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 _____	C 06/21/2023

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 Date: 6/21/23 Census: 53 Sample: 15 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		6/30/23

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

Electronically Signed | 07/11/2023

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F 657	Continued From page 1 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise a resident's comprehensive care plan to include the location of a elopement alarm. This deficient practice was identified for 1 of 17 residents reviewed for resident-centered care plans (Resident #6), and was evidenced by the following: On 06/13/23 at 11:40 AM, the surveyor observed Resident #6 in a wheelchair with a NJ Exec Order 26.4b1 [redacted] According to the Admission Record, Resident #6 was admitted with diagnosis that included, but were not limited to, NJ Exec Order 26.4b1 [redacted] A review of Resident #6's annual Minimum Data Set, an assessment tool dated NJ Exec Order 26.4, revealed that he/she had NJ Exec Order 26.4b1 and utilized a NJ Exec Order 26.4b1 daily. A review of Resident #6's Physician Order Sheet reveals an order dated NJ Exec Order 26 to check NJ Exec Order 26 [redacted]. A review of Resident #6's Care Plan Report with an effective date of NJ Exec Order 26.4b1 reflected that this resident has NJ Exec Order 26.4b1. One intervention included NJ Exec Order 26.4b1 to the wheelchair with the status as active/current.	F 657	1. How the Corrective Action will be Accomplished. The Care Plan for Resident#6 was reviewed to reflect the appropriate status of the NJ Exec Order 26.4b1. 2. Identifying other Residents who have the potential to be affected by the same deficient practice. All Residents that have a wander guard/Care Plan, have the potential to be affected. All Residents that have a wander guard had their Care Plans reviewed to ensure its current status. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. IT Staff assessed all license staffs' desk top computers for MyUnity (EMR) to ensure they were able to access the Residents' Care Plans and that the Care Plans' filter was on "Active Status", to have access to the Residents' current Care Plans. Licensed staff were educated on the meaning and purpose of the "Active Status" filter on MyUnity's Residents' Care	

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F 657	Continued From page 2 On 6/15/23 at 10:22 AM, the Licensed Practical Nurse/ Nurse Manager LPN/NM stated that the NJ Exec Order 26.4b1 used to be placed on the resident wheelchair, but the team decided to place on the resident instead. She acknowledged that the Care Plan for Resident #6 should have been updated to reflect that this resident has a NJ Exec Order 26.4b1 A review of the facility policy "Resident Care Plan" (RCP) revised 9/11/17 reflects that the effectiveness of the RCP must be regularly evaluated based on progress towards goals. The RCP will be modified as necessary based on the evaluation process. NJAC 8:39-11.2(i)	F 657	Plans. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON/Designee will perform audits bi-weekly (every 2 weeks) or with any change in wander guard status for 3 months for all Residents that have a Care Plan for "Exit Seeking" behavior and who wear a wander guard to have it accurately reflected on the "Active Status" Residents' Care Plans. The DON/Designee will report the audit results above monthly for 3 months to the QAPI Committee.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to check a resident's NJ Exec Order 26.4b1 for functioning for 1 of 2 residents reviewed for NJ Exec Order 26.4b1 (Resident #41) and was evidenced by the following: On 06/12/23 at 11:10 AM, during the initial tour of the facility, Resident #41 was in the activity room	F 658	1. How the Corrective Action be Accomplished. Resident #41 had their NJ Exec Order 26.4b1 checked for function and placement and documented on the Treatment Administration Record (TAR). The physician's order was revised for Resident #41 NJ Exec Order 26.4b1, to include the location	6/30/23

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F 658	Continued From page 3 in a wheelchair. The surveyor observed a NJ Exec Order 26 [redacted] Review of Resident #41's Face Sheet indicated the resident was admitted to the facility in NJ Exec Order 26.4b1. Medical diagnoses included, but were not limited to NJ Exec Order 26.4b1 [redacted] Review of quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4 reflected under section P titled, "Restraints and Alarms" was coded number NJ E meaning NJ Exec Order 26.4b1 [redacted] Review of section C titled, "Cognitive Status" revealed that Resident #41 had a Brief Interview of Mental Status of NJ E, meaning the resident had NJ Exec Order 26.4b1 On 06/13/23 at 11:28 AM, the surveyor observed Resident #41 in the activity room in a wheelchair. The resident had a NJ Exec Order 26.4b1 [redacted] On 06/13/23 at 12:03 PM, the surveyor reviewed the physician orders which revealed an order dated NJ Exec Order 26.4 to check placement of the NJ Exec Order 26 [redacted] every shift two times daily, the order did not specify where the NJ Exec Order 26.4b1 was located on the resident and there was not an order to check for function of the NJ Exec Order 26.4b1 On 06/14/23 at 11:26 AM, the surveyor interviewed unit Licensed Practical Nurse (LPN) regarding wander guards. The LPN told the surveyor, "We check for NJ Exec Order 26.4b1 [redacted]. We make sure there is an order for the NJ Exec Order 26.4b1 Its only for those	F 658	of the NJ Exec Order 26.4b1 on Resident #41, and to check for function and placement. 2. How the Facility will identify other Residents who have the potential to be affected by the same deficient practice. All residents that have a wander guard have the potential to be affected. All residents that have a wander guard had their physician orders reviewed to ensure it included location of the wander guard on the resident, and to check for placement and function. The residents with a wander guard had their TAR reviewed to ensure there is documentation every shift (12 hour shifts) for placement and function. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Licensed staff were educated on the Facility's "Wander Guard" policy, to include but not limited to, physician orders to include location of the wander guard on the resident and to check for placement and function. Licensed staff were educated on the location of the wander guard tester and how to use it. 4. How the Facility will monitor the Corrective Action to ensure that the deficient practice is being corrected and will not recur.	

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F 658	Continued From page 4 NJ Exec Order 26.4b1 so residents are monitored more closely. I don't know NJ Exec Order 26.4b1 [redacted] On 06/14/23 at 11:26 AM, the surveyor interviewed a unit Registered Nurse (RN) who said that Resident #41 NJ Exec Order 26.4b1 [redacted] twice daily (meaning every shift the staff checked to ensure it was on the resident), the surveyor asked who checks for function and the nurse told the surveyor, "That's done at night, I am not here at night so I'm not sure where it is documented." The RN referred the surveyor to the Director of Nursing. On 06/14/23 at 11:31 AM, the surveyor interviewed the Director of Nursing (DON) regarding NJ Exec Order 26.4b1 documentation. The DON said, "It should be in the documented Treatment Administration Record (TAR). The DON asked the unit charge nurse to check for the documentation, in the presence of the DON and surveyor and the charge nurse checked and said, "Nope, it's not there". On 06/15/23 at 09:25 AM, the surveyor reviewed Resident #41 current active care plan. The care plan had a focus of Fall/Injury/Elopement Risk and indicated the resident was at risk for NJ Exec Order [redacted] especially during the late afternoon and the evening. One intervention included wearing a NJ Exec Order 26.4b1. It was an active care plan. On 06/20/23 at 11:03 AM, the surveyor reviewed the policy titled, "Community Elopement Alert/Security System", with a revision date of 3/23/12, under the procedure section of the	F 658	The DON/Designee will conduct bi-weekly (every 2 weeks) audits for 3 months to review the physician orders and TARs for residents with wander guards to ensure appropriate orders are in place and license staff is documenting every shift for placement and function of the wander guard. The DON/Designee will report the audit results monthly for 3 months to the QAPI committee.	

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F 658	Continued From page 5 policy, it indicated that the facility would test resident signaling devices daily and record results. NJAC 8:39-27.1 (a)	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		6/30/23

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F 755	Continued From page 6 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and other facility documentation, it was determined that the facility failed to: a) maintain accurate accountability and reconciliation for controlled medications in a medication cart and automated medication dispensing system b) maintain the integrity of emergency medication boxes in a safe manner in accordance with the facility policy. This deficient practice was identified in 1 of 2 medication carts, 1 of 1 automated medication dispensing system, and 2 of 2 emergency medication boxes on 1 of 1 nursing unit. This deficient practice was evidenced by the following: 1. On 06/14/23 at 12:02 PM, the surveyor inspected the high side medication cart in the presence of the agency Registered Nurse (RN). Review of the Controlled Medication Count Sheet (CMCS) revealed that on 06/01/23, both the day nurse and the night nurse failed to sign the form in the space provided to confirm that a narcotic count was performed at the end of their shifts to ensure accuracy. Further review of the CMCS revealed that on 06/11/23, the night nurse failed to sign the CMCS at the end of their shift. The agency RN stated that if blanks were noted on the CMCS it indicated that the responsible nurse forgot to sign the entry after the narcotic count was completed and the Charge Nurse was required to be notified of the missing signature for follow-up. On 06/14/23 at 1:29 PM, in the presence of the	F 755	1. How the Corrective Action will be Accomplished. The automated medication dispensing system (Stat Safe) audit was conducted by the Pharmacy Provider, Pharmacist Consultant, and the Director of Nursing (DON), to ensure all licensed staff users of the Stat Safe did a daily declining balance narcotic count and that there were no discrepancies. The Controlled Medication Count Sheet (CMCS) for each Medication Cart was audited by the DON/Corporate RN, to ensure licensed staff sign every shift (12-hour shifts) and to identify any discrepancies with the Controlled Medication inventory count sheets. The Pharmacy Provider replaced the Emergency Medication box (E-Kit) and back up E-Kit and ensured that the E-Kit were fully stocked, and the locks were in place. The Medication Carts were audited by Pharmacist Consultant for all residents' medications to ensure all medications were labeled & stored properly, and with no discrepancies. 2. How the Facility will identify other Residents who have the potential to be affected by the same deficient practice.	

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F 755	Continued From page 7 Licensed Nursing Home Administrator (LNHA) the surveyor interviewed the Director of Nursing (DON) who stated that if nursing noted that someone failed to sign the CMCS they were required to report that the book was not signed before they assumed responsibility for the medication cart to assure that the count was right and nothing was missing. The DON further stated that she was not aware of the missing signatures. On 06/14/23 at at 12:25 PM, the surveyor inspected the automated medication dispensing system in the presence of the DON and Charge Nurse (CN). Review of the Narcotic Count form revealed that the form was not signed on 06/10/23 or 06/11/23. The DON stated that she glanced at the book once a week to see if there were signatures missing. The DON stated that she did not review the narcotic count on Monday 06/12/23, as it was the first day of survey. The CN and the facility Registered Nurse (RN) inventoried the narcotic count in the presence of the surveyor and there were no discrepancies noted. The surveyor asked the CN if she was aware of the missing signatures and who was responsible to perform the narcotic count. The RN who was present, stated that she worked on both 06/10/23 and 06/11/23 and performed the narcotic count with another nurse over the weekend but they both forgot to sign the Narcotic Count form after the count was completed. On 06/20/3 at 9:12 AM, the DON provided the surveyor with a print out of the automated medication dispensing system audit, which revealed that a narcotic count was not performed on 06/10/23 or 06/11/23 as previously described by the facility RN. The DON stated that while both she and the Charge Nurse shared the	F 755	All residents have the potential to be affected. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The 24-Hour Nursing Report was revised to include the licensed nurses' signature for accountability/monitoring for the signing of the declining CMCS for each medication cart (each 12-hour shift), the Stat Safe, and E-Kit daily, to ensure compliance with appropriate storage, labeling and signatures for controlled medication declining balances sheets for the medication carts and stat safe. Licensed staff were educated on the Facility's policies for "Controlled Substances", "Stat Safe", and the "Emergency Medication Policies". All licensed staff were educated on the revised 24-Hour Nursing Report required signatures for compliance, and accountability. 4. How the facility will monitor its Corrective Action to ensure that the deficient is being corrected. DON/Designee will monitor daily for compliance, the 24-Hour Nursing Reports, the Medication Carts controlled medication declining balance sheets, and the Stat Safe for the CMCS to ensure compliance with licensed staff signatures.	

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F 755	Continued From page 8 responsibility of ensuring that the narcotic counts were completed, it was ultimately her responsibility. 2. On 06/15/23 at 11:37 AM, the surveyor inspected two emergency medication boxes which were both unlocked and stored beneath the front counter of the nurse's station. When the surveyor opened the the first box there were three unused plastic yellow locks stored within the medication box. On the outside of the emergency medication boxes there was an inventory sheet which indicated that the medications contained within the box expired on 08/23 and 09/23. The DON stated that the boxes should have been locked. The DON stated that she noticed that the boxes were unlocked about a month ago and notified the pharmacy at that time to replace them. The DON explained that the boxes were delivered to the facility with a lock already on them. The DON further explained that when nursing accessed the box to remove an emergency medication they were required to notify the pharmacy so that the pharmacy could switch it out with a whole new box. The DON stated that if the pharmacy was not notified then we would not have the required medications in an emergency situation if needed. The DON confirmed that she did not follow-up with nursing to ensure that the emergency medication boxes were replaced. In a later interview with the DON on 06/15/23 at 12:25 PM, the DON stated that nursing did not have to call the pharmacy for a replacement emergency medication box when the box was accessed and a medication was removed as there were two of most drugs and a second box was available in her office as a back up. The	F 755	Daily the DON/Designee will audit the E-Kits to ensure the integrity and maintenance of the E-Kits. The DON/Designee will report to the QAPI Committee monthly for the next 6 months the results of the above audits.	

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F 755	Continued From page 9	F 755		

DON stated that when nursing stored both unlocked emergency medication boxes beneath the front counter of the unsecured nurse's station it posed a risk to resident safety.

On 06/15/23 at 12:52 PM, the DON confirmed that an inventory was performed of both emergency medication boxes and she stated that Vitamin K (used as an antidote for blood thinner medication) was missing from the first box and Insta-Glucose (used to treat low blood sugar in diabetics) was missing from the second box. At that time, the surveyor reviewed the Emergency Medication Box List provided by the DON which indicated the following: "*Important: Please notify pharmacy immediately upon opening kit for prompt replacement."

On 06/15/23 at 12:58 PM, the surveyor interviewed the Pharmacist who stated that the nurses were required to complete a form with the resident's name when they removed a medication from the emergency medication box and send it to the pharmacy. The Pharmacist stated that the pharmacy then picked up the box the next day and replaced it with another. The Pharmacist stated that there should have been a second box for back up. The Pharmacist stated that he did not keep records to confirm when the facility requested replacement emergency medication boxes. The Pharmacist stated that both emergency medication boxes should have been locked after opening as it was in their policy for security purposes.

On 06/20/23 at 10:59 AM, the surveyor interviewed the CN who stated that when a medication was removed from the emergency medication box a form was sent to pharmacy with

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F 755	Continued From page 10	F 755		

a request to replace the entire box. The CN stated that she did not know that either box was opened and unlocked. The CN explained that the unlocked emergency medication boxes could present a danger to residents if they wandered into the nurse's station.

Review of the facility's policy, "Controlled Substances" (Revised 02/06/18) revealed the following:

Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.

Review of the facility's policy, "Automated back up supply system" (01/03/20) revealed the following:

Controlled drugs will be inventoried by 2 licensed professionals per facility daily, preferably on the day shift...

Review of the pharmacy policy, "Emergency Medication Kit" (11/21/22) revealed he following:

Procedure: Tackle Box Version...

Verify that the serial number matches the last serial number entered on the Medication Use Log.

If it does not match or the kit is unlocked, (2) nurses must verify contents of the E-Kit. If drugs are missing, and not documented on the Medication Use Log, notify DON ASAP.

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F 755	Continued From page 11 Remove the required medication from the kit... Complete the pre-printed label on bag. Use as prescription label. Fax to pharmacy a physician's order with "Removed from E-kit and the quantity removed" noted directly on the order. Completely fill out the Medication Use Log. The pharmacy will send a replacement kit within 72 hours after receiving all appropriate information... NJAC 8:3929.7(C)	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		6/30/23

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 _____	C 06/21/2023

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 761	Continued From page 12 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to properly store and dispose of controlled medications in accordance with the facility policy and standards of professional practice. This deficient practice was identified for 1 of 2 medication carts on 1 of 1 nursing unit. This deficient practice was evidenced by the following: On 06/14/23 at 12:02 PM, the surveyor inspected the high side medication cart in the presence of the agency Registered Nurse (RN). The RN removed a pill bottle from the locked drawer where controlled substances were stored and identified the medication as NJ Exec Order 26.4b1 [redacted] The RN removed two clear sealed plastic bags from the pill bottle which each contained ten tablets. The RN then proceeded to pour five loose tablets into the lid of the pill bottle in order to demonstrate that there were 25 pills in the bottle which corresponded with the Individual Patient's Controlled Drug Record (IPCDR). When the RN began to return the loose tablets to the pill bottle she dropped one of them onto the IPCDR and used a plastic spoon to scoop up the dropped tablet which she returned to the pill bottle with the remainder of medication.	F 761	1. How the Corrective Action will be Accomplished. The [redacted] pill container was discarded that had the loose [redacted] pill dropped on the Individual Patients Controlled Drug Record (IPCDR) returned to the pill container. The physician was notified of the situation, and a new order was obtained for [redacted] to replace the discarded [redacted] pill container. 2. How the facility will identify other Residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The licensed staff were educated on the Facility's' policies for "Administering Medications", "Medications brought to the Facility by the Resident/Family", and "Infection Control practices during Medication Pass".	

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F 761	Continued From page 13 At that time, the surveyor asked the RN what the protocol was when a medication was dropped. the RN stated that if she dropped the medication on the floor, or in or on the medication cart which were not considered clean, then she would have wasted the medication with another nurse. The RN stated that the book where the IPCDR was clean, so the NJ Exec Orde tablet was returned to the pill bottle. The surveyor asked the RN why the NJ Exec Orde was stored in a pill bottle instead of on a Bingo Card (a method of packaging medications in a blister pack) as the remainder of the controlled substance tablets were stored. The RN explained that since the medication belonged to a resident who resided in the NJ Exec Order 26.4b1 of the facility who was admitted for NJ Exec Order 26.4b1 The RN further explained that the admitting nurse, who was not available for interview, created a declining inventory sheet to account for administration of the resident's own prescription of NJ Exec Order 2 On 06/14/23 at 12:42 PM, the surveyor interviewed the Director of Nursing (DON)who stated that if an NJ Exec Orde tablet were dropped on the IPCDR it should have been destroyed as it was considered "dirty". The DON stated that she was not aware that controlled medications were stored in the medication cart that were not supplied by the facility's pharmacy provider in bingo cards as required. On 06/14/23 at 1:29 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that if the RN dropped an Ativan tablet on top of the IPCDR it was considered contaminated and should have been discarded.	F 761	4. How the facility will monitor its Corrective Actions to ensure that the deficient practice is being corrected and will not recur. The DON/Designee will conduct monthly for 6 months, Medication Pass audits with licensed staff to ensure compliance with medication pass to include but not limited to Infection Control requirements during medication pass. DON/Designee will audit new Resident Respite admissions' orders and medications received from a Respite Resident to ensure appropriate storage and labeling of medication. The DON/Designee will report monthly for 6 months the results of the audits above to the QAPI committee.	

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F 761	Continued From page 14	F 761		

On 06/14/23 at 1:48 PM, in a later interview with the agency RN, she stated that when a resident was admitted to the facility from IL with their own controlled substances they were stored in a pill bottle from their own pharmacy and the nurses used blank copies of declining inventory sheets, known as IPCDR, that were created for inventory purposes. The RN explained that on 06/06/23, there were 28 tablets of [redacted] when the medication was received and 25 tablets remained.

Review of the unsampled resident's Physician's Order Sheet and Medication Administration Record (MAR) revealed that an order was obtained on [redacted] for [redacted] (1 tablet) oral as needed one time daily for fourteen days for [redacted].

On 06/15/23 at 11:27 AM, the surveyor interviewed the DON who stated that the unsampled resident's [redacted] prescription was destroyed and a new order was obtained. The DON stated that the unsampled resident's [redacted] prescription should not have been accepted by the admitting nurse as the medication was pre-poured and counted by the clinic.

Review of the facility's policies, "Administering Medications" (revised 02/06/20) and Medications brought to the facility by the Resident/Family (effective 02/01/17) revealed the following:

...Appropriate infection control procedures must be followed during the administration of medications...

The facility shall ordinarily not permit residents and families to bring medications into the facility.

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F 761	Continued From page 15 ...The facility discourages the use of medications brought in from outside, and will inform residents and families of that policy as well as applicable laws and regulations. NJAC 8:39-29.4(a)(h)(d)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner in order to prevent food borne illness. This deficient practice was evidenced by the	F 812	1. How the Corrective Action will be Accomplished. The food label machine was adjusted to print the appropriate dates. The unlabeled food items were identified	7/31/23

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F 812	Continued From page 16 following: On 06/12/2023 at 9:25 AM, the surveyor accompanied by the Food service Director (FSD) observed the following in the kitchen: The surveyor observed a number of unlabeled food items throughout the kitchen such as potatoes, a crate of milk, sugar, bagel, and cheese. The FSD observed at the time of the tour that these items were not labeled and confirmed the items should have been labeled appropriately. The surveyor further observed two items of french toast and french fries that had expiration dates that were dated out for one month. The FSD confirmed the label should only have been dated out for a couple of days and stated the labeling machine must have had a glitch and the FSD would check it to see and make the changes. The surveyor did not observe the french toast nor the french fries get discarded. The surveyor observed a liquid substance on the floor, which appeared to be water coming from the bottom of the refrigerator, that held the sandwiches. This was observed by the FSD as well at the time of the tour. The FSD confirmed it was water and stated he would get maintenance to look at it. During that same day of the kitchen tour at 10:14 AM, the surveyor observed a dining room hostess (DRH) walk into the middle of the kitchen prep area without a hair net on and without stopping to wash their hands. The FSD confirmed that the DRH was not wearing a hair net and should have worn a hair net before entering the kitchen.	F 812	as being put in the kitchen inventory within the past 24 hours, and therefore, they were relabeled with the appropriate label/dates. The liquid substance (water) from the bottom of the reach in refrigerator was removed and a new condensation evaporator was ordered and installed with no further water noted under the refrigerator. The other reach in refrigerators in the kitchen were assessed to ensure the condensation evaporator were functioning, no water was identified on the bottom of the other reach in refrigerators. The dishwasher gauges were cleaned removing film that was over the glass gauge. Dishwasher water temperatures were not affected, and met required temperatures. New dishwasher gauges were ordered and installed. The Dining Services Director/Designee audited all kitchen staff for the appropriate use of hair/beard nets. The kitchen staff were educated on the Facility's "Hand Washing" Policy. 2. How they Facility will identify other Residents who have the potential to be affected by the same deficient practice.	

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F 812	Continued From page 17 The FSD confirmed the staff was the DRH who normally cuts through the kitchen to go into the dining room area, but further confirmed with the surveyor, that the DRH should have put on a hairnet before walking into the kitchen. The surveyor interviewed the DRH who stated that they usually wear a hairnet but was looking for their supervisor and apologized for not having one on. The DRH then confirmed with the surveyor that a hairnet was important to be worn in the kitchen at all times. On the second tour of the kitchen, 06/20/23 at 10:05 AM, the FSD confirmed that adjustments were made to the label machine and the labels were correctly placed on the French toast and the French fries. The FSD further confirmed that the french toast and french fries were not discarded, just relabeled. The surveyor observed the dish machine temperatures during the wash cycle and was able to confirm the correct temperature but had difficulty reading the second and third glass coverings. The FSD observed at the time of the tour that the two gauges were hard to read and confirmed the second and third glass coverings should be replaced. The FSD pointed out that the first gauge had already been replaced and the surveyor observed that the first gauge appeared to be new and was clear. The FSD further confirmed that the gauges should be easy to read at a glance to ensure the machine was ran at the correct temperatures without any delays. During that same day of the second kitchen tour, the surveyor observed a facility's System Chef (SC) staff walk into the middle of the kitchen prep	F 812	All residents have the potential to be affected. 3. What measures will be in place or systemic changes made to ensure that the deficient practice will not recur. The kitchen staff were educated on the Facility's policy for "Food and Supply Storage", addressing food labeling but not limited to. The kitchen staff were educated to report to the Dining Services Director/Designee, any water identified under the reach in refrigerators. The kitchen staff operating the dishwasher and the Dining Service Cooks/Supervisors were educated on the importance of having a clean and readable dishwasher gauge and to inform the Dining Service Director/Designee with any unreadable/broken dishwasher gauge. The kitchen staff were educated on the Facility's policies for "Dress Guidelines for Food Service Management" and "Clinical Nutrition", stating that "hair restraints are worn by all in the kitchen. This includes department associates, associates from other departments, and guests such as vendors". Hair nets are made accessible for all staff at the points of entry to the kitchen. A new sign is in place at the points of	

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F 812	Continued From page 18 area without a hair net on and without stopping to wash their hands. The FSD confirmed that the SC staff usually wears a chef hat and a beard net and should have put on the chef hat and a beard net before entering the kitchen. The surveyor interviewed the SC who stated that they usually wear a chef hat and a beard net but only went into the kitchen to look for the FSD and apologized for not having one on. The SC then confirmed with the surveyor that a chef hat and the beard net was important to be worn in the kitchen at all times to prevent contamination. Review of the facility's policy, "Food and Supply Storage," dated for January 2023, revealed that all food, non food items and supplies used in food preparation shall be stored in such a manner to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Under procedures the policy stated to "cover, label, and date unused portions and open packages." Review of the policy, "Dress Guidelines for Food Service Management and Clinical Nutrition Staff," dated for January 2023, revealed under procedures that "hair restraints are worn by all when in the kitchen. This includes department associates, associates from other departments and guests such as vendors."	F 812	entry to the kitchen, that reads, "All persons entering the kitchen must wear a hairnet and remain wearing one at all times when in the kitchen". A new checklist was implemented to audit food labeling/dates, walk in refrigerators (water pooling underneath it), the dishwasher gauges (readable and intact glass covers), hairnets are worn at all times by all in the kitchen, and hand hygiene. The Dining Services Supervisors were educated on the audits/checklists. 4. How the Facility will monitor its Corrective Action to ensure that the deficient practice is being corrected and will not recur. The Dining Services Director/Designee will conduct daily audits for 4 weeks, then weekly for 8 weeks and then monthly for 3 months, for food labeling, walk in refrigerator's condensation evaporators function, the dishwasher gauges, the use of hairnets in the kitchen, and hand hygiene. The Dining Services Director/Designee will report monthly for 6 months to the QAPI Committee the results of the audits for all of the above audits mentioned.	

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	061533	A. BUILDING: _____ B. WING _____	C 06/21/2023

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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: Based on interview and review of other facility documents, 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 for a.) the week of 04/24/22 to 04/30/22 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:	S 560	The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction shall be construed as an admission that the Facility has failed to comply with all statutory or regulatory standards. 1. How the Corrective Action will be Accomplished. The Staffing Scheduler, Administrator, Director of Nursing (DON)/Designee will review daily for each shift direct care to resident ratios for compliance with mandatory staffing requirements. The Staffing Scheduler, DON/Designee,	6/30/23

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

Electronically Signed | 07/11/23

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S 560	Continued From page 1 One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) 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 05/28/2023 to 06/10/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift for residents on 2 of 7 day shifts as follows: -05/31/23 had 5 CNAs for 51 residents on the day shift, required 6 CNAs. -06/07/23 had 5 CNAs for 49 residents on the day shift, required 6 CNAs. On 06/23/21 at 11:48 AM, the surveyor reviewed the policy titled, "Skilled Nursing Facility Staffing (New Jersey). The policy had a revision date of 08/11/21. The policy indicated that the facility provides adequate staffing to meet needs and services for the resident population. Number three of the procedure section stated that the facility will make judicious efforts to enforce the minimum caregiver to resident ratios and follow all the other staffing guidelines and specifics as outlined on NJ Act 82712.	S 560	Administrator, and Human Resources (HR) will conduct bi-weekly (every 2 weeks) Staff Recruitment Meetings for 8 weeks, and monthly thereafter, to discuss open positions, staffing needs, recruitment efforts, and review any open resumes. Direct Care staff positions will be advertised in various venues, but not limited to, our Company's Website, Online Recruitment Companies, advertisements with local Vocational Tech and C.N.A training schools, and social media. Staffing Agency contracts will be utilized to supplement Direct Care staff. 2. How the Facility will identify other Residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. What measures will be put in 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 available staff to come to work an additional shift(s), and offer an incentive bonus pay to those who volunteer to work an additional shift(s), and/or contact Staffing Agencies to assist with the mandatory staffing levels. The Facility will conduct bi-weekly Staff Recruitment Meetings (refer to #1 above).	

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S 560	Continued From page 2 On 06/22/23 at 09:46 AM, the Licensed Nursing Home Administrator was made aware of the staffing ratios.	S 560	Administrator, DON/Designee, and HR will review wages/benefits to remain competitive, offer sign-on and referral bonuses to current staff and new hires. The Staffing Scheduler, DON/Designee will review weekly the staffing prior to the following week's staffing schedule to ensure compliance with the regulation for direct care to resident ratio. 4. How the Facility will monitor its Corrective Action 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 for 3 months to the QAPI Committee. Any staffing level inequities will be addressed with the appropriate corrective action Results of the Staff Recruitment Meetings will be reported by HR monthly for 3 months to the QAPI Committee.	

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
315298 Y1	A. Building B. Wing Y2	8/16/2023 Y3

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

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 F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	06/30/2023	LSC	06/30/2023	LSC	06/30/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	06/30/2023	LSC	07/31/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/21/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061533 Y1	A. Building B. Wing Y2	8/16/2023 Y3

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 06/30/2023	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

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/21/2023	☐ 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
	315298	A. BUILDING **01** B. WING _____	**06/21/2023**

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
K 000	INITIAL COMMENTS Crestwood Manor at Whiting is a one-story building that was built in the January 1989. It is Type II Protected construction. The facility is divided into five (5) smoke compartments and has a Diesel generator.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier 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)	K 321		6/22/23

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

Electronically Signed | 07/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 321	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 06/19/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 06/19/2023 during the survey entrance at approximately 9:22 AM, a request was made to the Facilities Maintenance Staff (FMS) 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 fifty-five (55) Resident sleeping room. Starting at approximately 9:49 AM on 06/19/2023 in the presence of the facility's FMS, a tour of the facility was conducted. Along the tour of the facility, the surveyor observed the following hazardous area that failed to have smoke resisting doors: 1) At approximately 11:35 AM, an inspection of the Commercial Laundry room was performed and the Medical records storage room was performed. During a closure test of the dirty linen corridor door leading into the Commercial Laundry room, the door did not close all the way into its frame. The surveyor observed and	K 321	1. How the Corrective Action will be Accomplished. The Maintenance Director adjusted/repaired the Commercial Laundry room door to ensure it closed and latched in its frame in accordance with National Fire Protection Association (NFPA). 2. How the facility will identify other Residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected. The Maintenance Staff performed an audit for all fire rated/smoke resistant doors to ensure compliance with NFPA for closing and latching in its frame. 3. What measures will be in put in place or systemic changes made to ensure that the deficient practice will not recur. The Maintenance Director/Designee will conduct daily inspections on the fire/smoke resistant doors for 4 weeks, and weekly ongoing audits thereafter. The Maintenance staff were educated on the requirements for fire rated/smoke resistant doors and on the new audit to inspect all fire rated/smoke resistant doors to ensure they close and latch in its frame.	

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	315298	A. BUILDING **01** B. WING _____	**06/21/2023**

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K 321	Continued From page 2 recorded the opening between the door and frame was 3/8 of an inch. The commercial Laundry room was larger than 50 square feet, with this corridor door not closing into its frame all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the area identified to pass the Commercial Laundry is the primary and/ or secondary egress route in the event of a fire. The FMS confirmed the finding at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/19/2023 at approximately 2:20 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	4. How the facility will monitor its Corrective Action to ensure that the deficient practice is being corrected and will not recur. The results of the daily/weekly inspections on the fire rated/smoke resistant doors performed by the Maintenance Director/Designee will be reported to the Administrator immediately with any deficiencies and the corrective action. The Maintenance Director/Designee will report monthly for 6 months to the QAPI Committee, the results of the audits on the fire rated/smoke resistant doors.	
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.	K 351		6/22/23

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K 351	Continued From page 3 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 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 06/19/2023, in the presence of facility management it was determined that: 1) 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 06/19/2023 during the survey entrance at approximately 9:22 AM, a request was made to the Facilities Maintenance Staff (FMS) 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 fifty-five (55) Resident sleeping room. Starting at approximately 9:49 AM on 06/19/2023 in the presence of the facility's FMS a tour of the facility was conducted. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage:	K 351	1. How the Corrective Action will be Accomplished The Maintenance staff replaced the fire sprinkler escheon caps for Residents' rooms #N-188 and #N-146 closets on 6/19/2023. The Maintenance Staff on 6/19/2023 installed a ceiling tile in the Main Electrical Room. 2. How the Facility will identify other Residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. What measures will be in place or systemic changes made to ensure that the deficient practice will not recur. The Maintenance staff completed an audit on 6/21 throughout the Facility to ensure all fire sprinkler escheon caps are in place and that there are no gaps between the fire sprinkler escheon caps and the ceiling tiles.	

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K 351	Continued From page 4 1) At approximately 9:59 AM, inside Resident room #N- 188 closet, the fire sprinkler had no evidence of an escheon cap. This left an approximately 3/8 inch gap in the drop ceiling tile. 2) At approximately 10:15 AM, inside Resident room #N- 146 closet, the fire sprinkler had no evidence of an escheon cap. This left an approximately 1/4 inch gap in the drop ceiling tile. 3) At approximately 11:21 AM, inside the Main Electrical room were missing one (1) 2' by 4' ceiling tile and one (1) approximately 2' by 3' ceiling tile. With the opening in the ceilings, in the event of a fire, the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system. The FMS confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/19/2023 at approximately 2:20 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	The Maintenance Director/Designee will conduct monthly audits throughout the facility on the fire sprinkler and the escheon caps to ensure compliance. A checklist was implemented for the monthly audits for compliance with ceiling tiles to be in place and for the fire sprinkler escheon caps. The Maintenance Staff education was completed on 6/21 for the new checklist. 4. How the Facility will monitor its Corrective Action to ensure that the deficient practice is being corrected and will not recur. The Maintenance Director/Designee will report monthly for 6 months to the QAPI Committee, the results of the monthly audits for the fire sprinkler and the escheon caps.	
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	K 355		7/31/23

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K 355	Continued From page 5 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations on 06/19/2023 in the presence of facility management, it was determined that the facility failed to failed: 1) Install portable fire extinguishers with-in the required height for 7 of 14 fire extinguishers observed, 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, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. During the building tour on 06/19/2023 in the presence of the facility Facilities Maintenance Staff (FMS), the surveyor observed and inspected Fourteen (14) portable fire extinguishers in various locations with the following: 1) At approximately 10:00 AM, one (1) ABC type fire extinguisher Facility Identification (FI) #55, next to Resident room #N-176. This fire extinguisher appeared to be mounted too high. The surveyor measured and recorded where the fire extinguisher was mounted at, it was mounted	K 355	1. How the Corrective Action will be Accomplished New Portable Fire Extinguishers and Fire Extinguisher cases were purchased and installed (for the 7 portal fire extinguishers identified) on 7/24/2023, and maintained to meet compliance (height requirement) and standards with Portable Fire Extinguishers 18.3.5.12, 19.3.5.12, the National Fire Protection Association (NFPA) 10. 2. How the Facility will identify other Residents who have the potential to be 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. The Maintenance Staff received education on 6/21/2023 regarding NFPA 10 requirements pertaining height requirements for Fire Extinguishers, the education was documented and maintained in the Administrator's Survey Binder. The Maintenance Director will conduct an an audit on 7/24/2023 of the newly installed Portable Fire Extinguishers and	

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K 355	Continued From page 6 5'- 4" to the center of the pressure indicating needle. 2) At approximately 10:18 AM, one (1) ABC type portable fire extinguisher Facility Identification (FI) #56, near Resident room #N-146. The surveyor measured and recorded where the fire extinguisher was mounted at, it was mounted 5'- 3" to the center of the pressure indicating needle. 3) At approximately 10:21 AM, one (1) ABC type portable fire extinguisher Facility Identification (FI) #57, near Resident room #N-146. The surveyor measured and recorded where the fire extinguisher was mounted at, it was mounted 5'- 3-1/2" to the center of the pressure indicating needle. 4) At approximately 10:21 AM, one (1) ABC type portable fire extinguisher Facility Identification (FI) #53, near the commercial laundry. The surveyor measured and recorded where the fire extinguisher was mounted at, it was mounted 5'- 1" to the center of the pressure indicating needle. 5) At approximately 10:25 AM, one (1) ABC type portable fire extinguisher Facility Identification (FI) #50. The surveyor measured and recorded where the fire extinguisher was mounted at, it was mounted 5'- 2" to the center of the pressure indicating needle. 6) At approximately 11:11 AM, one (1) ABC type portable fire extinguisher Inside the sprinkler control valves room. The surveyor measured and recorded where the fire extinguisher was mounted at, it was mounted 6'- 2-1/2" to the center of the pressure indicating	K 355	throughout the facility to ensure they meet compliance (height requirement) and standards with the Portable Fire Extinguishers 18.3.5.12, 19.3.5.12, NFPA 10. 4. How the facility will monitor its Corrective Action to ensure that the deficient practice is being corrected and will not recur. The Maintenance Director/Designee will perform monthly rounds and address any Fire Extinguishers needing attention and inform the Administrator of any corrective action. Any new Fire Extinguisher installations will be measured by the Maintenance Director/Designee to ensure the height requirement is met as indicated NFPA 10. The Maintenance Director/Designee will report monthly for 3 months to the QAPI Committee, the results of the Portable Fire Extinguisher audit/installation and any/or compliance issues with the Fire Extinguisher.	

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K 355	Continued From page 7 needle. 7) At approximately 11:56 AM, one (1) ABC type portable fire extinguisher Facility Identification (FI) #51. The surveyor measured and recorded where the fire extinguisher was mounted at, it was mounted 5'- 3-1/2" to the center of the pressure indicating needle. The FMS confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/19/2023 at approximately 2:20 PM.	K 355		
K 511 SS=D	NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e). Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation on 06/19/2023, in the presence of facility management, it was	K 511	1. How the Corrective Action will be Accomplished.	6/22/23

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K 511	Continued From page 8 determined that the facility failed to ensure that 2 of 7 electrical outlets located next to a water source (with-in 6 feet) was equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 06/19/2023 during the survey entrance at approximately 9:22 AM, a request was made to the Facilities Maintenance Staff (FMS) 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 fifty-five (55) Resident sleeping room. Starting at approximately 9:49 AM on 06/19/2023 in the presence of the facility's FMS a tour of the facility was conducted. Along the building tour the surveyor observed and tested seven (7) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1) At approximately 11:14 AM, the surveyor observed inside the Staff Lounge, one Duplex electrical outlet located 29 inches to the right of the hand washing sink in the room. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 2) At approximately 12:08 PM, the surveyor observed inside the Men's locker room bathroom, one Duplex electrical outlet 24 inches to the left of	K 511	The Maintenance staff installed on 6/20/2023, 2 Ground-Fault Circuit Interrupter (GFCI) outlets, one in the Staff Lounge and one in the Men's Locker room bathroom. 2. How the Facility will identify other Residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Maintenance Director/Designee will conduct monthly audits for 6 months throughout the facility on electrical outlets within 6 feet of a water source/wet location to ensure compliance of requirement for GFCI outlets placement and to assess function. An audit checklist was implemented for monthly audits on the GFCI outlets. All Maintenance Staff were educated on 6/21/2023 on the new checklist/audit. 4. How the Facility will monitor its Corrective Action to ensure that the deficient practice is being corrected and will not recur. The Maintenance Director/Designee will report monthly for 6 months to the QAPI	

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K 511	Continued From page 9 the hand washing sink in the room. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The FMS confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/19/2023 at approximately 2:20 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 511	Committee, the results of the monthly audits (above) for the GFCI outlets placement and function.	
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	K 918		8/11/23

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	315298	A. BUILDING **01** B. WING _____	**06/21/2023**

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
K 918	Continued From page 10 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 observation, interview and review of facility provided documentation on 06/19/2023 in the presence of the facility management, it was determined that the facility failed to 1) Exercise the emergency generator 12 times each year for at least 30 minutes in 20- to 40-day intervals; and document the time needed by the generator to transfer power to the building was within the 10-second time frame. accordance National Fire Protection Association (NFPA) 99 and 110, and 2) Ensure a remote manual stop station for 1 of 1 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 06/19/2023 during the survey entrance at approximately 9:22 AM, a request was made to the Facilities Maintenance Staff (FMS) if the facility had an Emergency Generator, and how often does the facility run the generator under	K 918	1. How the Corrective Action will be Accomplished All generator tests and inspections will be conducted in accordance with the National Fire Protection Association (NFPA) 99 and 110. 110. A remote emergency stop button for the Generator was purchased and installed by 8/11/2023. 2. How the Facility will identify other Residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**06/21/2023**

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

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K 918	Continued From page 11 load and document the load dates. The FMS told the surveyor, "yes we have one 125 KW Diesel Emergency Generator, we run it under load monthly." A request was made to the FMS to provide the last 18 months (January 1, 2022 through June 15, 2023) of the generator log book for review. During the building tour in the presence of the FMS at approximately 11:54 AM, an inspection outside of the building where the 125 KW diesel generator is located was performed. The surveyor observed that the emergency stop button was located inside the metal housing and on the front control panel of the generator. At this time, the surveyor asked the FMS, "Do you have a remote emergency stop button for the generator." The FMS said, "no." Later at approximately 1:30 PM, a review of the Emergency Generator Test for the previous 18 months indicated there was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load test was conducted for April, May, October, and November 2022. The FMS confirmed the findings at the time of observation. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 06/19/2023 at approximately 2:20 PM. NJAC 8:39-31.2(e), 31.2(g)	K 918	The Maintenance Director/Designee will perform weekly testing of generator and monthly load tests and document findings. Maintenance staff were educated on 6/21/2023 and the inservice was documented (6/21/2023) on the requirements and importance of the Generator remote emergency stop button, and how to conduct a weekly/monthly inspection of the Generator exercising it under load 30 minutes 12 times a year in 20-30-day intervals and exercised once every 36 months for 4 continuous hours. 4. How the Facility will monitor its Corrective Action to ensure that the deficient practice is being corrected and will not recur. The Maintenance Director/Designee will review/monitor weekly/monthly generator testing audits and will report monthly for 6 months to the QAPI Committee, the results of the weekly/monthly audit results (above) on the Generator load tests and on the function and status of the Generator remote emergency stop button.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING **01** B. WING _____	**06/21/2023**

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

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K 918	Continued From page 12 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
315298 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/16/2023 Y3

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

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 K0321	06/22/2023	LSC K0351	06/22/2023	LSC K0355	07/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0511	06/22/2023	LSC K0918	08/11/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
6/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO