lighting of at least a 90 minute duration in accordance with 7.9, 18.2.9.1 and 19.2.9.1. In an interview, the US FOIA (b)(6) [redacted] stated that the emergency generator transfer switch did not have a battery back-up emergency lighting of at least a 90 minute duration in accordance with 7.9. 18.2.9.1, 19.2.9.1. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit on 3/14/25 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	K291 Emergency Lighting Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. No residents or staff have been harmed by this deficiency. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; B. All Residents would have the potential to be affected by this deficiency. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; C. Upon notice of the deficiency during the survey, the electrical contractor (Positive Electric) installed the battery backup emergency light above the interior emergency generator transfer switch that is independent of the building's electrical system on 3/25/2025. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and D. To ensure that these corrective actions will not cause any future non-compliance situations and maintain its desired function. The Director of Operations will inspect the battery backup emergency light quarterly to ensure proper function through routine inspections set up in accordance with the	

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K 291	Continued From page 2	K 291	acceptable time frames in our [redacted] building maintenance application. Director of Plant Operations, will oversee monitoring the maintenance of the above-mentioned. This device will be inspected by our electrical contractor yearly during the annual electrical inspections for the property. 90 minutes back up battery. The results of inspection will be presented to the QAPI committee quarterly. The LNHA will be responsible for overall compliance.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/14/25 in the presence of the [redacted], it was determined that the facility failed to ensure that ventilation complied with NFPA 101:2012 Edition, Sections 19.5.2.1 and 9.2. This deficient practice had the potential to affect 25 residents and was evidenced for 10 of 18 resident room bathrooms by the following: Observations on 3/14/25 from 9:30 AM to 11:40	K 521	K-521-HVAC Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. No residents or staff have been harmed by this deficiency. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	3/18/25

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LUTHERAN SOCIAL MINISTRIES CRANES MILL	**459 PASSAIC AVENUE** **WEST CALDWELL, NJ 07006**

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K 521	Continued From page 3 AM revealed that the bathroom ventilation in resident rooms: 2203, 2204, 2206, 2209, 2210, 2211, 2212, 2411, 2425, and 2426 did not function when tested the by the [redacted] In an interview, the [redacted] confirmed the above observations. The [redacted] was informed of the deficient practices at the Life Safety Code exit conference on 3/14/25 at 12:45 PM. N.J.A.C 8:39-31.2(e)	K 521	B. All Residents would have the potential to be affected by this deficiency. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; C. The Director of Plant Operations on 3/14/2025 conducted an audit of all the resident rooms and ensured that all HVAV units were operational. The HVAC units were installed on 3/18/2025 by our in-house licensed HVAC technician. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and D. The Director of Plant Operations, will oversee monitoring of the above-mentioned exhaust fans monthly for three (3) months. Findings will be presented to the QAPI committee monthly and discontinued when 100 percent compliance is achieved for 3 months. The LNHA will be responsible for overall compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712		3/17/25

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LUTHERAN SOCIAL MINISTRIES CRANES MILL	459 PASSAIC AVENUE WEST CALDWELL, NJ 07006

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K 712	Continued From page 4 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 3/13/25, in the presence of the[US FOIA (b)(6)], it was determined that the facility failed to conduct fire drills with varying activation types and specific simulation of emergency fire conditions at unpredictable times, in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's fire drill reports revealed only one method for the for the activation type for the last 12-months indicating: Code Red only (Page) and did not include: Pull and Smoke activation. Fire drill times were predictable for the 2nd and 3rd shift as follows: - 3-11 shift 4 of 4 drills within 1-hour: 3:00 PM, 3:00 PM, 3:05 PM and 3:10 PM. - 11-7 shift 4 of 4 drills within 1-hour: 6:00 AM, 6:10 AM, 6:30 AM, and 6:30 AM. In an interview at 11:15 AM, the [US FOIA (b)] confirmed the document review. The[US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 3/14/25 at 12:45 PM.	K 712	K712 Fire Drills Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. No residents or staff have been harmed by this deficiency. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; B. All Residents would have the potential to be affected by this deficiency. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; C. Upon notice of the deficiency during the survey on 3/13/2025 the Director of Plant Operations created a new log sheet with the required information to prompt the community to keep the required records of devices used, unpredictable drill times with varied methods and activation types. A drill was conducted on 3.13.25 at 4:07 with the pull station. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and D. The Director of Plant Operations or designee will oversee monitoring monthly to ensure unpredictable drill times with varied methods and activation types. Findings will be presented to the QAPI	

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	315457	A. BUILDING **01** B. WING _____	**03/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SOCIAL MINISTRIES CRANES MILL	**459 PASSAIC AVENUE** **WEST CALDWELL, NJ 07006**

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K 712	Continued From page 5 NJAC 8:39-31.2(e)	K 712	committee monthly and discontinued when 100 percent compliance is achieved for 3 months. The LNHA will be responsible for overall compliance. COMPLETION DATE FOR CORRECTION: 3/17/2025	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the 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	K 918		3/25/25

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	315457	A. BUILDING **01** B. WING _____	**03/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SOCIAL MINISTRIES CRANES MILL	**459 PASSAIC AVENUE** **WEST CALDWELL, NJ 07006**

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K 918	Continued From page 6 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 observations, record review and interview on 3/13/25 in the presence of the [redacted], a). it was determined the facility failed to ensure the Emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test and failed to properly document the monthly testing of the emergency generator 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, Sections: 8.1.1, 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 and b). it was determined that the facility failed to ensure Essential Electrical System (EES) was provided with a remote manual stop station for the generator set in accordance with the requirements of NFPA 99, 2012 Edition Section 6 and NFPA 110, 2010 Edition. These deficient practices could affect all residents and were evidenced by the following: a). A record review on 3/13/25 at 9:30 AM of the emergency power generator logs revealed the facility did not record the percentage of the EPS nameplate KW rating that the generator was exercised monthly to determine if the load met the 30% of the nameplate rating requirement or perform a 90 minute annual load bank test for the last 12 months, normal operating temperature, identification of ATS(s) used to initiate the test,	K 918	K918 Electrical Systems Logs and Remote Manuel Stop Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A. No residents or staff have been harmed by this deficiency. Immediately following the surveyors finding no emergency generator stop, the Director of Plant Operations made arrangements for a quote of installation of an emergency generator stop button that will be completed in accordance with 2010 NFPA 110 Sect. 5.6.5.6. and installed on 3/25/2025 and Upon notice of the deficiency of not ensuring that 1/3 of the total generator kilowatt is under load during tests during the survey on 3/13/2025, The director of Plant Operations created a new log sheet with the required information to capture that 1/3 of the total generator kilowatt is under load during tests. As of 3/17/2025 the log form will be included in the weekly, monthly, quarterly, and annual inspections along with the other required documents in our generator binder. Address how the facility will identify other residents having the potential to be	

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	315457	A. BUILDING **01** B. WING _____	**03/14/2025**

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LUTHERAN SOCIAL MINISTRIES CRANES MILL	**459 PASSAIC AVENUE** **WEST CALDWELL, NJ 07006**

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K 918	Continued From page 7 time delay for cool-down, oil pressure during test, operating temperature during test, engine exhaust temperature during test (if applicable), identification of unsatisfactory conditions and corrective action taken (including parts replaced) and battery system (corrosion, check specific gravity, electrolyte level and battery charger. b). An observation on 3/13/25 at approximately 11:14 AM revealed the facility generator (200 KW) was located outside the building. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. In an interview at the time, the US FOIA (b) stated facility was not aware of the requirement to provide a remote manual stop station. In an interview, the US FOIA (b) confirmed the observation's and record review findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 3/14/25 at 12:45 PM. NJAC 8:39-31.2 (e) NFPA 99, 110	K 918	affected by the same deficient practice; B. All Residents would have the potential to be affected by this deficiency. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Plant Operations provided in-service education to all of the plant operations TM, by April 1st 2025 regarding the requirement for and the location of the emergency generator stop button. Any integrity issues will be reported to the Director of Plant Operations and they will annually audit the generator test log book for compliance of checks for functionality and integrity of the emergency generator stop. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Plant Operations / or designee will annually audit the generator test log book for compliance. A report of the results for these audits will be submitted to and reviewed by the QAPI committee quarterly and may be discontinued when 100% compliance is achieved for 1 month and 2 months respectively The LNHA will be responsible for overall compliance.	

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
315457 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/7/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SOCIAL MINISTRIES CRANES MILL	459 PASSAIC AVENUE WEST CALDWELL, NJ 07006

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 K0291	03/25/2025	LSC K0521	03/18/2025	LSC K0712	03/17/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	03/25/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/14/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO