CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0988 STRUENT OF PORPORINCIES AND PLAN OF CORRECTION (X1) PROVIDER INPLICATION NUMBER: 316125 (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED C (X3) DATE SURVEY C (X4) DATE SURVEY C (X4) DATE SURVEY C	DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FOR	M APPROVED
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F 580 Notify of Changes (Injury/Decline/Room, etc.) F 580 8/9/19 SS=D CFR(s): 483.10(g)(14)(i)-(iv)(15) \$483.10(g)(14) Notification of Changes. \$(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- \$(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; \$(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); \$(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident in §483.15(c)(1)(ii).		Sample Size: 4					
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 (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- 		 (i) A facility must imm consult with the resid consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue treatment due to advec commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provi- physician. (iii) The facility must a resident and the resident 	rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE				 :			(X6) DATE

Electronically Signed

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.

07/29/2019

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
315125			B. WING				C / 03/2019
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01	
COVETAL	LAKE HLTHCARE & RE			39	95 LAKESIDE BLVD		
CITIONAL				В	BAYVILLE, NJ 08721		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	as specified in §483. (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite of §483.5) must discloss its physical configurat locations that compri- part, and must specifi	n or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph n. record and periodically (mailing and email) and	F	580			
	by: C #: NJ 125452 Based on interviews as review of pertinen 7/2/19 and 7/3/19, it facility failed to notify notification of the res was a significant cha condition for 1 of 2 re	T is not met as evidenced , and record review, as well at facility documents on was determined that the y and/or document the sident's physician when there ange in the resident's esidents (Resident #2), in condition. This deficient			 Resident #2 was affected by this deficient practice. LPN # 1 was provid one to one education by ADON on Reporting Change in Resident's Cond Policy/Procedure. All residents have the potential to b affected by this deficient practice. ADON/Designee to provide education all Licensed Nurses on Reporting Chan in Resident's Condition Policy/Procedure starting July 4, 2019 	ition e on to inge	
		ially admitted to the facility on ses that included but were			 ADON/designee will monitor 24 hour reports daily for four weeks on resider who have a change in condition, starti July 7, 2019. Those charts will be aud 	nts ng	

Facility ID: NJ61501

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 315125		A. BUILDIN	COMPLETED		
		B. WING		C 07/03/2019	
NAME OF F	ROVIDER OR SUPPLIER	<u>I</u>		STREET ADDRESS, CITY, STATE, ZIP	•
CRYSTAL	LAKE HLTHCARE & RE	НАВ		395 LAKESIDE BLVD BAYVILLE, NJ 08721	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE
F 580	The AR revealed the diagnoses with an or The Minimum Data S tool dated for the second	following additional haset date on the set of the set o	F 5	80 for proper notification of a condition as per policy. T be conducted weekly for then monthly for 3 month be reported at the monthl These meetings are com LNHA, Medical Director, I Unit managers.	hese audits will 4 weeks and s. The results will ly QI meetings. posed of the

Facility ID: NJ61501

If continuation sheet Page 3 of 6

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315125	B. WING				C 103/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CRYSTAL LAKE HLTHCARE & REHAB					95 LAKESIDE BLVD BAYVILLE, NJ 08721			
							0(5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 580	Continued From page	3	F	580				
	Observations" form da under Resident #2's r p.m., shift showed the increased weakness, Resident denied pain reflect documentation notified that the Reside The "Supervisor Shift differentiation", did not show of Resident #2's change was notified of the Re- condition. The surveyor conduct Manager (UM) on 7/2 stated change in Resi observations, that we gray skin color must be physician should be m The surveyor conduct Licensed Practical Nu 1:21 p.m., the nurse w Resident #2 on The LPN stated she co skin color (referring to color) that day on that the Resident's no pale and not gray. LP Resident was not in re However, the Resident	ted an interview with the Unit /19 at 12:34 p.m., she ident's condition, including re out of ordinary such as be documented and hotified. ted an interview with the arse (LPN#1) on 7/2/19 at who was assigned to from 3:00 p.m11:00 p.m. lid not like Resident #2's b Resident #2's gray skin . Furthermore, she stated formal color was pink, not N #1 revealed that the						
	not recall if she report	. LPN #1 stated she could ted the aforementioned o the Registered Nurse						

Facility ID: NJ61501

If continuation sheet Page 4 of 6

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		315125	B. WING				C /03/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>		
				:	395 LAKESIDE BLVD			
CRYSIAL	YSTAL LAKE HLTHCARE & REHAB			1	BAYVILLE, NJ 08721			
(X4) ID PREFIX TAG			ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 580	Supervisor. Furtherm could not recall if she unable to provide doc been notified of the R condition on the R Blood Loss, and Infect have definitely order the an Acute Hospital on about it. The "Charge Nurse J updated on 10/4/18, s Registered Profession Practical Nurse in the Reports to: Nursing S under "Duties and Re direct nursing care ar activities on the nursi evaluate and report p and progress to the a An undated policy title Resident's Condition "It is the policy of the monitor resident's cor changes on a timely r appropriate assessme clinicians to maintain careProcedure: 1. U changes of a resident levels) the change is	ore, the LPN revealed she informed the PP and was sumentation that the PP had resident's change in t 9:40 p.m. ted an interview with y Physician on 7/2/19 at 2:19 ecall being informed of the condition on at 9:40 ed that gray skin color could at not limited to: Anemia, ction. He revealed he would to transfer the Resident to to the supervise all nursing ing unit To observe, atients' symptoms, reactions ttending physician" ed "Reporting Change in Policy Procedure" showed: [name of the facility] to notition closely and report all manner to ensure ent and intervention by all optimum resident	F	580				

Facility ID: NJ61501

If continuation sheet Page 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER DENTIFICATION NUMBER (X2) MULTIFIC CONSTRUCTION A BULLDING (X3) DATE SUPPLYED COMPLETED C NAME OF PROVIDER OR SUPPLIER 315125 STREET ADDRESS, CITY, STATE, ZIP CODE 335 LAKESIDE BLVD BAYULLE, NJ 08721 (X3) DATE SUPPLYED C CRYSTAL LAKE HLTHCARE & REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 335 LAKESIDE BLVD BAYULLE, NJ 08721 (X4) D COMPLETED C PREFIX TAG SUMMARY STATEMENT OF DERICENCIES IN USING SUPPLY STATEMENT OF DERICENCIES TAGE D C (X4) D CONSS-REPERTIENCE ACTION BOULD BE CONSS-REPERTIENCE ACTION BOULD BE CONSS-REPERTIENCE ACTION BOULD BE CONSS-REPERTIENCE TO THE APPROPRIATE DEFICIENCY (X4) D CONSS-REPERTIENCE TO THE APPROPRIATE DEFICIENCY F 580 Continued From page 5 Nursing SupervisorThe Physician notified with updided clinical information2. All changes of condition to be reported are to include, but is not limited to: general condition*'The rongent intervention when a significant change occurs in the resident's physicalFrocedure: When onset of new symptoms is noted, the physical is to be notified by telephone* F 580 NJAC 8:39-13.1(d) I I I			ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/13/2019 MAPPROVED D. 0938-0391
315125 B. WING							(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CRYSTAL LAKE HLTHCARE & REHAB STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (CACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (CACH OERCETIVE ACTION SHOULD BE CONFLETION DATE F 580 Continued From page 5 Nursing SupervisorThe Physician notified with updated clinical information2. All changes of condition to be reported are to include, but is not limited to: general conditionskin condition" F 580 The policy titled, "Response to Change in Resident Condition" was revised on 8/1/111, showed: "Purpose: To provide prompt intervention when a significant change occurs in the resident's physicalProcedure: When onset of new symptoms is noted, the physician is to be notified by telephone"			315125	B. WING			_		
CRYSTAL LAKE HLTHCARE & REHAB BAYVILLE, NJ 08721 (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) COMPLETION DATE F 580 Continued From page 5 Nursing SupervisorThe Physician notified with updated clinical information2. All changes of condition to be reported are to include, but is not limited to: general conditionskin condition" F 580 The policy titled, "Response to Change in Resident Condition" was revised on 8/1/11, showed: "Purpose: To provide prompt intervention when a significant change occurs in the resident's physicalProcedure: When onset of new symptoms is noted, the physician is to be notified by telephone" F 580	NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	017	00/2010
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Nursing SupervisorThe Physician notified with updated clinical information2. All changes of condition to be reported are to include, but is not limited to: general conditionskin condition" The policy titled, "Response to Change in Resident Condition" was revised on 8/1/11, showed: "Purpose: To provide prompt intervention when a significant change occurs in the resident's physicalProcedure: When onset of new symptoms is noted, the physician is to be notified by telephone"	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD B		COMPLETION
		Continued From page Nursing Supervisor updated clinical inforr condition to be report limited to: general cor The policy titled, "Res Resident Condition' showed: "Purpose: To when a significant cha physicalProcedure: symptoms is noted, th by telephone"	e 5 The Physician notified with mation2. All changes of ed are to include, but is not nditionskin condition" sponse to Change in " was revised on 8/1/11, o provide prompt intervention ange occurs in the resident's When onset of new						

Facility ID: NJ61501

If continuation sheet Page 6 of 6