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 _____	01/06/2023

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 000	INITIAL COMMENTS Survey Dates: 12/27/22-12/30/22 Survey Census: 81 Sample Size: 25 Supplemental Residents: 0 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found to be in substantial compliance with 42 CFR 483 subpart B.	F 000		

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

Electronically Signed | 01/27/2023

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.

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 _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CEN	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 000	Initial Comments 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 deficieny 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: Base on interview and review of other facility documentation , it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift. This was evident for 3 of 14 day shifts reviewed. Findings include: 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. "Direct care staff member" means any registered professional nurse,	S 560	1. The corrective action taken based on the new policy will asssure that resident are provided with ample care with certified nurse aide to resident ratio as follows; 1 certified nurse aide to 8 residents during the 7-3 shift, 1 certified nurse aide or other direct licensed healthcare professional assigned as a certified nurse aide for up to 10 residents during the 3-11 shift, and 1 certified nurse aide or other direct licensed healthcare professional assigned for up to 14 residents during the 11 to 7 shift. We currently have contracts with several agencies and our utilized on a daily basis by a staffing coordinater. The use of overtime and agency staff is permissable per facility policy. The facility will use an	2/15/23

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

Electronically Signed | 01/27/23

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 _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CEN	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 1 licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 2 weeks of staffing (12/11/2022 to 12/17/2022 and 12/18/2022 to 12/24/2022) for the 12/30/2022 Standard survey were reviewed. For the week of 12/18/2022 to 12/24/22, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -12/18/22 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. -12/20/22 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. -12/24/22 had 6 CNAs for 80 residents on the day shift, required 10 CNAs.	S 560	on-line website to advertise for direct care assistance. The county maintains a website containing job openings for the facility. The county technical center will meet with Director of Nursing. The facility is in the process of contracting an on-site certified nurse aide class. 2. All residents have the potential to be affected. Staffing practices could effect all three nursing units. The Director of Nursing/Designee conitinues to have daily staffing meetings with administration. The Nursing Administration we continue to use outside resources, the technical school, agencies, advertisements, and the addition of a training class in the facilty to fill staffing needs. There will be situations where nurses may have to work as certified nurse aides. 3. The Director of Nurses and Assistant Director of Nurses will in-service/reeducate direct care staff of Crest Haven regarding the staffing policy. Prior to the end of business each day the Director of Nurses, Assistant Director of Nurses, Staffing Coordinater and Administration will review/monitor the staffing schedule and contact all available nurses, certified nurse aides, and agency personel to procure staff if/as needed. Nursing staff will be reassigned to certified nursing aide assignments when necessary. If the facility is unable supply required staff to meet resident care needs, on-call nursing management will be notified. Recruitment ads on the websites will be ongoing. Recruitment from the Cape May County technical school will be	

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 _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CEN	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	ongoing. The facility in the process of having onsite training program for the certified Nurse Aides. 4. Monitoring mechanisms to assure compliance. The supervisors will daily check staffing for the upcoming 3 shifts. The supervisors on off shifts will check daily staffing at the beginning of each shift. The staffing coordinator will continue to schedule/monitor all shifts on a daily basis. The staffing coordinator will report deficient needs to nurse management to activate further assistance. The Director of Nursing/Designee will meet with the staffing coorinator daily and report all findings to the QAPI Committee monthly and address noncompliance as necessary.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060501 Y1	A. Building B. Wing Y2	2/28/2023 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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/15/2023	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	
1/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING **01** B. WING _____	**01/06/2023**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/06/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/06/23 and was found to not be in compliance with 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. The facility is two stories first occupied in 1989. The second floor is over the foyer area and used for office space only. The facility has concrete flooring, block bearing walls and flat concrete roofing. The facility is noted to be a type II protected (222) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has two generators, one 100 KW (kilowatt) and one 600 KW natural gas generator.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by	K 211		2/15/23

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

Electronically Signed | 01/27/2023

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.

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 _____	**01/06/2023**

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 211	Continued From page 1 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that all corridors and exit discharges and means of egress were continuously maintained free of all obstructions for full use in case of emergency in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.1.10.1. This deficient practice had the potential to affect 11 residents. Findings include: An observation on 01/06/23 at 9:30 AM revealed the north wing had storage in the exit corridor, located beyond the cross-corridor doors at Room 327. Stored items included one cart containing personal protective equipment, two large laundry carts, one patient lift, a six foot long by six foot high cart, one storage cabinet six feet long, three wooden crates with storage five feet high on each crate, one recliner chair and two bed frames. In one area for over six feet, the total clearance in the middle of the corridor was three feet rather than the required four feet. The Surveyor utilized the 12 inches by 12 inches floor tiles to measure the distance. In an interview with the Maintenance Man (MM) at the time of the observation, the MM verified that the storage was excessive and obstructing passage to the exit at the end of the corridor. An observation on 01/06/23 at 10:00 AM revealed two exit discharges, located near Room 323 and 324, led to a gate 50 yards away. The gate was chained and locked with a padlock.	K 211	1. The North wing corridor where room 327 is located will have the one protective equipment cart, two laundry carts, one patient lift, six by six foot high cart, one six foot long cabinet, three wooden crates with storage five feet high on each crate, one recliner chair and two bed frames were removed and stored in another area. The gate located outside Room 323 and 324 beyond the the two exit discharges had the lock removed. In the North wing the small corridor off the Physical Therapy room had the 6 wheelchairs removed. 2. All North wing residents have the potential to be affected by the one protective equipment cart, two laundry carts, one patient lift, six by six foot high cart, one six foot long cabinet, three wooden crates with storage five feet high on each crate, one recliner chair and two bed frames were removed and stored in another area. All North wing residents have the potential to be affected by the locked gate on the patio area outside the rooms 323 and 324 near the two exit discharges. All residents have the potential to be affected by the physical therapy corridor allowing for less than two feet clearance rather than the four feet. All Maintenance staff will be inserviced on storing the one protective equipment cart, two laundry carts, one patient lift, six by six foot high cart, one six foot long cabinet, three wooden crates with storage	

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 _____	**01/06/2023**

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 211	Continued From page 2 In an interview with the MM at the time of the observation, the MM verified the gate at the passageway was locked shut and no staff had keys for the lock. An observation on 01/06/23 at 12:10 PM revealed a small corridor off the Physical Therapy room extending four feet in width and 25 feet long had an exit sign above the door. The corridor contained six folded wheelchairs on both sides of the corridor allowing for less than two feet clearance rather than the required four feet. The Surveyor utilized the 12 inches by 12 inches floor tiles to measure the distance. In an interview at the time of the observation, the MM verified the clearance in the corridor. NJAC 8:39-31.1(c), 31.2(e)	K 211	five feet high on each crate, one recliner chair and two bed frames in the north wing exit corridor near room 327. Maintenance staff will be inserviced not to lock the gate outside from two exit discharges located outside room 323 and 324. All the therapy staff will be inserviced not to store wheelcairs by the physical therapy corridor allowing for less than two feet clearance rather than the four feet. 3. All Maintenance staff will be inserviced during fire drills on storing the one protective equipment cart, two laundry carts, one patient lift, six by six foot high cart, one six foot long cabinet, three wooden crates with storage five feet high on each crate, one recliner chair and two bed frames in the north wing exit corridor near room 327. Maintenance staff will be inserviced during fire drills not to lock the gate outside from two exit discharges located outside room 323 and 324. All the Therapy and Maintenance staff will be inserviced during fire drills not to store wheelcairs by the physical therapy corridor allowing for less than two feet clearance rather than the four feet. 4. The Maintenance staff/designee will make rounds once a week to ensure compliance to not store any type of equipment in corridors with exits and the North wing therapy corridor. The gate will be checked monthly to ensure the gate being lock free. They will report the results of their rounds to the QAPI Committee monthly and address noncompliance as necessary.	

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 _____	**01/06/2023**

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 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that two exit discharges had illumination of the means of egress including exit discharge arranged in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.8.1.1. This deficient practice had the potential to affect eight residents. Findings include: An observation on 01/06/23 at 10:00 AM revealed the means of egress on the North Wing, located at the exit doors adjacent to Room 324 and Room 323, had no lights above the exit doors and lacked any type of illumination. An interview with the Maintenance Director at the time of the observation verified there were no lights above the exit doors and no illumination in the area. NJAC 8:39-31.1(c), 31.2(e)	K 281	1. The means of egress on the north wing, located at the exit doors adjacent to Room 324 and Room 323, will have some type of illumination above the exit doors. 2. All residents have the potential to be affected by the exit doors on North wing adjacent to Room 324 and Room 323 having some type of illumination above the exit doors. The maintenance has ordered illumination for this location. 3. Maintenance will check all outside lighting to ensure illumination above all exit doors during rounds. 4. The Maintenance staff/Designee will monitor the means of egress on the North wing, located at the exit doors adjacent to Room 324 and Room 323 monthly. They will report the results of their round to the QAPI Committee monthly and address noncompliance as necessary.	2/15/23
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		2/15/23

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 _____	**01/06/2023**

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 321	Continued From page 4 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that hazardous areas were protected with self-closing or automatically closing doors and failed to ensure that doors were not secured in the open position at any time in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.2.1.8.1. and 19.3.2.1.3. This deficient practice had the potential to affect all 78 residents.	K 321	1. The facility will be installing self-closing door device for Rooms 334, 336, 341, and 339. The wedge was discarded in room 339 and the facilty will be installing a self-closing door devices for all the affected rooms. Room 329 received a new door with a self-closing door device. The facility will also be installing for the three electrical rooms, located on West, East, and North Wings self-closing door	

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 _____	**01/06/2023**

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 321	Continued From page 5 Findings include: An observation on 01/06/23 at 9:30 AM revealed the North Wing Medical Record Storage area, located adjacent to Room 339, contained over 50 boxes of paper storage and the self-closing door was propped open with a wedge. An observation on 01/06/23 at 9:30 AM revealed the North Wing Medical Record Storage area, located adjacent to Room 341, contained over 75 boxes of medical records and the door was not equipped with a self-closing device. An observation on 01/06/23 at 9:40 AM revealed the closed North Wing Medical Record Storage area, located adjacent to Room 336, contained over 50 boxes of medical records and the door was not equipped with a self-closing device. An observation on 01/06/23 at 9:40 AM revealed the closed North Wing Medical Record Storage area, located adjacent to Room 334, contained over 75 personal protective equipment gowns and the door was not equipped with a self-closing device. An observation on 01/06/23 at 9:45 AM revealed the closed North Wing Medical Record Storage area, located adjacent to Room 329, contained over 20 boxes of medical records and combustibles and the door was missing. An observation on 01/06/23 between 10:05 AM and 12:25 PM revealed three of three electrical rooms, located on the West, East and North Wings, were high hazard rooms. The rooms were equipped with two door leafs. One leaf was self-closing and the smaller leaf was not	K 321	devices for one of the two door rooms. The facility will also be installing for the three soiled linen rooms, located on West, East, and North Wings self-closing door devices for one of the two door rooms. 2. All residents have the potential to be affected by the deficient absence of self-closing door devices for Rooms 329, 334, 336, 341, and 339. All residents have the potential to be affected by Room 329 not having a door. All other rooms were checked for wedge devices used to prop doors open. All residents have the potential to be affected by the deficient absence of self-closing door devices for three electrical rooms and three soiled linen rooms, located on West, East, and North Wings self-closing door devices for one of the two door rooms. All the self-closing door devices have been ordered. 3. All Maintenance staff will be inserviced on self-closing door devices and the requirements. Maintenance staff will check the self-closing door devices monthly to ensure they are working. Maintenance will be inserviced on not using door wedges to prop open doors. All rooms will have doors operating. 4. The Maintenance Supervisor/Designee will make rounds monthly to check the self-closing door devices for working operations and to make sure there are no doors using wedges to prop open doors. The Maintenance Supervisor will report the results to the QAPI Committee	

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 _____	**01/06/2023**

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 321	Continued From page 6 self-closing. An observation on 01/06/23 between 10:05 AM and 10:55 AM, revealed three of three soiled linen rooms, located adjacent to Room 121, Rooms 221 and Room 321, contained fiberglass 100 gallon trash storage containers with trash storage. The rooms were equipped with two door leafs. One leaf was self-closing and the smaller leaf was not self-closing. In an interview at the time of each observation, the Maintenance Director verified the storage and lack of adequate protection such as doors held open, lack of doors or lack of self-closing devices. NJAC 8:39-31.1(c), 31.2(e)	K 321	monthly and address noncompliance as necessary.	
K 345 SS=E	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 observation and interview, the facility failed to ensure smoke detectors were not installed within a 36-inch (910 mm) horizontal path from the supply registers of a forced air heating or cooling system and installed outside of the direct airflow from those registers in accordance with NFPA 72 National Fire Alarm	K 345	1. The Maintenance staff had the smoke detectors in the recreation office located that were located 16 inches from the air supply diffuser, relocated to them to a least 36 inches from the air supply diffuser.	2/15/23

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 _____	**01/06/2023**

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 345	Continued From page 7 and Signaling Code (2010 edition) section 29.8.3.4.(6). This deficient practice had the potential to affect five residents. Findings include: An observation on 01/06/23 at 10:30 AM revealed the recreation offices, located off the main recreation room, had two smoke detectors that were installed 16 inches from an air supply diffuser. In an interview at the time of the observation, the Maintenance Man verified the location of each smoke detector in relation to the air supply diffuser. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	2. All residents have the potential to be affected by the smoke detectors located in the recreation offices 16 inches from the air supply diffuser. Other areas of the building were reviewed for smoke detectors located within 36 inches from the supply registers of a forced air heating or cooling system. 3. When smoke detectors are inspected by the vendor, they will check all locations to ensure compliance that they are at least 36 inches from any air diffuser. Also during monthly rounds Maintenance will check the building smoke detectors to ensure compliance from any air diffuser. 4. The Maintenance Supervisor/Designee will round monthly to ensure compliance of the smoke detectors located not installed within a 36 inche horizontal path from the supply registers of a forced air heating or cooling system. The Maintenace Supervisor will report the results of the rounds to the QAPI Committee monthly and address noncompliance as necessary.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where	K 372		2/15/23

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 _____	**01/06/2023**

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 372	Continued From page 8 an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) section 8.5.2.1 and 8.5.6.2. This deficient practice had the potential affect all 78 residents. Findings include: An observation of the smoke barrier wall at the maintenance room on the North unit on 01/06/23 at 1:25 PM revealed one inch and one-half inch hole at a silver conduit, one three-inch conduit not sealed, and one hole six inches wide not sealed. An observation of the smoke barrier wall at bedroom 301 on the North unit on 01/06/23 at 1:30 PM revealed one four-inch diameter sprinkler pipe with foam on the edge to seal the wall and one three-inch conduit not sealed on the inside or outside. An observation of the smoke barrier wall at bedroom 312 on the North unit on 01/06/23 at 1:35 PM revealed one four-inch sprinkler pipe with foam to seal the outside. An observation of a smoke barrier wall near bedroom 327 on the North unit on 01/06/23 at	K 372	1. The facility will seal/fill penetrations in smoke barriers located at the maintenance room on the North unit, near Room 301, near Room 312 and near Room 327. The facility will fill/seal penetrations in the smoke barriers located at the nursing office on the East unit and near Room 228. The facility will seal/fill penetrations on the smoke barriers located on West unit near Room 111 and 127. 2. All residents have the potential to be affected by penetrations in smoke barriers at the listed locations. Maintenance staff will check other smoke barriers in the building to ensure compliance. Maintenance staff will review all outside work performed by vendors working in the smoke barrier areas. 3. Maintenance staff will ask all vendors performing work in the building if they will be working in the smoke barrier areas. The Maintenance staff will review all work performed by vendors in the smoke barrier areas on a daily basis. 4. The Maintenance Supervisor/Designee will review all work performed by vendors in the smoke barrier areas on a daily	

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 _____	**01/06/2023**

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 372	Continued From page 9 1:40 PM revealed a two-inch hole near two silver conduits. An observation of the smoke barrier wall near bedroom 111 on the West unit on 01/06/23 at 1:45 PM revealed a two-inch diameter hole in the wall. An observation of the smoke barrier wall near bedroom 127 on the West unit on 01/06/23 at 1:50 AM revealed one three-inch sprinkler pipe with foam seal on the edges, one three-inch hole diameter hole and a one-inch diameter hole. An observation of the smoke barrier wall near the nursing office on 01/06/23 at 1:55 PM on the East unit one revealed a two-inch diameter hole. An observation of the smoke barrier wall near bedroom 228 on 01/06/23 at 2:00 PM on the East unit revealed a hole above a six-inch insulated white pipe, a two-inch diameter hole and one hole at a one- and one-half inch cast pipe. In an interview at the time of the observations, the Maintenance Man verified the unsealed openings and penetrations in the smoke barriers.	K 372	basis. Maintenance/Designee will report the results to the QAPI Committee monthly and address noncompliance as necessary.	
K 918 SS=F	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	K 918		2/15/23

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 _____	**01/06/2023**

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 918	Continued From page 10 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing 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 record reviews and interview, the facility failed to ensure weekly inspections for two of two generators were completed in the past 12 months in accordance with NFPA 110 Emergency and Standby Power Systems (2010 edition) section 8.4.1. This deficient practice had the potential to affect all 78 residents. Findings include:	K 918	1. The Maintenance Department began weekly checks to both generators after inspection. The Maintenance Supervisor is creating a new log book and form to monitor readings. 2. All residents have the potential to be affected. The Maintenance staff will be inserviced on procedures and regulations	

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 _____	**01/06/2023**

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 918	Continued From page 11 A review of the fire safety records for the 600 KW (kilowatt) generator in the "Log Book" revealed the dates of 09/27/22, 10/11/22, 10/25/22, 11/08/22, 11/22/22, 12/06/22 and 12/20/22 were lacking weekly inspections. A review of the fire safety records for the 100 KW (kilowatt) generator in the "Log Book" revealed the dates of 01/11/22, 01/25/22, 02/08/22, 02/23/22, 03/08/22, 03/23/22, 04/05/22, 04/19/22, 05/03/22, 05/17/22, 06/01/22, 06/14/22, 06/28/22, 07/02/22, 07/26/22, 08/09/22, 08/23/22, 09/07/22, 09/20/22, 10/04/22, 10/18/22, 11/01/22, 11/15/22, 11/29/22, 12/13/22 and 12/27/22 were lacking weekly inspections. In an interview on 01/06/23 at 2:30 PM, the Maintenance Man (MM) verified the lack of inspections. The MM stated that the generator runs weekly on a timer and occasionally the maintenance department does not conduct and document those inspections. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	regarding the generator. The Maintenance staff will be inserviced to the new generator log book and form. 3. Administrator/designee will review the generator log book monthly to ensure compliance. Administrator/Designee will make sure all Maintenance staff is inserviced regarding the generator. 4. The Maintenance Supervisor/Designee will continuously monitor the generator log book. The Maintenance Supervisor will report the results to the QAPI Committee monthly and address noncompliance as necessary.	

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	2/28/2023 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 K0211	02/15/2023	LSC K0281	02/15/2023	LSC K0321	02/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	02/15/2023	LSC K0372	02/15/2023	LSC K0918	02/15/2023
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	
1/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO