STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING ______ B. WING ______	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974**

(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 A Recertification and complaint 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. Survey Dates: 08/15/23 to 08/18/23 Survey Census: 40 Sample Size: 12 Supplemental Residents: 0 No deficiencies were issued related to Complaint Intakes NJ162192, NJ163620, NJ163741, NJ164118, NJ164483, NJ164624, and NJ165562.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 09/01/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20016	A. BUILDING: ______ B. WING ______	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974**

(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 is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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	S 560	1. No residents were affected by the deficient practice. 2.The facility acknowledges that all residents have the potential of being affected by the deficient practice. The administrator of designee has reviewed the staffing for 2 weeks to validate that the facility meets the minimum staffing requirement for certified nursing assistants. 3.The administrator or designee will provide education regarding the required direct care staff to resident ratios to the clinical leadership staff and the scheduler. The facility has job postings and has	9/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20016	A. BUILDING: ______ B. WING ______	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974**

(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 nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (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. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on day shifts as follows: For the 3 weeks of Complaint staffing from 01/29/2023 to 02/18/2023, the facility was deficient in CNA staffing for residents on 4 of 21 day shifts as follows: -01/29/23 had 4 CNAs for 39 residents on the day shift, required at least 5 CNAs. -02/05/23 had 4 CNAs for 38 residents on the day shift, required at least 5 CNAs. -02/08/23 had 4 CNAs for 37 residents on the day shift, required at least 5 CNAs. -02/17/23 had 4 CNAs for 38 residents on the day shift, required at least 5 CNAs. For the 3 weeks of Complaint staffing from 04/23/2023 to 05/13/2023, the facility was	S 560	advertised for all open certified nurse aide positions. The administrator or designee will pursue securing direct care staffing services from staffing agencies and will utilize floating staff from our Assisted Living with short notice vacancies. 4.The administrator or designee will review the certified nurse aide staffing and resident census to ensure compliance with the required direct care staff to resident ratios daily for one month and then weekly for 2 months. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly until 1/1/2024. Additional audits and education may be determined based on audit findings.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20016	A. BUILDING: ____ B. WING ____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(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 deficient in CNA staffing for residents on 1 of 21 day shifts as follows: -05/06/2023 had 4 CNAs for 38 residents on the day shift, required at least 5 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
20016		9/12/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/11/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
20016		9/12/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/11/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/18/2023	☐ 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
	315523	A. BUILDING **01** B. WING ___	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(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 08/16/2023. 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 Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/16/23 and 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. Continuing Care at Lantern Hill is an eight-story building that was built in 2016. Skilled nursing is located on the fourth floor. It is composed of Type II (222) protected construction. The facility is divided into two - smoke zones. The generator does 100 % of the building as per the Senior Facilities Manager. The current occupied beds are 37 of 40.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 291	1.No residents were affected by the	9/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/01/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING **01** B. WING ______	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(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 291	Continued From page 1 failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 37 residents. Findings include: An observation on 08/16/23 at 2:21 PM revealed emergency lighting was not provided at the emergency generator transfer switch. During an interview at the time of the observation, the Facility Supervisor confirmed emergency lighting was not provided at the emergency generator transfer switch. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	deficient practice. An emergency light was purchased and placed at the site of the emergency transfer generator switch on 8/29/23. 2.The facility acknowledges that all residents have the potential of being affected by the deficient practice. 3.The Senior Facilities Manager (SFM) was re-educated on having an emergency lighting source at least 1-1/2 hours at the site of the emergency generator transfer switch in accordance with NFPA 110. SFM will educate Maintenance department to check this light for functionality during the monthly generator inspections in the absence of the SFM. 4.SFM will include emergency light functionality on the monthly generator report form and provide to the administrator or designee on a monthly basis until 1/1/2024 and quarterly thereafter until 8/28/2024. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly until 1/1/2024 and quarterly until 8/28/2024. Additional audits and education may be determined based on audit findings.	
K 355 SS=F	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	K 355		9/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING **01** B. WING ___________	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(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 355	Continued From page 2 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the stored-pressure fire extinguishers had a six-year internal examination and were equipped with a verification of service collar in accordance with NFPA 10 (Standard for Portable Fire Extinguishers) 2010 Edition Sections 7.3.1.2.1 and 7.3.3.2.2. This deficient practice had the potential to affect all 37 residents. Findings include: An observation on 08/16/23 at 1:00 PM revealed the fire extinguisher, located in the corridor by Room 444, had a manufacture date of 2016 marked on the bottom of the cylinder and was missing the Verification of Service Collar for the six-year internal examination around the neck of the container. An observation on 08/16/23 at 1:30 PM revealed the fire extinguisher, located in the corridor by Room 428, had a manufacture date of 2016 marked on the bottom of the cylinder and was missing the Verification of Service Collar for the six-year internal examination around the neck of the container. An observation on 08/16/23 at 1:54 PM revealed the fire extinguisher, located in the corridor by Room 416 had a manufacture date of 2016 marked on the bottom of the cylinder and was missing the Verification of Service Collar for the six-year internal examination around the neck of the container.	K 355	1.No residents were affected by the deficient practice. The vendor visited the facility on 8/31/23 and performed the 6 year internal examination on all extinguishers listed in the statement of deficienies and provided each with a service collar. 2.The facility acknowledges that all residents have the potential of being affected by the deficient practice. 3.The Senior Facilities Manager (SFM) was re-educated on the six-year internal examination and service collar requirement in accordance with NFPA 110. The SFM will educate the security department to complete these audits in absence of the SFM. 4.The SFM or designee will coordinate with vendor the annual inspection on fire extinguishers. The SFM will provide the administrator the fire extinguisher report form on a annual basis. The SFM and Administrator will meet annually to confirm all fire extinguishers have the service collar and confirm the last year of the six-year internal examination. This will be reported during the Quality Assurance/Performance Improvement Committee QAPI monthly until 1/1/2024 and annually until 8/28/24. Additional audits and education may be determined based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING **01** B. WING ______	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(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 355	Continued From page 3 During an interview at the time of observations, the Senior Facilities Manager confirmed the fire extinguishers did not have a six-year internal examination and were not equipped with a verification of service collar. The Senior Facilities Manager contacted the contracted fire extinguisher inspection company and the company confirmed via email the six-year internal inspection had not been completed and was overdue. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 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: 1. penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke; and 2. smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 8.5.6.1 and 8.5.6.2. This deficient	K 372	1.No residents were affected by the deficient practice. The unsealed opening in the smoke barrier wall located above the corridor doors by room 416 was repaired same day of survey(8/16/23). The unsealed opening in the smoke barrier wall located above the corridor	9/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. BUILDING **01** B. WING ______	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE** **NEW PROVIDENCE, NJ 07974**

(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 4 practice had the potential to affect 37 residents. Findings include: An observation on 08/16/23 at 1:31 PM revealed the smoke barrier wall, located above the corridor doors by Room 416, had an unsealed opening approximately three inches in diameter between a conduit and pipe penetration. An observation on 08/16/23 at 1:35 PM revealed the smoke barrier wall, located above the corridor doors by Room 418 in the memory care unit, had an unsealed two-inch gap around two conduit penetrations. An observation on 08/16/23 at 1:39 PM revealed the smoke barrier wall, located above the corridor doors by Room 418, had a one-half inch conduit penetrating a one-inch unsealed pipe sleeve. During an interview at the time of the observations, the Maintenance Director confirmed the unsealed penetrations in the smoke barrier walls. NJAC 8:39-31.1(c), 31.2(e)	K 372	doors near room 418 were repaired the same day of survey (8/16/2023). The one inch penetration in the pipe sleeve of the smoke barrier wall near room 418 was repaired the same day of survey (8/16/2023). 2.The facility acknowledges that all residents have the potential of being affected by the deficient practice. 3. The Senior Facilities Manager (SFM) was re-educated on the assessment of the smoke barrier construction in accordance with NFPA. The SFM will educate the maintenance department to complete these assessments in the absence of the SFM. 4.The SFM will provide the administrator documentation of the smoke barrier assessment to ensure of no penetrations on a monthly basis until 1/1/2024 and annually thereafter until 8/28/24. This will be reported during the Quality Assurance/Performance Improvement Committee QAPI monthly until 1/1/2024 and annually until 8/28/24. Additional audits and education may be determined based on audit findings.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315523	A. Building 01 - CONTINUING CARE AT LANTERN HILL B. Wing	9/12/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974

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 Reg. # NFPA 101 LSC K0291	Correction Completed 09/11/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 09/11/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 09/11/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO