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

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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. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 918 SS=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**

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