STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	**50 LACEY ROAD WHITING, NJ 08759**

(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 date: 6/20/22 Census: 46 Sample: 5 Residents, 5 Staff A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		

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

Electronically Signed | 07/01/2022

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
	061533	A. BUILDING: _____ B. WING _____	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 Survey date: 6/20/21 Census: 46 Sample: 5 Residents, 5 Staff THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (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 interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide)	S 560	The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory	8/2/22

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

Electronically Signed | 07/01/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061533	A. BUILDING: _____ B. WING _____	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 staffing for 1 of 14 day shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One 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. As per the "Nurse Staffing Report" completed by the facility for the weeks of 6/5/22 and 6/12/22, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -06/13/22 had 5 CNAs for 49 residents on the day shift, required 6 CNAs. On 6/21/22 via email communication, the surveyor asked the Licensed Nursing Home	S 560	standard. 1. How the corrective action will be accomplished: The Staffing Scheduler/Administrator/Director of Nursing (DON)/Designee will review direct care staff to resident ratios for compliance with mandatory staffing requirements. The Administrator, DON, Staffing Scheduler and HR will conduct a weekly Recruitment meeting to review Direct Care Staffing needs, and discuss recruitment efforts/status for Direct Care Staff. The above persons will review resumes, applications and advertising. Direct Care Staff will be advertised with various venues, but not limited to, Our Company Website, Online Recruitment companies, Flyers to local Vocational Tech and C.N.A Training schools and social media. Agency Contracts will be utilized to supplement Direct Care Staff to meet compliance with staffing levels. 2. How the facility will identify other residents affected by the same deficient practice: All residents have the potential to be affected. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: When a staff to resident ratio inequity is identified, the facility will contact all	

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	061533	A. BUILDING: _____ B. WING _____	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

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S 560	Continued From page 2 Administrator (LNHA) if she was aware of the required minimum direct care staff to resident ratios. The LNHA wrote that she was "aware of the staffing requirements/ratios for NJ LTC facilities." The surveyor then asked the LNHA if the facility was meeting the required minimum direct care staff to resident ratios and she did not directly answer the question. The LNHA wrote "Our goal is always to staff to meet our resident's needs and to meet compliance." The surveyor requested a copy of the facility's staffing policy. The LNHA wrote that the facility did not have a staffing policy. The facility did not provide a staffing policy.	S 560	available staff to come to work for an additional shift(s), offer incentive pay to those volunteering to work an additional shift(s), and/or contact contracted staffing agencies to assist with the mandatory staffing levels. The facility will conduct weekly Recruitment Meetings to recruit staff and review efforts/status (refer to #1 above). Administrative Staff (refer to #1) will review wages/benefits to remain competitive, offer sign-on and referral bonuses, to new hires and current staff. Daily staffing levels will be reviewed by the Administrator, DON/Designee to ensure compliance with the regulation for direct care staff to resident ratio. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Results of the daily staffing levels will be reported by the DON/Designee monthly to the QAPI Committee for a period of 3 months. Any staffing level inequities that are identified will be addressed immediately with the appropriate corrective action. Results of the weekly Recruitment Meetings (refer to #1 above) will be reported by HR/Designee monthly to the QAPI Committee for a period of 3 months.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061533		8/2/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

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 08/02/2022	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
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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 6/20/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			