

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

PRINTED: 05/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                  |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>315457</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br><b>01/27/2023</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>LUTHERAN SOCIAL MINISTRIES CRANES MILL</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>459 PASSAIC AVENUE<br/>WEST CALDWELL, NJ 07006</b>   |                      |   |
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| F 000   | INITIAL COMMENTS<br><br>Standard Survey: 1/27/23<br><br>Census : 43<br><br>Sample Size : 14<br><br>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 695<br>SS=D   | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to maintain oxygen supplies in a manner that was consistent with infection control protocols and professional standards of practice. This was found with 1 of 3 residents reviewed for NJ Exec. Order 26:4.b.1, Resident # 26.<br><br>The deficient practice was evidenced by the following:<br><br>On 1/23/23 at 9:23 AM, the surveyor observed Resident #26 in bed, awake. The resident was | F 695   | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br>- NJ Exec. Order 26:4.b.1 for Resident was changed and dated NJ Exec. Order 26:4.b.1 by Floor Nurse.<br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br>- On 1/23/2023, 100% audit of the 4 residents that are on oxygen for compliance with changed tubing and | 2/3/23               |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/09/2023

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 695   | <p>Continued From page 1</p> <p>receiving <b>NJ Exec. Order 26:4.b.1</b> )<br/>that was connected to an <b>NJ Exec. Order 26:4.b.1</b><br/>with <b>NJ Exec. Order 26:4.b.1</b>. The <b>NJ Exec. Order 26:4.b.1</b> was<br/>set to deliver <b>NJ Exec. Order 26:4.b.1</b> to the resident at a <b>NJ Exec. Order 26:4.b.1</b><br/><b>NJ Exec. Order 26:4.b.1</b>. The tubing that delivered the<br/><b>NJ Exec. Order 26:4.b.1</b> from the concentrator was dated<br/><b>NJ Exec. Order 26:4.b.1</b>.</p> <p>On 1/24/23 at 12:17 PM, the surveyor went to the resident's room but the resident wasn't there. The resident was in Physical Therapy (PT). The resident's "Private Aide" was in the resident's room and said the resident would be out of the room for the afternoon due to PT and then lunch. The <b>NJ Exec. Order 26:4.b.1</b> was in the room with the <b>NJ Exec. Order 26:4.b.1</b> attached. The <b>NJ Exec. Order 26:4.b.1</b> attached to the <b>NJ Exec. Order 26:4.b.1</b> was dated <b>NJ Exec. Order 26:4.b.1</b>. The private aide said the resident only used the <b>NJ Exec. Order 26:4.b.1</b> in bed.</p> <p>On 1/24/23 at 12:21 PM, the surveyor observed the resident arrive in the dining area without wearing <b>NJ Exec. Order 26:4.b.1</b>. The resident's private aide wheeled the resident over to a table. The resident completed the meal without wearing <b>NJ Exec. Order 26:4.b.1</b>.</p> <p>On 1/24/23 at 12:52 PM, the surveyor spoke with the resident's Licensed Practical Nurse (LPN) and asked how often the <b>NJ Exec. Order 26:4.b.1</b> should be changed. The LPN said weekly, she said the night shift changed the <b>NJ Exec. Order 26:4.b.1</b> weekly. The surveyor asked the LPN if she routinely checked the <b>NJ Exec. Order 26:4.b.1</b> when she was in the room to make sure the <b>NJ Exec. Order 26:4.b.1</b> was not out dated. The LPN said yes. The surveyor told the LPN that the <b>NJ Exec. Order 26:4.b.1</b> was dated <b>NJ Exec. Order 26:4.b.1</b>, on <b>NJ Exec. Order 26:4.b.1</b> and asked if she noticed that. The LPN said no, she did not notice. The surveyor asked</p> | F 695   | <p>dating by a floor nurse. The facility will continue to monitor residents on oxygen for compliance.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <ul style="list-style-type: none"> <li>- Reeducation was performed regarding changing oxygen tubing for residents on oxygen on Tuesday by DON /Nurse Supervisor, to all SNF nurses completed 2/3/2023</li> <li>- Education was added to the new hire orientation for all new nurses or contracted nurses, 1/30/2023</li> <li>- On 1/24/2023, DON added change oxygen tubing weekly on the TAR where the nurse must sign off that it was completed.</li> </ul> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and</p> <ul style="list-style-type: none"> <li>- On Tuesday weekly, Unit Manager or designee will audit all residents on oxygen for compliance.</li> <li>- DON or Unit Manager will complete 100% audit of all residents on oxygen weekly times one month, bi-weekly times one month, and monthly thereafter for compliance with oxygen tubing. DON will report audit findings monthly to the QAPI team for review.</li> </ul> |   |

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| F 695   | <p>Continued From page 2</p> <p>the LPN if she worked full time on that wing. The LPN said yes.</p> <p>On 1/24/23 at 1:05 PM, the surveyor reviewed the resident's medical record which revealed the following:</p> <p>A Face Sheet with diagnoses which included, <b>NJ Exec. Order 26:4.b.1</b> [REDACTED].</p> <p>An annual minimum data set (MDS-An assessment tool used by the facility) assessment dated <b>NJ Exec. Order 26:4.b.1</b>. The MDS indicated that the resident scored [REDACTED] when the brief interview for mental status was done. This indicated that the resident had <b>NJ Exec. Order 26:4.b.1</b>. The MDS also indicated that the resident received <b>NJ Exec. Order 26:4.b.1</b> while a resident at the facility.</p> <p>A Physician's Order Sheet with an order dated <b>NJ Exec. Order 26:4.b.1</b> that read <b>NJ Exec. Order 26:4.b.1</b> by shift."</p> <p>A Care Plan with a problem listed which read "[Resident] has <b>NJ Exec. Order 26:4.b.1</b> due to <b>NJ Exec. Order 26:4.b.1</b>." Intervention #5 read "Provide <b>NJ Exec. Order 26:4.b.1</b>."</p> <p>An electronic treatment administration record (ETAR) with an order that read <b>NJ Exec. Order 26:4.b.1</b> by shift." The order date was <b>NJ Exec. Order 26:4.b.1</b>. It was signed every day, every shift by the nurse to indicate that the resident had received the <b>NJ Exec. Order 26:4.b.1</b></p> <p>On 1/25/23 at 11:35 AM, the surveyor reviewed</p> | F 695  |   |   |

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| F 695   | Continued From page 3<br>the facility's policy and procedure titled "Oxygen Administration" Under "After Care" Number 1. read "Change oxygen tubing and humidifier, if in use, weekly according to facility schedule." Number 3. read "The tubing is to be dated and initialed at the time of the weekly change."<br><br>On 1/26/23 at 1:15 PM, the surveyor spoke with the Director of Nursing (DON) about the concern with the [redacted] being [redacted]. The DON confirmed that the [redacted] should have been changed weekly and that it was an error on the nurses part, the [redacted] should not have been out dated.   | F 695   |   |                      |   |
| F 755<br>SS=D   | NJAC 8:39-27.1 (a)<br>Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- | F 755   |   | 2/10/23              |   |

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| F 755   | <p>Continued From page 4</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§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:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a.) expired narcotic medications were removed from active inventory b.) dispensed and received medication from the pharmacy were reconciled for accuracy which resulted in the wrong dosage stocked in the active inventory for one of one of the electronic emergency (backup) machine observed, and c.) proper disposal of medication during medication administration observation for one of two nurses.</p> <p>The deficient practice was evidenced by the following:</p> <p>1. On 1/24/23 at 9:34 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM) stated every nurse had their own log on for the backup machine and the pharmacy provider [name redacted] performed their own count weekly. The medications that were not at PAR level (minimum and maximum quantity limits that was set for a certain</p> | F 755   | <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> <li>- Pharmacy tech corrected automatic medication dispensing unit on 1/26/2023 to have the correct bins and par level.</li> <li>- 1/24/2023, Unit Manager discarded the Alprazolam (Xanax) in the Drug disposal receptacle</li> <li>- 1/24/2023, DON removed the Amlodipine and called pharmacy tech to correct the placement of the drug in automatic medication dispensing unit. Service was completed and corrected by pharmacy tech on 1/25/2023.</li> <li>- 1/27/2023, Facility purchased Drug disposal receptacle for carts.</li> <li>- 1/26/2023, Nurse was provided education regarding medication destruction by DON</li> <li>- 1/27/2023, Unit Manager conducted a med pass audit and education with that nurse.</li> </ul> |                      |   |

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| F 755   | <p>Continued From page 5</p> <p>medication) were sent with the regular delivery and marked nurse supervisor, "back up replacement". When the medication was received, the Director of Nursing (DON), or the supervisor logged on and restocked the machine. We entered the quantity, expiration date, scanned the barcoded medication then placed the medication into its designated compartment.</p> <p>On 1/24/23 at 10:01 AM, during an interview with the surveyor, the DON stated we do not do a shift-to-shift count for the backup machine, and we do not have a logbook. In the event the nurse who retrieved the narcotic identified a discrepancy, a sheet would have printed from the backup machine. The printout would have been left for me which I checked weekly.</p> <p>On 1/24/23 at 10:29 AM, the surveyor observed the RN/UM begin the cycle count for the controlled substance (narcotic) medications.</p> <p>On 1/24/23 at 10:38 AM, the surveyor in the presence of RN/UM observed three (3) tablets of eight (8) tablets for Alprazolam 0.25 milligram (mg) tablet that expired on 11/30/22.</p> <p>2. On 1/24/23 at 11:40 AM, during the cycle count for the non-controlled medications the surveyor and RN/UM observed the compartment for Amlodipine 5 mg that contained six tablets of Amlodipine 2.5 mg with thirteen tablets of Amlodipine 5 mg.</p> <p>On 1/23/23 at 11:58 the surveyor and RN/UM observed a second compartment for Amlodipine 5 mg that contained ten tablets of Amlodipine 2.5 mg.</p> | F 755   | <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <ul style="list-style-type: none"> <li>- While there is the potential that all residents could be affected, none were affected. Below are the actions that were taken to prevent it from occurring in the future.</li> <li>- On 1/26/2023, DON completed an audit of 100% cycle of automatic medication dispensing unit to verify all medications were accurate. No errors were identified. Ongoing Monitoring and audits will be completed to assure compliance.</li> <li>- On 1/26/2023 Unit Manager conducted education to SNF nurses regarding medication destruction, 100% was achieved by 2/10/2023. Ongoing Monitoring and audits will be completed to assure compliance.</li> <li>- DON educated nurses who are responsible for restocking the automatic medication dispensing unit on the new process for compliance, completed by 1/30/2023. Weekly Monitoring and audits will be completed to assure compliance by DON.</li> </ul> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <ul style="list-style-type: none"> <li>- Medications need to be scanned in as per automatic medication dispensing unit process. If a medication is unable to be scanned, it will be placed to the side in a secure location and the omnice representative will be notified immediately. We have spoken to our automatic</li> </ul> |                      |   |

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| F 755   | <p>Continued From page 6</p> <p>A review of the facility provided, Item Table List Report for the backup machine revealed Amlodipine 2.5 mg had zero quantity on-hand (the total amount the facility had physically available).</p> <p>During an interview with the surveyor, the RN/UM stated it was important not to have expired medications in the active inventory because the resident would not receive the full efficacy, "it may not work".</p> <p>At that time, the RN/UM stated that medications received from the pharmacy should have been reconciled properly to avoid medication administration error. The wrong dosage could have been given to the resident. The RN/UM also stated that she would remove the expired item and inform the DON of the discrepancies found.</p> <p>On 1/26/23 at 9:55 AM, in the presence of the survey team, DON and the Licensed Nursing Home Administrator (LNHA), the technician for the backup machine stated he arrived every month. He was in the facility on 1/3/23, conducted a cycle count for non-controlled medications only and had not observed the Amlodipine 2.5 mg in the incorrect compartments. The DON is responsible for the narcotics.</p> <p>At that time, the DON stated that the misplaced Amlodipine 2.5 mg in the wrong compartments was because of a scanner issue. The DON explained that when the manufacturer of the medication on record in the backup machine was different from the manufacturer sent by the pharmacy provider, the medication could not be scanned.</p> | F 755   | <p>medication dispensing unit technician about this issue and he is aware that we will be calling him from now on when a medication is unable to be scanned and will NOT be overriding the system to place them in, as the pharmacy had previously instructed us to do.</p> <ul style="list-style-type: none"> <li>- Drug disposal receptacle was added to the cart and will be restocked by unit clerk as needed.</li> </ul> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and</p> <ul style="list-style-type: none"> <li>- The DON or Nurse Management will complete daily cycle count for scheduled medication audit daily times one month, weekly times one month, and monthly thereafter. DON or Nurse Management will report audit findings monthly to the QAPI team for review.</li> <li>- The DON or designee will complete two random med pass that include proper destruction of medication audit weekly times one month, bi-weekly times one month, and monthly thereafter on completing a med pass. The DON will report audit findings monthly to the QAPI team for review.</li> </ul> |                      |   |

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| F 755   | <p>Continued From page 7</p> <p>At that time the DON stated there was no policy for the backup machine accountability.</p> <p>On 1/27/23 at 8:51 AM, during a follow up interview with the surveyor, the DON stated the cycle counts were done weekly based on discrepancy slips and random reports. She stated she had not received printed sheets since the supervisors had been proactive in resolving discrepancies. The DON stated that there appeared to be a miscommunication between her and the supervisors. The DON clarified that random reports included all narcotic medications, PAR level counts and as needed. The DON stated the last time she had checked Alprazolam 0.25 mg was in November 2022 and have not checked it since. The DON acknowledged that random report checks of medications needed to be improved.</p> <p>Refer to F760</p> <p>3. On 1/25/23 at 9:33 AM, during the medication administration observation for Resident #245, the surveyor and the LPN reviewed the electronic Medication Administration (eMAR) record together against the bingo cards (blister packet which contained the medications). The eMAR revealed one order of <a href="#">NJ Exec. Order 26:4.b.1</a> [REDACTED], 1 tablet two times a day starting <a href="#">NJ Exec. Order 26:4.b.1</a> [REDACTED] with an administration schedule of 9:00 AM and 5:00 PM.</p> <p>During review of the bingo cards, the LPN stated she had 2 different bingo cards of <a href="#">NJ Exec. Order 26:4.b.1</a> [REDACTED] for Resident #245. The LPN stated she should have dispensed only 1 tablet of the <a href="#">NJ Exec. Order 26:4.b.1</a> [REDACTED] tablet</p> | F 755   |   |                      |   |

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| F 755   | <p>Continued From page 8</p> <p>from one of the two bingo cards. The LPN acknowledged it was her error. The LPN removed one tablet of <b>NJ Exec. Order 26:4.b.1</b> from the dosing cup and disposed <b>NJ Exec. Order 26:4.b.1</b> into the sharps container (red needle container) attached to the medication cart.</p> <p>At that time, the LPN stated she did not have a drug disposal solution (bottle of solution used to disintegrate pills and tablets) in the medication cart, "ours is in the medication room". The LPN also stated that she was oriented to dispose medications into the red needle container.</p> <p>On 1/26/23 at 11:19 AM, during an interview with the surveyor, the RN/UM stated that disposal of all medications such as dropped or refused, were to be placed into the drug disposal solution which was located-in the medication room. It was expected that the nurse would walk to the medication storage room to dispose of medications. The RN/UM informed the surveyor that the red needle containers were specifically for needles.</p> <p>On 1/27/23 at 10:06 AM, in the presence of the survey team and the Licensed Nursing Home Administrator (LNHA), the DON stated she had spoken with the LPN for Resident #245. She was informed that the LPN was aware that <b>NJ Exec. Order 26:4.b.1</b> should have been disposed in the drug disposal solution located in the medication storage room but did not want to leave the medication cart unattended.</p> <p>At that time, the DON stated that a drug disposal solution was usually in the medication cart and the LPN recognized her error in disposing of the medication in the red needle container.</p> | F 755   |   |                      |   |

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| F 755   | Continued From page 9<br><br>A review of the facility provided policy, Storage of Medications with an effective date of 6/8/15, included:<br>Purpose: To properly store medication and accept properly labeled medication from the pharmacy to assure compliance with state and federal regulations.<br>Policy: The facility shall store all drugs and biologicals in a safe, secure and orderly manner.<br>Procedure:2. The nursing staff shall be responsible for maintaining medication storage AND [and] preparation areas in a clean, safe ...<br>8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems<br><br>A review of the facility provided policy, Destruction/Disposal of Medications with an effective date 9/29/20, included:<br>Purpose: To ensure medications no longer in use are disposed of<br>Policy: Medications are disposed of or returned to the Pharmacy<br>Procedure: 2. Non- scheduled medications are packed in the medication room for return to the pharmacy. The return form is completed and place in the envelope with the medications.<br>3. Scheduled medications are placed in the [name redacted; drug disposal solution] by 2 [two] nurses ... | F 755   |   |                      |   |
| F 760<br>SS=D   | NJAC 8:39- 29.2(d), 29.4 (f) (g)<br>Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant   | F 760   |   | 2/10/23              |   |

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| F 760   | <p>Continued From page 10 medication errors.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure medication administration without significant error when the surveyor observed two nurses administer 25 doses to six residents. The deficient practice was identified for one of six residents, Resident #245 as evidenced by the following:</p> <p>On 1/25/23 at 9:25 AM, the surveyor observed the Licensed Practical Nurse (LPN) preparing medications for Resident #245 in the following order:<br/><b>NJ Exec. Order 26:4.b.1</b><br/>[REDACTED]</p> <p>On 1/25/23 at 9:33 AM, the LPN confirmed she had seven medications in the unit dose cups and stated she was ready to administer the medication to Resident #245. The LPN walked toward Resident #245 for administration.</p> <p>At that time, the surveyor stopped and requested for the LPN to return to the medication cart. The surveyor and the LPN reviewed the electronic Medication Administration Record (eMAR) together against the bingo cards (blister packet</p> | F 760   | <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> <li>- 1/27/2023, Unit Manager conducted a med pass audit and education with nurse.</li> <li>- 1/26/2023, DON educated nurse on the "Rights of medication administration"</li> </ul> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <ul style="list-style-type: none"> <li>- While there is the potential that all residents could be affected, none were affected. Below are the actions that were taken to prevent it from occurring in the future.</li> <li>- On 1/30/2023, DON, Unit Manager, and RN Supervisor completed 100% education and med pass competency for all SNF nurses regarding "Right medication administration", completed 2/10/2023.</li> <li>- On 1/30/2023, DON and Unit Manager audited resident bingo cards from the pharmacy and identified 10 residents with bingo cards from pharmacy with the same medication but different administration times. As a result, no resident was affected.</li> </ul> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <ul style="list-style-type: none"> <li>- All newly hired nurses will have a</li> </ul> |                      |   |

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| F 760   | <p>Continued From page 11</p> <p>which contained the medications). The eMAR revealed one order of <b>NJ Exec. Order 26:4.b.1</b> [redacted] with an administration schedule of 9:00 AM and 5:00 PM.</p> <p>During review of the bingo cards, the LPN stated she had 2 different bingo cards of <b>NJ Exec. Order 26:4.b.1</b> for Resident #245. One of <b>NJ Exec. Order 26:4.b.1</b> bingo cards had 29 tablets remaining and the other <b>NJ Exec. Order 26:4.b.1</b> bingo card had 17 tablets remaining. The LPN stated she should have dispensed only 1 tablet of the <b>NJ Exec. Order 26:4.b.1</b> tablet from one of the two bingo cards. The LPN acknowledged it was her error.</p> <p>A review of the Face Sheet reflected Resident #245 was admitted to the facility on <b>NJ Exec. Order 26:4.b.1</b> with diagnoses which included <b>NJ Exec. Order 26:4.b.1</b> [redacted].</p> <p>A review of the Physician's Orders Sheet revealed an order dated <b>NJ Exec. Order 26:4.b.1</b> for <b>NJ Exec. Order 26:4.b.1</b> tablet (1 tablet) oral <b>NJ Exec. Order 26:4.b.1</b> [redacted] scheduled at 9:00 AM and 5:00 PM</p> <p>A review of the Medication Administration Record revealed there were 13 doses of <b>NJ Exec. Order 26:4.b.1</b> administered from <b>NJ Exec. Order 26:4.b.1</b> to 9:00 AM of <b>NJ Exec. Order 26:4.b.1</b> and the administration commenced on <b>NJ Exec. Order 26:4.b.1</b>.</p> <p>On 1/27/23 at 9:53AM, in the presence of the survey team and the Licensed Nursing Home Administrator (LNHA), the DON stated she had spoken with the LPN regarding the medication administration for Resident #245. The LPN explained to her that she would have went over the medications individually with the resident and would have noticed the duplicate <b>NJ Exec. Order 26:4.b.1</b> in the dosing cup.</p> | F 760   | <p>competency med pass audit done prior to being released on the cart, monthly med audits done until three months of success of no more than 5% error and semiannual audits will be conducted on all remaining nurses.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and</p> <ul style="list-style-type: none"> <li>- The DON or Nurse Management will complete two random med pass audit weekly times one month, bi-weekly times one month, and monthly thereafter on completing a med pass. The DON will report audit findings monthly to the QAPI team for review.</li> </ul> |   |

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| F 760   | Continued From page 12<br><br>A review of the facility provided policy, Medication Administration Overview effective 9/29/22, included:<br>Policy: Medications will be administered to residents as prescribed ...<br>Administration: 2. Medications are administered in accordance with written orders of the attending physician or physician extender.   | F 760   |   |                      |   |
| F 812<br>SS=D   | NJAC 8:39-11.2(b), 29.2(d)<br>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review | F 812   | Address how corrective action will be   | 2/10/23              |   |

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| F 812   | <p>Continued From page 13</p> <p>and policy review, it was determined that the facility failed to a.) failed to sanitize and air dry steam table pans in a manner to prevent microbial growth and b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following:</p> <p>On 1/23/23 at 10:30 AM, in the presence of the Registered Dietitian, General Manager (GM) and the Vice President of Culinary Services, the surveyor observed the following:</p> <ol style="list-style-type: none"> <li>In the food preparation area, on metal dishware drying shelving unit, the surveyor observed five half sized steam table pans and eight quarter sized pans which were stacked with water between them.</li> <li>On a shelf in the dairy walk in fridge the surveyor observed a half empty bag of salami with an open date of 1/10/23 and the GM stated that this item should be discarded after 5 days.</li> <li>In the dry storage area, the surveyor observed a random sampling of dented cans which were in rotation for use. The surveyor observed the following: <ul style="list-style-type: none"> <li>- A #10 sized can of peaches with a 2-inch sized dent on the body of the can,</li> <li>- A #10 sized can of peaches with a 4-inch sized dent on the upper lip of the can,</li> <li>- A #10 sized can of baked beans with a 1-inch sized dent on the upper lip of the can,</li> <li>- A #10 sized can of apple slices with a 2-inch sized dent on the upper lip of the can,</li> <li>- A #10 sized can of mandarin oranges with a</li> </ul> </li> </ol> | F 812   | <p>accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> <li>- 1/23/2023, General Manager corrected wet nesting by having the dishes rewashed, dented cans where moved out of circulation, and threw away pepperoni that wasn't labeled with a date/</li> <li>- 1/23/2023, Dietary staff was reeducated on wet nesting, dented cans, and dating and labeling by General Manager</li> </ul> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <ul style="list-style-type: none"> <li>- While there is the potential that all residents could be affected, none were affected. Below are the actions that were taken to prevent it from occurring in the future.</li> <li>- The General Manager completed audit on all other storage and labeled food items in kitchen on 1/23/2023.</li> <li>- General Manager completed audit of all pot and pans throughout the kitchen for wet nesting and had all washed again properly on 1/23/2023.</li> <li>- 1/23/2023, 100% of Dietary staff was reeducated on proper drying procedures, the procedure for removal of dented cans from active storage and dating and labeling by General Manager.</li> </ul> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <ul style="list-style-type: none"> <li>- Dietary Managing supervisors and managers were reeducated on proper</li> </ul> |                      |   |

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| F 812   | Continued From page 14<br>6-inch sized dent on the entire side of the can,<br><br>On 1/23/23 at 12:31 PM, the surveyor discussed the kitchen concerns with the facility Administrator and Director of Nursing.<br><br>The surveyor reviewed the Sanitizing of Equipment policy and procedure, which revealed that kitchen equipment will be air dried.<br><br>NJAC 8:39-17.2(g)  | F 812   | closing and opening of the kitchen to include using the opening and closing checklists.<br>- Nutrition Management Services Company added checking for proper drying and the need to remove dented cans from active storage to the Opening and Closing checklist on 1/24/2023, the checklist is completed daily by dietary management.<br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and<br>- The General Manager will complete a random audit weekly times one month, bi-weekly times one month, and monthly thereafter for proper opening and closing the kitchen. General Manager will report audit findings monthly to the QAPI team for review. |                      |   |
| F 880<br>SS=D   | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, | F 880   |  | 2/10/23              |   |

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| F 880   | <p>Continued From page 15</p> <p>reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the</p> | F 880   |   |                      |   |

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| F 880   | <p>Continued From page 16<br/>corrective actions taken by the facility.</p> <p>§483.80(e) Linens.<br/>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.<br/>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate measures to prevent and control the spread of infection for failure to properly wear personal protective equipment (PPE) while entering a resident's room who was on droplet precautions. The deficient practices were evidenced by the following:<br/><br/>On 1/24/23 at 12:20 PM, the surveyor observed a Certified Nursing Assistant (CNA) at the door of a resident who was on transmission-based droplet precautions. The CNA donned (put on) a disposable gown and had a KN95 mask on her face and no eye protection or gloves. The CNA took the resident's lunch tray, opened the door and entered the resident's room. The CNA then closed the door and approximately one minute later she opened the resident's door, removed her gown and washed her hands.<br/><br/>At 12:25 PM, the surveyor interviewed the CNA, who stated that she should have worn an N95 mask and eye protection in addition to the gown. She stated that she put gloves after entering the residents room. The CNA stated that she did not wear eye protection or the N95 as she was just</p> | F 880   | <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br/>         √ 1/24/2023, CNA, was reeducated and competency checklist was conducted by DON on expectation for PPE donning and doffing going into an isolation room and using droplet precautions<br/>         √ 1/24/2023, CNA, was given a corrective action by DON &amp; HR regarding not complying with facility P&amp;P<br/>         Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br/>         " 100% competency checklist and education will be conducted on all staff serving in the health center by Nurse Management, to be completed by 2/10/2023 for Donning and Doffing PPE<br/>         Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br/>         " During Management rounds at mealtime, an observation item was added to check compliance with donning and</p> |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>LUTHERAN SOCIAL MINISTRIES CRANES MILL</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>459 PASSAIC AVENUE<br/>WEST CALDWELL, NJ 07006</b>   |                      |   |
| (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 17<br>going into the room to drop off the resident's tray.<br><br>On 1/24/23 at 1:45 PM, the surveyor discussed the above concerns with Administrator and Director of Nursing.<br><br>NJAC 8:39-19.4 (a) | F 880   | doffing of PPE when entering the room of a resident on isolation.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and<br>↳ DON/Unit Management will complete random three audits weekly for one month, bi-weekly for one month, and monthly thereafter for compliance with donning and doffing of PPE. DON will report audit findings monthly to the QAPI team for review until 100% compliance times three months. |                      |   |

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>306300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>01/27/2023</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>LUTHERAN SOCIAL MINISTRIES CRANES MILL</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>459 PASSAIC AVENUE<br/>WEST CALDWELL, NJ 07006</b> |
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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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| S 000              | Initial Comments<br><br>THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.   | S 000         |   |                    |
| S 560              | 8:39-5.1(a) Mandatory Access to Care<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following:<br><br>Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. | S 560         | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br>- Education was provided to Director of Nursing and Health Center Coordinator regarding NJ staffing requirements by the Executive Director 1/27/2023. All residents received care from a CNA or LPN during the one shift with the call off when the facility was unable to get a replacement. The facility will continue to hire PRN staff to assist with this process, but staff cannot | 2/3/23             |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

02/09/23

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>306300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>01/27/2023</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>LUTHERAN SOCIAL MINISTRIES CRANES MILL</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>459 PASSAIC AVENUE<br/>WEST CALDWELL, NJ 07006</b> |
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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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| S 560              | <p>Continued From page 1</p> <p>Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.</p> <p>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:</p> <p>(1) one certified nurse aide to every eight residents for the day shift;</p> <p>(2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and</p> <p>(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties</p> <p>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.</p> | S 560         | <p>work sick.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <ul style="list-style-type: none"> <li>- While there is the potential that all residents could be affected, none were affected. Below are the actions that were taken to prevent it from occurring in the future.</li> <li>- Healthcare Center Coordinator will call and post to staffing agencies to secure a CNA to fill the position. If we are unable to secure a CNA through the agency the facility LPN staff will be assigned assisted with care of the residents.</li> </ul> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <ul style="list-style-type: none"> <li>- We schedule sufficient staff daily to meet or exceed the CNA required ratio. In the event of an unexpected CNA call out, we will call per diem staff, contact contracted agencies, and/or pull from internal staff in other qualified roles.</li> </ul> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and</p> <ul style="list-style-type: none"> <li>- The Administrator will complete audit daily times 2 weeks, weekly times 1.5 month, and monthly thereafter for sufficient ratio for NJ CNA requirement. The Administrator will report audit findings monthly to the QAPI team for review until 100% compliance times 3 months.</li> </ul> |                    |

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>306300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>01/27/2023</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>LUTHERAN SOCIAL MINISTRIES CRANES MILL</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>459 PASSAIC AVENUE<br/>WEST CALDWELL, NJ 07006</b> |
|---|--|

| (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              | <p>Continued From page 2</p> <p>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...</p> <p>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 1/8/23 and 1/15/23 revealed the following:</p> <p>The facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows:</p> <p>-01/12/23 had 4 CNAs for 42 residents on the day shift, required 5 CNAs.</p> | S 560         |   |                    |

## POST-CERTIFICATION REVISIT REPORT

|  |    |   |  |                             |    |
|--|----|---|--|-----------------------------|----|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>315457 | Y1 | MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing | Y2   | DATE OF REVISIT<br>3/2/2023 | Y3 |
| NAME OF FACILITY<br>LUTHERAN SOCIAL MINISTRIES CRANES MILL   |    |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>459 PASSAIC AVENUE<br>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<br>Y4             | DATE<br>Y5 | ITEM<br>Y4                      | DATE<br>Y5 | ITEM<br>Y4          | DATE<br>Y5 |
|------------------------|------------|---------------------------------|------------|---------------------|------------|
| ID Prefix F0695        | Correction | ID Prefix F0755                 | Correction | ID Prefix F0760     | Correction |
| Reg. # 483.25(i)       | Completed  | Reg. # 483.45(a)(b)(1)-(3)      | Completed  | Reg. # 483.45(f)(2) | Completed  |
| LSC                    | 02/03/2023 | LSC                             | 02/10/2023 | LSC                 | 02/10/2023 |
| ID Prefix F0812        | Correction | ID Prefix F0880                 | Correction | ID Prefix           | Correction |
| Reg. # 483.60(i)(1)(2) | Completed  | Reg. # 483.80(a)(1)(2)(4)(e)(f) | Completed  | Reg. #              | Completed  |
| LSC                    | 02/10/2023 | LSC                             | 02/10/2023 | 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 <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE  | SIGNATURE OF SURVEYOR | DATE |
| REVIEWED BY CMS RO <input type="checkbox"/>       | REVIEWED BY (INITIALS) | DATE  | TITLE                 | DATE |
| FOLLOWUP TO SURVEY COMPLETED ON<br>1/27/2023      |                        | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> |                       |      |

**STATE FORM: REVISIT REPORT**

|  |  |                             |
|--|--|-----------------------------|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>306300 | MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | DATE OF REVISIT<br>3/2/2023 |
| NAME OF FACILITY<br>LUTHERAN SOCIAL MINISTRIES CRANES MILL   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>459 PASSAIC AVENUE<br>WEST CALDWELL, NJ 07006 |                             |

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<br>Y4         | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 |
|--------------------|------------|------------|------------|------------|------------|
| ID Prefix S0560    | Correction | ID Prefix  | Correction | ID Prefix  | Correction |
| Reg. # 8:39-5.1(a) | Completed  | Reg. #     | Completed  | Reg. #     | Completed  |
| LSC                | 02/03/2023 | 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        |            |
| ID Prefix          | Correction | ID Prefix  | Correction | ID Prefix  | Correction |
| Reg. #             | Completed  | Reg. #     | Completed  | Reg. #     | Completed  |
| LSC                |            | LSC        |            | LSC        |            |

|   |                        |      |                       |      |
|---|------------------------|------|-----------------------|------|
| REVIEWED BY STATE AGENCY <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
| REVIEWED BY CMS RO <input type="checkbox"/>       | REVIEWED BY (INITIALS) | DATE | TITLE                 | DATE |

FOLLOWUP TO SURVEY COMPLETED ON 1/27/2023

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

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

PRINTED: 05/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>315457</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>01/27/2023</b> |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LUTHERAN SOCIAL MINISTRIES CRANES MILL</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>459 PASSAIC AVENUE<br/>WEST CALDWELL, NJ 07006</b>                  |                      |   |
| (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<br><br>An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/25/23. The facility was found to be in compliance with 42 CFR 483.73.  | E 000   |   |                      |   |
| K 000   | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/25/23 and was found to be in 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.<br><br>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 does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 43 of 56. | K 000   |   |                      |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/01/2023

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.