STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315125	A. BUILDING _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	**395 LAKESIDE BLVD BAYVILLE, NJ 08721**

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F 000	INITIAL COMMENTS A Complaint survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00165693, NJ00164145, NJ00164082, NJ00163445, NJ00162420, NJ00159225, NJ00157035, NJ00155008, NJ00154346, NJ00154159, NJ00153728, NJ00153625, NJ00153320, and NJ00151371. Survey Dates: 08/15/23 to 08/18/23 Survey Census: 212 Sample Size: 17 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) 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,	F 580		9/8/23

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

Electronically Signed | 09/08/2023

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F 580	Continued From page 1 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 from the facility as specified in §483.15(c)(1)(ii). (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- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint # NJ 151371 Based on interview, record review, and policy	F 580	F-580 SS-D Resident #R12's family member is now	

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F 580	Continued From page 2 review, the facility failed to notify one (Resident (R) 12)'s representative, out of a survey sample of 17, when the resident sustained a change in her condition and had to be transported to a local hospital. Findings include: Review of a policy provided by the facility titled "Notification of Change of Condition: Responsible Party/Guardian," dated 09/21/21 indicated ". . .The responsible party or guardian is to be notified of changes in condition or occurrences to ensure that the resident's responsible party or guardian is notified of changes and/or occurrences and action and pertinent information are documented. . . When any one of the following instances occurs, the resident's responsible party or guardian will be notified. . .There is a significant change in the resident's physical, mental or psychosocial status, weight loss. . ." Review of R12's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on EX Order 26.4B1 Review of R12's EMR titled nursing "Progress Notes" dated 01/05/22 indicated the resident had a change in her condition, EX Order 26.4B1 The physician was notified and ordered the NJ Exec. Order 26:4.b.1 . On the nursing "Progress Notes" indicated the resident had been for EX Order 26.4B1. There was no evidence the resident's representative was	F 580	notified the resident sustained a change in her condition and had to be transported to a local hospital. Director of Social Services let the family member know of the process in place to assure she will be notified in future. All residents have the potential to be affected by this deficient practice. Social service staff and nursing staff, as well as all Department Heads have been in-serviced on the buildings policy and procedures on Notification when there is a change in condition of the resident, specifically transfer to hospital. Social service staff and nursing staff, as well as all Department Heads, will be in-serviced upon new hire orientation regarding importance of following buildings policy and procedures on Notification when there is a change in condition of the resident, specifically transfer to hospital. Social Service Director/designee will audit residents with change in condition, specifically transfer to hospital, to assure our policy and procedures on proper notification is followed. Audits will be completed weekly for the next 4 weeks and monthly for next 3 months. Audits will be on-going to prevent this deficient practice.	

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F 580	Continued From page 3 notified of the resident's status change and subsequent hospitalization. Review of R12's EMR titled quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of EX Order 26.4B1 indicated the resident had a "Brief Interview of Mental Status (BIMS)" score of EX Order 26.4B1 which revealed the resident was EX Order 26.4B1 . An attempt was made to contact R12's representative but it was unsuccessful. During an interview on 08/16/23 at 4:58 PM, the Assistant Director of Nursing (ADON) stated if a resident sustained a change in condition, the physician would need to be notified then the resident's representative, especially if the resident was to then be transported to the hospital. During an interview on 08/18/23 at 10:59 AM, the Director of Nursing (DON) confirmed there was no notification to the resident representative for R12 and her change of the condition, documented in the resident's clinical record. NJAC : 8:39-13.1 (c)	F 580	A monthly report will be given to the Administrator and the QAPI Committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of the Resident	F 641	F-641 SS-D	9/8/23

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F 641	Continued From page 4 Assessment Instrument (RAI) Manual, the facility failed to ensure one (Resident (R) 17) out of 17 sampled residents had an accurate "Minimum Data Set (MDS)" assessment. Failure to code the "MDS" correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the resident. Findings include: Review R17's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on EX Order 26.4B1 Review of R17's EMR titled annual "MDS" with an Assessment Reference Date (ARD) of EX Order 26.4B1 indicated the resident had a "Brief Interview for Mental Status (BIMS" score of EX Order 26.4 EX Order 26.4B1 which revealed the resident was EX Order 26.4B1. The assessment indicated the resident had no obvious EX Order 26.4B1 EX Order 26. During an interview on 08/16/23 at 1:44 PM, R17 stated EX Order 26.4B1 and when asked about EX Order 26.4B1 the resident EX Order 26.4B1 The resident stated that EX Order 26.4B1 During an interview on 08/17/23 at 2:36 AM, the Director of Nursing (DON) confirmed R17 had EX Order 26.4 that were EX Order 26.4B1 and expected the "MDS" to accurately reflect the current status of the resident.	F 641	Resident #R17□s was put on list for NJ Exec. Order 26.4. MDS was updated to reflect correct assessment. All residents have the potential to be affected by this deficient practice. Nurses, MDS Nurse and IDT (interdisciplinary team) have been in-serviced on importance of following company policy on proper assessments upon admission, re-admission and change in condition, specifically condition of NJ Exec. Order 26. MDS Nurse has been in-serviced on the importance of validating for accuracy what the resident□s actual status is during the observation period by the IDT completing the assessment, specifically condition of NJ Exec. Order 2 Nurses, MDS Nurse and IDT (interdisciplinary team), will be in-serviced upon new hire orientation regarding importance of following buildings policy and procedures on proper assessments upon admission, re-admission and change in condition and the importance of validating for accuracy what the resident□s actual status is during the observation period by the IDT completing the assessment. Director of Nursing/designee will audit 10 resident MDS to assure proper assessments specifically condition of NJ Exec. Orde and accuracy of coding are being followed.	

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F 641	Continued From page 5 Review of the RAI Manual, dated 10/01/19, indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT (Interdisciplinary Team) completing the assessment. . ." NJAC : 8:39-11.1	F 641	Audits will be completed weekly for the next 4 weeks and monthly for next 3 months. Audits will be on-going to prevent this deficient practice. A monthly report will be given to the Administrator and the QAPI Committee.	
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.	F 755		9/8/23

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F 755	Continued From page 6 §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 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Complaint # NJ 155008 Based on interviews, record reviews, and facility policy review, the facility failed to ensure that EX Order 26.4B1 medication was ordered and available in a timely manner for one resident (Resident (R) 7) out of 17 sampled residents. Findings include: Review of the facility policy titled, "4.0 Schedule II Controlled Substance Medication," revised 09/2020 stated, " ... B. If a medication shortage is noted during normal pharmacy hours: a. A licensed nurse notifies the pharmacy and speaks to a registered pharmacist to determine the status of the order. If not ordered, place the order or re-order to be sent with the next scheduled delivery. 2. If the next available delivery results in a delay or missed dose in the customer's medication schedule ... If ordered medication is not available in the emergency stock supply, notify the pharmacist that an emergency delivery is requested ...C. If a medication shortage is noted after normal pharmacy hours: ... 2. If the ordered medication is unavailable in the emergency stock supply, a licensed nurse calls the pharmacy's emergency answering service	F 755	F-755 SS-D Resident #7 no longer resides at Crystal Lake. This is a closed record. All residents have the potential to be affected by this deficient practice. Nurses have been in-serviced on the facility policies and procedures on medication administration, medication documentation, medication orders. Nursing staff will be in-serviced upon new hire orientation regarding importance of following buildings the facility policies and procedures on medication administration, medication documentation, medication orders. Director of Nursing/designee will audit 10 resident medication administration records, medication logs, medication orders for accuracy and to assure the companies policies on these procedures are being followed. Audits will be completed weekly for the next 4 weeks and monthly for next 3	

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F 755	Continued From page 7 and requests to speak with the registered pharmacist on call to determine a plan of action which may include: a. Emergency/stat delivery b. Use of emergency (back-up) pharmacy D. If an emergency delivery is not feasible, a licensed nurse contact the attending physician to obtain orders or directions which may include: 1. Holding the dose/doses 2. Use of an alternative medication available from the emergency stock supply 3. Change in order ..." Policy r/t "Reorders for controlled medications" stated 1. The facility will be able to request partial fillings of the Schedule II medications until the original prescription is completed. Once all the available partial fills have been used, one of the following must be provided for additional quantities to be filled: a. A new hard copy prescription from the prescribing physician either left at the facility or faxed directly from his/her office. B. a signed and dated order that has not yet been utilized by Geriscript. 2. Geriscript pharmacy will assist the facility in contacting the physician to obtain a new written order. 3. If the facility needs the medication delivered that evening or as a stat and there is not a valid signed order available at the facility, the facility must contact the physician to have him/her either fax a written prescription to Geriscript Pharmacy or have him/her contact Geriscript Pharmacy and speak directly with a pharmacist to authorize an emergency dispensing. If Geriscript Pharmacy does not receive a fax or phone call from the prescribing physician, the medication will not be provided ...." Review of R7's "Admission Record" located in the "Electronic Medical Record (EMR)" under the	F 755	months. Audits will be on-going to prevent this deficient practice. A monthly report will be given to the Administrator and the QAPI Committee.	

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F 755	Continued From page 8 "Profile" tab indicated the resident was admitted to the facility on EX Order 26.4B1 with a primary diagnosis of EX Order 26.4B1 EX Order 26.4B1 . The resident was discharged on EX Order 26.4B1 Review of R7's quarterly "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of EX Order 26.4B1 indicated the resident had a "Brief Interview of Mental Status (BIMS)" score of EX Order 26.4B1 which indicated the resident was EX Order 26.4B1 . Additionally, the "MDS" indicated EX Orde received EX Order 26.4B1 for EX Order 26.4B1 . Review of R7's "Orders" located in the EMR under the "Orders" tab revealed orders for EX Order 26.4B1 by mouth every EX Order 26 hours (EX Order 26.4B1 management, dated EX Order 26.4B1 . Review of R7's "Declining Inventory Sheets," provided by the facility, indicated R7 did not have any EX Order 26.4B1 for administration and/or did not receive the medication on NJ Exec. Order 26:4.b.1 During an interview on 08/17/23 at 1:04 PM with R7's family member stated the facility ran out of EX Order 26.4B1 multiple times before the medication was supposed to run out and that R7 missed multiple days of his EX Order 26.4B1 doses due to the facility not ordering the medication in a timely manner.	F 755		

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F 755	Continued From page 9 During an interview on 08/18/23 at 1:00 PM with the Assistant Director of Nurses (ADON) stated that any new EX Order 26.4B1 orders should be entered by the nurse into the EMR and then faxed to the pharmacy. If a medication was not available for same day delivery, then the nurse was expected to notify the physician of the unavailable medication, obtain an order to hold the medication, or orders for an alternative medication. Additionally, a progress note should be entered in the EMR. The ADON confirmed that EX Order 26.4B1 was not available in the emergency medication supply EX Order 26.4B1. During an interview on 08/18/23 at 2:43 PM with the Director of Nursing (DON) stated that she was not aware that R7's EX Order 26.4B1 was not available for administration on multiple dates. The DON confirmed that R7 had standing orders for routine doses of EX Order 26.4B1 times per day and that [redacted] was not receptive to receiving alternative medications. Additionally, the DON stated she was aware that upon admission, [redacted] missed one to two doses because there was a problem with the accuracy of the prescription submitted to the pharmacy. The DON stated she was not aware of R7 missing any other days of scheduled EX Order 26.4B1 and that her expectation was for the nurses to request a refill of all medications prior to running out of the current supply. NJAC: 8:39-29.2 (d)	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		9/8/23

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F 842	Continued From page 10 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR	F 842		

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F 842	Continued From page 11 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint # NJ 155008 Based on record review, interviews, and policy review, the facility failed to ensure that clinical records related to the administration of [redacted] medication was complete and contained accurate documentation for one resident (Resident (R) 7) out of 17 sampled residents. Findings include:	F 842	F-842 SS-D Resident #7 no longer resides at Crystal Lake. This is a closed record. All residents have the potential to be affected by this deficient practice. All nurses have been in-serviced on the	

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(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 842	Continued From page 12 Review of the facility policy titled, "4.0 Schedule II Controlled Substance Medication," revised 09/2020 stated, " ... 3. A declining inventory sheet will be provided with each dispensed prescription for controlled dangerous medications. The form will contain the following information: customer name, medication name, medication strength, dosage form, name of prescribing physician, amount dispensed, prescription number and date dispensed ...5. When a CDS (controlled dangerous substance) is administered, in addition to following proper procedure for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/her initials. 6. An inventory count of all CDS medications stored on each nursing unit will be performed at each change of each shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form ...J. Waste of controlled dangerous substance 1. In the event a CDS medication is wasted such as spillage, refusal by a patient or a damaged item, the dose must be destroyed in accordance with facility policy. 2. The nurse must date and sign the declining inventory sheet in the appropriate location to indicate the waste/destruction. 3. The destruction of the wasted dose must be witnessed, cosigned, and dated by another nurse on the declining inventory form immediately ..." Review of the facility policy titled, "1.0 Medication Dispensing System," revised 09/2020 stated, " ... K. After medication administration: 1. Document necessary medication administration/treatment	F 842	facility policies and procedures on medication administration, medication documentation and medication orders for narcotic medications. All nursing staff will be in-serviced upon new hire orientation regarding importance of following buildings the facility policies and procedures on medication administration, medication documentation, medication orders for narcotic medications. Director of Nursing/designee will conduct audits on 10 resident medication administration records, medication logs, medication orders for accuracy and to assure the companies policies on these procedures for narcotic medications are being followed. Audits will be completed weekly for the next 4 weeks and monthly for next 3 months. Audits will be on-going to prevent this deficient practice. A monthly report will be given to the Administrator and the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315125	A. BUILDING _____ B. WING _____	C 08/18/2023

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F 842	Continued From page 13	F 842		

information (e.g., when medications are administered, ..., refused medications and reason, prn (as needed) medications, etc.) ... "

Review of R7's "Admission Record" located in the "electronic medical record (EMR)" under the "Profile" tab indicated the resident was admitted to the facility on EX Order 26.4B1 with a primary diagnosis of EX Order 26.4B1 [redacted]

Review of R7's quarterly "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of EX Order 26.4B1 indicated the resident had a "Brief Interview of Mental Status (BIMS)" score of EX Order 26.4B1 which indicated the resident was EX Order 26.4B1. Additionally, the "MDS" indicated [redacted] received EX Order 26.4B1 for EX Order 26.4B1.

Review of R7's "Orders" located in the EMR under the "Orders" tab revealed orders for EX Order 26.4B1 [redacted]

Review of R7's "Treatment Administration Record (TAR)," dated EX Order 26.4B1 revealed that EX Order 26.4B1 [redacted] was not signed out on the "Declining Inventory Sheet" for those dates and times.

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F 842	Continued From page 14 Review of R7's "TAR," dated EX Order 26.4B1 and located in the EMR under the "Orders" tab revealed that EX Order 26.4B1 was not signed out on the "Declining Inventory Sheet" for those dates and times. Additionally, doses were signed off in the EMR as administered on EX Order 26.4B1 and no "Declining Inventory Sheet" was available. Review of R7's "TAR," dated EX Order 26.4B1 and located in the EMR under the "Orders" tab revealed that EX Order 26.4B1 for that date and time. Review of R7's "TAR," dated EX Order 26.4B1 and located in the EMR under the "Orders" tab revealed that EX Order 26.4B1 was not signed out on the "Declining Inventory Sheet" for that date and time. Additionally, on EX Order 26.4B1 the "TAR" indicated a EX Order 26.4B1 records indicated that no EX Order 26.4B1 was available on that date and time. Review of R7's "TAR," dated EX Order 26.4B1 and located in the EMR under the "Orders" tab revealed that EX Order 26.4B1 was administered on EX Order 26.4B1 and the EX Order 26.4B1 was not signed out on the "Declining	F 842		

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F 842	Continued From page 15 Inventory Sheet" for that date and time. Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 had incorrect dose deduction calculations that were off by EX Order 26.4B1 Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 revealed EX Order 26.4B1 was administered on EX Order 26.4B1 and the dose was not signed out in the EMR for that date and time. Additionally, on EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 was noted to have been "wasted" without any explanation or nursing signatures. Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 revealed EX Order 26.4B1 was administered on EX Order 26.4B1 2 at 9:00 AM, and no physician's order was in place for the extra dose. Additionally, EX Order 26.4B1 administered on EX Order 26.4B1 at 10:00 PM was not signed out on the "Declining Inventory Sheet" until EX Order 26.4B1, and a dose on EX Order 26.4B1 at 6:00 AM was not signed out until EX Order 26.4B1. Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 revealed EX Order 26.4B1 was signed out on EX Order 26.4B1 and the same dose was signed out on the "Declining Inventory Sheet" dated EX Order 26.4B1 and deducted from the running total on the two different logs. Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 revealed an EX Order 26.4B1	F 842		

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F 842	Continued From page 16	F 842		

was given on EX Order 26.4B1 as it was documented the resident received doses at EX Order 26.4B1 There was no physician's order for the additional dose.

Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 revealed EX Order 26.4B1 was administered on EX Order 26.4B1 and was not documented on the "TAR" located in the EMR under the "Orders" tab. Additionally, on EX Order 26.4B1 EX Order 26.4B1 was administered at EX Order 2 . No physician's order was located for the additional dose administered.

Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 revealed EX Order 26.4B1 was administered on EX Order 26.4B1 No physician's order was located for the additiona EX Order 26.4B1 of medication administered.

Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 revealed EX Order 26.4B1 was administered on EX Order 26.4B1 was not signed out on the "Declining Inventory Sheet" until EX Order 26.4B1

Review of R7's "Declining Inventory Sheet," provided by the facility, dated EX Order 26.4B1 revealed EX Order 26.4B1 was administered on EX Order 26.4B1 at 10:00 PM and was not documented on the "TAR" located in the EMR under the "Orders" tab.

During an interview on 08/18/23 at 2:43 PM, the

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F 842	Continued From page 17 Director of Nursing (DON) indicated that her expectation was for nurses to administer the medication to the resident and then document in the "TAR" located in the "EMR" under the "Orders" tab. The medication should also be signed off on the "Declining Inventory Sheet" as well if the medication was a [redacted]. Upon review of the documentation reviewed on the "Declining Inventory Sheets" and in the EMR, the DON confirmed that she was unaware of the documentation inconsistencies. NJAC: 8:39-35.2 (d) (9) 8:39-27.1	F 842		

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	061501	A. BUILDING: _____ B. WING _____	C 08/18/2023

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S 000	Initial Comments Complaint #: NJ00165693, NJ00164145, NJ00164082, NJ00163445, NJ00162420, NJ00159225, NJ00157035, NJ00155008, NJ00154346, NJ00154159, NJ00153728, NJ00153625, NJ00153320, and NJ00151371. Survey Dates: 08/15/23 to 08/18/23 Survey Census: 212 Sample Size: 17 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # 157035 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to	S 560	S-560 No residents were identified. All residents have the potential to be	9/8/23

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

Electronically Signed | 09/08/23

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S 560	Continued From page 1 maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 147 of 189 day shifts, 2 of 28 evening shifts and 10 of 98 overnight shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 27 weeks of staffing from; 01/09/2022 to 01/22/2022, 03/27/2022 to 04/30/2022, 05/15/2022 to 05/28/2022, 08/07/2022 to 08/20/2022, 10/23/2022 to 11/05/2022, 02/26/2023 to 04/15/2023, 04/30/2023 to 05/20/2023, 07/09/2023 to 07/22/2023 and 07/30/2023 to 08/12/2023, the staffing to resident ratios did not meet the	S 560	affected by this deficient practice. Director of Nursing, and Staffing coordinator were in-serviced on new minimum staffing requirements on 8/30/2023. DON, Staffing Coordinator, Human Resource Director and Administraor will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week, as well as review Contract staff utilization to identify trends and opportunities. The facility has developed an employee culture committee focused on morale to help retention of staff. The facility participates in a weekly meeting to review open positions, recruitment tactics, and changes to improve outcomes. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, rehire campaign to rehire staff that have left our employ. The DON/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for three months and then quarterly.	

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S 560	Continued From page 2 minimum requirement of one CNA to eight residents for the day shift, one CNA to 10 residents for the evening shift and one to 14 residents for the overnight shift as documented below: 1. For the following 27 weeks of staffing, the facility was deficient in CNA staffing for residents on 147 of 189 day shifts, 2 of 28 evening shifts and 10 of 98 overnight shifts as follows: 1. For the 2 weeks of staffing from 01/09/2022 to 01/22/2022, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -01/09/22 had 20 CNAs for 204 residents on the day shift, required at least 25 CNAs. -01/10/22 had 21 CNAs for 204 residents on the day shift, required at least 25 CNAs. -01/11/22 had 24 CNAs for 204 residents on the day shift, required at least 25 CNAs. -01/12/22 had 24 CNAs for 204 residents on the day shift, required at least 25 CNAs. -01/14/22 had 19 CNAs for 204 residents on the day shift, required at least 25 CNAs. -01/15/22 had 18 CNAs for 206 residents on the day shift, required at least 26 CNAs. -01/16/22 had 16 CNAs for 206 residents on the day shift, required at least 26 CNAs. -01/16/22 had 14 total staff for 206 residents on the overnight shift, required at least 15 total staff. -01/17/22 had 20 CNAs for 206 residents on the day shift, required at least 26 CNAs. -01/18/22 had 22 CNAs for 205 residents on the day shift, required at least 26 CNAs. -01/19/22 had 23 CNAs for 205 residents on the	S 560	The administrator/designee will interview five residents weekly for 4 weeks and then monthly to determine if needs are being met. Results of the audits will be reported to the QAPI committee monthly. The QAPI Committee will make recommendations based upon the results of the audits, and will recommend tapering and dissolution of audits once consistent compliance is achieved. We also recruit nursing aids and send to school. Director of Nursing/designee will conduct audits of staffing ratios. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months Audits will be on-going to prevent this deficient practice. A monthly report will be given to the Administrator and the QAPI Committee.	

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S 560	Continued From page 3 day shift, required at least 26 CNAs. -01/20/22 had 24 CNAs for 205 residents on the day shift, required at least 26 CNAs. -01/21/22 had 24 CNAs for 204 residents on the day shift, required at least 25 CNAs. -01/22/22 had 22 CNAs for 204 residents on the day shift, required at least 25 CNAs. 2. For the 5 weeks of staffing from 03/27/2022 to 04/30/2022, the facility was deficient in CNA staffing for residents on 28 of 35 day shifts and deficient in total staff for residents on 2 of 35 overnight shifts as follows: -03/27/22 had 17 CNAs for 207 residents on the day shift, required at least 26 CNAs. -03/28/22 had 24 CNAs for 207 residents on the day shift, required at least 26 CNAs. -03/29/22 had 24 CNAs for 207 residents on the day shift, required at least 26 CNAs. -03/30/22 had 22 CNAs for 207 residents on the day shift, required at least 26 CNAs. -03/31/22 had 23 CNAs for 210 residents on the day shift, required at least 26 CNAs. -04/01/22 had 22 CNAs for 210 residents on the day shift, required at least 26 CNAs. -04/02/22 had 23 CNAs for 210 residents on the day shift, required at least 26 CNAs. -04/03/22 had 16 CNAs for 220 residents on the day shift, required at least 27 CNAs. -04/04/22 had 23 CNAs for 220 residents on the day shift, required at least 27 CNAs. -04/05/22 had 20 CNAs for 220 residents on the day shift, required at least 27 CNAs. -04/06/22 had 26 CNAs for 218 residents on the day shift, required at least 27 CNAs. -04/07/22 had 23 CNAs for 218 residents on the day shift, required at least 27 CNAs. -04/08/22 had 20 CNAs for 218 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 4	S 560		

day shift, required at least 27 CNAs.
-04/09/22 had 21 CNAs for 218 residents on the day shift, required at least 27 CNAs.

-04/10/22 had 16 CNAs for 219 residents on the day shift, required at least 27 CNAs.
-04/11/22 had 25 CNAs for 219 residents on the day shift, required at least 27 CNAs.
-04/12/22 had 25 CNAs for 219 residents on the day shift, required at least 27 CNAs.
-04/13/22 had 26 CNAs for 218 residents on the day shift, required at least 27 CNAs.
-04/15/22 had 22 CNAs for 218 residents on the day shift, required at least 27 CNAs.
-04/16/22 had 22 CNAs for 218 residents on the day shift, required at least 27 CNAs.
-04/16/22 had 15 total staff for 218 residents on the overnight shift, required at least 16 total staff.

-04/17/22 had 17 CNAs for 217 residents on the day shift, required at least 27 CNAs.
-04/19/22 had 22 CNAs for 217 residents on the day shift, required at least 27 CNAs.
-04/22/22 had 24 CNAs for 217 residents on the day shift, required at least 27 CNAs.
-04/23/22 had 15 CNAs for 217 residents on the day shift, required at least 27 CNAs.

-04/24/22 had 18 CNAs for 217 residents on the day shift, required at least 27 CNAs.
-04/24/22 had 14 total staff for 217 residents on the overnight shift, required at least 15 total staff.
-04/25/22 had 22 CNAs for 217 residents on the day shift, required at least 27 CNAs.
-04/30/22 had 20 CNAs for 217 residents on the day shift, required at least 27 CNAs.

3. For the 2 weeks of staffing from 05/15/2022 to 05/28/2022, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts,

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CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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S 560	Continued From page 5 deficient in total staff for residents on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -05/15/22 had 19 CNAs for 220 residents on the day shift, required at least 27 CNAs. -05/15/22 had 15 total staff for 220 residents on the overnight shift, required at least 16 total staff. -05/16/22 had 19 CNAs for 220 residents on the day shift, required at least 27 CNAs. -05/17/22 had 20 CNAs for 220 residents on the day shift, required at least 27 CNAs. -05/19/22 had 23 CNAs for 222 residents on the day shift, required at least 28 CNAs. -05/20/22 had 23 CNAs for 222 residents on the day shift, required at least 28 CNAs. -05/21/22 had 17 CNAs for 222 residents on the day shift, required at least 28 CNAs. -05/21/22 had 21 total staff for 222 residents on the evening shift, required at least 22 total staff. -05/21/22 had 15 total staff for 222 residents on the overnight shift, required at least 16 total staff. -05/22/22 had 12 CNAs for 223 residents on the day shift, required at least 28 CNAs. -05/23/22 had 20 CNAs for 223 residents on the day shift, required at least 28 CNAs. -05/24/22 had 27 CNAs for 223 residents on the day shift, required at least 28 CNAs. -05/25/22 had 25 CNAs for 223 residents on the day shift, required at least 28 CNAs. -05/26/22 had 26 CNAs for 223 residents on the day shift, required at least 28 CNAs. -05/27/22 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs. -05/28/22 had 21 CNAs for 226 residents on the day shift, required at least 28 CNAs. 4. For the 2 weeks of staffing from 08/07/2022 to 08/20/2022, the facility was deficient in CNA	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061501	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD 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)	(X5) COMPLETE DATE
S 560	Continued From page 6 staffing for residents on 8 of 14 day shifts as follows: -08/07/22 had 18 CNAs for 231 residents on the day shift, required at least 29 CNAs. -08/08/22 had 23 CNAs for 231 residents on the day shift, required at least 29 CNAs. -08/11/22 had 23 CNAs for 231 residents on the day shift, required at least 29 CNAs. -08/13/22 had 27 CNAs for 231 residents on the day shift, required at least 29 CNAs. -08/14/22 had 17 CNAs for 229 residents on the day shift, required at least 29 CNAs. -08/15/22 had 16 CNAs for 229 residents on the day shift, required at least 28 CNAs. -08/18/22 had 23 CNAs for 228 residents on the day shift, required at least 28 CNAs. -08/20/22 had 14 CNAs for 228 residents on the day shift, required at least 28 CNAs. 5. For the 2 weeks of staffing from 10/23/2022 to 11/05/2022, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -10/23/22 had 18 CNAs for 223 residents on the day shift, required at least 28 CNAs. -10/24/22 had 23 CNAs for 223 residents on the day shift, required at least 28 CNAs. -10/30/22 had 20 CNAs for 223 residents on the day shift, required at least 28 CNAs. -10/31/22 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs. -11/01/22 had 24 CNAs for 222 residents on the day shift, required at least 28 CNAs. -11/05/22 had 20 CNAs for 220 residents on the day shift, required at least 27 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061501	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD 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)	(X5) COMPLETE DATE
S 560	Continued From page 7 6. For the 7 weeks of staffing from 02/26/2023 to 04/15/2023, the facility was deficient in CNA staffing for residents on 41 of 49 day shifts and deficient in total staff for residents on 6 of 49 overnight shifts as follows: -02/26/23 had 22 CNAs for 223 residents on the day shift, required at least 28 CNAs. -02/27/23 had 27 CNAs for 223 residents on the day shift, required at least 28 CNAs. -02/28/23 had 25 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/01/23 had 27 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/02/23 had 24 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/03/23 had 25 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/04/23 had 24 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/05/23 had 24 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/05/23 had 14 total staff for 221 residents on the overnight shift, required at least 16 total staff. -03/06/23 had 21 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/07/23 had 27 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/11/23 had 25 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/11/23 had 15 total staff for 221 residents on the overnight shift, required at least 16 total staff. -03/12/23 had 21 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/13/23 had 24 CNAs for 221 residents on the day shift, required at least 28 CNAs. -03/14/23 had 24 CNAs for 220 residents on the day shift, required at least 28 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061501	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD 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)	(X5) COMPLETE DATE
S 560	Continued From page 8 -03/15/23 had 25 CNAs for 219 residents on the day shift, required at least 27 CNAs. -03/15/23 had 15 total staff for 219 residents on the overnight shift, required at least 16 total staff. -03/17/23 had 25 CNAs for 219 residents on the day shift, required at least 27 CNAs. -03/18/23 had 24 CNAs for 219 residents on the day shift, required at least 27 CNAs. -03/19/23 had 22 CNAs for 218 residents on the day shift, required at least 27 CNAs. -03/20/23 had 24 CNAs for 218 residents on the day shift, required at least 27 CNAs. -03/21/23 had 24 CNAs for 218 residents on the day shift, required at least 27 CNAs. -03/25/23 had 25 CNAs for 219 residents on the day shift, required at least 27 CNAs. -03/26/23 had 22 CNAs for 218 residents on the day shift, required at least 27 CNAs. -03/27/23 had 26 CNAs for 218 residents on the day shift, required at least 27 CNAs. -03/29/23 had 26 CNAs for 218 residents on the day shift, required at least 27 CNAs. -03/30/23 had 24 CNAs for 220 residents on the day shift, required at least 27 CNAs. -03/31/23 had 25 CNAs for 220 residents on the day shift, required at least 27 CNAs. -04/01/23 had 26 CNAs for 220 residents on the day shift, required at least 27 CNAs. -04/01/23 had 15 total staff for 220 residents on the overnight shift, required at least 16 total staff. -04/02/23 had 20 CNAs for 220 residents on the day shift, required at least 27 CNAs. -04/02/23 had 15 total staff for 220 residents on the overnight shift, required at least 16 total staff. -04/03/23 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs. -04/04/23 had 21 CNAs for 223 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061501	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD 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)	(X5) COMPLETE DATE
S 560	Continued From page 9	S 560		

day shift, required at least 28 CNAs.
-04/05/23 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs.
-04/06/23 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs.
-04/07/23 had 23 CNAs for 224 residents on the day shift, required at least 28 CNAs.
-04/07/23 had 15 total staff for 224 residents on the overnight shift, required at least 16 total staff.
-04/08/23 had 25 CNAs for 222 residents on the day shift, required at least 28 CNAs.

-04/09/23 had 17 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-04/10/23 had 20 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-04/11/23 had 22 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-04/12/23 had 25 CNAs for 221 residents on the day shift, required at least 28 CNAs.
-04/13/23 had 24 CNAs for 221 residents on the day shift, required at least 28 CNAs.
-04/14/23 had 24 CNAs for 221 residents on the day shift, required at least 28 CNAs.
-04/15/23 had 24 CNAs for 221 residents on the day shift, required at least 28 CNAs.

7. For the 3 weeks of staffing from 04/30/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 20 of 21 day shifts as follows:

-04/30/23 had 21 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-05/01/23 had 24 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-05/02/23 had 25 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-05/03/23 had 23 CNAs for 221 residents on the day shift, required at least 28 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061501	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD 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)	(X5) COMPLETE DATE
S 560	Continued From page 10 -05/04/23 had 24 CNAs for 218 residents on the day shift, required at least 27 CNAs. -05/05/23 had 18 CNAs for 218 residents on the day shift, required at least 27 CNAs. -05/06/23 had 16 CNAs for 218 residents on the day shift, required at least 27 CNAs. -05/07/23 had 15 CNAs for 218 residents on the day shift, required at least 27 CNAs. -05/08/23 had 18 CNAs for 220 residents on the day shift, required at least 27 CNAs. -05/09/23 had 21 CNAs for 220 residents on the day shift, required at least 27 CNAs. -05/10/23 had 21 CNAs for 220 residents on the day shift, required at least 27 CNAs. -05/11/23 had 24 CNAs for 219 residents on the day shift, required at least 27 CNAs. -05/12/23 had 24 CNAs for 219 residents on the day shift, required at least 27 CNAs. -05/13/23 had 17 CNAs for 219 residents on the day shift, required at least 27 CNAs. -05/14/23 had 18 CNAs for 219 residents on the day shift, required at least 27 CNAs. -05/16/23 had 24 CNAs for 219 residents on the day shift, required at least 27 CNAs. -05/17/23 had 26 CNAs for 219 residents on the day shift, required at least 27 CNAs. -05/18/23 had 26 CNAs for 219 residents on the day shift, required at least 27 CNAs. -05/19/23 had 22 CNAs for 219 residents on the day shift, required at least 27 CNAs. -05/20/23 had 20 CNAs for 219 residents on the day shift, required at least 27 CNAs. 8. For the 2 weeks of staffing from 07/09/2023 to 07/22/2023, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD 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)	(X5) COMPLETE DATE
S 560	Continued From page 11 -07/09/23 had 20 CNAs for 220 residents on the day shift, required at least 27 CNAs. -07/10/23 had 22 CNAs for 218 residents on the day shift, required at least 27 CNAs. -07/12/23 had 25 CNAs for 218 residents on the day shift, required at least 27 CNAs. -07/16/23 had 21 CNAs for 216 residents on the day shift, required at least 27 CNAs. -07/17/23 had 26 CNAs for 216 residents on the day shift, required at least 27 CNAs. -07/18/23 had 24 CNAs for 216 residents on the day shift, required at least 27 CNAs. -07/21/23 had 26 CNAs for 213 residents on the day shift, required at least 27 CNAs. -07/22/23 had 14 CNAs for 213 residents on the day shift, required at least 27 CNAs. 9. For the 2 weeks of staffing prior to survey from 07/30/2023 to 08/12/2023, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -07/30/23 had 22 CNAs for 214 residents on the day shift, required at least 27 CNAs. -07/31/23 had 24 CNAs for 214 residents on the day shift, required at least 27 CNAs. -08/01/23 had 25 CNAs for 214 residents on the day shift, required at least 27 CNAs. -08/02/23 had 26 CNAs for 214 residents on the day shift, required at least 27 CNAs. -08/04/23 had 25 CNAs for 214 residents on the day shift, required at least 27 CNAs. -08/05/23 had 24 CNAs for 214 residents on the day shift, required at least 27 CNAs. -08/06/23 had 24 CNAs for 214 residents on the day shift, required at least 27 CNAs. -08/07/23 had 23 CNAs for 214 residents on the day shift, required at least 27 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061501	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 12 -08/10/23 had 26 CNAs for 213 residents on the day shift, required at least 27 CNAs. -08/11/23 had 26 CNAs for 213 residents on the day shift, required at least 27 CNAs.	S 560		

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
315125 Y1	A. Building B. Wing Y2	9/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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 F0580	Correction	ID Prefix F0641	Correction	ID Prefix F0755	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	09/08/2023	LSC	09/08/2023	LSC	09/08/2023
ID Prefix F0842	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/08/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061501 Y1	A. Building B. Wing Y2	9/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE HEALTHCARE AND REHABILITATION	395 LAKESIDE BLVD BAYVILLE, NJ 08721

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/08/2023	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

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