STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	**4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ #: 157448, 158079, 162538, 162579, 163502 STANDARD SURVEY: 11/17/2023 CENSUS: 94 SAMPLE SIZE: 19 + 2 closed records 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 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the	F 576		12/10/23

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

Electronically Signed | 12/01/2023

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.

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F 576	Continued From page 1 facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide mail delivery services on Saturdays for residents who resided in the facility. The deficient practice was identified for 5 of 5 residents, (Resident #12, #39, #41, #63, and #72) interviewed during the Resident Council Facility Task (a meeting with residents). The deficient practice was evidenced by the following: On 11/08/2023 at 10:33 AM, during the Resident Council Meeting, the surveyor interviewed	F 576	1. The facility can not retroactively correct the deficient practice of delayed mail delivery to residents #12,#39,#21,#63,#72.A new mailbox was mounted by the facility at 12 Moore Rd to separate facility mail from county mail. USPS was notified to forward all residents' mail to 12 Moore Rd and discontinue the previous practice of sending the residents mail to 4 Moore Rd. 2. All residents have the potential to be affected by the deficient practice. Activities department initiated a log to	

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F 576	Continued From page 2 Residents #12, #39, #41, #63, and #72 regarding mail delivery services. The five residents reported that the mail was not delivered on Saturdays. On 11/08/2023 at 12:45 PM, during an interview with the surveyor, the Director of Activities stated that residents' mail was delivered to the administrative building (building at a different location from the facility) where it got sorted. Then, an activity person picked up the mail and delivered it to the residents. During the same interview, the Activity Aide who was also present in the room, stated that letters were not delivered on Saturdays and Sundays because the administrative building was only opened from Monday through Friday. On 11/09/2023 at 11:34 AM, during an interview with the surveyor, the Administrator stated that residents' mail was delivered and sorted at another county building (the administrative building), and that they did not work on the weekends. A review of the facility policy titled, "Opening Facility Mail," dated 10/14, did not address residents' mail delivery on Saturdays. N.J.A.C. 8:39-4.1(a)(19)	F 576	record the delivery of all resident mail received by facility. 3. All resident mail will be sent directly to facility to avoid sorting process delay in county office. Receptionist will sort resident mail for activity department to distribute that day. All receptionist and Activites Staff in-serviced on new process on 12/1/23. 4. Administrator or designee will audit the mail received on weekends for 4 weeks and then Monthly for 2 months to ensure that all resident mail received on weekends gets delivered to the resident that day. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		12/10/23

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F 610	Continued From page 3 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate an accident/incident for 3 of 6 residents (Resident #22, #55, and #78) reviewed for accident/incidents. This deficient practice was evidenced by the following: 1.) On 11/03/23 at 10:23 AM, during the initial tour, the surveyor observed Resident #22 sitting in a wheelchair in their room. Resident #22 stated that he/she did not have any complaints about the facility. The surveyor reviewed the medical records for Resident #22. According to the Resident Face Sheet, Resident #22 was admitted with diagnoses that included *Ex Order 26. 4B1* [redacted] A review of the quarterly Minimum Data Set	F 610	1. The report and investigation for Resident #22□s *Ex Order 26. 4B1*, and Residents #55 & #78□s *Ex Order 26. 4B1* could not be retroactively completed due to the passage of time. A full body assessment and *Ex Order 26. 4B1* consultation were performed for resident #55 and *Ex Order 26. 4B1* [redacted] were obtained and implemented for the *Ex Order 26. 4B1*. *Ex Order 26. 4B1* and Kardex were updated. A full body assessment was performed for resident #78 and *Ex Order 26. 4B1* were obtained and implemented for the *Ex Order 26. 4B1*. *Ex Order 26. 4B1* and Kardex were updated. 2. All residents who experience an incident or accident are at risk of being affected by the deficient practice. Accident and incident files were reviewed to ensure that proper investigations were completed. 3. All Nursing staff were re-in-service on facility policies on investigating and reporting accidents and incidents by 12/8/23. All new nursing staff will receive in-service upon hire.	

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F 610	Continued From page 4 (MDS), an assessment tool utilized to facilitate care, dated [redacted], included the resident had a [redacted] score of [redacted] out of 15, which indicated the resident's cognition was [redacted]. A review of the Care Plan (CP), start date on [redacted], included the resident was at risk for [redacted] r/t [related to] decreased [redacted], poor safety awareness with an approach to conduct a [redacted] per protocol. A review of the Progress Notes (PN) from August 2023 revealed the following: [redacted] 10:34, the Registered Nurse (RN) was called into the resident's room for assessment due to [redacted]. The RN noted a negative [redacted] result from [redacted] earlier in the week. The RN was unable to remove the resident's [redacted] to assess, due to the resident's refusal. [redacted] medication was administered. The Certified Nursing Assistant (CNA) assisted the resident with [redacted] and noticed a [redacted] on the resident's [redacted]. The RN was called back in the resident's room and noted [redacted] had a [redacted] with a [redacted] noted in entire [redacted] area. Resident #22 was sent out to the [redacted] to rule out (r/o) [redacted] or [redacted] - [redacted] 18:46 (6:46pm), Resident #22 returned to the facility, included [redacted] to the [redacted] remains the same.	F 610	All Nursing staff will be re-in-service on facility policies for [redacted]. 4. DON or Designee will review 3 Accident/Incident reports weekly for 4 weeks and then monthly for 2 months to ensure facility policies on investigating and reporting accidents and incidents are being followed. DON or Designee will review 3 skin assessments weekly for 4 weeks and then monthly for 2 months to ensure facility policy on [redacted] are being followed. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed	

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F 610	Continued From page 5 [NJ Exec. Order 26:4.b.1] 12:16, [Ex Order 26. 4B1] noted to [Ex Order 26. 4B1], excessive [Ex Order 26. 4B1] noted. [NJ Exec. Order 26:4.b.1] 06:33, [Ex Order 26. 4B1] to back of [Ex Order 26. 4B1] continues. [NJ Exec. Order 26:4.b.1] 06:15, observed [Ex Order 26. 4B] at the [Ex Order 26] . On 11/06/23 at 10:48 AM, the surveyor requested any accident and incident reports for Resident #22. On 11/08/23 at 10:07 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), again, any accident and incident reports for Resident #22. On 11/08/23 at 10:51 AM, the surveyor observed Resident #22 in his/her room sitting in a wheelchair watching tv. Resident #22 stated that he/she did not remember having any [Ex Order 26. 4B1] on their [Ex Orde] but that they were doing okay. Resident #22 stated that the care was good and that anything he/she needed that the staff assisted. On 11/08/23 at 11:05 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1) who stated that Resident #22 was on [Ex Order 26. 4B1] . LPN #1 stated that [NJ Exec. Or] were documented on the "paper chart" on the resident's shower days which were twice a week. The surveyor asked LPN #1 what the process was if a resident obtained a [Ex Order 26. 4B] from an unknown origin and LPN #1 stated that for an unknown [Ex Order 26. 4B] they would have completed an incident report that went back for 72 hours. She further stated they obtained statements from the staff within the past 72 hours	F 610		

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F 610	Continued From page 6 that cared for or had seen the resident. She then stated that the statements went to the Unit Manager (UM) which were then discussed during the morning meeting with the administrative team, and that the physician and the family were notified. LPN #1 reiterated the protocol for an unknown [Ex Order 26. 4B] included to write up an incident report to investigate on how it occurred. On 11/08/23 at 12:25 PM, the Director of Nursing (DON) stated that the incident report was completed but that she was still trying to find it. On 11/09/23 at 10:03 AM, the DON stated that she still had not found the incident report. At that time, the surveyor inquired about the [Ex Order 26. 4B] that was documented in the PN. The DON stated that she could not recall at that time about the [Ex Order 26. 4B]. On 11/09/23 at 10:29 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that if she observed a [Ex Order 26. 4B] on the resident or it was something new, she would inform the nurse. She stated that she would have had to write a statement on what she saw or what the resident was doing during the last time she saw the resident, and if it was witnessed or not. CNA #1 stated that once the statement was completed she gave it to the nurse. On 11/13/23 at 12:03 PM, the surveyor interviewed LPN #2 who stated that the [Ex Order 2] assessments were in the medication administration record (MAR) and treatment administration record (TAR) which was signed on the shower days. LPN #2 stated that if there was something new then a progress note would have been written. The surveyor asked what the process for NJ Exec. Order 26:4.b.1 origins such as	F 610		

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Ex Order 26. 4B1 were and LPN #2 stated that if there was a Ex Order 26. 4B of an unknown origin then they would investigate and complete written statements that would go back three (3) days. She further stated that in the 3 day look back period, it included statements from whomever cared for the resident such as the aide, the nurses, as well as any staff member that may have seen the resident. LPN #2 stated that once the statements were completed that they were then given to the supervisor to be reviewed. LPN #2 stated it was important that a thorough investigation was completed so that the cause of the Ex Order 26. 4B would have been identified and then it would have been determined how to fix the problem based on what happened. LPN #2 stated that she cared for Resident #22 a few times but was not aware of any Ex Order 26. 4B1 back in August.

On 11/13/23 at 12:13 PM, LPN #2 and the surveyor reviewed the PN in the electronic medical record (EMR) from NJ Exec. Order 26 10:34, which reflected the Ex Order 26. 4B1. She stated that an incident report should have been completed because "we don't know what caused it and it looked unwitnessed."

On 11/13/23 at 12:25 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that she did recall the incident but did not know if there were statements. She stated that the statements should have been completed as the nurse normally completed them, but again reiterated, she was not sure if it was done since she could not find them. The ADON stated that a completed incident report was important because it ensured the resident was being taken care of and for the health and safety of the resident. She explained it

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was a communication tool for our staff to discuss what occurred and to brainstorm new interventions. The ADON stated that she knew the DON had looked to see if the incident reports were done but would look for the incident report and the 24-hour report related to the [Ex Order 26. 4B].

On 11/13/23 at 12:44 PM, in the presence of the survey team, the ADON confirmed that if the [Ex Order 26. 4B] was of an unknown origin, then an incident report should have been completed and that she would continue to look for the incident report.

On 11/14/23 at 09:00 AM, in the presence of the survey team, the DON stated that an investigation was not completed and acknowledged it should have been done. She further stated that "it was a learning experience and a good opportunity to educate the staff".

On 11/14/23 at 01:05 PM, in the presence of the survey team, the DON stated the incident report should have been completed because it was important to know what happened and how an injury occurred. She further stated that after surveyor inquiry she educated the staff to ensure that an investigation was completed each time.

On 11/15/23 at 10:12 AM, in the presence of the survey team, the ADON stated that during the assessment she looked at various reasons as to what may have caused the incident, which was the reason for completing an investigation. She further stated that Resident #22 tried to be independent as much as possible and liked to do things for themselves and would not always ask for help. The ADON stated that she asked if an incident reporting sheet was done but further stated that she did not follow up to see if it was

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completed. The ADON stated that it was protocol to investigate and get statements for any injury of unknown origin and "it was my mistake that I did not follow up" with making sure an incident report was completed.

On 11/17/23 at 09:42 AM, in the presence of the survey team, the DON stated that it was important to investigate an injury of unknown origin to make sure abuse and neglect did not occur. She further stated that the only way to rule out abuse was to investigate it. The DON stated that it was important because it helped them track and care for the resident according to their needs.

2.) According to Resident #55's Face Sheet, the resident was admitted to the facility with the diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted].

A review of the quarterly MDS, dated NJ Exec. Order 26:4.b.1 [redacted] indicated that Resident #55 had Ex Order 26. 4B1 [redacted] and required NJ Exec. Order 26:4.b.1 [redacted] with Ex Order 26. 4B1 [redacted].

On 11/08/23 at 11:29 AM, the surveyor observed Resident #55 sitting in a reclining chair with his/her Ex Order 2 [redacted] hanging over the arm of the chair. The surveyor observed that the resident had Ex Order 26. 4B1 [redacted] and Ex Order 26. 4B1 [redacted] on the Ex Order 26. 4B1 [redacted]. The surveyor observed that one (1) Ex Order 26. 4B1 [redacted] on the Ex Order 26. 4B1 [redacted] had a Ex Order 26. 4B1 [redacted] intact. There was another Ex Order 26. [redacted] on the Ex Order 26. 4B1 [redacted] near the Ex Order 26. [redacted] that was undressed and a Ex Order 26. 4B1 [redacted] on the Ex Order 26. 4B1 [redacted]

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that was NJ Exec. Order 26:4.b.1. The surveyor observed that the resident had a Ex Order 26. 4B1 intact to the Ex Orde area. The resident was NJ Exec. Order 26:4.b.1 interviewed due to Ex Order 26. 4B1.

The surveyor reviewed the Treatment Administration Record (TAR) for November 2023 and there were no Ex Order 26. 4B1 for the Ex Order 2 openings on the residents Ex Order 26. 4B1 near the Ex Order 26. and the Ex Order 26. 4B1 area.

The surveyor reviewed the physician order sheet dated 11/02/23 and there was a physician's order for a Ex Order 26. 4B1 to the Ex Order 26. 4B1. The ordered indicated that the Ex Order 26. 4B1 was to be cleansed with Ex Order 26. 4B1, gently pat dry, cover with border Ex Order 26. 4B1, leave Ex Order 26. 4B1 in place until they fall off daily in14 days. The surveyor observed that the physician's order did not get transcribed onto the Treatment Administration Record (TAR) and there was no documentation that the treatment was being done.

On 11/08/23 at 11:53 AM, the surveyor interviewed CNA #2 who stated that she had been employed in the facility for five (5) years. CNA #2 stated that Resident #55 required total care with all aspects of Ex Order 26. 4 and was Ex Order 26. 4B1. CNA #2 stated that the resident required two person assist for transfers and bed Ex Order 26. 4B1. CNA #2 stated that the resident had Ex Order 26. 4B1 on the Ex Order 26. 4B1 area. She also added that the resident had Ex Order 26. 4B1 and opening on the Ex Order 26 .

On 11/08/23 at 01:03 PM, the surveyor,

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accompanied by the DON and ADON, all observed Resident # 55's [redacted]. Resident #55 was in the dayroom sitting up in the reclining chair. The DON and ADON both confirmed that the resident had [redacted] on the [redacted], the [redacted], and the [redacted]. They also confirmed that there were no treatments written in the TAR for any of these [redacted]. The DON and ADON also both confirmed that there were no [redacted] for the [redacted], [redacted] and [redacted]. The ADON stated that this was not acceptable and that a full body assessment would be performed and that [redacted] would be obtained for the [redacted].

The DON then explained that she received a verbal statement from the LPN, a full-time employee employed for many years, who identified that the resident had a [redacted] on the [redacted] on 11/02/23. The DON also stated that the LPN never initiated the incident/accident report and that the investigation into the cause of the [redacted] on the [redacted] was not conducted.

The DON also confirmed that there was no documentation in the resident's [redacted] regarding the [redacted], the [redacted] on the [redacted] nor the [redacted]. The DON also confirmed that investigations into these [redacted] were not conducted for the injuries of unknown origin. The DON explained that when the nurses performed [redacted] checks on 11/01/23, 11/04/23 and 11/08/23 that the nurse did not put in any codes and there was no documentation of any new [redacted]. She admitted that the nurse may have been signing the TAR and not actually looking at the resident's [redacted].

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	315294	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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F 610	Continued From page 12 On 11/13/23 at 09:30 AM, the DON approached the surveyor and explained to the surveyor that the Ex Order 26. 4B1 practitioner came in to see Resident #55 on 11/08/23 and that treatments were ordered for all the resident's Ex Order 26. 4B1 and that that all the Ex Order 26. 4B1 were documented on the resident's Ex Order 26. 4B1. She also stated that investigations would be conducted related to the Ex Order 26. 4B1 that were on the resident's Ex Order 26. 4B1, Ex Order 26. 4B1 and Ex Order 26. 4B1 and that the Resident's Ex Order 26. 4B1 would be updated to include all interventions to prevent further reoccurrence of Ex Order 26. 4B1. The surveyor reviewed the Ex Order 26. 4B1 practitioner's consult, dated 11/13/23, which indicated that the Ex Order 26. 4B1 Nurse Practitioner (NP) identified that the resident had Ex Order 2 located on the Ex Order 26. 4B1 1cm x 0.8 cm x 0.1 cm, right shin 0.5. x 0.4 x 0.1 cm, Ex Order 26. 4B1 2.4 cm x 0.3 cm x 0.1 cm and Ex Orde 0.9 cm x 1.2 cm x 0.1 cm. The NP documented that the resident had a Ex Order 26. 4B1 related to Ex Order 26. 4B1. Recommended preventing further Ex Order 2 injury by avoiding Ex Order 26. 4B1, careful handling during ambulation assistance and transfer, using Ex Order 26. 4B1, long sleeves, and pants when possible. On 11/14/23 at 11:20 AM, the DON explained the process for incident and accidents and conducting investigations. She stated that the incident/accident report was generated by the nurse that discovered the incident and an investigation would then have been conducted. She stated that the UM's responsibility was to review the report and ensure that treatments	F 610		

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F 610	Continued From page 13 were in place. The UM was also responsible to review the preventative interventions, update the Care Plan with new interventions, and update the CNA Kardex with the new interventions. On 11/15/23 at 12:48 PM, the surveyor interviewed the Medical Director who stated that he was employed by the facility for [NJ Exec. Order 26:4]. He stated that due to staff turnover and use of agency, it could complicate care and follow-through regarding resident care. 3.) A review of the resident Face Sheet (FS) indicated that Resident #78 was admitted to the facility with the diagnoses that included but was not limited to [Ex Order 26. 4B1]. The admission MDS, dated 08/30/23, indicated that the resident had [Ex Order 26. 4B1]. On 11/03/23 at 10:55 AM, during tour of the [Ex Order 26. 4 Unit, the surveyor observed Resident #78 sitting up in a reclining chair. The resident's eyes were closed, and he/she was not able to be interviewed due to [Ex Order 26. 4B1]. A [NJ Exec. Order 26:4.b.1] was observed on the [NJ Exec. Order 26:4.b.1] CNA #3 was tending to the resident at this time and was interviewed. CNA #3 stated that the resident had fallen last week. The surveyor reviewed the residents' medical records which indicated the following: The Progress Note (PN) dated 11/03/2023 at 22:30 (10:30 PM) indicated that Resident #78 was found with a [Ex Order 26. 4B1] to the [Ex Order 26. 4B1] and [Ex Order 26. 4B1]. The PN also indicated that a treatment was ordered, and the physician	F 610		

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F 610	Continued From page 14 and supervisor was made aware. The PN dated 11/04/2023 at 02:52 PM, a CNA identified that Resident #78 had a Ex Order 26. 4B1 with some NJ Exec. Order 26:4.b.1 on the resident's Ex Order 26. 4B1 while the resident was in the recliner outside of the nurses' station. The Ex Order 26. 4B1 measured 3.5 centimeters (cm) by 3 cm and a treatment was provided with Ex Order 26. 4B1 and Ex Order 26. 4B1 . A Ex Order 26. 4B1 was also applied. The PN indicated that the resident was NJ Exec. Order 26:4.b.1 in the recliner before the Ex Order 26. 4B1 was found and may have bumped Ex Order 26. 4B1 against the recliner. The PN also indicated that the resident had Ex Order 26. 4B1 that were on, but the Ex Orde one was pulled up on the Ex Orde towards the Ex Order 26. and was put back on Ex Order 26. 4B1 . The Treatment Administration Record (TAR) dated 11/03/23, reflected a physician's order to cleanse Ex Order 26. 4B1 on the Ex Order 26. 4B1 with Ex Order 26 and apply Ex Order 26. 4B1 and cover with a NJ Exec. Order 26:4.b.1 day for seven days. On 11/06/23 at 10:23 AM, the surveyor observed Resident #78 in a low bed with a mattress on the floor next to the bed. The resident was noted to be confused, had garbled speech, and was agitated. The resident had Ex Order 26. 4B1 on the Ex Order 26. 4B1 . The surveyor observed that the resident had Ex Order 26. 4B1 and Ex Order 26. 4B1 . The surveyor also observed a dressing on the Ex Orde . CNA #3 entered the room at that time and was interviewed. CNA #3 stated that the resident had a Ex Order 26. 4B1 on the Ex Order 26. 4B1 but did not wear Ex Order 26. 4B1 on Ex Order 26. 4B1 , just the Ex Order 26. 4B1 .	F 610		

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F 610	Continued From page 15 On 11/06/23 at 10:29 AM, the surveyor interviewed the LPN #3 who stated that she had been employed through the agency and had been coming to the facility for 22 years. The LPN described Resident #78 as NJ Exec. Order 26:4.b.1, and required complete care Ex Order 26. 4B1. LPN #3 stated that the resident's medications were changed last week for the Ex Order 26. 4B1. She also explained that the resident was Ex Order 26. 4B1 and required 1 staff member to transfer. She stated that the resident utilized the wheelchair (w/c) or the reclining chair when he/she got out of bed. She stated that the resident was NJ Exec. Order 26:4.b.1 and that the NJ Exec. Order 26:4.b.1 precautions in place which included: bed alarm, chair alarm, low bed, and a mattress on the floor next to Ex Orde bed (Ex Order 26. 4B1). LPN #3 stated that the resident's NJ Exec. Orde was very Ex Order 26. 4B1, and it did not take much for his/her Ex Order 2 to Ex Order 26. 4B1 or develop a Ex Order 26. 4B1. LPN #3 stated that the protective preventive measures to protect the resident's Ex Order 2 included Ex Order 26. 4B1 on the resident's Ex Order 26. 4B1 and moisturizer. LPN #3 stated that the resident did not wear any Ex Order 26. 4B1 on his/her Ex Order 26. 4B1 and did not have any response as to why there were no protective measures for Resident #78's Ex Order 26. 4B1 on the Ex Order 26. 4B1. The LPN stated that she was not sure if an incident or accident report was completed when the resident developed the Ex Order 26. 4B1 on 1 NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 The DON admitted that she was not aware that Resident #78 had developed Ex Order 26. 4B1 on the Ex Orde and Ex Order 26. 4B1 on NJ Exec. Order 26:4.b.1 and on the Ex Order 26. 4B1 on NJ Exec. Order 26:4.b.1. The DON explained that she did not think that any incident or accident reports were completed when	F 610		

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F 610	Continued From page 16 Resident #78 developed the Ex Order 26. 4B1 on NJ Exec. Order 26:4.b.1. She stated that she would find out what happened and maybe the incident reports were on the unit. The DON indicated that it would have been important to ensure that preventive/protective measures were put in place to prevent the reoccurrence of [redacted] on the resident's Ex Order 26. 4B1. She stated that protective or preventive measure should have been documented on the CNA Kardex and the Ex Order 26. 4B1. The DON confirmed that the resident's CP and CNA Kardex were not updated with any new interventions to prevent the reoccurrence of Ex Order 26. 4B1 on Resident #78's [redacted]. On 11/13/23 at 12:36 PM, the DON provided the surveyor with incident reports for Resident #78's Ex Order 26. 4B1 that were found on NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1. She stated that the incident reports were sitting on the UM's desk and have not yet been investigated. She stated that the acting UM told her that she did not know what to do with the incident reports and that she was going to give them to the DON during the morning meeting but never did. The DON admitted that interventions were not implemented to protect the resident from further injury after the discovery of the [redacted] on the Ex Order 26. 4B1 and the back of the [redacted] on 1[redacted] and after the discovery of the Ex Order 26. 4B1 on the Ex Order 26. 4B1 on NJ Exec. Order 26:4.b.1. On 11/17/23 at 09:49 AM, in the presence of the survey team, the DON stated that she tried to investigate the Ex Order 26. 4B1 after the fact and the information she had received was that the incident report did not make it to a supervisor or UM for review. She stated that there was an oversite related to a communication breakdown.	F 610		

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F 610	Continued From page 17 A review of the facility's policy titled, "Skin Report Worksheet," revised 04/2013, included, 2. The CNA Skin Report Worksheet is to be completed by the CNA at the time care is rendered and when that CNA observes a possible skin integrity concern. A review of the facility's policy titled, "Skin Integrity Log: Impaired," revised 05/2015, included, "To provide documentation and follow up of resident skin impairments such as bruises. 1. An Impaired Skin Integrity Log is to be initiated whenever new skin impairment is noted, other than a pressure sore. 7. Bruises will be assessed weekly for 2 weeks." A review of the facility's policy titled, "Accident/Incident - Residents, Employees, Visitors and Agency Staff," revised 10/2021, included, "1. Reporting of Accident or Incidents: a. Regardless of how minor an accident or incident may be, it must be reported to the Department Supervisor, and the appropriate Accident/Incident Report form must be completed on the shift that the accident or incident occurred. 4. Investigative Action: a. The Nursing Supervisor or Department Supervisor must conduct an immediate investigation of the accident or incident and thoroughly complete the appropriate Incident/Accident Investigation Report. B. In completing any of the Accident/Injury Reports all witnesses and pertinent person(s) statement's must be obtained and attached. All completed Accident/Injury Reports, along with any documentations obtained, must be forwarded to the Director of Nurses Office as soon as possible".	F 610		

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F 610	Continued From page 18 A review of the facility's policy titled, "Investigating Unexplained Injuries," revised 09/2015, included, 1. Should a resident be observed with unexplained injuries (injuries of unknown source), the staff nurse must complete an Accident/Incident form and record such information into the resident's clinical record. 3. The Investigation will follow the protocols set for the facility's established investigational guidelines. On 11/15/23 at 12:32 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he could not provide the facility's established investigational guidelines that were stipulated in the policy titled, "Investigations of Unexplained Injuries".	F 610		
F 684 SS=E	NJAC-8.39-4.1(a)5 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to follow professional standards of practice	F 684	1. Facility is unable to retroactively correct the deficient practice of obtaining orders and following procedures for Ex Order 26. 4B1 for Residents #55 & #195. A	12/10/23

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F 684	Continued From page 19 for 2 of 19 residents (Resident #55 and # 195) by not a.) obtaining physicians' orders for treatments for (Resident #55 and #195), b.) providing treatments as ordered by a physician (Resident #55), c.) accurately assessing a resident's [redacted] during weekly [redacted] (Resident #55), d.) implementing interventions to protect a resident's [redacted] identified as having [redacted] (Resident #55) and e.) accurately assessing a resident's [redacted] during a admission physical (Resident #195). This deficient practice was evidenced by the following: 1.) According to Resident #55's Face Sheet, the resident was admitted to the facility with the diagnoses which included but was not limited to [redacted] The quarterly [redacted] an assessment tool that facilitates care dated [redacted], indicated that Resident #55 had [redacted] and required [redacted] to assistance with [redacted]. On 11/08/23 at 11:29 AM, the surveyor observed Resident #55 sitting in a reclining chair with his/her legs hanging over the arm of the chair. The surveyor observed that the resident had multiple small [redacted] and openings on the [redacted]. The surveyor observed that one (1) [redacted] on the [redacted] had a [redacted] intact. There was another small [redacted] on the [redacted] near the [redacted] that was undressed and a [redacted] on the [redacted]	F 684	full body assessment and [redacted] consultation were performed for resident #55 and [redacted] were obtained and transcribed for the [redacted]. [redacted] and Kardex were updated. A full body assessment and [redacted] consultation were performed for resident #195 and [redacted] were obtained and transcribed for the [redacted]. [redacted] and Kardex were updated. 2. All residents have the potential to be affected by this deficient practice. Facility reviewed the charts of all residents with known wounds to ensure that [redacted] were in place and documented in [redacted] Kardex, and [redacted]. 3. All Nursing staff were re-in-service on correct procedures for [redacted] and [redacted] healing by 12/8/23. All new nursing staff with be in-serviced upon hire. All Nurses were re-in-service on the importance of and process on documenting and following [redacted], implementing interventions, updating [redacted], and updating Kardex by 12/8/23. All new nursing staff with be in-serviced upon hire. 4. DON or Designee will audit the charts of 3 resident with a known history of [redacted], weekly for 4 weeks and then monthly for 2 months to ensure that assessments, orders and treatments are accurately documented. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

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F 684	Continued From page 20	F 684		

that was undressed. The surveyor observed that the resident had a unsigned/undated [redacted] intact to the [redacted] and the area. The resident was [redacted] due to [redacted]. The surveyor did not observe any [redacted] in place to prevent the resident from developing any further [redacted].

The surveyor reviewed the Treatment Administration Record (TAR) dated [redacted], and observed that there were no [redacted] for the [redacted] openings on the residents [redacted] near the [redacted] or the [redacted] area.

The surveyor reviewed the physician order sheet dated [redacted] and there was a physician's order for a treatment order to the [redacted]. The ordered indicated that the [redacted] was to be cleansed with [redacted], gently pat dry, cover with [redacted], leave [redacted] in place until they fall off daily in14 days. The surveyor observed that the physician's order did not get transcribed onto the Treatment Administration Record (TAR) and there was no documentation that the treatment was being done.

The surveyor reviewed the Progress Note (PN) dated 1[redacted] at 07:18 AM, written by a Licensed Practical Nurse (LPN) that discovered the [redacted] on the [redacted]. The progress note indicated that a treatment was applied to the [redacted], however the note did not contain a description of the [redacted] or measurement of the [redacted].

On 11/08/23 at 11:53 AM, the surveyor interviewed the Certified Nursing Assistant (CNA)

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F 684	Continued From page 21	F 684		

who stated that she had been employed in the facility for [NJ Exec. Order 26:] years. The CNA stated that Resident #55 required [NJ Exec. Order 26:4.b.1] with all aspects of [Ex Order 26. 4] and was *Ex Order 26. 4B1* [redacted]. The CNA stated that the resident required NJ Exec. Order 26:4.b.1 for transfers and bed [Ex Order 26. 4B1]. The CNA stated that the resident had [Ex Order 26. 4B1] on the *Ex Order 26. 4B1* area and there was a dressing on the area. She also added that the resident had [Ex Order 26. 4B1] and [Ex Order 26. 4B1] on the *Ex Order 26. 4B1* but did not wear any *Ex Order 26. 4B1* or [Ex Order 26. 4B1] on the [Ex Order 26. 4B1] [redacted].

On 11/08/23 at 12:00 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that she worked for an outside agency. LPN #1 stated that the resident had [Ex Order 26. 4B1] and was [NJ Exec. Order 26:4.b.1] and requires total care and two persons assist with transfers and bed [Ex Order 26. 4B1]. LPN #1 stated that the only treatment that the resident had was for [Ex Order 2] [redacted] and that the resident did not have [Ex Order 26. 4B1] and the resident's [Ex Order 2] was intact. LPN #1stated that she did not receive any communication a in report about anything new happening with the resident. LPN #1 reviewed the Resident #55's TAR in the presence of the surveyor and confirmed that there were no treatment orders for the resident documented in the TAR. LPN #1 accompanied the surveyor to see the resident and confirmed that the resident had [Ex Order 26. 4B1] on the *Ex Order 26. 4B1* and the [Ex Order 26. 4B1] area. She stated that she would get the resident back to bed to examine the resident's [Ex Order 2]. LPN #1 reviewed the physician order sheet with the surveyor and confirmed that the treatment order for Resident #55's [Ex Order 26. 4B1] [redacted] should have been transcribed onto the TAR

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F 684	Continued From page 22	F 684		

to assure that the treatment was applied. The surveyor reviewed the TAR with LPN #1 who signed the TAR indicating she performed a [redacted] for the resident on [redacted], however the resident had *Ex Order 26. 4B1*. LPN #1 admitted that she signed the [redacted] that she performed a NJ Exec. Order 26:4.b.1 check but did not actually look at the resident's entire [redacted] and did not identify that the resident had *Ex Order 26. 4B1* on the *Ex Order 26. 4B1*, *Ex Order 26. 4B1*, *Ex Order 26. 4B1* and the *Ex Order 26. 4B1*.

On 11/08/23 at 12:14 PM, the surveyor interviewed LPN #2 who explained that when a nurse performed the weekly resident *Ex Order 26. 4B1*, the nurse would document a code on the TAR. The codes were as followed: *Ex Order 26. 4B1* [redacted], *Ex Order 26. 4B1* [redacted], and [redacted] see NJ Exec. Order 26:4.b.1 report. The surveyor observed that on the TAR there were only nurses' signature and no codes that indicated the skin was checked. LPN #2 reviewed the TAR with the surveyor and confirmed that the nurses who performed the *Ex Order 26. 4B1* for Resident #55 on NJ Exec. Order 26:4.b.1 [redacted] failed to document the code and therefore you could not tell by looking at the documentation if the resident developed a new [redacted] condition or not.

On 11/08/23 at 12:25 PM, the surveyor interviewed the Director of Nursing (DON) who stated that if the nurse received a treatment order for Resident #55's *Ex Order 26. 4B1* of the *Ex Order 26. 4B1*, the nurse must assure that the order was transcribed to the TAR so that the treatment got performed. The DON also stated that when the nurse performed the NJ Exec. Order 26:4.b.1 on [redacted], NJ Exec. Order 26:4.b.1 the nurse should have documented that the resident had *Ex Order 26. 4B1*

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F 684	Continued From page 23 Ex Order 26. on the Ex Order 26. 4B1, Ex Order 26. 4B1 and Ex Order 26. 4B1 area. The DON did not have a response as to how the nurses did not observe these Ex Order 26. 4B1 during their assessments of the resident's Ex Order 2. On 11/08/23 at 01:03 PM, the surveyor, accompanied by the DON and Assistant Director of Nursing (ADON) to observe Resident # 55 Ex Order 2. The surveyor observed Resident #55 sitting up in the dayroom sitting in the reclining chair. The DON and ADON both confirmed that the resident had Ex Order 26. 4B1 on the Ex Order 26. 4B1, the Ex Order 26. 4B1, and the Ex Order 26. 4B1. They also confirmed that there were no treatments written in the TAR for any of these Ex Order 26. 4B1. The ADON and DON had both reviewed the physician orders and both confirmed that there was a treatment order written for the Ex Order 26. 4B1 on the Ex Order 26. 4B1, however the treatment order was not transcribed to the TAR and therefore the treatment was never performed. The DON and ADON also both confirmed that there were no treatment orders for the Ex Order 26. 4B1, Ex Order 26. 4B1 and Ex Orde. The ADON stated that this was not acceptable and that a ful NJ Exec. Order 26:4.b.1 would be performed and that Ex Order 26. 4B1 will be obtained for the Ex Order 26. 4B1. The surveyor reviewed the progress notes (PN) dated NJ Exec. Order 26:4.b.1 at 21:17 (09:17PM) which indicated that the nurse observed NJ Exec. Order 26 small Ex Order 26. 4B1 on the Ex Order 26. 4B1 area. The note reflected that the physician was notified, and the family was notified. The surveyor reviewed the physician' orders for NJ Exec. Order 26:4.b.1, and could not find a Ex Order 26. 4B1 for the 5 Ex Order 26. 4B1 that were located on the Ex Order 26. 4B1 area.	F 684		

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The surveyor reviewed the PN dated [NJ Exec. Order 26:4.b.1] at 07:55 AM, which reflected that Resident #55 would receive treatments to [Ex Order 26. 4B1] as ordered and would be given *Ex Order 26. 4B1* for the *Ex Order 26. 4B1* and that the resident's recliner arms would be padded to prevent further [Ex Order 26]. The surveyor observed the resident on 11/08/23, and the resident was not wearing *Ex Order 26. 4B1* on the *Ex Order 26. 4B1* and the surveyor did not observe that the resident's reclining chair arms were padded. The surveyor also reviewed the resident's medical records and there were no treatments ordered for the [Ex Order 26. 4B1] that were observed on the [Ex Order 26].

The surveyor reviewed a facility Incident and Accident report (IR) dated [NJ Exec. Order 26:4.b.1] at 20:00 (8:00 PM) which indicated that the resident was noted to have 5 small [Ex Order 26. 4B1] on the [Ex Order 26. 4B1]. The IR indicated that the possible cause of the [Ex Order 26] was that the resident swings his/her [Ex Order 26] over the side of the recliner and there were metal sides to the reclining chair. The interventions were to pad the arms of the reclining chair. The surveyor did not observe the resident's reclining arms of the chair to be padded. The IR also indicated that *Ex Order 26. 4B1* would be applied to the residents' *Ex Order 26. 4B1*, however the surveyor did not observe the resident wearing *Ex Order 26. 4B1* to the *Ex Order 26. 4B1*. There also was not a physician's order for the *Ex Order 26. 4B1* to the [Ex Order 26. 4B1] and the resident's Care Plan did not reflect that these interventions were put in place to prevent further [Ex Order 26. 4B1] from occurring.

On 11/09/23 at 09:40 AM, the surveyor

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interviewed the DON who confirmed that the preventive interventions that were to be put in place to protect the resident from further development of Ex Order 26. 4B1 were not implemented as indicated on the IR investigation dated NJ Exec. Order 26:4.b.1 at 08:00 PM. The DON also confirmed that the nurse did not put verbal physician orders in for treatments to be performed to the Ex Order 26. 4B1 , therefore treatment was not rendered from NJ Exec. Order 26:4.b.1 after surveyor inquiry.

The DON then explained that she received a verbal statement from the LPN a full-time employee employed for many years who identified that the resident had a Ex Order 26. 4B1 on the Ex Order 26. 4B1 on NJ Exec. Order 26:4.b.1 and had written verbal treatment order for the Ex Order 26. 4B1 however she forgot to transcribe the order to the TAR. The DON stated that as a result of not transcribing the order to the TAR, the treatment was never done to the Ex Order 26. 4B1 on the Ex Order 26. 4B1 from NJ Exec. Order 26:4.b.1 until NJ Exec. Order 26:4.b.1 after surveyor inquiry. The DON also stated that the LPN never initiated the incident/accident report and that the investigation into the cause of the Ex Order 26. 4B1 was not conducted.

The DON also confirmed that there was no documentation in the resident's medical record regarding the Ex Order 26. 4B1 or Ex Order 26. 4B1 and that Ex Order 26. 4B1 were not obtained and no investigation was conducted for the injuries of unknown origin. The DON explained that when the nurses performed Ex Order 26. 4B1 on NJ Exec. Order 26:4.b.1 the nurse did not put in any codes and there was no documentation of any new Ex Order 26. 4B1. She admitted that the nurse may have been signing the TAR and not actually looking at the resident's Ex Order 2.

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On 11/13/23 at 11:02 AM, the surveyor interviewed the Licensed Practical Nurse acting Unit Manager (LPN/UM #1) who documented the Progress Notes (PN) on NJ Exec. Order 26:4.b.1 at 07:55 AM, that she would obtain Ex Order 26. 4B1 for 5 small Ex Order 26. 4B1 that were located on the Ex Order 26. 4B1 area. The acting LPN/UM #1 stated that she must have asked another nurse to obtain the Ex Order 26. 4B1 for the residents' Ex Order 26. 4B1 and the other nurse did not obtain the orders. She continued to explain that would have been important to assure that these treatments were done to NJ Exec. Order 26:4.b.1 and to promote NJ Exec. Order 26:4 of the NJ Exec. Order The acting LPN/UM #1 continued to admit that she also failed to assure that the interventions such as Ex Order 26. 4B1 or Ex Order 26. 4B1 of the chair was done. She stated that the interventions would have been important to put in place at the time to prevent Ex Order 26. 4B1 from reoccurring.

On 11/13/23 at 09:30 AM, the DON approached the surveyor and explained to the surveyor that the Ex Order 26. 4B1 practitioner came in to see Resident #55 on NJ Exec. Order 26:4.b.1 and that treatments were ordered for all the resident's Ex Order 26. 4B1 and that that all the Ex Order 26. 4B1 were documented on the resident's Ex Order 26. 4B1. She also stated that investigations will be conducted and that the Resident's Care Plan would be updated to include all interventions to prevent further reoccurrence of Ex Order 26. 4B1.

The surveyor reviewed the Ex Order 26. 4B1 practitioners consult dated NJ Exec. Order 26:4.b.1, which indicated that the Ex Order 26. 4B1 Nurse Practitioner (NP) identified that the resident had Ex Order 2 located on the Ex Order 26. 4B1

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1cm x 0.8 cm x 0.1 [NJ Exec. Order 26:4.b.1] 0.5. x 0.4 x 0.1 cm, [NJ Exec. Order 26:4.b.1] 2.4 cm x 0.3 cm x 0.1 cm and [Ex Orde] 0.9 cm x 1.2 cm x 0.1 cm. The NP documented that the resident had a [Ex Order 26. 4B1] related to [Ex Order 26. 4B1]. Recommended preventing further [NJ Exec. Order 26:4.b.1] by avoiding [Ex Order 26. 4B1], carful handling during ambulation assistance and transfer, using [Ex Order 26. 4B1], long sleeves, and pants when possible.

On 11/14/23 at 11:20 AM, the DON explained the process for incident and accidents and conducting investigations. She stated that the incident/accident report was generated on the unit by the nurse that discovered the incident. The unit manager was then responsible to review the report and assured that treatments were in place. The Unit Manager was also responsible to review the preventative interventions, update the Care Plan with new interventions, and update the CNA Kardex with the new interventions. The DON stated that the CNA Kardex was the most easily accessed piece of information regarding resident care and the needed to be updated to assure that the CNA knew how to care for the resident.

On 11/15/23 at 12:48 PM, the surveyor interviewed the Medical Director who stated that he was employed by the facility for [NJ Exec. Order 26:4]. He stated that due to staff turnover and use of agency, it could complicate care and follow-through regarding resident care.

On 11/16/23 at 11:03 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that she could not provide a policy regarding the weekly [NJ Exec. Orde] checks that were done on shower days. The ADON also confirmed

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that when then [redacted] were identified that a weekly [redacted] log should have been implemented so that the [redacted] could be monitored weekly. She stated that this process was never implemented for Resident #55's [redacted].

2. On 11/06/23 at 11:40 AM, the surveyor observed Resident #195 in the room sitting up in a recliner eating lunch. The resident told the surveyor that staff respond if anything was needed. At that time, the surveyor observed a [redacted] on the resident's [redacted] side of the resident's [redacted]. The [redacted] was not signed or dated.

The surveyor reviewed the hybrid [redacted] for Resident #195.

According to the [redacted], Resident #195 was admitted with diagnoses that included, but were not limited to, [redacted].

A review of the resident's Minimum Data Set (MDS) dated [redacted], had a BIMS of [redacted]/15 which indicated that the resident was [redacted].

A review of the Admission Physical dated [redacted], indicated in the [redacted] Section: "[redacted]." The Admission Physical documentation further reflected that there was no identified concern with the resident's [redacted].

A review of progress note dated [redacted] at 15:56 (3:56 PM), indicated, "[Resident #195]

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presents with Ex Order 26. 4B1 related to using Ex Order 26. 4B1 at home, Ex Order 26. 4B1 area on top of Ex Order 26. 4B1, Ex Order 26. 4B1 to Ex Order 26. 4B1, and moist Ex Order 26. 4B1 area to Ex Order 26. 4B1."

A review of the Physician's Orders reflected an order dated NJ Exec. Order 26:4, for the treatment of the Ex Order 26. 4B1 area on the resident's Ex Order 26. 4B1. This Ex Order 26. 4B1 was implemented after surveyor inquiry.

A review of the November 2023, Treatment Administration Record (TAR) reflected that the nurses were not signing for the care of the Ex Order 26. 4B1 area on the resident's Ex Order 26. 4B1 from NJ Exec. Order 26:4.b.1.

A review of the Care Plan initiated NJ Exec. Order 26:4.b.1, included a focus area that the resident was at risk for Ex Order 26. 4B1 related to Ex Order 26. 4B1, decreased Ex Order 26. 4B1 Ex Order 26. 4B1 and history of breakdown. Th care plan intervention included that any signs of Ex Order 2 breakdown (Ex Order 26.[redacted]) were to be reported.

On 11/09/23 at 08:47 AM, the surveyor observed the resident lying in bed. The resident stated that staff changed his/her Ex Order 26. 4B1 every other day. The surveyor observed a 2x2 inch Ex Order 26. 4B1 on the Ex Order 26. 4B1 of the resident's Ex Order 26. 4B1. The Ex Order 26. 4B1 was not signed or dated.

On 11/15/23 at 10:49 AM, the surveyor entered the resident's room accompanied by the LPN/UM #2. The resident was awake, lying in bed, and watching television. LPN/UM #2 asked the resident if it was okay to look under the Ex Order 26. 4B1 on Ex Order 26. 4B1 and the resident stated it was fine.

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The surveyor noted that the Ex Order 26. 4B1 was timed, initialed, and dated for that morning. LPN/UM #2 told the surveyor that the treatment nurse had changed it as ordered. LPN/UM #2 removed the Ex Order 26. 4B1 from the resident in the presence of the surveyor. The surveyor observed a light amount of bright Ex Order 26. 4B1, visible on the gauze of the Ex Order 26. 4B1 and a NJ Exec. Order 26:4.b.1 appeared to have been applied. The surveyor further observed the opened area as a Ex Order 26. 4B1 with bright Ex Orde [redacted] at the tip. Upon resealing the Ex Order 26. 4B1 the resident asked how it looked, and LPN/UM #2 stated that compared to what LPN/UM #2 remembered there was no longer a Ex Order 26. and the Ex Order 2 was healing, and they would continue to monitor.

On 11/09/23 at 09:25 AM, the surveyor interviewed the LPN/UM #2, who stated that Ex Order 2 assessments were completed for each resident on shower days but also at each time of contact. The LPN/UM #2 said that any new observations or significant changes in current Ex Order 26. 4B1 could be reported by any staff member. Each concern should be documented, and the doctor would be notified so that treatment could be recommended if needed. The LPN/UM #2 explained that the facility contracts for Ex Order 26. 4B1 services. There was also a Ex Order 26. 4B1 nurse on staff in case there is an immediate concern. LPN/UM #2 said that if a new NJ Exec. Order 26:4 was identified, or a change in a current one was noted, the in-house doctor was notified as well as the contracted provider. If the concern was not immediate, the contracted provider would assess in-person on their next scheduled day at the facility.

On 11/09/23 at 10:59 AM, surveyor interviewed LPN #3, who stated that they could not speak to

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Ex Order 26. 4B1 because those treatments were completed by treatment nurse and LPN #3 was the Medication Nurse for the unit. LPN #3 said that they are aware that Resident #195 had a Ex Order 26. 4B1 on the Ex Order 26. 4B1 and on the Ex Order 26. LPN #3 said that any new Ex Order 26. 4B1 were reported to the Unit Manager immediately and if new treatments were implemented, they would be followed. LPN #3 said that Ex Order 26. 4B1 were updated by the UM. When asked about the Ex Order 26. 4B1 on the Ex Order 26. 4B1 of Resident #195, LPN #3 stated that the resident was admitted to the facility with a Ex Order 26. 4B1 on the Ex Order 26. 4B1 and, at the request of Resident #195 and the family, the Ex Order 26. 4B1 was placed as a deterrent to prevent the resident from picking at the Ex Order 26.

On 11/14/23 at 11:18 AM, the surveyor interviewed LPN #4 who said that he/she was assigned as the unit's treatment nurse and that treatments were completed as ordered. When asked about Ex Order 26. 4B1, LPN #4 said that they had just completed the Ex Order 26. 4B1 on the Ex Order 26. 4B1 of Resident #195.

On 11/14/23 at 12:05 PM, the surveyor interviewed the ADON who said that the resident was admitted to the facility with a Ex Order 26. 4B1 and a Ex Order 26. 4B1 had been placed per the request of the family to deter the resident from picking at the Ex Order 26. ADON said that on 11/9/23 after the resident's shower, the family requested for the area to be assessed because the Ex Order 26. 4B1 was falling off. ADON said that the doctor was contacted, and a treatment was ordered and implemented on NJ Exec. Order 26:4.b

On 11/15/23 at 10:45 AM, the surveyor interviewed the LPN/UM #2 who said that

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F 684	Continued From page 32 Resident #195 was admitted to the facility with a Ex Order 26. 4B1 and the original Ex Order 26. 4B1 was placed as a preventative measure, per the resident and family's request because the resident would pick at it at home. The family expressed concern on 1 NJ Exec. Order 26 that the Ex Order 26. 4B1 fell off after the shower and Resident #195 started picking at it again. LPN/UM #2 said that the doctor was contacted and a treatment was ordered. The surveyor asked how long the previous Ex Order 26. 4B1 had been on for and LPN/UM #2 said it was changed daily but there was no documentation noting that. LPN/UM #2 stated that a treatment should have been ordered upon admission. LPN/UM #2 said that a request for a Ex Order 26. 4B1 was emailed to the contracted provider. On 11/15/23 at 11:00 AM, the surveyor interviewed NP who was at the nurse's station. The NP said that they had been asked to assess the Ex Order 26. 4B1 of Resident #195 that morning. The NP further explained that a treatment was currently in place and that the NP was planning on seeing the resident next week because the resident had already been seen for that week and the concern was not reported as an emergency. The NP further stated that the Resident #195 was under their care, but NP had not been asked to assess the resident's Ex Order 26. 4B1 prior to that day (NJ Exec. Order 26:4.b.1). On 11/16/23 at 12:50 PM, the surveyor interviewed the DON who stated that the Ex Order 26. should have been noted on the Admission Physical by the doctor. The DON further stated to the surveyor that the area should have been assessed and a treatment should have been implemented by a physician. The DON explained	F 684		

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F 684	Continued From page 33 that the resident's care plan should have been updated to reflect the resident's [NJ Exec. Order 26:4.b.1].	F 684		

The facility policy titled, "Skin Integrity Log: Impaired" dated 05/15 indicated the purpose for the policy was to provide documentation and follow-up of resident skin impairments such as skin tears, abrasions, rashes, bruises, and other types of impaired skin integrity other than pressure ulcers. The policy indicated that weekly assessments of skin tears would continue until the area was resolved.

The facilities policy titled, "Wound and Skin Care Protocols" dated 02/13 indicated that the purpose of the policy was to provide a systematic approach and monitoring process for skin integrity and chronic wound care. The policy purpose also indicated that the facility would maintain the resident's skin integrity and promote wound healing.

The facility policy titled, "Physician's Orders" and dated 01/13 indicated the purpose of the policy was to communicate and document the physician's order for care and treatment of residents. The policy reflected that the licensed nurse would note all orders to indicate that the order has been carried through including notifying the pharmacy, transcribing the orders to the Medication Administration Record (MAR) and the TAR or other documentation as indicated. The policy further indicated that each chart would be reviewed during the twenty-four (24) hour chart check procedure by the night nurse. All orders written since the last chart check will be reviewed to ensure it has been noted and transcribed correctly.

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	315294	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

(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 684	Continued From page 34 The facility policy, "Kardex" with a revised date of 01/15 indicated that the purpose of this tool is to communicate resident care information to all nursing, rehabilitation, restorative and interdisciplinary (IDT) team members. The policy also indicated that the Kardex would be changed, as Resident care needs change. NJAC 8:39-27.1	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to implement Care Plan interventions to reduce the risk for injury for a resident with a known history of Ex Order 26. 4B1. This deficient practice was identified for Resident #78, 1 of 3 residents reviewed for accidents, and was evidenced by the following: The resident's Face Sheet (FS) indicated that Resident #78 was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted]. The admission *Ex Order 26. 4B1* [redacted] an assessment tool utilized to facilitate care, dated NJ Exec. Order 26:4.b.1 indicated that the resident	F 689	1. Facility is unable to retroactively correct the deficient practice of proper care planning and *Ex Order 26. 4B1* interventions for resident #78. A full body assessment was performed for resident #78 and *Ex Order 26. 4B1* were obtained and implemented for *Ex Order 26. 4B1* to the *Ex Order 26. 4B1*. *Ex Order 26. 4B1* and Kardex were updated including use of *Ex Order 26. 4B1* [redacted] under resident [redacted] and at [redacted] for comfort and positioning while in the *Ex Order 26. 4B1*. 2. All residents have the potential to be affected by this deficient practice. Facility reviewed the charts of all residents to ensure that a proper [redacted] assessment	12/10/23

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F 689	Continued From page 35 had Ex Order 26. 4B1 and required NJ Exec. Order 26:4.b.1 assistance with Ex Order 26. 4B1 . On 11/03/23 at 10:55 AM, during tour of the Ex Order 26. Unit, the surveyor observed Resident #78 sitting up in a reclining chair. The resident's eyes were closed, and he/she was NJ Exec. Order 26:4.b.1 due to Ex Order 26. 4B1 . A Ex Order 26. 4B1 was observed on the Ex Order 26. 4B1 of the resident's Ex Order 26. . The Certified Nursing Assistant (CNA) was tending to the resident at this time and was interviewed. The CNA stated that the resident had fallen last week. The surveyor reviewed the resident's medical records which indicated the following: The Progress Note (PN) dated NJ Exec. Order 26:4.b.1 at 22:30 (10:30 PM) indicated that Resident #78 was found with a Ex Order 26. 4B1 to the Ex Order 26. 4B1 and Ex Order 26. 4B1 . The PN also indicated that a treatment was ordered, and the physician and supervisor were made aware. The PN dated 1 NJ Exec. Order 26:4.b.1 at 02:52 PM, indicated that a CNA identified that Resident #78 had a Ex Order 2 with some NJ Exec. Order 26:4.b.1 on the resident's Ex Orde while the resident was in the recliner outside of the nurse's station. The Ex Order 2 measured 3.5 centimeters (cm) by 3 cm and a treatment was provided with Ex Order 26. 4B1 and Ex Order 26. 4B1 . A Ex Order 26. 4B1 was also applied. The PN indicated that the resident was NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 in the recliner before the Ex Order 26. 4B1 was found and may have bumped his/her Ex Orde against the recliner. The PN also indicated that the resident had Ex Order 26. 4B1 on, but the Ex Order 26. 4B1	F 689	was completed and all Ex Order 26. 4B1 interventions were care planed appropriately. 3. All Nurses were re-in-service on the required components of resident care planning, including risk for injury and resident safety by 12/8/23. All new nursing staff with be in-serviced upon hire. All Nurses will be re-in-service on the importance of and process on implementing safety interventions. 4. DON or Designee will audit the charts of 3 resident with a known history of wounds, weekly for 4 weeks and then monthly for 2 months to ensure that proper interventions and care planning are in place. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

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F 689	Continued From page 36	F 689		

was pulled up on the [redacted] towards the [redacted] and was put back on his/her [redacted].

The Treatment Administration Record (TAR), dated [redacted] reflected a physician's order to cleanse [redacted] on the [redacted] with [redacted] and appy [redacted] and cover with a [redacted] a day for seven days.

Resident #78's CNA Kardex (gives a overview of each resident's care) indicated that the resident required [redacted] of one (1) staff member for ambulation and moderate assistance of one (1) staff member for transfers.

Resident #78's Care Plan (CP) did not reflect interventions regarding preventative/protective measures for Resident #78's [redacted] on the resident's [redacted].

On 11/06/23 at 10:23 AM, the surveyor observed Resident #78 in a low bed with a mattress on the floor next to the bed. The resident was noted to be [redacted], had [redacted], and was [redacted]. The resident had [redacted] on the [redacted]. The surveyor observed that the resident had [redacted] and [redacted] on both [redacted]. The surveyor also observed a dressing on the [redacted]. The CNA entered the room and that time and was interviewed. The CNA stated indicated that the resident had a [redacted] on the [redacted] but did not wear [redacted] on [redacted], just [redacted].

On 11/06/23 at 10:29 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she had been employed through the agency and had been coming to the facility for

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F 689	Continued From page 37 NJ Exec. Order 26:4.b.1. The LPN described Resident #78 as NJ Exec. Order 26:4.b.1, and required NJ Exec. Order 26:4.b.1 care with Ex Order 26. 4B1. The LPN stated that the resident's medications were changed last week for the NJ Exec. Order 26:4.b.1 She also explained that the resident was Ex Order 26. 4B1 and required one (1) staff member to transfer. She stated that the resident utilized the wheelchair (w/c) or the reclining chair when he/she got out of bed. She stated that the resident was at NJ Exec. Order 26:4.b.1 and that preventative NJ Exec. Order 26:4.b.1 were in place which included: bed alarm, chair alarm, low bed, and a mattress on the floor next to Ex Order bed (Ex Order 26. 4B1). The LPN stated that the resident's Ex Order 2 was very Ex Order 26. 4B1, and it did not take much for his/her Ex Order 2 to Ex Order 26. 4B1 or develop a Ex Order 26. 4B1. The LPN stated that the protective preventive measures to protect the resident's Ex Order 2 included Ex Order 26. 4B1 on the resident's Ex Order 26. 4B1 and Ex Order 26. 4B1. The LPN stated that the resident did not wear any Ex Order 26. 4B1 on his/her Ex Order 26. 4B1 and did not have any response as to why there were no protective measures for Resident #78's Ex Order 26. 4B1 on the Ex Order 26. 4B1. The LPN stated that she was not sure if an incident or accident report was completed when the resident developed the Ex Order 26. 4B1 on NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1. On 11/08/23 at 10:27 AM, the surveyor interviewed the Director of Nursing (DON) who admitted that she was not aware that Resident #78 had developed Ex Order 26. 4B1 on the Ex Order 26. 4B1 and Ex Order 26. 4B1 on NJ Exec. Order 26:4 3 and on the resident's Ex Order 26. 4B1 on 1 NJ Exec. Order 26:4. The DON explained that she did not think that any incident or accident reports were completed when Resident #78 developed the Ex Order 26. 4B1 on NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 She stated that she would find out what happened and that maybe the	F 689		

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F 689	Continued From page 38 incident reports were on the unit. The DON indicated that it would have been important to ensure that preventive/protective measures were put in place to prevent the reoccurrence of [redacted] on the resident's Ex Order 26. 4B1. She stated that protective or preventive measure should have been documented on the CNA Kardex and the CP. The DON confirmed that the resident's CP and CNA Kardex were not updated with any new interventions to prevent the reoccurrence of Ex Order 26. 4B1 on Resident #78's [redacted]. On 11/13/23 at 12:36 PM, the DON provided the surveyor with incident reports for Resident #78's Ex Order 26. 4B1 that were found on [redacted] and [redacted]. She stated that the incident reports were sitting on the Units Manager's desk and have not yet been investigated. She stated that the acting Unit Manager told her that she did not know what to do with the incident reports and was going to give them to the DON during the morning meeting but never did. The DON admitted that interventions were not implemented to protect the resident from further injury after the discovery of the Ex Order 26. 4B1 on the Ex Order 26. 4B1 and the back of the Ex Order 26. 4B1 on [redacted], and after the discovery of the Ex Order 26. 4B1 on the Ex Order 26. 4B1 on [redacted]. On 11/17/23 at 09:49 AM, in the presence of the survey team, the DON stated that she tried to investigate the Ex Order 26. 4B1 after the fact and that the information she had received was that the incident report did not make it to a supervisor or unit manager for review. She stated that there was oversite related to a communication breakdown. The DON also stated that there was not a policy regarding Care Plan or updating Care Plans.	F 689		

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F 689	Continued From page 39 The surveyor reviewed the facility policy titled, "Skin Report Worksheet," dated 04/2013, that indicated any preventative devices such as a wheelchair or geri-chair cushions, wedge cushions, boots, extra pillows, etc. will be ordered to relieve pressure to the area. The surveyor reviewed the facility policy titled, "Kardex," with a revised date of 01/15, that indicated the purpose of this tool was to communicate resident care information to all nursing, rehabilitation, restorative and interdisciplinary (IDT) team members. The policy also indicated that the Kardex would be changed, as Resident care needs change.	F 689		
F 727 SS=D	N.J.A.C 8:39-33.1 (d) RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 157448, 158079, 162538,	F 727	1. Facility is unable to retroactively	12/10/23

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F 727	Continued From page 40 162579, 163502 Based on interview and review of the Nurse Staffing Report and Payroll Based Journal (PBJ) Staffing Data Report, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 6 of 13 days reviewed. This deficient practice was evidenced by the following: Review of the Nurse Staffing Report completed by the facility for the week of 08/21/22 to 08/27/22 revealed the facility had no RN coverage for all shifts on 08/24/22 and 08/26/22. Review of the PBJ Staffing Data Report for Quarter 3 2023 (April 1 - June 30) revealed the facility had no RN hours for the following dates: -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 Review of the Employee Daily Schedule By Shift, provided by the facility, for the aforementioned dates verified that there was no RN scheduled to work 8 consecutive hours on the following days: -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 -Ex Order 26. 4B1 During an interview with the surveyor on 11/14/23	F 727	correct this deficient practice of staffing an RN for a minimum of 8 consecutive hours daily. 2. All residents have the potential to be affected by the deficient practice. No residents were adversely affected by this deficient practice. 3. Staffing coordinator was re-In-serviced by Director of Nursing on 12/8/23 on the requirement to staff an RN for a minimum of 8 consecutive hours daily. DON created a "Backup RN rotation list" in the event of a call out and will be the point person for RN coverage. 4. Administrator or Designee will audit the RN staffing schedule weekly for 4 weeks and then monthly for 2 months to ensure that an RN is staffed for a minimum of 8 consecutive hours daily. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

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F 727	Continued From page 41 at 10:51 AM, the Staffing Coordinator stated there should be a RN in the facility daily for 8 consecutive hours. During an interview with the surveyor on 11/15/23 at 11:06 AM, the Director of Nursing (DON) stated there should be a RN in the facility for 8 consecutive hours daily. The DON further stated that there had been times when there is no RN for 8 consecutive hours when there are call outs. During an interview with the surveyor on 11/15/23 at 11:23 AM, the Licensed Nursing Home Administrator (LNHA) stated that there should be a RN in the facility daily for 8 consecutive hours. Review of the facility's Nursing Policy and Procedure Staffing Guidelines policy, revied 08/2022, included, "The minimum staffing needed for each skill level (RN, LPN, CNA, and Unit Clerk) is determined by the nurse-patient ratio guidelines and the patient/resident care needs, i.e., level of acuity and based on New Jersey state minimum requirements."	F 727		
F 730 SS=E	NJAC 8:39-25.2(h) Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced	F 730		12/10/23

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F 730	Continued From page 42 by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to: a.) provide in-service education at least once every 12 months for 2 out of 5 Certified Nursing Aides (CNA)s personnel files reviewed, (CNA#1 and CNA#4) and b.) complete annual performance reviews for 5 out of 5 CNA personnel files reviewed, (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5). This deficient practice was evidenced by the following: On 11/16/23 at 9:09 AM, the surveyor reviewed the five CNA personnel files which revealed the following: - CNA#1 in-service education was dated [redacted]. CNA#1 did not receive a performance evaluation. - CNA#2 did not receive a performance evaluation. - CNA#3 did not receive a performance evaluation. - CNA#4 in-service education was dated [redacted]. CNA#1 did not receive a performance evaluation. - CNA#5 did not receive a performance evaluation. On 11/16/23 at 09:20 AM, the surveyor interviewed the Director of Human Resources for the county who stated that she oversaw the Human Resource Department for the entire	F 730	1. Facility is unable to retroactively correct this deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A performance review will be conducted by the DON or Nursing Designee for all CNAs annually. Facility initiated performance reviews for all CNAs. 12 hours of regular In-service education will be based on performance evaluation results and provided to all CNAs annually. 4. DON or Designee will audit 3 employee files weekly for 4 weeks and then monthly for 2 months to ensure that a performance review is conducted, and mandatory In-service training is provided to all CNAs annually. Audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

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F 730	Continued From page 43	F 730		

county which consisted of over 40 different departments and she was solely responsible for holding the employee files. The Director of Human Resources told the surveyor that the facility had always been responsible for providing in-service education for the staff working at the county facility as well as conducting annual performance evaluations for staff.

On 11/16/23 at 10:31 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that the facility did not have a Staff Educator who was the previous staff member responsible for providing in-service education. The LPN/IP further stated that the Staff Educator had stopped working at the facility in April or May of 2023 and was also the person who was responsible for completing the performance evaluations for the CNAs.

On 11/16/23 at 11:12 AM, the surveyor interviewed the facility's Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) who stated that the Staff Educator had stopped working at the facility in late spring of 2023 and since then herself, the Assistant Director of Nursing (ADON), and LPN/IP had been fulfilling that job responsibility at the facility. The DON explained that the Staff Educator was a flexible position, the former staff member was available to work all shifts and was responsible for completing the CNAs performance evaluations which were not done.

On 11/16/23 at 11:16 AM, the surveyor interviewed the facility's LNHA in the presence of the DON who agreed with the DON that the previous Staff Educator was formally responsible

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F 730	Continued From page 44 for providing annual in-service education to all staff working at the facility and was also responsible for performing the performance evaluations. The LNHA stated that process changed due to the fact the county implemented a hiring freeze upon the facility. On 11/17/23 at 09:58 AM, the surveyor conducted a follow up interview with the DON who stated that she did not recall the name of CNA#1 and CNA#4 had not worked at the facility for more than a year, however they were county employees. The DON told the surveyor that the facility did not have a policy and procedure for annual in-service education or a policy and procedure for annual performance evaluations. NJAC 8:39-43.17(b)	F 730		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		12/10/23

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F 761	Continued From page 45 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to properly label and date opened multidose medications for 2 of 3 medication carts (West Side 1 and East Side 1) inspected. This deficient practice was evidenced by the following: On 11/09/23 at 10:16 AM, the surveyor inspected the West Side 1 medication cart in the presence of Licensed Practical Nurse (LPN) #1. Inside the medication cart, the surveyor observed the following: -1 insulin lispro pen which was opened but not labeled with an opened date -1 insulin glargine pen which was opened but not labeled with an opened date At that time, the Assistant Director of Nursing (ADON) verified the insulin pens had been opened but not labeled with an open date. The ADON further stated that the pens should have been dated upon opening and that she would dispose of the insulin pens. On 11/09/23 at 10:30 AM, the surveyor inspected the East Side 1 medication cart in the presence of LPN #2. Inside the medication cart, the surveyor	F 761	1. Ex Order 26. 4B1 and Ex Order 26. 4B1 that had been opened but not labeled were disposed of immediately. Discarded medications were replaced and replacements were dated immediately. 2. All residents with a prescription for Ex Order 26. 4B1 or Ex Order 26. 4B1 have the potential to be affected by this deficient practice. 3. All Nurses were re-In-serviced by the DON or Designee on proper storage and expiration dating of medications by 12/8/23. All new nursing staff with be in-serviced upon hire. 4. DON or Designee will conduct a medication storage audit, weekly for 4 weeks and then monthly for 2 months to ensure the proper storage and dating of medications. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

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F 761	Continued From page 46	F 761		

observed the following:
-1 Breo Ellipta inhaler which was opened but not labeled with an opened date
-1 Trelegy Ellipta inhaler which was opened but not labeled with an opened date

At that time, LPN #2 stated the inhalers should have been dated upon opening.

During an interview with the surveyor on 11/15/23 at 11:06 AM, the Director of Nursing (DON) stated insulin pens and inhalers should be dated upon opening. The DON explained that opened multidose medications should be labeled with an opened date so that the nurse knows how long the medication is good for based on manufacturer's guidelines.

Review of the manufacturer's guidelines for Humalog (insulin lispro), revised 03/2013, included, "In-use Humalog vials, cartridges, pens, and Humalog Kwikpen should be stored at room temperature ... and must be used within 28 days or be discarded, even if they still contain Humalog."

Review of the manufacturer's guidelines for Lantus (insulin glargine), revised 05/2019, included, "Do not use Lantus after the expiration date stamped on the label or 28 days after you first use it."

Review of the manufacturer's guidelines for Breo Ellipta, revised 05/2023, included, "Discard Breo Ellipta 6 weeks after opening the foil tray or when the counter reads '0' (after all blisters have been used), whichever comes first."

Review of the manufacturer's guidelines for

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F 761	Continued From page 47 Trelegy Ellipta, revised 06/2023, included, "Discard Trelegy Ellipta 6 weeks after opening the foil tray or when the counter reads '0' (after all blisters have been used), whichever comes first." Review of the facility's Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles policy, dated 01/2020, included, "Once any medication or biological package is opened, the Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened."	F 761		
F 812 SS=E	NJAC 8:39-29.4(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		12/10/23

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F 812	Continued From page 48 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility documentation it was determined that the facility failed to: a.) ensure that food items were labeled, dated, and stored properly, b.) ensure that ice machines were cleaned and in safe operating condition, and c.) ensure that equipment was cleaned and maintained to prevent foodborne illnesses. This deficient practice was evidenced by the following: On 11/03/23 at 9:56 AM, the surveyor met with the Food Service Director (FSD) to begin the kitchen tour. 1. One gallon opened container of lemon juice was on the shelf on the seasoning rack. The FSD stated that the container did not belong there and it should have been refrigerated. The FSD immediately disposed of the container. 2. On the Salad Dressing Rack, located next to seasoning rack across from 3 compartment sink in the main kitchen, the surveyor observed a 2.5 feet by 1.5 feet sheet pan that contained food particles and stains. Two knives, a cardboard box, and an unknown kitchen appliance were on top. The FSD stated, "I am not sure why it is there," then removed the tray and all items from the area to be washed. The FSD said that the purpose of keeping clean and dirty areas separate was, "You don't want any areas where bacteria could be growing mixed with clean	F 812	1.1. The following immediate actions were taken in the kitchen: a. Gallon bottle of lemon juice was discarded. b. The sheet pan and its contents were cleaned, and the cardboard box was discarded. c. The red cutting board and blue cutting board were cleaned. d. Ice machine in the kitchen was cleaned and sanitized. e. Roast beef was discarded. f. Open biscuits were discarded. g. Expired and undated bread items were discarded. h. Cooking wine was discarded. 2. All residents have the potential to be affected by the deficient practice. Kitchen was inspected for cleanliness and to ensure that no food items had missing dates. 3. All Dietary staff were re-in-serviced by the Food Service Director on proper storage, labeling, and dating of food items by 12/8/23. All new dietary staff with be in-serviced upon hire. All Dietary staff were re-in-serviced by food service director on cleanliness and sanitation standards by 12/8/23. All new dietary staff with be in-serviced upon hire. All Dietary staff were re-in-serviced by food service director on Ice machine cleaning procedure and schedule by 12/8/23. All new dietary staff with be	

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F 812	Continued From page 49 items." 3. At the time of the observation, the surveyor asked the FSD if the area was a clean area and the FSD explained that it was where clean items were kept after they were dry. The surveyor observed a red cutting board, 3 feet by 2 feet, which contained a black substance streaked across both sides. The surveyor observed a yellow cutting board, 3 feet by 2 feet, that had a black substance streaked across one side. The surveyor also observed a blue cutting board, 3 feet by 2 feet which contained food particles throughout the cutting board. The FSD immediately removed the cutting boards and stated that all cutting boards should be clean and free of particles and substances to prevent the spread of bacteria. 4. No log was noted on the ice machine in the main kitchen. The surveyor asked the FSD if there was a log and the FSD said, "no." The surveyor wiped a clean paper towel across the inside cover and a black substance adhered to the paper towel. The surveyor observed the FSD do the same, and she obtained the same results. The FSD stated that there should not be black substance on the ice machine to prevent the growth of bacteria. 5. The surveyor and the FSD entered the walk-in refrigerator in the main kitchen. The surveyor observed nine, 10-pound unknown meats sealed in plastic wrap with no identifying information. The surveyor asked the FSD what they were, and the FSD explained that they were roast beefs that had previously been cooked. The FSD further stated that the meat should have a label identifying what it is and when it was opened, so	F 812	in-serviced upon hire. 4. Administrator or Designee will conduct an audit of the dietary sanitation and proper food storage, weekly for 4 weeks and then monthly for 2 months to ensure food safety. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

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F 812	Continued From page 50 that others can be aware of how long the meat is good for. 6. The surveyor and the FSD entered the walk-in freezer in the main kitchen. The surveyor observed a tray of biscuits that were open to air and not labeled. The FSD stated that they had served beef stew last night and that it should have been wrapped and labeled after use. The FSD further stated that food needed to be covered, labeled, and dated. The FSD removed the item to be disposed of in the presence of the surveyor. 7. On the bread rack, the surveyor observed: - 4 bags of hoagie rolls dated 10/26/23. - a loaf of sliced rye bread with no label and no expiration date. - a loaf of club wheat bread dated 10/30/23. - a loaf of marble rye, no date, no label, with greenish brown patches. At the time of the observations, the FSD disposed of each item and stated that each item should have been dated and anything that had expired should have been disposed of. 8. One gallon of Sherry Cooking Wine on a shelf with a Best Buy date of 8/9/23. The bottle was open. The FSD disposed of the bottle. A review of the undated facility's, "Dietary Orientation: Safe Food Handling,", revealed 1. Cutting boards in good condition ... 3. Cleaned and sanitized in dish machine after each use ... A review of the undated facility policy, "Proper storage and labeling of food in the refrigerator," indicated within the policy statement that: All food is to be stored and labeled in a safe and sanitary	F 812		

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F 812	Continued From page 51 manner. Procedures: Food is to be labeled with what is inside the container ... and Food is to be labeled with the use by date ... Open items stored in freezer will be dated for a 6 month use by date ...	F 812		
F 880 SS=D	NJAC 8:39-17.2(g) 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 §483.70(e) 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	F 880		12/10/23

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F 880	Continued From page 52 possible communicable diseases or 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, medical record	F 880	1. Facility is unable to retroactively	

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F 880	Continued From page 53 review and review of other pertinent facility documentation it was determined that the facility failed to a.) provide a safe environment to prevent the potential spread of infection by not following standards of Ex Order 26. 4B1 procedures for 1 of 6 residents reviewed for Ex Order 26. 4B1 (Resident #82) from NJ Exec. Order 26:4.b.1, and b.) follow appropriate Ex Order 26. 4B1 practices and perform hand hygiene as indicated during dining observation for 1 of 3 units ([redacted] Wing) observed. The deficient practice was evidenced by the following: 1.) The surveyor reviewed Resident #82's Face Sheet (FS) which indicated that the resident had the diagnoses which included but was not limited to Ex Order 26. 4B1 [redacted]. The admission Minimum Data Set (MDS) an assessment tool that facilitates a resident's care, dated NJ Exec. Order 26:4.b.1, reflected that the resident had Ex Order 26. 4B1 [redacted] and required limited to extensive assistance with Ex Order 26. 4B1 [redacted]. On 11/03/23 at 12:06 PM, the surveyor observed the resident sitting up in the chair in his/her room. The resident's responsible party (RP) was present in the room and was interviewed at the time. The RP stated that the resident had a [redacted] and was not sure what the [redacted] was but was being treated with a [redacted] that appeared to be helping. The RP stated that she had no complaints regarding the care the resident received and that she was very happy with the care. The surveyor observed an Ex Order 26. 4B1	F 880	correct the deficient practice of properly communicating Ex Order 26. 4B1 precautions. Facility is unable to retroactively correct the deficient practice of hand hygiene during dining. 2. All residents have the potential to be affected by this deficient practice 3. All facility staff were re-in-serviced by DON/Designee on procedures of communication for patients with Ex Order 26. 4B1 [redacted] precautions in place by 12/8/23. All new nursing staff with be in-serviced upon hire. All nursing staff will be re-in-serviced on the requirements to Preform hand hygiene before each contact with food. 4. [redacted] or Designee will conduct an audit of 2 residents charts with infection prevention precautions, weekly for 4 weeks and then monthly for 2 months to ensure that signage is in place, and order, Ex Order 26. 4B1, [redacted], and Kardex are updated accordingly. [redacted] or Designee will observe dining services once weekly for 4 weeks and then monthly for 2 months to ensure that proper hand hygiene is performed. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

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cart (cart containing personal protective equipment (PPE) such as gloves, isolation gowns, gloves and face masks) located in the front of the resident's doorway, however the surveyor did not observe any signage on the resident's door to indicate that the resident was on isolation. The surveyor interviewed the RP who stated that the isolation cart was in front of the door because the resident had a [redacted] on the [redacted] and that you had to wear a gown and gloves when you provided care to Resident #82.

The surveyor reviewed the nursing Progress Notes (PN) that indicated that following information:

The PN dated [redacted] at 08:00 AM [Recorded as Late Entry on [redacted] 08:08] for [redacted], indicated that the Nurse Practitioner (NP) was told by the Resident's spouse that Resident #82 had [redacted] on his/her [redacted]. The PN indicated that the resident was assessed by the NP and it had appeared that there were more [redacted] with [redacted] and that some [redacted] seemed to have flattened out and appeared smooth. The PN also indicated that the [redacted] had [redacted] and that the resident stated that the areas were [redacted], however there was some [redacted]. A [redacted] was ordered, and the resident was put on contact precautions (used when a patient has an [redacted] that may be spread by touching either the patient or other objects the patient had handled).

The PN dated [redacted] at 22:29 (10:29 PM), indicated that the resident was seen by [redacted] and the [redacted] area on the resident's [redacted] were [redacted].

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The PN dated [NJ Exec. Order 26:4.b.1] at 04:27 AM, indicated that the resident was on contact [Ex Order 26. 4B1].

The PN dated [NJ Exec. Order 26:4.b.1] 22:33 (10:33 PM), indicated that the resident was on contact [Ex Order 26. 4B1].

The PN dated [NJ Exec. Order 26:4.b.1] at 14:57 (02:57 PM) indicated that Resident #82 was on contact [Ex Order 26. 4B1] precautions related to [NJ Exec. Order 26:4.b.1] [Ex Order 26. 4] on the [Ex Order 26. 4B1] and [Ex Order 26. 4B1] precautions were maintained during the shift.

The surveyor reviewed the Care Plan and there was no documentation that the resident was on contact [Ex Order 26. 4B1].

The surveyor reviewed the Certified Nursing Assistant Kardex (provides an overview of each patient and what care that was to be provided) and there was no documentation the resident was on contact [Ex Order 26. 4B1].

The surveyor reviewed the Physicians Orders (PO) and there was no PO that the resident was to be on contact [Ex Order 26. 4B1].

On 11/06/23 at 11:57 AM, the surveyor interviewed the primary care Certified Nursing Assistant (CNA #1) who stated that he was assigned to provide care for Resident #82. CNA #1 explained to the surveyor that the resident required extensive assistance with [Ex Order 26. 4B1] [redacted]. The surveyor asked CNA #1 why there was an [Ex Order 26. 4B1] cart placed outside Resident #82's doorway and the CNA stated that Resident #82 was not on contact [Ex Order 26. 4B1] and that the [Ex Order 26. 4B1] cart in front of the resident's

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room was for another resident that had [redacted]. He stated that the resident's RP came in daily to wash and dress the resident. CNA #1 added that he was not aware that the resident was on contact [redacted] for a [redacted] on the [redacted] and was not aware that he was supposed to don (put on) [redacted] when caring for the resident. He also stated that there was no signage on the door that indicated that the resident was on contact [redacted]. He stated that he did not get report this morning because he was there early before every other staff member.

On 11/06/23 at 11:58 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that it was written on the 24-hour report that Resident #82 was on contact [redacted] for red [redacted] on the [redacted]. She stated that she was not sure what the [redacted] was and that she had not looked at it yet and was going to do the treatment this afternoon. She stated that it was documented on the 24 report that the resident was on contact [redacted]. She stated that contact [redacted] consisted of wearing gloves, gown, and mask when in contact with the resident or when performing care. The surveyor questioned LPN #1 regarding why the CNA was not informed that the resident was on contact [redacted] and LPN #1 stated that this was her first day and that she did not give the CNA report this morning. LPN #1 then proceeded to ask CNA #1, in the presence of the surveyor, why he did not know that the resident was on contact [redacted], and CNA #1 responded, "Because nobody told me."

On 11/06/23 at 12:16 PM, the surveyor interviewed a nurse who identified herself as the acting LPN Unit Manager (LPN/UM). The acting LPN/UM stated that if any resident had a

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CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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contagious infection that the nurse would have had to obtain a PO for the resident to be on Ex Order 26. 4B1. She stated that she was not positive that you had to get a PO and would have to check with management. She continued to explain that that if a nurse found out that a resident had a Ex Order 26. 4B1 that the nurse would have been responsible to notify the physician and the resident's family. She explained that if a resident was on Ex Order 26 then signs would have been posted on the door to "see the nurse" and Ex Order 26. 4B1 carts would have been placed in the front of the resident's room. She also added that all staff would have been notified regarding the resident condition and that the family would also have been notified. She confirmed that it would have been important for staff to know if the resident had a Ex Order 26. 4B1 and what PPE the staff were required to wear when they cared for or came in contact with the resident. She stated that it was important that the appropriate PPE was worn, hand hygiene was performed and that specific medical equipment was assigned to that resident to both contain, and prevent, the spread of infection. She stated that it would have been documented in the 24 hour report and also documented on the resident's CNA Kardex and Care plan. She stated that Resident #82 had a Ex Order 26. 4B1 and that it was determined that it was Ex Order 26. 4B1, however the resident was put on contact Ex Order 26. 4B1 "just in case" because they did not know what the Ex Order 26 was. The acting LPN/UM stated that CNA #1 should have known that the resident was on contact Ex Order 26. 4B1 so that he could have worn the appropriate Ex Order 26 when in the resident's room or when caring for the resident. She also reviewed Resident #82's medical record with the surveyor and confirmed that there was

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not a PO for the resident to be on contact Ex Order 26. 4B1 and it was not documented on the Care Plan, the resident's CNA Kardex, nor on the Treatment Administration Record (TAR). She stated that the resident's Kardex was something that the CNAs utilized to find out what type of care a resident required.

On 11/06/23 at 12:23 PM, the surveyor interviewed LPN #2 who stated that you would not have to obtain a PO to put a resident on Ex Order 26. 4B1 and that it was nursing judgment.

On 11/06/23 12:34 PM, the surveyor interviewed the Infection Preventionist (IP) who stated that stated that a PO was required to put a resident on Ex Order 26. 4B1 [redacted]. She stated that the [redacted] should have been obtained for whatever type of [redacted] the resident was to be on. She also explained that signage should have been posted on the resident's door to "see nurse". She stated the sign posted on the door was a notification to visitors or staff that something was going on with the resident and that they should see the nurse to obtain additional information before entering the resident's room. She continued to explain that an Ex Order 26. 4B1 cart was placed outside the room with the appropriate PPE, and that it should have been documented on the 24- hour report (24-hour communication form for each shift) that the resident was put on Ex Order 26. 4B1. She stated that she told the nurse last week to put Resident #82 on contact Ex Order 26. 4B1 for the Ex Order 26. 4B1 because she was not sure what the [redacted] was. She admitted that she did not follow-up to make sure that the staff obtained a physician's order for the Ex Order 26. 4B1. She stated that it should also have been documented in the TAR, on the CNA Kardex, and on the CP that the

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resident was on contact [Ex Order 26. 4B1]. The IP admitted that she did not follow-up with Resident #82 to assure that this was implemented and stated that it was hard for her to follow-up because the administration had her performing other duties instead of focusing on her role as the facility's IP. The IP stated that the importance of ensuring that staff adhered to the contact [Ex Order 26. 4B1] policy was to prevent the spread of infection.

The surveyor reviewed the PN dated [NJ Exec. Order 26:4.b.1] 3 at 13:51 (01:51 PM) that the [Ex Order 26. 4B1] results came back from the [Ex Order 26. 4B1] office and the [Ex Order 26] was not [Ex Order 26. 4B1]. The note also reflected that the resident was removed from contact [Ex Order 26. 4B1].

On 11/08/23 at 10:15 AM, the surveyor interviewed the Director of Nursing (DON) who stated that when the resident was put on [Ex Order 26] the nurse should have called the physician to obtain an order for the resident to be on [Ex Order 26]. She continued to explain that the nurse would also have been responsible to get an [Ex Order 26. 4B1] set up outside the resident's room which contained [Ex Order 26. 4B1] gowns, masks, gloves, facial shields (PPE), and that signage was supposed to be placed outside the resident's door. The signage indicated that the visitor should "stop" and come to the nurse's station to find out what type of PPE and [Ex Order 26. 4B1] was required to visit that resident. The notification that the resident was on contact [Ex Order 26. 4B1] was written on the 24-hour report and the nurse would communicate this information to the CNA. She continued to explain that the IP usually would notify administration by way of phone and email. She stated that this all should have been documented in the progress notes, resident Care Plan and CNA Kardex. The DON

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F 880	Continued From page 60 confirmed that all these Ex Order 26. 4B1 processes should have been implemented. The DON also stated that these processes were required to be put into place to prevent the potential spread of infection. On 11/14/23 at 11:20 AM, the surveyor interviewed the DON who stated that the CNA Kardex was the most easily accessed piece of information regarding resident care and that it needed to be updated to assure that the CNA knew how to care for the resident. She stated that it would have been important to document in the Kardex that the resident was on contact Ex Order 26. 4B1 so that the CNA knew. The DON stated that the facility did not have a policy regarding Care Planning. On 11/15/23 01:20 PM, the surveyor interviewed the IP and the Medical Director who stated that a physician's order was required to put a resident on Ex Order 26. 4B1. 2.) On 11/09/23 at 11:56 AM, the surveyor observed a Certified Nursing Assistant (CNA #2) with two lunch meal trays on a rolling bedside table (BST) in the Ex Order 26.7 Wing hallway. CNA #2 entered room Ex Order and placed a meal tray on the resident's BST then returned to the hallway, gathered the second meal tray, and entered room Ex Order. CNA #2 placed the meal tray on the resident's BST, opened the carton of milk and poured the contents into a cup, opened a straw, and placed it into the cup, opened the lid from the ice cream, then removed the plastic food lid and placed it on the BST. CNA #2 then opened the potato chip bag, cut up the food with the fork and	F 880		

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knife, opened two sugar packets and poured them into the coffee and mixed it with a spoon. She then moved the BST closer to the resident, collected the trash and placed it into the food lid and left the room with the lid which contained the empty milk container, straw paper, sugar wrappers and ice cream lid and placed them on the rolling BST in the hall. The resident was then observed using her fork to eat her lunch. CNA #2 then moved the rolling BST with the dirty lid, up the hallway to the food cart, where she placed the dirty lid containing the trash, on top of the cart. She moved the BST aside, took a lunch meal tray from the food cart and placed it on the rolling BST, touched the front of her surgical mask to adjust the mask on her nose, rolled the BST down the hallway while stopping to remove an additional BST from the hall and placed it into room [Ex Order], then stopped at room [Ex Order], an [Ex Order 26. 4B1] room. CNA #2 stood at the doorway and removed a disposable [Ex Order 26. 4B1] gown from the personal protective equipment (PPE) bin and unfolded it. A [Ex Order 26. 4B1] approached and spoke with the CNA, at which time CNA #2 loosely rolled up the [Ex Order 26. 4B1] gown and placed it on top of the PPE bin and walked up the hallway. CNA #2 touched the right side of her hair while she stopped to speak with another staff member in the hallway, then walked to another hall to retrieve a towel from the linen cart and walked back to room [Ex Order]. CNA #2 then donned (put on) the rolled-up gown from the top of the PPE bin, donned gloves, knocked and entered room [Ex Order]. CNA #2 reached down with her right hand and moved the blue mat that was on the floor, she then pulled the privacy curtain partially between the residents, placed the towel over the resident as a clothing protector, moved the resident's BST, adjusted the bed linens, pulled a chair near the resident, moved the

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resident's bed closer to the wall, removed the food lid, set up the meal tray then sat in the chair and fed the resident lunch. No hand hygiene (HH) was observed during the observation.

During an interview at that time, CNA #2 stated that HH should have been performed between each resident and acknowledged she did not clean her hands correctly during the meal tray pass observation. The CNA stated it was important to make sure HH was completed correctly during tray pass so germs were not transferred.

On 11/09/23 at 12:18 PM, the surveyor interviewed the assigned Licensed Practical Nurse (LPN #3) who stated that during meal tray pass, hand sanitizing should have been done between residents to prevent cross contamination and spreading of germs.

On 11/09/23 at 12:22 PM, the surveyor interviewed LPN #2, who stated she was the Charge Nurse on the unit today, and informed her of CNA #2's meal tray pass observation. LPN #2 acknowledged that CNA #2 did not perform HH correctly and stated that there were several missed opportunities for the CNA to perform HH. LPN#2 stated that HH should have been performed between each resident and that it was important to perform HH correctly to prevent cross contamination.

On 11/09/23 at 12:36 PM, the surveyor interviewed the LPN Unit Manager (LPN/UM) who stated that HH should have been performed any time before and after resident care. The surveyor informed the LPN/UM of CNA #2's meal pass observation, and she acknowledged that the CNA

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did not perform HH correctly. She further stated that it was important to perform HH correctly to prevent the spread of germs.

On 11/09/23 at 12:49 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that HH should have been performed by staff: prior to touching meal trays, with any contact with food items, with any personal contact with residents, and performed between residents. The surveyor informed the ADON of CNA #2's meal pass observation. She acknowledged that the CNA did not perform HH correctly and stated that it was important to perform HH correctly to prevent infection.

On 11/13/23 at 09:58 AM, the surveyor interviewed the Director of Nursing (DON) who stated that HH should have been performed before entering a resident's room, when handling food, and performed between residents. The surveyor informed the DON of CNA #2's meal pass observation from 11/09/23. She acknowledged that the CNA did not perform HH correctly and stated that it was important to perform HH correctly to prevent the transmission of infection.

On 11/13/23 at 10:15 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that HH should have been performed before passing meal trays, after providing the resident with their tray and preparing their food and performed in between each resident. The surveyor informed the IP of CNA #2's meal pass observation from 11/09/23. The IP acknowledged that the CNA did not perform HH correctly and stated that HH was the important first step in breaking the chain of transmission to any

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F 880	Continued From page 64 pathogen. On 11/15/23 at 12:19 PM, the surveyors met with the Administration team and the team was informed of CNA #2's meal pass observation from 11/09/23. The surveyor requested from the LPN/UM, IP, ADON, DON and Licensed Nursing Home Administrator any hand hygiene inservices for CNA #2 prior to 11/09/23. No documentation was provided. The surveyor reviewed the facility policy titled, "Isolation-Notices of Transmission-Based Precautions," dated August 2019, that indicated that notices will be used to alert personnel and visitors of TBP while protecting the privacy of the residents. The policy indicated that when TPB are implemented, the IP or designee determines the appropriate notification to be placed on the room entrance door and on the front of the resident's chart to that personnel and visitors are aware on the need for and type of precautions. The surveyor reviewed the facility policy titled, "Isolation-Initiating Transmission-Based Precautions," dated August 2019, that indicated that if a resident was suspected of, or identified as, having a communicable infectious disease, the charge nurse or nursing supervisor notified the IP and resident's attending physician for evaluation of appropriate TBP. When TPB are implement, the IP clearly identifies the type of precautions, anticipated duration and the PPE that must be used. The policy also indicated that the physicians are involved in decisions related to infection control and residents under their care.	F 880		

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The surveyor reviewed the facility policy titled, "Physician's Orders," dated 01/13, that indicated the purpose of the policy was to communicate and document the physician's order for care and treatment of residents.

The surveyor reviewed the facility policy titled, "Kardex," with a revised date of 01/15, that indicated that the purpose of this tool is to communicate resident care information to all nursing, rehabilitation, restorative and interdisciplinary (IDT) team members. The policy also indicated that the Kardex would be changed, as Resident care needs change.

The surveyor reviewed the facility policy titled, "Hand Hygiene," reviewed 2/14, that indicated, Procedure: 1. Indications for hand washing and hand antisepsis: c. Before having direct contact with Residents. i. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the Resident.

The surveyor reviewed the facility policy titled, "Personal Protective Equipment-Contingency and Crisis Use of Facemasks," dated April 2020, that indicated, General Procedure for Donning and Doffing Masks. 1. D. After touching a facemask or before changing a face mask, perform hand hygiene. f. Handle a mask only by the elastic ear loops. g. Refrain from touching the mask while it is in use. 2.a. Front of mask is contaminated-DO NOT TOUCH.

The surveyor reviewed the facility policy titled, "Personal Protective Equipment-Using Face Masks," revised September 2010, that indicated, Miscellaneous. 8. Handle mask only by the strings (ties). 9. Never touch the mask while it is

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F 880	Continued From page 66 in use. NJAC 8:39-19.4 (a)(m)(n)	F 880		

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S 000	Initial Comments Complaint # NJ: 158079, 163502, 162579, 162538, 157448 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 158079; 163502; 162579; 162538, 157448 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey. This deficient practice was identified for 4 of 6 weeks of complaint staffing reviewed and 2 of 2 weeks of staffing prior to the recertification survey dated 11/17/2023. This deficient practice was evidenced by the following:	S 560	1. The facility is unable to retroactively correct the deficient practice. The facility recently implemented higher rates for C.N.A's. Facility signed new contracts with 3 additional staffing agencies. Facility has hired LPNs from agency, at LPN rate, to fill required CNA positions. Facility has been offering bonus PTO to minimize call outs, and encourages cash-in option. 2. All residents have the potential of being affected by the deficient practice. 3. Facility will perform a wage analysis to ensure competitive rates. Facility will offer staff referral and sign-on bonuses. Facility	12/10/23

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

Electronically Signed | 12/01/23

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: As per the "Nursing Staffing Report" completed by the facility for the complaint staffing for the week of 08/21/2022 to 08/27/2022, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -08/21/22 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -08/22/22 had 10 CNAs for 93 residents on the	S 560	will offer CNAs retention bonuses. Facility will flexibly work with CNA schedules. Facility will continue to offer free meals to CNAs when encouraging them to pick up shifts. Nursing department will conduct a daily meeting to collaborate staffing efforts. 4. DON or Designee will review staffing ratios daily for 4 weeks and then weekly for 2 months, to ensure all efforts to meet proper standards are being met. Findings will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060501	A. BUILDING: _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATIC	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2	S 560		

day shift, required at least 12 CNAs.
-08/24/22 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-08/27/22 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs.

As per the "Nursing Staffing Report" completed by the facility for the complaint staffing for the weeks of 03/12/2023 to 03/25/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows:

-03/13/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-03/16/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/17/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/18/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/21/23 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs.
-03/25/23 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs.

As per the "Nursing Staffing Report" completed by the facility for the complaint staffing for the week of 04/16/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and 1 of 7 evening shifts as follows:

-04/16/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-04/17/23 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-04/18/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-04/19/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-04/20/23 had 8 CNAs for 88 residents on the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060501	A. BUILDING: _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATIO	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3	S 560		

shift, required at least 11 CNAs.
-04/20/23 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs.
-04/21/23 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-04/22/23 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs.

As per the "Nursing Staffing Report" completed by the facility for the complaint staffing for the week of 04/30/2023 to 05/06/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts and 1 of 7 evening shifts as follows:

04/30/23 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs.
-05/02/23 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs.
-05/03/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-05/04/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-05/04/23 had 9 CNAs to 20 total staff on the evening shift, required at least 10 CNAs.
-05/05/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-05/06/23 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs.

As per the "Nursing Staffing Report" completed by the facility for the 11/17/2023 recertification survey for the weeks of 10/15/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows:

-10/15/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-10/16/23 had 9 CNAs for 92 residents on the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060501	A. BUILDING: _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATIC	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4	S 560		

shift, required at least 11 CNAs.
-10/17/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.
-10/22/23 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-10/23/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-10/23/23 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs.
-10/25/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-10/26/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-10/27/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.

On 11/09/23 at 10:25 AM, the surveyor interviewed the CNA who stated she was agency staff and had only been working at the facility for approximately one (1) week. The CNA further stated that she currently had seven (7) or eight (8) residents and believed there were only six (6) CNAs here at the facility that day.

On 11/14/23 at 10:51 AM, the surveyor interviewed the Staffing Coordinator (SC) who had been employed at the facility for approximately 16 years but had been the SC for approximately two (2) years. When asked if she knew what the staffing ratios where, the SC stated that it was one (1) CNA to eight (8) Residents on the 7:00 AM - 3:00 PM shift (day shift); one (1) CNA to 10 Residents on the 3:00 PM - 11:00 PM shift (evening shift); and one (1) CNA to 12 to 15 Residents on 11:00 PM -7:00 AM shift (Night shift).

On 11/15/23 at 11:06 AM, the surveyor interviewed the Director of Nursing (DON) about the staffing ratios for the facility. The DON stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060501	A. BUILDING: _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATIO	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 that the staffing ratios where, one (1) CNA to eight (8) Residents on the 7:00 AM - 3:00 PM shift (day shift); one (1) CNA to 10 Residents on the 3:00 PM - 11:00 PM shift (evening shift); and one (1) CNA to 12 to 15 Residents on 11:00 PM -7:00 AM shift (Night shift). On 11/15/23 at 11:23 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) about the staffing ratios for CNAs. When asked if he knew what the staffing rations where, the LNHA stated that it was one (1) CNA to eight (8) Residents on the 7:00 AM - 3:00 PM shift (day shift); one (1) CNA to 10 Residents on the 3:00 PM - 11:00 PM shift (evening shift); and one (1) CNA to 14 Residents on 11:00 PM -7:00 AM shift (Night shift). A Review of the facility policy titled, "Nursing Policy and Procedure Staffing Guidelines," with a revised date of 08/2022, indicated that "The minimum staffing needed for each skill level (RN, LPN, CNA, and Unit Clerk) is determined by the nurse -patient ratio guidelines and the patient/ resident care needs, i.e., level of acuity and based on New Jersey state minimum requirements".	S 560		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year,	S1410		12/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060501	A. BUILDING: _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATIC	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

(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
S1410	Continued From page 6 employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to administer a [redacted] for 1 of 1 new employees hired since the last Re-certification survey dated [redacted]. This deficient practice is evidenced by the following: A complete review of the new employees Human Resource paperwork/Employee File revealed that the staff member was not administered a [redacted]. On 11/16/23 at 09:20 AM, the surveyor interviewed the County Director of Human Resources (CDHR) who stated that she oversaw Human Resources for the entire county which consisted of 40 different departments. The CDHR stated that she was responsible for holding employee files within the county department and	S1410	1. Facility is unable to retroactively correct the deficient practice of [redacted] testing. 2. All residents have the potential of being affected by the deficient practice. 3. Orientation Nurse was re-in-serviced by the DON on the requirements to ensure that all new hires have record of a [redacted] testing or [redacted] on 12/8/23. 4. [redacted] or Designee will conduct an audit of 2 employee files weekly for 4 weeks and then monthly for 2 months to ensure that all employees are compliant with [redacted] monitoring requirements. Results of these audits will be submitted to the quarterly QAPI meeting for 1 quarter. The QAPI committee will determine further interventions as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1410	Continued From page 7 that the facility was responsible to follow State and Federal regulations. On 11/16/23 at 10:24 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that she did not know that the new hire started in his job position because she was not notified of the new hire by the county Human Resources Department. The IP acknowledged that the new hire was not administered the two-step tuberculin skin test and stated that if she knew the new employee was recently hired that she would have offered the tuberculin skin test and that a lack of communication had caused the breakdown of information. On 11/16/23 at 11:19 AM, in the presence of the Licensed Nursing Home Administrator (LNHA), the surveyor interviewed the Director of Nursing (DON) who stated that there was no Human Resources Department in the facility and that the county was in control of staff hiring. The DON stated that there was no email notification between departments to notify the nursing staff that there was a new hire in the facility and that was why the tuberculin testing was not completed for the new employee. During the interview at that time, the LNHA agreed with the DON as to the hiring process and added that the process was due to the fact that the county implemented a hiring freeze upon the facility. The surveyor reviewed the facility policy titled, "Employee Health-Screening, Illness and Vaccinations," revised 10/21, which revealed Purpose: To prevent the transmission of infectious diseases to or from residents and employees. Scope: All Employees,	S1410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060501	A. BUILDING: _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATIC	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

(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
S1410	Continued From page 8 Administration, Staff Development, Infection Prevention, Nursing. Procedure: 1. Screening: *A two step tuberculin skin test (TST) will be completed unless the employee has a documented negative 2 step TST within the last year, a documented positive skin test, history of medical treatment for tuberculosis or if medically contraindicated ...4. All the above information will be kept in the employee health file.	S1410		

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
315294 Y1	A. Building B. Wing Y2	1/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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 F0576	Correction	ID Prefix F0610	Correction	ID Prefix F0684	Correction
Reg. # 483.10(g)(6)-(9)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.25	Completed
LSC	12/10/2023	LSC	12/10/2023	LSC	12/10/2023
ID Prefix F0689	Correction	ID Prefix F0727	Correction	ID Prefix F0730	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.35(d)(7)	Completed
LSC	12/10/2023	LSC	12/10/2023	LSC	12/10/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	12/10/2023	LSC	12/10/2023	LSC	12/10/2023
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/17/2023	☐ YES ☐ NO

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
315294 Y1	A. Building B. Wing Y2	1/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0727	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.35(b)(1)-(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/10/2023	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	

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/17/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060501 Y1	A. Building B. Wing Y2	1/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1410	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(b)(1)	Completed	Reg. #	Completed
LSC	12/10/2023	LSC	12/10/2023	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/17/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060501 Y1	A. Building B. Wing Y2	1/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/10/2023	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/17/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING **01** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	**4 MOORE ROAD** **CAPE MAY COURT HOUSE, NJ 08210**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/03/2023 and 11/06/2023, and Crest Haven Nursing and Rehabilitation Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Crest Haven Nursing and Rehabilitation Center is a 2-story building that was built in 1989, It is composed of Type I fire resistant construction. The facility is divided into 9- smoke zones. The facility has 2 generators, one 100 KW (Kilowatt) and one 600 KW (Natural Gas).	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 11/03/2023 and 11/06/2023 in the presence of facility management, it was determined that the facility failed to provide four (4) illuminated exit signs to	K 293	1. All residents have the potential to be affected by this deficient practice. 2. The four identified missing illuminated exit signs in the two courtyards were	12/15/23

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

Electronically Signed | 12/01/2023

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.

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K 293	Continued From page 1 clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants.	K 293	ordered on 11/9/23. The Maintenance Director and his staff were educated on the requirement to ensure that illuminated exit signs are in locations that clearly identify the exit access path to reach an exit discharge door. 3. The DOM/Designee will audit all locations that require illuminated exit signs monthly x3 months and submit the audit findings to the facility administrator. Any deficient practice observed during the audit will be corrected immediately. 4. The audit findings will be submitted to the Quarterly QAA committee meeting x3 Quarters to review and determine if further interventions are needed.	

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K 293	Continued From page 2 Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 11/03/2023 (day one of survey) during the survey entrance at approximately 8:58 AM, a request was made to the Administrator and Facility Carpenter (FC) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with two (2) enclosed (surrounded by the building) outside courtyards that Resident, Staff and Visitors could use. Starting at approximately 9:33 AM on 11/03/2023 and continued on 11/06/2023 in the presence of the FC a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor observed four (4) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, On 11/03/2023: 1) At approximately 11:55 AM, he surveyor observed in the enclosed outside courtyard (near the Physical Therapy room) #1, that the facility failed the have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. On 11/06/2023: 2) At approximately 10:21 AM, the surveyor observed in the enclosed outside courtyard (near	K 293		

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K 293	Continued From page 3 the Doctors Office) #2 that the facility failed the have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. The FC confirmed the findings at the time of observations. On 11/06/2023 at approximately 12:33 AM during the survey exit, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324		12/10/23

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K 324	Continued From page 4 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation on 11/03/2023 and 11/06/2023, in the presence of facility management, it was determined that the facility failed to inspect the kitchen range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. The deficient practice was evidenced by the following: On 11/03/2023 during the survey entrance at approximately 8:58 AM a request was made to the Administrator and Facility Carpenter (FC) to provide all mandatory inspections from 01/01/22 to 11/03/2023 for review. Starting at approximately 9:33 AM on 11/03/2023 in the presence of the FC a tour of the building was conducted. At approximately 11:10 AM, an inspection inside the Main Kitchen was performed. The surveyor observed on the inspection tag attached to the manual pull station for the kitchen stove's "Wet Chemical" fire suppression system was last semi-annually inspected in March 2023. Later a review of the facility's range-hood fire	K 324	1. All residents have the potential to be affected by this deficient practice. 2. The Maintenance Director scheduled a semi-annual range-hood fire suppression system inspection on 11/9/23. The Maintenance Director and his staff were educated on the requirement to inspect the range-hood fire suppression system semi-annually (every 6 months) in accordance with NFPA 96. 3. The DOM/Designee will audit all monthly inspections x3 months and submit findings to the facility administrator. Any deficient practice observed during the audits will be corrected immediately. 4. Audit findings will be submitted to the Quarterly QAA Committee meeting x3 Quarters to review and determine if further interventions are needed.	

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K 324	Continued From page 5 suppression system inspections for the previous 22 months identified the system had three (3) semi-annual inspections on the following dates: - February 9. 2022. August 16, 2022 and March 24, 2023. A request was made to the FC if the facility could provide any additional kitchen hood semi-annual inspections. The FC could not provide any additional semi-annul inspections. The facility did not semi-annually inspect the kitchen suppression system for the 7 months between March 24, 2023 and November 3. 2023. The FC confirmed the finding at the times of review. On 11/06/2023 at approximately 12:33 AM during the survey exit , the surveyor informed the Administrator of the deficiency. NFPA 101, NFPA 96 NJAC 8:39-31.2(e)	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on	K 345	1. All residents are at risk to be affected	12/1/23

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K 345	Continued From page 6 11/03/2023 and 11/06/2023, in the presence of the facility management, it was determined that the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: On 11/03/2023 during the survey entrance at approximately 8:58 AM a request was made to the Administrator and Facility Carpenter (FC) to provide all mandatory inspections from 01/01/22 to 11/03/2023 for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. Later at approximately 12:31 PM a review of the facility provided mandatory inspections for the previous 22 months identified was performed. The surveyor reviewed the following Fire Alarm and Detection system inspections, - 05/06/2022 semi-annual inspection. - 11/11/2022 semi-annual inspection. - 05/05/2023 semi-annual inspection. - 11/01/2023 semi-annual inspection. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. At approximately 1;45 PM on 11/03/2023, the surveyor asked the facility Administrator and FC they may have to call the fire alarm and detection vendor and ask for a copy of the last smoke	K 345	by the deficient practice. 2. The Director of Maintenance scheduled a smoke sensitivity test to be done on 11/06. The maintenance director was in-serviced on the requirements to ensure smoke detection sensitivity is checked every alternate year of the facility smoke detectors. 3. DOM/Designee will audit the Fire Alarm Testing and Maintenance inspections monthly x3 months and submit findings to the facility administrator. Any deficient practice observed during the audits will be corrected immediately. 4. Audit findings will be submitted to the monthly QAA Committee meeting x3 quarters to review and determine if further interventions are needed.	

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K 345	Continued From page 7 detector sensitivity testing and to provide the copy of the testing to the surveyor on 11/06/2023 (day two of survey) for review. On 11/06/2023 at approximately 9:30 AM, the Administrator provided a copy of the 05/05/2023 Fire Alarm and Detection system inspection that reads in part, Equipment Summary: Smoke Detector - PE No Sensitivity. Total 297. The smoke detector sensitivity testing of the fire alarm and detection system had not been done. On 11/06/2023 at approximately 12:33 AM during the survey exit, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of	K 351		12/1/23

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K 351	Continued From page 8 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 11/03/2023 and 11/06/2023, in the presence of facility management it was determined that: The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 11/03/2023 (day one of survey) during the survey entrance at approximately 8:58 AM, a request was made to the Administrator and Facility Carpenter (FC) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with one hundred and fifteen (115) Resident sleeping rooms. Starting at approximately 9:33 AM on 11/03/2023 and continued on 11/06/2023 in the presence of the FC a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage:	K 351	1. All residents are at risk to be affected by the deficient practice. 2. The 8 identified missing ceiling tiles were installed on 11/6/23. The maintenance director performed a facility sweep on DATE to ensure proper sprinkler coverage is being provided. The Maintenance Director was in-serviced on the CMS requirement to provide proper sprinkler coverage. 3. DOM/Designee will audit the areas requiring complete sprinkler coverage monthly x3 months and submit findings to the facility administrator. Any deficient practice observed during the audits will be corrected immediately. 4. Audit findings will be submitted to the quarterly QAA Committee meeting x3 quarters to review and determine if further interventions are needed.	

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K 351	Continued From page 9 On 11/03/2023: 1) At approximately 11:03 AM, inside the Residents Recreation room the surveyor observed the drop ceiling grid were missing seven (7) 2' by 2' ceiling tiles With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. On 11/06/2023: 2) At approximately 10:10 AM, on the Memory Impaired unit corridor to the left of Resident room #SW 110 the surveyor observed the drop ceiling grid were missing one (1) 2' by 2' ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. The FC confirmed the findings at the time of observations. On 11/06/2023 at approximately 12:33 AM during the survey exit, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K 355		12/1/23

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K 355	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 11/03/2023 and 11/06/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examinations for 3 of 48 portable fire extinguishers, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following,	K 355	1. All residents have the potential to be affected by this deficient practice. 2. The listed fire extinguishers in the maintenance shop and memory care unit and were visually examined and found to be operational on 11/9/23. Findings were documented on the tags attached to each fire extinguisher. The Maintenance Director and his staff were educated on the requirements for portable fire extinguishers to be selected, installed, inspected and maintained in accordance with NFPA 10. 3. The DOM/Designee will visually audit the facility's fire extinguishers monthly x3 months and submit findings to the facility administrator. Any deficient practice observed during the audits will be corrected immediately. 4. Audit findings will be submitted to the Quarterly QAA Committee meeting x3 Quarters to review and determine if further interventions are needed.	

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K 355	Continued From page 11 On 11/03/2023 (day one of survey) during the survey entrance at approximately 8:58 AM, a request was made to the Administrator and Facility Carpenter (FC) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at approximately 9:33 AM on 11/03/2023 and continued on 11/06/2023 in the presence of the FC a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor observed forty-eight (48) portable fire extinguishers in various locations. These 48 portable fire extinguishers were last annually inspected in March 2023 with the surveyor observing the following issues that were identified: On 11/03/2023: 1) At approximately 12:01 PM, the surveyor observed inside the Maintenance shop, two (2) fire extinguishers. At this time the surveyor asked the FC, "Are these two fire extinguishers spare extinguishers." The FC said yes they are spares. Further inspection identified the two fire extinguishers were annually inspected March 2023 with no evidence of a monthly visual examination being performed and documented on the tags attached to the extinguishers for April, May, June, July, August, September and October 2023. On 11/06/2023: 2) At approximately 10:06 AM, the surveyor observed on the Memory Impaired Unit one "ABC-Type" fire extinguisher (identification number #39) was last annually inspected March	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING **01** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	**4 MOORE ROAD** **CAPE MAY COURT HOUSE, NJ 08210**

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K 355	Continued From page 12 2023 with no evidence of a monthly examination performed and documented on the tag attached to the extinguisher for October 2023. The FC confirmed the findings at the time of observations. On 11/06/2023 at approximately 12:33 AM during the survey exit, the surveyor informed the Administrator of the deficiency.	K 355		
K 918 SS=E	NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e). 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	K 918		12/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING **01** B. WING _____	**11/17/2023**

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CREST HAVEN NURSING AND REHABILITATION CENTER	**4 MOORE ROAD** **CAPE MAY COURT HOUSE, NJ 08210**

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K 918	Continued From page 13 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/03/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 2 of 2 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 11/03/2023 (day one of survey) during the survey entrance at approximately 8:58 AM, a request was made to the Administrator and Facility Carpenter (FC) if the facility had an Emergency Generator. The FC told the surveyor, yes we have two (2), one is a 100 KW (Kilowatt) and one is a 600 KW Emergency Generator. Starting at approximately 9:33 AM on 11/03/2023 and continued on 11/06/2023 in the presence of the FC a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor observed the following:	K 918	1. All residents have the potential to be affected by this deficient practice. 2. On 11/9/23, the Generator Services Vendor installed a remote manual stop station for the two identified Generators. The Maintenance Director and his staff were educated on the requirements to ensure a remote manual stop station for the emergency generator is installed in accordance with the requirements of NFPA 110. 3. The DOM/Designee will audit the Maintenance and Testing of the Essential Electric Systems monthly x3 months and submit the report to the facility administrator. Any deficient practice observed during the audits will be corrected immediately. 4. The audit findings will be submitted to the Quarterly QAA committee meeting x3 Quarters to review and determine if further interventions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING **01** B. WING _____	**11/17/2023**

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CREST HAVEN NURSING AND REHABILITATION CENTER	**4 MOORE ROAD** **CAPE MAY COURT HOUSE, NJ 08210**

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K 918	Continued From page 14 On 11/03/2023 at approximately 11:40 AM, an inspection inside the electrical room where the 100 KW Onan emergency generator was located was performed. The surveyor observed no evidence of a remote emergency stop button for the generator. At this time the surveyor asked the FC, does the facility have a remote emergency stop for the generator. The FC placed a phone call and asked about a remote emergency stop for both generators. The FC told the surveyor that there has never been remote emergency stops for the two (2) generators. On 11/06/2023 at approximately 10:49 AM, an inspection outside of the building where the 600 KW Kohler emergency generator was performed. The surveyor observed that the emergency stop button was located on the control panel on the generator. The FC confirmed the finding on 11/03/2023 at the time of inspection. On 11/06/2023 at approximately 12:33 AM during the survey exit, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315294 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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 K0293	12/15/2023	LSC K0324	12/10/2023	LSC K0345	12/01/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	12/01/2023	LSC K0355	12/01/2023	LSC K0918	12/01/2023
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/17/2023	☐ YES ☐ NO