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	315125	A. BUILDING _____ B. WING _____	10/29/2021

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F 000	INITIAL COMMENTS STANDARD SURVEY: 10/29/21 CENSUS: 197 SAMPLE SIZE: 37 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		11/26/21

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

Electronically Signed | 11/12/2021

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation Interview and review of other facility documentation, it was determined that the facility failed to a. maintain a clean and sanitary environment. This deficient practice was identified for 3 of 5 units and was evidenced by the following: 1. During the initial tour of the 5th floor on 10/25/21 at 11:48 AM the surveyor observed the following: 2. the floor along where the floor meets the baseboard was soiled brown colored marks and stained for most all of the unit hallway 3. windows by the elevator had smudges 4. the hallway floors had dried stains on both sides of the unit. 5. Resident room doors had chipped paint and gouges in the wood 6. There was peeling wallpaper in room 501 and 518. 7. At the end of the low hallway the floor had black marks on floor, stains rust in color, dark	F 584	Areas identified to not be sanitary and clean have been cleaned. The floors have been stripped and waxed. The smoking area has been power washed. Benches have been replaced prior before 10/29/2021. All residents have the potential to be affected by this deficient practice. Outside vendor was contracted to strip and wax the floors completed. In addtion to areas identified, stripping and waxing of other areas were completed as well. The activities staff, maintenance and housekeeping staff has been in-serviced on cleanliness of smoking area. The housekeeping staff has been in-serviced on hallway cleanliness,	

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F 584	Continued From page 2 substance at the corner of the baseboards, along with trash. 8. Mechanical lift wheels had buildup of hair wrapped around the wheels During an interview with the surveyor on 10/26/21 at 09:06 AM the housekeeper #1 assigned to the 5th floor said she cleans resident room every day and mop the halls daily. She also said she does not have time to buff the hallways. During an interview with the surveyor on 10/26/21 at 9:25 AM, the Manager of Housekeeping (MH) who said there is one housekeeper per unit, and they are responsible to clean resident rooms, day room, nurses' stations, and chart rooms daily. The MH went on to say he has to be honest and hasn't stripped or waxed the hallways in about a year. 2. During an interview with the surveyor on 10/27/21 at 9:56 AM, housekeeper #2 assigned to the 3rd floor said that she cleans every resident room during her shift. She stated is responsible for cleaning the entire unit including the hallways and nursing areas. She also added that she is the only housekeeper for the 3rd floor. During a tour of the 3rd floor unit on 10/27/21 at 10:07 AM, the surveyor observed the following: 1. a bathroom shared by rooms 302 and 303 with an adjustable raised toilet seat with a safety frame that was positioned over the toilet. The raised toilet seat had brown substance covering the toilet seat, 2. a brown substance on the shower curtain 3. a brown substance smeared on the doorway leading into room 303.	F 584	removal of debris from wheels on equipment on their floors in hallways and to report to director if they need assistance in cleaning wheels of equipment. Housekeeping staff is responsible for buffing and maintaining the floors. This will become part of our orientation education. Maintenance Director/Activity Director/and Housekeeping Director will audit the smoking area, the hallways and floors, poles and equipment for cleanliness. Wallpaper was fixed. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	

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F 584	Continued From page 3	F 584		

3. On 10/27/21 at 10:32 AM, The surveyor on a tour of the 7th floor observed the following:
1. The floor tiles outside of room 719, the were cracked and had accumulated debris at the baseboards.
2. The vestibule area, adjacent to the pipe on the 7th floor southside by the emergency exit door had accumulated dust and built up of unidentifiable debris.
3. The floor in front of the emergency exit doors on the southside of the 7th floor was visibly soiled with accumulated dust and unidentifiable debris.

On 10/28/21 at 11:25 AM, housekeeper #2 stated her responsibilities were to clean the hallway, mop the floors and elevator area, wipe the tables and chairs in the dayroom, and clean the bathrooms. She further stated we have no porters now, so I cover their jobs as well. They don't even buff the floors anymore.

4. On 10/27/21 at 10:29 AM, Resident #138 complained to surveyor that the wall inside of the smoking area was filthy and disgusting, that people would spit on the wall and it was all black.

On 10/27/21 at 2:12 PM, the surveyor observed the second-floor smoking balcony. The surveyor observed the benches in the smoking area had brown stains and with noticeably worn areas. The surveyor also observed the half wall opposite the smoking benches had dark brown and black splatters up and down the wall.

During an interview with the surveyor on 10/27/21 at 2:14 PM, the smoking monitor stated that housekeeping was responsible for keeping the smoking area clean. He stated he was responsible for sweeping and emptying the ash

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trays. When asked what the black marks were from, he responded he believed the marks were from the smoke and nicotine build-up, and that even if you wiped the walls they wouldn't come clean. He further stated that either maintenance or housekeeping would every once in a while come and wipe the walls.

During an interview with the surveyor on 10/28/21 at 12:00 PM, the Housekeeping Manager stated that the smoking monitor has a broom and dust pan to clean the smoking area. He was not sure who cleaned the splatters on the wall and that housekeeping doesn't go up there and clean that area.

On 10/27/21 at 12:16 PM, the Housekeeping Manager and Activities Director accompanied the surveyor to the smoking balcony on the second floor. The Activities Director who was responsible for the smoking program at the facility, stated the area was supposed to be power washed by maintenance at night. It should have been done in August. The Housekeeping Manager again stated it was not housekeeping's responsibility. The Directors both agreed the wall should not look the way it did and acknowledged there was black unidentifiable splashes all over the walls. They further agreed the area should be monitored for cleanliness. The Activities Director stated monitoring should be interdisciplinary, but ultimately the responsibility resided with her, and stated the area was power washed quarterly. She further stated this area needs to be addressed, and she would have someone clean it today, and that no one had notified her there was an issue. The Activities Director and the Housekeeping Manager acknowledged the benches in the smoking area also had brown stains and were

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F 584	Continued From page 5 worn in multiple places. The Housekeeping Manager stated the seats are cleaned daily with paper towels and sienna cleaner by the smoking monitor. The Activities Director then stated she would have the benches power washed as well, that she wouldn't want to sit on these benches in the state they were currently in. During an interview with the surveyor on 10/26/21 at 9:25 AM, the Manager of Housekeeping (MH) who said there is one housekeeper per unit, and they are responsible to clean resident rooms, day room, nurses' stations, and chart rooms daily. The MH went on to say he has to be honest and hasn't stripped or waxed the hallways in about a year. A review of first and second floor housekeeper as well as 3rd floor, 4th floor, 5th floor, 6th floor and 7th floor housekeeper assignments did not indicate what if anything should be done in the hallways.	F 584		
F 636 SS=B	NJAC 8:39-31.4(a) Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths,	F 636		11/26/21

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goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not

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F 636	Continued From page 7 apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete the Comprehensive Minimum Data Set assessment in a timely manner for 8 residents. This deficient practice was identified for Residents #11, #10, #17, #54, #6, #13, #27, and #736, 8 of 78 residents reviewed for comprehensive assessments and was evidenced by the following: Resident #11 was admitted with diagnoses that included but was not limited to mild cognitive impairment and schizoaffective disorder. On 10/26/2021, the surveyor reviewed the electronic medical record (EMR) for resident #11. The Comprehensive Minimum Data Set (MDS), an assessment tool completed on admission and annually, revealed an Assessment Reference Date (ARD), a date used as the last day of a look-back period, of 9/4/2021. The EMR revealed that the Annual MDS for Resident #11 had not been completed and was "in progress." As of 10/26/2021, the Annual MDS was 31 days late. Resident #10 was admitted with diagnoses that included but was not limited to schizophrenia and seizures. On 10/26/2021, the surveyor reviewed the EMR	F 636	The Comprehensive Minimum Data Set assessment was completed immediately for 8 residents identified by 10/29/21. All residents have the potential to be affected by this deficient practice. Residents will have comprehensive minimum data set assessment completed timely. The Minimum Data Set Coordinator, and Inter Disciplinary Care team have been in-serviced on completing Minimum Data Set timely and accurately. This will become part of our orientation education. Director of Nursing/Assistant Director of Nursing/designee will audit all Minimum Data Set to assure they are completed timely. Audits to assure the Minimum Data Set will be completed weekly for the next 4 weeks and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	

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for resident #10. The Annual MDS revealed an ARD of 9/4/2021. The EMR revealed that the Annual MDS for Resident #10 had not been completed and was "in progress." As of 10/26/2021, the Annual MDS was 31 days late.

Resident #17 was admitted with diagnoses which included but was not limited to unspecified intellectual disabilities and hyperlipidemia.
On 10/26/2021, the surveyor reviewed the EMR for resident #17. The MDS revealed an ARD of 9/14/2021. The EMR revealed that the Annual MDS for Resident #17 had not been completed and was "in progress." As of 10/26/2021, the Annual MDS was 30 days late.

Resident #54 was admitted with diagnoses which included but was not limited to major depressive disorder and hypothyroidism.
On 10/28/2021, the surveyor reviewed the EMR for resident #54. The Annual MDS revealed an ARD of 10/4/2021. The EMR revealed that the Annual MDS for Resident #54 had not been completed and was "in progress." As of 10/28/2021, the Annual MDS was 10 days late.

Resident #6 was admitted with diagnoses which included but was not limited to hypertension and schizoaffective disorder.
On 10/28/2021, the surveyor reviewed the EMR for resident #6. The Annual MDS revealed an ARD of 9/4/2021. The EMR revealed that the Annual MDS for Resident #6 had not been completed and was "in progress." As of 10/28/2021, the Annual MDS was 32 days late.

Resident #13 was admitted with diagnoses which included but was not limited to major depressive

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disorder and schizoaffective disorder.
On 10/28/2021, the surveyor reviewed the EMR for resident #13. The Annual MDS revealed an ARD of 9/13/2021. The EMR revealed that the Annual MDS for Resident #13 had not been completed and was "in progress." As of 10/28/2021, the Annual MDS was 31 days late.

Resident #27 was admitted with diagnoses which included but was not limited to diabetes and schizoaffective disorder.
On 10/28/2021, the surveyor reviewed the EMR for resident #27. The Annual MDS revealed an ARD of 9/20/2021. The EMR revealed that the Annual MDS for Resident #27 had not been completed and was "in progress." As of 10/28/2021, the Annual MDS was 24 days late.

Resident #736 was admitted with diagnoses which included but was not limited to bipolar disorder and major depressive disorder.

On 10/28/2021, the surveyor reviewed the EMR for resident #736. The EMR revealed an entry date of 10/05/2021 for Resident #736. As of 10/28/2021, the Admission MDS was "in progress" and had not been completed.

On 10/28/2021 at 9:02 a.m., the surveyor interviewed the Assistant Director of Nursing who is the acting Minimum Data Set Coordinator (MDS Coordinator). The MDS Coordinator stated that the MDSs should be completed within 14 days of the ARD. She acknowledged that the comprehensive MDSs were late and should have been completed within 14 days of the ARD.

The surveyor reviewed the "MDS 3.0 RAI Manual

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F 636	Continued From page 10 dated October 1, 2019". The Manual revealed on Page 2-16 that the Annual MDS assessment has a completion date "No Later Than" the ARD +14 calendar days. NJAC 8:39 - 11.2	F 636		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete the Quarterly Minimum Data Set assessment in a timely manner for 27 residents. This deficient practice was identified for Residents #32, #3, #9, #25, #22, #18, #31, #14, #23, #28, #7, #2, #37, #4, #5, #8, #12, #15, #16, #19, #20, #21, #24, #29, #30, and #144, 26 of 78 residents reviewed for quarterly assessments and was evidenced by the following: Resident #32 was admitted with diagnoses that included but was not limited to schizophrenia and anemia. On 10/26/2021, the surveyor reviewed the electronic medical record (EMR) for resident #32. The Quarterly Minimum Data Set (QMDS), an assessment tool completed every 3 months, revealed an Assessment Reference Date (ARD), a date used as the last day of a look-back period, of 9/23/2021. The EMR revealed that the Quarterly MDS for Resident #32 had not been	F 638	Quarterly Minimum Data Set assessments were completed for 27 residents by 10/29/21. Re-education on completing quarterly Minimum Data Set in a timely manner was given to Minimum Data Set Coordinator/ Interdisciplinary Department Care team. All residents have the potential to be affected by this deficient practice. Director of Nursing/Assistant Director of Nursing/Interdisciplinary Department Care Team has been in-serviced on completing quarterly assessments timely. This will become part of our orientation education. Minimum Data Set Coordinator/Director of Nursing will audit all residents Minimum Data Set to assure quarterly minimum data set are completed timely. Audits will be completed weekly for the next 4 weeks	11/26/21

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F 638	Continued From page 11 completed and was "in progress." As of 10/26/2021, the Quarterly MDS was 21 days late. Resident #3 was admitted with diagnoses that included but was not limited to Parkinson's Disease and anxiety. On 10/26/2021, the surveyor reviewed the EMR for Resident #3. The QMDS revealed an ARD of 09/04/2021. The EMR revealed that the QMDS for Resident #3 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 31 days late. Resident #9 was admitted with diagnoses which included but was not limited to schizoaffective disorder and anemia. On 10/26/2021, the surveyor reviewed the EMR for Resident #9. The QMDS an ARD of 09/12/2021. The EMR revealed that the QMDS for Resident #9 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 31 days late. Resident #25 was admitted with diagnoses which included but was not limited to schizoaffective disorder and Vitamin D deficiency. On 10/26/2021, the surveyor reviewed EMR for Resident #25. The QMDS revealed an ARD of 09/19/2021. The EMR revealed that the QMDS for Resident #25 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 24 days late. Resident #22 was admitted with diagnoses which included but was not limited to schizophrenia and hyperlipidemia. On 10/26/2021, the surveyor reviewed the EMR for Resident #22. The QMDS revealed an ARD of 09/19/2021. The EMR revealed that the QMDS	F 638	and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	

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for Resident #22 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 25 days late.

Resident #18 was admitted with diagnoses which included but was not limited to hyperlipidemia and Vitamin D deficiency.
On 10/26/2021, the surveyor reviewed EMR for Resident #18. The QMDS revealed an ARD of 09/19/2021. The EMR revealed that the QMDS for Resident #18 had not been completed and was "in progress." As of 10/26/2021, the Quarterly MDS was 25 days late.

Resident #31 was admitted with diagnoses which included but was not limited to paranoid schizophrenia and sleep disorder.
On 10/26/2021, the surveyor reviewed the EMR for Resident #31. The QMDS revealed an ARD of 09/23/2021. The EMR revealed that the QMDS for Resident #31 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 21 days late.

Resident #14 was admitted with diagnoses which included but was not limited to schizophrenia and dementia.
On 10/26/2021, the surveyor reviewed the EMR for Resident #14. The QMDS revealed an ARD of 09/05/2021. The EMR revealed that the QMDS for Resident #14 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 31 days late.

Resident #23 was admitted with diagnoses which included but was not limited to dementia and basal cell carcinoma.
On 10/26/2021, the surveyor reviewed the EMR for Resident #23. The QMDS revealed an ARD

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of 09/19/2021. The EMR revealed that the QMDS for Resident #23 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 25 days late.

Resident #28 was admitted with diagnoses which included but was not limited to diabetes mellitus and benign prostatic hyperplasia.
On 10/26/2021, the surveyor reviewed the EMR for Resident #28. The QMDS revealed an ARD of 09/20/2021. The EMR revealed that the QMDS for Resident #28 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 24 days late.

Resident #7 was admitted with diagnoses which included but was not limited to type 2 diabetes mellitus and anemia.
On 10/26/2021, the surveyor reviewed the EMR for Resident #7. The QMDS revealed an ARD of 09/04/2021. The EMR revealed that the QMDS for Resident #7 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 31 days late.

Resident #2 was admitted with diagnoses which included but was not limited to schizoaffective disorder and human immunodeficiency virus.
On 10/26/2021, the surveyor reviewed the EMR for Resident #2. The QMDS revealed an ARD of 09/02/2021. The EMR revealed that the QMDS for Resident #2 had not been completed and was "in progress." As of 10/26/2021, the QMDS was 29 days late.

Resident #37 was admitted with diagnoses which included but was not limited to Parkinson's Disease and sepsis.
On 10/28/2021, the surveyor reviewed the EMR

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for Resident #37. The QMDS revealed an ARD of 09/27/2021. The EMR revealed that the QMDS for Resident #37 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 17 days late.

Resident #4 was admitted with diagnoses which included but was not limited to disorganized schizophrenia and bipolar disorder.
On 10/28/2021, the surveyor reviewed the EMR for Resident #4. The QMDS revealed an ARD of 09/04/2021. The EMR revealed that the QMDS for Resident #4 was completed on 10/28/21. The QMDS was completed 40 days late.

Resident #5 was admitted with diagnoses which included but was not limited to dementia with behavioral disturbance and mood disorder.
On 10/28/2021, the surveyor reviewed the EMR for Resident #5. The QMDS revealed an ARD of 09/12/2021. The EMR revealed that the QMDS for Resident #5 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 32 days late.

Resident #8 was admitted with diagnoses which included but was not limited to dementia with anxiety disorder and bipolar disorder.

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On 10/28/2021, the surveyor reviewed the EMR for Resident #8. The QMDS revealed an ARD of 09/12/2021. The EMR revealed that the QMDS for Resident #8 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 32 days late.

Resident #12 was admitted with diagnoses which included but was not limited to dementia with diabetes and hypertension.
On 10/28/2021, the surveyor reviewed the EMR for Resident #12. The QMDS revealed an ARD of 09/13/2021. The EMR revealed that the QMDS for Resident #12 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 31 days late.

Resident #15 was admitted with diagnoses which included but was not limited to dementia with paranoid schizophrenia and major depressive disorder.
On 10/28/2021, the surveyor reviewed the EMR for Resident #15. The QMDS revealed an ARD of 09/05/2021. The EMR revealed that the QMDS for Resident #15 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 39 days late.

Resident #16 was admitted with diagnoses which included but was not limited to dementia with muscle weakness and major depressive disorder.
On 10/28/2021, the surveyor reviewed the EMR for Resident #16. The QMDS revealed an ARD of 09/14/2021. The EMR revealed that the QMDS for Resident #16 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 30 days late.

Resident #19 was admitted with diagnoses which

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F 638	Continued From page 16 included but was not limited to dementia with schizoaffective disorder and diabetes. On 10/28/2021, the surveyor reviewed the EMR for Resident #19. The QMDS revealed an ARD of 09/19/2021. The EMR revealed that the QMDS for Resident #19 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 25 days late. Resident #20 was admitted with diagnoses which included but was not limited to dementia with schizophrenia and kidney failure. On 10/28/2021, the surveyor reviewed the EMR for Resident #20. The QMDS revealed an ARD of 09/19/2021. The EMR revealed that the QMDS for Resident #20 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 25 days late. Resident #21 was admitted with diagnoses which included but was not limited to dementia with schizophrenia and anxiety. On 10/28/2021, the surveyor reviewed the EMR for Resident #21. The QMDS revealed an ARD of 09/19/2021. The EMR revealed that the QMDS for Resident #21 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 25 days late. Resident #24 was admitted with diagnoses which included but was not limited to dementia with paranoid schizophrenia and hypertension. On 10/28/2021, the surveyor reviewed the EMR for Resident #24. The QMDS revealed an ARD of 09/19/2021. The EMR revealed that the QMDS for Resident #24 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 25 days late.	F 638		

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Resident #29 was admitted with diagnoses which included but was not limited to dementia with paranoid schizophrenia and hypertension.
On 10/28/2021, the surveyor reviewed the EMR for Resident #29. The QMDS revealed an ARD of 09/20/2021. The EMR revealed that the QMDS for Resident #29 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 24 days late.

Resident #30 was admitted with diagnoses which included but was not limited to dementia with schizophrenia and vitamin deficiency.
On 10/28/2021, the surveyor reviewed the EMR for Resident #30. The QMDS revealed an ARD of 09/21/2021. The EMR revealed that the QMDS for Resident #30 had not been completed and was "in progress." As of 10/28/2021, the QMDS was 23 days late.

Resident #144 was admitted with diagnoses which included but was not limited to dementia with paranoid schizophrenia and anxiety disorder.
On 10/28/2021, the surveyor reviewed the EMR for Resident #144. The QMDS revealed an ARD of 08/21/2021. The EMR revealed that the QMDS for Resident #144 was completed on 09/14/21. The QMDS was completed 10 days late.

On 10/28/2021 at 9:02 a.m., the surveyor interviewed the Assistant Director of Nursing who is the acting Minimum Data Set Coordinator (MDS). The MDS Coordinator stated that the Quarterly MDSs should be completed within 14 days of the ARD. She acknowledged that the Quarterly MDSs of were late and should have completed within 14 days of the ARD.

The surveyor reviewed the "MDS 3.0 RAI Manual

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F 638	Continued From page 18 dated October 1, 2019". The Manual revealed on Page 2-17 that the Quarterly MDS assessment has a completion date "No Later Than" the ARD +14 calendar days.	F 638		
F 641 SS=B	NJAC 8:39 - 11.2 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, interview, review of the medical record and other facility documentation, it was determined that the facility failed to ensure that an accurate Minimum Data Set (MDS), an assessment tool, was completed. This deficient practice was identified for 2 of 37 residents reviewed for MDS's (Residents # 89 and Resident # 84) and was evidenced by the following: 1. During the initial tour of the 5th floor unit on 10/25/21 at 09:55 AM, Resident #89 was observed lying in bed with a blue splint on her left hand. The resident said she has had contracture left hand for at least a month. She also said she exercises her own hand. According to the Admission Record, Resident # 89 was admitted to the facility with diagnosis including but not limited to: Multiple Sclerosis. A review of the Order Summary Report (OSR)	F 641	An accurate Minimum Data Set (MDS), an assessment tool, was completed to accurately reflect the resident's status for the two residents by 10/29/2021. Re-education began 10/29/21 to assure Minimum Data Set are completed to accurately reflect the resident□s status. All residents have the potential to be affected by this deficient practice. Director of Nursing/Assistant Director of Nursing/Minimum Data Set Coordinator has been in-serviced on completing Minimum Data Set to accurately reflect the resident□s status. This will become part of our orientation education. The Director of Nursing /Assistant Director of Nursing/ Minimum Data Set Coordinator will audit all Minimum Data	11/26/21

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F 641	Continued From page 19 dated 10/4/21, revealed an order for Left hand grip splint at all times except for hygiene every shift. The OSR dated 10/4/21 further revealed an order for Towel roll left hand at all times except for hygiene for contracture management every shift A review of the Quarterly Minimum Data set (MDS), an assessment tool dated 7/25/21, under section G-4-A. coded as zero (0) for upper extremity indicating "No impairment." During an interview with the surveyor on 10/28/21 at 11:29 AM, the Assistant Director of Nursing (ADON) /acting MDS coordinator said the quarterly MDS was not coded correctly under G0400 (functional status) and section O (Special Treatments and Programs) should also have had a splint or brace coded. 2. On 10/26/21 at 9:36 AM, Resident #84 was observed lying in bed watching television. Resident #84's legs were contracted towards his/her chest and his/her bilateral hands were tightly closed and turned in. The resident demonstrated how he/she attempts to grasp a soda can stating that he/she does this to help keep her hands exercised. According to the Admission Record, Resident #84 was admitted to the facility with diagnoses including but not limited to; Paranoid Schizophrenia, Unspecified Dementia without Behavioral Disturbance. A review of Resident #84's MDS, an assessment tool dated 07/19/21, revealed under section G0400- (Functional Status), that Resident #84	F 641	Set to assure they accurately reflect the residents status. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months A monthly report will be given to the Administrator and the QAPI Committee.	

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F 641	Continued From page 20 had impairment of both sides of the lower extremities and no impairment to the upper extremities. The MDS also revealed in section O-(Special Treatments and Programs), that Resident #84 did not receive any restorative nursing programs that included range of motion exercises, splint, or brace assistance. A review of the Physician Order Sheet (POS) dated 10/29/21 revealed no order for services related to the resident's contractures (a condition of shortening and hardening of muscles, tendons, and other tissue often leading to deformity and rigidity of joints). On 10/27/21 at 12:28 PM, the surveyor reviewed the MDS with the ADON/acting MDS coordinator. The MDS coordinator acknowledged that the MDS did not accurately identify Resident #84's functional abilities and diagnosis of upper extremity contractures. The MDS coordinator further said that Resident #84 should have been identified as requiring total care, and he/she should have had some form of a splint to benefit his/her range of motion. NJAC 8:39-11.2(e)(1)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		11/26/21

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F 656	Continued From page 21 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, review of medical record and review of other facility documentation, it was determined that the facility failed to ensure that a comprehensive care plan was completed and accurate for 1 of 37 sampled residents, (Resident	F 656	The comprehensive care plan was completed and accurate for 1 resident that was found to be out of compliance by 10/29/21.	

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F 656	Continued From page 22 # 736). This deficient practice was evidenced by the following: Resident # 736 was admitted to the facility with diagnosis of Bipolar Disorder and Major Depressive Disorder. On 10/26/21 at 09:58 AM, during an interview with the surveyor, Resident # 736 informed that they had leg pain since being admitted to this facility. Resident #736 said the nurse provides Tylenol for the pain. A review of a nursing progress note dated 10/5/21, revealed Resident # 736 was transferred to the facility alert, oriented, and able to make needs known to the facility. On 10/26/21 at 10:46 AM, the surveyor reviewed Resident # 736's electronic medical records, which revealed a care plan initiated on 10/6/21 and had a focus of nutritional problem or potential nutritional problems related to bipolar disorder and major depressive disorder. There was no further documentation to indicate Resident # 736 had any other care plan in place for any other documented needs. During an interview with the surveyor on 10/28/21 at 09:32 AM, the facility Licensed Practical Nurse # 6 (LPN # 6) reviewed Resident #736's medical record and confirmed the resident was care planned for diet, nutrition only with no other care plan addressing other resident needs. LPN # 6 stated regarding care plan, that the resident's pain "would not be in the care plan unless there is a goal or continuous treatment for it. Something like this is immediate action." During an interview with the surveyor in the presence of a second surveyor on 10/28/21 at	F 656	All residents have the potential to be affected by this deficient practice. DON/ADON/IDCTeam has been in-serviced on completing accurate and comprehensive care plans on all residents. This will become part of our orientation education MDS Coordinator/DON will conduct audits of care plans for completeness and comprehensiveness. 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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F 656	Continued From page 23 11:24 AM, the Assistant Director of Nursing (ADON) who is also the acting Minimum Data Set (MDS) Coordinator stated that resident care plans are created by all members of the Interdisciplinary Team (IDT) which is includes nursing, dietary, social services, and therapy to address all the needs of the resident. The ADON confirmed that all focused needs on the care plan at the time of this interview were initiated on 10/28/21, with only a nutritional care plan having been initiated on 10/6/21. The facility was unable to provide a comprehensive care plan policy. NJAC 8:39- 11.2(e)-(i); 27.1(a)(d)	F 656		
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, record review and review of facility documents, it was determined that the facility failed to a.) monitor resident behaviors with the administration of a psychotropic medication (a medication used to treat mental disorders) and b.) transcribe a handwritten physician order into the Electronic Medical Record (EMR) for 1 of 5 residents (Resident #123) reviewed for unnecessary medications and c.) failed to complete neurological assessments after a resident fell in accordance with professional standards for 1 of	F 658	Orders for Resident 123 was checked for accuracy 10/29/21. No discrepancies noted. Medication for PRN duration ended prior 10/29/21. Physician was informed, no new orders were initiated. All residents have the potential to be affected by this deficient practice. In-service for policy on psychotropic medications and proper documentation on behaviors started 10/29/21 with nurses.	11/26/21

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F 658	Continued From page 24 6 residents (Resident #135) reviewed for accidents. This deficient practice was identified as follows: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. According to the Admission Record, Resident #123, was admitted with diagnoses, which included but were not limited to, schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly), major depressive disorder and anxiety disorder.	F 658	Nursing Staff have been in-serviced on policy for psychotropic medication to include having 14 days pmc forms completed. Electronic Medical record is now interfaced with pharmacy. Nurses were in-serviced on inputting orders properly. Falls and Events in-service for nursing staff started 10/29/21, to include documenting proper dates and times of events. Unwitnessed falls must have neuro checks completed. Nurses have been in-serviced regarding policy on residents with unwitnessed falls and neuro checks being completed. This will become part of our orientation education. Director of Nursing/Assistant Director Nursing/designee will Audit all events and psychotropic medication changes checking for; accuracy of neuro checks post, accuracy of order transcription, as well as psychotropic medication behavior-monitoring. 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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F 658	Continued From page 25 On 10/26/21 at 12:54 PM, 10/27/21 at 9:23 AM and 10/28/21 at 11:39 AM, the surveyor observed Resident #123 lying supine in bed with the head of bed elevated. A review of the handwritten July 2021 Physician's Orders (POS) revealed an order dated 07/22/21 at 12:00 PM, to start Abilify (an antipsychotic medication) 15 mg (milligrams) daily for schizophrenia and to start Buspar (an antianxiety medication) 10 mg three times daily for anxiety. The July 2021 POS further revealed an order dated 07/29/21 at 1:00 PM to discontinue Abilify 15 mg and to start Abilify 20 mg daily. The medical record reflected an incomplete Psychotropic Medication Change (PMC) form (a form used to monitor resident behaviors with a psychotropic medication change) dated 07/22/21 for the medication Buspar 10 mg for Resident #123. The medical record did not reflect a PMC form dated 7/22/21 for the medication Abilify 15 mg for Resident #123. The medical record further reflected an incomplete PMC form dated 07/29/21 for the medication Abilify 20 mg daily for Resident #123. The surveyor observed that each PMC form included the name of the medication, the resident's name, and the date/time the medication change started. The nurse would document and initial the resident's change in behaviors on each shift (7-3, 3-11 and 11-7) for 14 days by checking "No change in beh. [behavior]" or documenting in the progress notes for "Change * See documentation." At the bottom of the PMC form the nurse would indicate her "Full Signature/Title" and "Initials."	F 658		

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F 658	Continued From page 26 The surveyor reviewed the 07/22/21 Buspar 10 mg PMC form for Resident #123 which reflected that two nurses signed the "Full Signature/Title and Initials," and that behavior monitoring was not completed for the following shifts: Day 1: 7-3, 3-11, 11-7 Day 2: 7-3, 11-7 Day 3: 3-11, 11-7 Day 4: 3-11, 11-7 Day 5: 3-11, 11-7 Day 6: 3-11, 11-7 Day 7: 3-11, 11-7 Day 8: 3-11, 11-7 Day 9: 11-7 Day 10: 3-11, 11-7 Day 11: 7-3, 3-11, 11-7 Day 12: 3-11, 11-7 Day 13: 11-7 Day 14: 11-7 The surveyor reviewed the 07/29/21 Abilify 20 mg PMC form for Resident #123 which reflected that one nurse signed the "Full Signature/Title and Initials," and that behavior monitoring was not completed for the following shifts: Day 1: 7-3, 3-11, 11-7 Day 2: 3-11, 11-7 Day 3: 11-7 Day 4: 3-11, 11-7 Day 5: 7-3, 3-11, 11-7 Day 6: 3-11, 11-7 Day 7: 11-7 Day 8: 11-7 Day 9: 7-3 Day 10: 7-3, 3-11, 11-7 Day 11: 3-11, 11-7 Day 12: 3-11 Day 13: 11-7 Day 14: 11-7	F 658		

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F 658	Continued From page 27 During an interview with the surveyor on 10/27/21 at 1:49 PM, the Licensed Practical Nurse #5 (LPN) reviewed the orders dated 07/22/21 for Buspar 10 mg and Abilify 15 mg, the order dated 07/29/21 for Abilify 20 mg and the corresponding PMC forms with the surveyor. LPN #5 verified that a PMC form was started for Buspar 10 mg and Abilify 20 mg. LPN #5 further verified that a PMC form was not initiated for the Abilify 10 mg. LPN #5 stated that with each new psychotropic medication change, a PMC form would be completed by the nurse on each shift for 14 days. The nurse on each shift would either check "no change in behavior" or if there was a change, the nurse would document in the progress notes. LPN #5 further stated that each nurse would initial the PMC form next to their daily shift and the nurse would also sign their full signature/title and initials at the bottom of the page. LPN #5 verified that the PMC forms for Buspar 10 mg and Abilify 20 mg were incomplete and that she could not locate the 07/22/21 PMC form for Abilify 15 mg. During an interview with the surveyor on 10/28/21 at 1:55 PM, the Director of Nursing (DON) stated her expectations were for every change in a resident's psychotropic medication, the nurse should monitor the resident's behaviors. A review of the facility's Antipsychotic Medication Use policy, dated January 2021, reflected the staff will monitor resident behaviors. 2. The surveyor reviewed the 10/2021 handwritten POS for Resident #123. The 10/2021 POS revealed an order dated 10/11/21 for Ativan (an antianxiety medication) 0.5 mg	F 658		

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every six hours as needed for 14 days for anxiety.

A review of the EMR did not reveal an order dated 10/11/21 for Ativan 0.5 mg.

A review of the 10/2021 Medication Administration Record did not reveal an order dated 10/11/21 for Ativan 0.5 mg.

During an interview with the surveyor on 10/27/21 at 10:58 AM, LPN #5 reviewed the handwritten 10/11/21 POS order, the EMR orders and the 10/2021 Medication Administration Record (MAR) for the 10/11/21 Ativan order in the presence of the surveyor. LPN #5 verified that the handwritten Ativan order was on the POS dated 10/11/21. She further verified that the order was not in the EMR or in the 10/21 MAR.

During an interview with the surveyor on 10/29/21 at 11:35 AM, the DON reviewed the 10/11/21 Ativan order with the surveyor. The DON verified that the Ativan 0.5 mg handwritten order dated 10/11/21 was not sent to the pharmacy. When asked to confirm whether the referenced order was transcribed into the EMR and the MAR, the DON stated that she would review it and follow up with the surveyor.

During a follow up interview with the surveyor on 10/29/21 at 1:18 PM, the DON failed to clarify any matters related to the 10/11/21 Ativan order and further revealed that an order for Prozac 40 mg capsule dated 10/04/21 for Resident #123 was not addressed.

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3. The surveyor observed Resident #135, lying in bed, with the bed in the lowest position, during the following dates and times: 10/25/21 at 11:20 AM, 10/26/21 at 8:30 AM, and 10/27/21 at 8:53 AM.

The surveyor obtained and reviewed a copy of the resident's Admission Record, which revealed diagnoses that included, but were not limited Parkinson's Disease (a movement disorder), major depressive disorder, unspecified kidney failure, and schizophrenia (a psychotic disorder).

The surveyor requested, obtained, and reviewed a copy of an incident report, related to an unwitnessed fall that occurred on 07/28/21, for Resident #135. According to the "Fall Incident Report Check List" on the report, it is necessary to conduct "Neuro checks if fall was not witnessed." Further review of the report revealed neuro checks were conducted for a period beginning on 07/27/21 at 1:30 AM, approximately 15 minutes after the fall, continued for the next four hours, and then stopped. A review of the report also revealed that it was dated as 01/27/21 in some areas and 07/27/21 at other areas.

During an interview with the surveyor on 10/28/21 at 9:53 AM, the Licensed Practical Nurse - Unit Manager (LPN-UM) confirmed that Resident #135 fell on 07/27/21 in the early morning. She stated there was no fall on 01/27/21 and did not know why the referenced fall report was sometimes dated 01/27/21 and at other times dated 07/27/21. She also described the processes involved for resident care after a fall occurs. The post-fall caring process included observing a resident every shift for three days to ensure that he/she is okay. She further stated

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that this included neuro checks for three days. The LPN-UM reviewed Resident #135's 07/27/21 Neurological Assessment Flow Sheet (neuro check sheet) in the presence of the surveyor and confirmed that neuro checks were implemented but could not provide a reason for why they were not completed. Review of the neuro check sheet, at this time, revealed that neuro checks were not completed on 07/27/21 at 9:15 AM, 1:15 PM, 5:15 PM, 9:15 PM and on 07/28/21 at 1: 15 AM. The LPN-UM indicated that perhaps there was additional documentation located somewhere else and she would try to locate it.

Later during the same day, the LPN-UM was able to provide the surveyor a copy of additional neuro checks, which included a period from 07/28/21 at 11:00 PM, 07/29/21, and into to morning of 07/30/21. According to the documentation, there were no neuro checks conducted from 07/27/21 at 5:15 AM onward. The additional neuro check document revealed that neuro checks were completed at 11:00 PM and 3:00 AM of an undisclosed date. There were no neuro checks documented for 07/28/21.

The surveyor attempted telephone interview with the Licensed Practical Nurse (LPN #2), who completed Resident #135's 07/27/21 incident report. LPN #2 did not follow up with surveyor.

During a follow-up interview with the surveyor on 10/28/21 at 1:52 PM, the LPN-UM confirmed that Resident #135's fall was not witnessed by staff. She further stated that as a result, this type of fall would be considered "unwitnessed" and require neuro checks for three to four days. In addition, the LPN-UM also confirmed that neuro checks were listed as a necessary task on the document

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titled, "Fall Incident Report Checklist" and should have been thoroughly completed. The LPN-UM acknowledged there was an absence of consistent neuro checks but could not provide further information related to the missing documentation.

During an interview with the surveyor on 10/28/21 at 2:25 PM, the DON stated that neuro checks should occur for the first 72 hours after a fall. The surveyor questioned the importance of completing the neuro check sheet after an unwitnessed fall. The DON stated that an absence of such monitoring would be a problem since staff would not know to what extent the head may have been involved with injuries. The DON also stated that sometimes residents who fall are sent to the hospital for evaluation and this may be the reason for the absence of neuro checks. At this time, the Licensed Nursing Home Administrator (LNHA) stated that there is nothing indicating that Resident #135 was hospitalized after the fall on 07/27/21.

The LNHA provided the surveyor with additional documentation on Resident #135, on the morning of 10/29/21. The new document revealed that additional neuro checks were conducted for the absent times on 07/27/21 and into the early morning of 07/28/21. In addition, there were discrepancies between the neurological report copied by the surveyor on 10/28/21 and the copy provided by facility staff on 10/29/21. According to a comparison of the two copies, two different staff members were conducting neurological assessments on Resident #135 at that same exact dates and times, on 07/27/21 from 1:30 AM through the same date at 5:15 AM. In addition, Resident had different blood pressures, pulse

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rates, and respiratory rates at the same times, during multiple times, on the morning of 07/27/21.

During an interview with the surveyor on 10/29/21 at 1:30 PM, the DON confirmed Resident #135 was not hospitalized after the fall on 07/27/21. The DON stated there were no additional neurological assessments that could be furnished during the time periods in question, for which neuro checks were absent. She stated she searched and could not find any additional documentation anywhere. The LNHA stated that facility staff could not account for the discrepancy of dates listed on the fall report, involving 01/27/21 and 07/27/21, and that no determination could be made regarding this apparent error. The DON stated one assigned nurse would be responsible for conducting neuro checks after a fall occurred. The DON could not provide further detail as to why there was documentation related to neuro checks, completed by two different nurses for the same resident, during some of the exact same dates and times on 07/27/21. The DON could not provide a rationale for why Resident #135 had varying vital signs (blood pressure, pulse, and respiratory rate) at some of the same exact times on 07/27/21. The LNHA stated there were no other policies related to completion of neurological assessments.

A policy titled, "Pyramid Healthcare Management Events Documentation" revealed that neurological assessments were to be uploaded into a resident's chart, but this electronic (computerized) record-keeping was not in effect at the time of the referenced incident, as confirmed by the LNHA during the survey entrance conference on 10/25/21.

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. 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 ensure all laundry room doors with laundry chutes were securely locked to prevent accidents. This deficient practice was identified for 1 of 5 laundry room doors (7th floor) observed and was evidenced by the following: On 10/27/21 at 10:29 AM, Resident #138 told surveyor #1 to check out the laundry room door, that it was not locked. At that time the surveyor approached the door and was able to turn the handle without resistance and enter the room where a laundry chute was located and latched closed. At 10:37 AM, Licensed Practical Nurse #7 (LPN #7) who worked for an outside agency, and had worked at the facility for a month, stated the laundry room door should automatically lock. LPN #7 further stated the laundry door should be locked for safety, because there is a laundry chute in there.	F 689	The laundry chute door on 7th floor was fixed 10/26/21. All residents have the potential to be affected by this deficient practice. Maintenance staff, housekeeping staff and nursing staff have been in-serviced on assuring the laundry chute door is locked at all times. In addition they have been educated on making sure to report any issues with the lock to maintenance department immediately whether maintenance staff are in building or not. In the absence of Maintenance response they are to inform the Administrator. The staff will document in the maintenance log any issue they find with the laundry chute doors as well. The maintenance staff will reveiew the maintenance log daily and look for any issues regarding the laundry chute doors. This will become part of our orientation education.	11/26/21

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F 689	Continued From page 34 At 10:38 AM, Certified Nursing Assistant (CNA #1) stated to surveyor #1 the lock to the laundry room was broken, and inside there was the laundry chute, and it should be locked at all times. CNA #1 stated it should be locked because a resident could hide in there or they could open the chute. At 10:39 AM, the surveyor interviewed the Licensed Practical Nurse, Unit Manager (LPN/UM) who stated the door should be locked at all times and would immediately call maintenance to fix the door. At 11:20 AM, the maintenance technician came to the 7th floor carrying a box and stated the nurse manager had called him to say the door was not locking and asked him to replace the lock. At that same time, surveyor #2 inspected the 6th floor laundry room door which was locked and the knob was unable to be opened without inputting the code. At 11:25 AM, surveyor #2 inspected the 4th floor laundry room door which was locked, and the handle was unable to be opened without inputting the code. At 11:26 AM, surveyor #1 again interviewed CNA #1 who stated the laundry room was where the CNAs and nurses threw soiled linen down the laundry chute. CNA #1 stated he noticed the lock didn't work yesterday (10/26/21), that it was working on Friday (10/21/21) and he had not worked over the weekend. He further stated he had not told anyone yesterday because it was busy and he had forgotten. He stated he should	F 689	The mainteance staff will also maintain logs of laundry door lock checks that they conduct daily. Administrator/Maintenance Director/or designee will audit maintenance logs for any issues with laundry chute doors and audit the laudnry door lock check logs. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	

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have reported the lock was not working by recording it in the maintenance book and also telling the charge nurse. CNA #1 stated maintenance came around daily to do rounds and check the maintenance log book.

At 11:28 AM, surveyor #4 went to the 5th floor and checked the laundry chute door, which was found to be locked. Surveyor #4 then checked the door to the laundry chute on the 3rd floor and the laundry chute was found to be locked.

At 11:30 AM, CNA #2, stated to surveyor #1, she used the laundry room that morning for soiled linen, and that CNA #1 had just told her the lock was broken, and that she had not noticed because she always punched the code in first then turned the knob. She had not noticed anything wrong when she used it this morning.

At that same time, surveyor #3 reviewed the 7th floor maintenance log and it did not have any notations for a need to repair a broken lock as far back as 10/1/21.

On 10/28/21 at 11:20 AM, surveyor #1 observed CNA #3 ask LPN #8 for the key to the laundry room door. The surveyor observed CNA #3 unlock the soiled laundry room door and place soiled laundry down the chute. The lock on the door had been changed from a combination lock to a keyed lock. CNA #3 stated the LPN/UM had told us this morning we were using a key to lock the door to soiled linens because the old lock was broken. She further stated she hadn't noticed in the past that there was a problem with the lock. She stated she had worked on Tuesday (10/26/21) and the lock was not broken.

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At 11:28 AM, surveyor #1 interviewed the LPN/UM who stated the lock on the soiled linen door was fixed yesterday and that maintenance swapped out the combination lock for a key lock. The key for the new lock would be kept on a key ring and the southside nurse would be responsible for it.

At 10/28/21 at 12:03 PM, surveyor #1 interviewed the Director of Maintenance (DOM). The DOM stated yesterday on the 7th floor they reported to us the lock got broken to the chute room door. That's where we throw the laundry down the chute. The DOM acknowledged that room was to be locked at all times for safety reasons and the chute only has a latch so the door must be locked. That's the only floor that has a chute room, the others the chute is right when you open the door. As soon as we were notified, we went up to the 7th floor and repaired the lock. The DOM went on to say the facility process was when repairs were needed, if the repair was an emergency repair they would call maintenance. If it was not an emergency the repair was entered on the floor's maintenance log. The log gets checked for each floor, by the maintenance staff, when they do hourly rounds. The DOM further stated he did not know if the 7th floor's maintenance log had an indication to fix the lock, but on that morning's, maintenance rounds and wander guard check his staff had reported all the chute doors were locked.

On 10/28/21 the survey team met with the Regional Director of Clinical Operations, the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the Licensed Nursing Home Administrator (LNHA). At 2:15 PM, the LNHA stated No, the door to the laundry chute

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F 689	Continued From page 37 shouldn't be open and accessible, that none of the laundry doors or housekeeping doors should be left unlocked, that it could be a potential danger if a resident were to access that area. At 2:16 PM, the Regional Director of clinical Operations stated the facility did not have a policy in regard to the locking of laundry room doors. NJAC 8:39-27.1(a)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 a) obtain a physician's order to administer oxygen therapy in accordance with professional standards of practice and b) change oxygen tubing to prevent the spread of infection for 2 of 2 residents reviewed for respiratory care, (Resident # 37 and Resident # 175). This deficient practice was evidenced by the following: 1. During the initial tour of the 5th floor unit on 10/25/21 at 09:58 AM, Resident # 37 was observed lying in bed with the head of the bed elevated. Resident # 37 had nasal	F 695	The two residents on oxygen had all their tubing changed and dated 10/25/2021. The two medical records were audited and orders were obtained from the resident's physician and orders were entered into electronic medical record. All residents have the potential to be affected by this deficient practice. Nursing staff has been in-serviced on the policy of changing and dating oxygen tubing, as well as the policy of transcribing and entering orders into electronic medical record. This will become part of	11/26/21

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F 695	Continued From page 38 oxygen in use at 2 liters (L) per minute. The tubing was undated. According to the Admission Record, Resident #37 was admitted to the facility with diagnoses including but not limited to; Cerebral Infarction (stroke). A review of the Order Summary Report (OSR) with date range of 10/1/21-10/31/21 did not include a physician order for the use of oxygen or when to change the tubing. A review of a Progress Note dated 10/14/21 indicated O2 (oxygen) via nasal cannula continued. A review of Resident # 37's care plan did not include the use of oxygen. 2. During the initial tour of the 5th floor unit on 10/25/21 at 10:01 AM, Resident # 175 was observed lying in bed with the head of the bed elevated with nasal oxygen in use at 2 liters per minute. The tubing was undated. According to the Admission Record Resident # 175 was admitted to the facility with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease (COPD) (disease of the lungs making it difficult to breathe). A review of OSR for August 2021, September 2021, and October 2021, did not include a physician order for the use of oxygen or when to change the tubing. A review of a care plan reveled focus area of Respiratory with interventions including but not	F 695	our orientation education. Director of Nursing/Assistant Director of Nursing/designee will audit residents with oxygen to assure tubing is being changed. In addition electronic medical record will be audited to assure all residents on oxygen have the proper orders. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	

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F 695	Continued From page 39 limited to, Oxygen therapy per MD order. During an interview with the surveyor on 10/27/21 at 10:31 AM, Licensed Practical Nurse (LPN #4), who was the assigned nurse, said when a resident admitted with oxygen, we get an order from physician for standing order for oxygen. LPN # 4 confirmed we do need a physician order for oxygen. She went on to say that they should change tubing and humidification bottle at least weekly. LPN #4 said Yes this is what policy is and normally done on 3-11 shift. LPN #4 reviewed the OSR for Resident # 37 and Resident # 175 in the presence of the surveyor and she said it doesn't look like he/she has one on here. Yes, he/she is on oxygen. During an interview with the survey on 10/28/21 at 09:16 AM, the Director of Nursing (DON) said yes, we are required to have a physician order for oxygen. The DON went on to say tubing's are changed every Wednesday on 11-7 shift and it should be tagged on tubing itself with the date. A review of a facility policy titled Oxygen Administration with a revised date of October 2010, revealed under the Preparation section 1. Verify that there is a physician's order for this procedure. The policy did not include documentation as to when to change the oxygen tubing.	F 695		
F 761 SS=D	NJAC 8:39-27.1(a) 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	F 761		11/26/21

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F 761	Continued From page 40 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 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, and review of facility documentation, it was determined that the facility failed to ensure two, multi-use medications were dated with an opened date. This deficient practice was identified for 1 of 6 medication carts (fourth floor south medication cart) that were reviewed as part of the Medication Storage Task and was evidenced by the following: On 10/26/21 at 12:43 PM, the surveyor observed an opened vial of Humulin N (medication given to help control blood sugar levels) prescribed to Resident #114. The vial label did not reveal an opened date. LPN #2 confirmed there was no	F 761	The two multi-use insulin medications were discarded. New medication was dated upon opening. All residents have the potential to be affected by this deficient practice. Nursing staff has been in-serviced on policy for insulin storage. This will become part of our orientation education Pharmacy Consultant/DON/ADON will	

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F 761	Continued From page 41 opened date on the vial. On the same date and time, the surveyor observed an opened Basaglar injection pen (an injection device with a needle that delivers insulin into the body) prescribed to Resident #740. The injection pen label did not reveal an opened date. LPN #2 confirmed there was no opened date on the injection pen. A review of Resident #114's Medication Review Report revealed a physician's order for Insulin NPH Suspension (Humulin N) 100unit/mL. A review of Resident #114's Medication Administration Record revealed that he/she received 22 units of Humulin N on October 25th, 2021 at 7:30 AM. A review of Resident #740's Medication Review Report revealed a physician's order for Basaglar KwikPen Solution Pen-Injector 100unit/mL. A review of Resident #740's Medication Administration Record revealed that he/she received 45units of Basaglar on October 26th, 2021 at 09:00 AM. On 10/28/21 at 2:30 PM, during an interview with the surveyor, the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) confirmed multi-dose vials and insulin pens should be dated with an opened date. On 10/29/21 at 11:38, during an interview with the surveyor, the ADON explained that multi-dose medications should be labeled with the opened date because the medication expires after a certain amount of time.	F 761	audit medication carts to assure insulin is properly dated and stored. 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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F 761	Continued From page 42 A review of the facility policy titled, "7.0 Insulin Pen Labeling & Packaging" with an effective date of 10/01/2018 and a revision date of the same did not address open dates.	F 761		
F 812 SS=F	N.J.A.C. 8:39-29.4 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 review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following:	F 812	Areas identified to not be in compliance to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness have been cleaned. Dill weed was discarded. Cans of madarin oranges that had dents were discarded. Observed	11/26/21

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F 812	Continued From page 43 On 10/26/2021 from 8:42 AM to 10:12 AM, the surveyor, accompanied by the Food Service Director (FSD) observed the following in the kitchen: 1. On an upper shelf in the dry storage area a container of dill weed was dated 5/16/20. On interview the FSD stated, "They are good for one year." The FSD threw the container of dill weed in the trash. 2. (2) cans of Mandarin Oranges on a multi-tiered mobile storage rack had significant dents on the lower seams of the can. The FSD removed the cans to the designated dented can area. On interview the FSD stated, "The dietary aides who receive the cans are responsible for removing the dented cans to the designated dented can area." 3. On an upper shelf of the dry pot storage rack a stack of 7 deep, quarter pans were observed to be wet to the touch with a watery like substance. The pans were observed to be wet nesting (a term used in the food service industry when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow. FDA guidelines mandate that wares should be air dried.). On interview the FSD stated, "They should be completely air dried before being stacked." 4. A cleaned, and sanitized meat slicer was on top of a prep table. The surveyor placed their finger on the slicer wheelbase and an unidentifiable brown, sticky substance was observed on the surveyor's index finger. The surveyor interviewed the dietary assistant (DA) who stated that she had not used the meat slicer	F 812	pans that had wet to touch watery substance were cleaned. The meat slicer was cleaned and bagged to prevent exposure. Red bucket on shelf under coffee machine was emptied. The kitchen was thoroughly cleaned. The Candy stove legs the worktable, the fan were all cleaned during this thorough cleaning. The knives with wooden handles were discarded. The fan above the clean exit area of the dish was cleaned. The tops of the ice machine were cleaned. Refrigerators and pantries on nursing floors were cleaned by 10/29/21. The bagel/breakfast sandwich was discarded. The freezer was defrosted and cleaned. The cheddar cheese was discarded. The Hi Cal was discarded. The watermelon was discarded. The WAWA bag was discarded. The salad was discarded and the refrigerator was defrosted and was cleaned. The hot pocket, silver sealed plastic bag, a gray plastic bag, were all discarded and the refrigerator was defrosted and cleaned out. New temperature logs were started 10/28/21. 11-7 nurse complete the new temperature logs. All residents have the potential to be affected by this deficient practice. Dietary Director and dietary staff has been in-serviced by Assistant Director of Nursing and Registered Dietician on sanitation policy for kitchen, refrigerators and pantries. In addition they were all	

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F 812	Continued From page 44 this morning. The FSD on interview stated, "I'm going to use it to slice lunch meat for lunch." The surveyor questioned the FSD if the meat slicer had been used this AM. The FSD responded, "No, but I'm going to." The meat slicer was not bagged and was exposed. 5. A red bucket on a shelf under the coffee machine was identified by the FSD as containing sanitizer solution to sanitize soiled work areas (Santec Resolve Eight quaternary ammonium disinfectant and sanitizer was in use). The FSD utilized a Hydrion QT-40 test strip (utilized to measure the concentration of Quaternary Sanitizers). The FSD submerged a test strip in the bucket for 10 seconds per manufacturer's instructions. The FSD removed the test strip from the sanitizing solution and compared it to the color chart on the test strip dispenser. The test strip revealed a sanitizer level of approximately 100 ppm (parts per million). The FSD performed a second test of the quaternary sanitizing solution utilizing the Hydrion QT-40 test strip and dipping the test strip in the sanitizing solution for 10 seconds, per manufacturer recommendations. The second test strip showed a ppm of less than 100 ppm. Manufacturer recommends 200 ppm - 400 ppm active quat for effective sanitizing of work surfaces. 6. A stock table (a type of worktable used in foodservice) located between the steamer and the candy stove was covered with unidentified debris on the legs of the table. The surveyor used their index finger to wipe the debris and a tan, gummy substance remained on the surveyor's index finger. In addition, the legs of the candy stove were covered with unidentified brown/tan debris. Fan #1 was observed to be in operation	F 812	in-serviced on hair nets being worn properly. 11-7 Nursing staff has been in-serviced on completing temperature logs for the refrigerators on the floors. In addition nursing staff has been in-serviced on refrigerator cleanliness, recording temperatures, discarding 1. improperly labeled items, 2. items 48 hours old, or 3. uncovered items. They have been in-serviced not to store personal items in the refrigerators or pantries. They have been in-serviced on reporting refrigerators when dirty or have ice build up to the housekeeping director. This will become part of our orientation education. Dietary Director/Director of Nursing/Dietician/designee will audit temperature log book, refrigerators for cleanliness and properly dated items, and pantries as well as kitchen sanitation. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	

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F 812	Continued From page 45	F 812		

and was observed to have black, gummy unidentifiable debris on the wire cage, as well as the fan motor and fan blades. On interview the FSD stated, "Maintenance cleans it monthly, I guess."

7. An electrical junction box above the designated hand washing sink was observed to be covered with unidentifiable tan/brown debris that was sticky to the touch. When interviewed the FSD stated, "Ultimately, I am responsible for cleaning of the kitchen."

8. A wall mounted knife storage box in the cook's prep area contained 2 wooden handled knives. When interviewed the FSD stated, "Those are bread knives. I wasn't aware that they shouldn't be used. I'll throw them away."

9. Fan #3 above the clean exit area of the dish was observed to have unidentified black dust and debris on the fan cage and fan motor. The fan was actively in use.

10. The tops of the ice machines were covered with unidentifiable, whitish, tan debris that was flaky to the touch. The debris had the potential to fall into the ice box when the door was opened to access ice and possibly contaminate the ice supply. This was observed for 2 of 2 ice machines. On interview the FSD stated, "That's from the water supply, we changed filters, but I don't know what to do." The surveyor observed the Ice Machine Cleaning -2021 sheet attached to the ice machine which revealed that the machine had last been cleaned on 10/20/2021.

On 10/26/2021 from 11:19 to 11:49 AM the surveyor, accompanied by the Licensed Practical

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F 812	Continued From page 46	F 812		

Nurse (LPN#1) observed the following on the 3rd floor pantry:

1. A frozen bagel/breakfast sandwich in a clear plastic wrapper had no dates. The interior of the freezer had an ice buildup on the freezer bottom. In addition to the ice buildup there was a reddish substance that was mixed into the ice buildup, as well as splattered all over the interior of the freezer door.

2. On the refrigerator door a piece of what appeared to be cheddar cheese, was wrapped in manufacturer's plastic, and had no dates. An opened container of Hi Cal high calorie Oral Supplement (33.8 Fl oz (1.05 QT) 1 L) was opened and had a date of 10/21. Manufacturer's instructions (Abbott Nutrition) revealed the following is recommended: "Once opened, reclose, label with time and date, refrigerate, cover and use within 48 hours."

3. In the refrigerator a clear zip lock bag contained what appeared to be diced watermelon. The bag had no dates, name, or room number. A plastic WAWA bag contained a Styrofoam soup type bowl with a plastic lid and another sealed food container of an undetermined food type. The bag had no dates and no name. A white plastic bag contained a Tupperware style container with a clear plastic lid. The container appeared to be a garden salad with some hard-boiled eggs. The bag and container had no dates or names. In addition, the lower shelf of the refrigerator was covered with an unidentifiable tan/yellow substance/debris.

4. The surveyor reviewed the October 2021 Food Temperature Log for the 3rd floor pantry. The log

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revealed that staff failed to record the refrigerator temperature for the following dates/shifts:

10/1/2021: 11 AM, 3 PM, 7 PM
10/2/2021: 7 AM/11 AM, 3 PM/7 PM
10/3/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/4/2021: 7 AM/11 AM, 3 PM/7 PM
10/5/2021: 7 AM/11 AM
10/6/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/7/2021: 7 AM/11 AM, 3 PM/7 PM
10/8/2021: 7 AM/11 AM, 3 PM/7 PM
10/9/2021: 7 AM/11 AM, 3 PM/7 PM
10/10/2021: 7 AM/11 AM, 3PM/7 PM
10/11/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/12/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/13/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/14/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/15/2021: 7 AM/11 AM, 3 PM/7 PM
10/16/2021: 3 PM/7 PM
10/17/2021: 3 PM/7 PM
10/18/2021: 7 AM/11 AM, 3 PM/7 PM
10/19/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/20/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/21/2021: 7 AM/11 AM, 3 PM/7 PM, 11 PM/3 AM
10/22/2021: 11 AM
10/23/2021: 7 AM/11 AM, 3 PM/7 PM,
10/24/2021: 7 AM/11 AM, 3 PM/7 PM
10/25/2021: 3 PM/7 PM, 11 PM/3 AM
10/26/2021: 7 AM

5. The surveyor interviewed the LPN#1. On

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CRYSTAL SPRING CENTER LLC	395 LAKESIDE BLVD BAYVILLE, NJ 08721

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interview LPN#1 stated, "I honestly don't know who is responsible for cleaning the refrigerator. The nursing staff is responsible for the monitoring of the refrigerator temperature. Nursing, CNA's and pretty much everybody who works on the unit is responsible for monitoring the refrigerator. The watermelon and salad belong to staff." Upon observation of the freezer the LPN responded, "Well that's disgusting."

6. On 10/26/21 at 12:22 PM LPN#1 revealed the following to the surveyor "That was staff food in the pantry refrigerator that you found." The surveyor questioned whether staff food is to be kept in the resident refrigerator and should it also be labeled and dated. The LPN stated, "To be honest I have no idea."

On 10/26/2021 from 1:23 to 12: 35 PM the surveyor, accompanied by LPN#2 observed the following on the 4th floor pantry:

1. An opened container of Hi Cal High Calorie Oral Supplement (33.8 Fl oz (1.05 QT) 1 L) was opened and contained approximately 2/3 of formula left in the bottle. The had an open date of "10/15/2021." When interviewed the nurse stated, "They are good for 24 hours after opening." The LPN threw the HI Cal in the trash in the presence of the surveyor.

2. The surveyor reviewed the October 2021 Food Refrigerator Log for the 4th floor pantry. The log revealed that facility staff failed to record refrigerator temperatures on the following dates/shifts:

10/1/2021: 7-3 and 3-11
10/2/2021: 7-3, 3-11 and 11-7

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10/3/2021: 7-3, 3-11 and 11-7
10/4/2021: 7-3, 3-11 and 11-7
10/5/2021: 7-3
10/6/2021: 7-3, 3-11 and 11-7
10/7/2021: 7-3
10/8/2021: 7-3, 3-11 and 11-7
10/9/2021: 3-11 and 11-7
10/10/2021: 3-11 and 11-7
10/11/2021: 7-3 and 3-11
10/12/2021: 7-3, 3-11 and 11-7
10/13/2021: 7-3, 3-11 and 11-7
10/14/2021: 7-3, 3-11 and 11-7
10/15/2021: 7-3, 3-11 and 11-7
10/16/2021: 7-3, 3-11 and 11-7
10/17/2021: 7-3 and 3-11
10/18/2021: 7-3 and 3-11
10/19/2021: 7-3 and 3-11
10/20/2021: 7-3, 3-11 and 11-7
10/21/2021: 7-3, 3-11 and 11-7
10/22/2021: 7-3, 3-11 and 11-7
10/23/2021: 7-3, 3-11 and 11-7
10/24/2021: 7-3, 3-11 and 11-7
10/25/2021: 7-3 and 3-11
10/26/2021: 7-3

On 10/27/2021 from 9:37 to 9:53 AM the surveyor, accompanied by the LPN#3 observed the following on the 5th floor pantry

1. In the freezer a Hot Pocket (An American brand of microwaveable turnovers generally containing one or more types of cheese, meat, or vegetables) was in the manufacturer's plastic wrapping. The Hot Pocket had no dates, name, or room number. A silver sealed plastic bag contained an unidentified food product. The bag had no dates, name, or room number. A gray plastic bag contained three individual zip lock type bags of unidentified food product. The bags

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had no dates, name, or room numbers. In addition, the inside of the freezer had an unidentified brown stain on the bottom of the freezer approximately 2-3 inches in diameter.

2. The surveyor reviewed the Oct 2021 Food Refrigerator Log for the 5th floor pantry. The log revealed that facility staff failed to record refrigerator temperatures for the following dates/shifts:

10/1/2021 to 10/25/2021: 7-3, 3-11 and 11-7 shifts
10/26/2021: 7-3

On 10/27/2021 from 11:31 AM to 12:01 PM the surveyor, accompanied by the FSD observed the following in the kitchen:

1. During tray line preparation the cook was observed to wear a hair net. The hair net only partially covered the cook's hair leaving the front of the hair partially exposed. The cook's hair was observed to extend approximately 4 inches out the front of the hair net and was resting on the cook's forehead at eyebrow level. The hair was exposed and not covered by the hair net.

The surveyor reviewed the facility policy titled FOOD BROUGHT IN FROM OUTSIDE, effective date 1/16/18. The following was revealed under the heading PROCEDURE:

3. "Foods and beverages brought in from outside sources that require refrigeration or freezing will be labeled with the resident's name, date, and stored in common areas or residents' personal refrigerators for resident use."

6. "All refrigerator and freezer units will have

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internal thermometers to monitor for safe food storage temperatures. Refrigerators should be kept at 41 degrees or below and freezers cold enough to keep foods frozen solid. Assigned staff will monitor temperatures in resident/employee use units and Employee Dining Room. Assigned staff will monitor units in resident rooms, in the volunteer/nursing office, and in the activity room. If temperatures are out of range, notify maintenance immediately. Dispose of refrigerated foods if they are above 41 degrees and freezer foods if no longer frozen solid to the touch."

7. "Dietary staff will also be responsible to check resident/employee use units in, and Employee Dining Room for food that is outdated, unlabeled, or not stored properly and discard. Housekeeping will do the same in all units in resident rooms, in the volunteer/nursing office, and in the activity room. Housekeeping will be responsible to check resident rooms through housekeeping processes for food and beverage items for safe and sanitary storage and handling."

The surveyor reviewed the facility policy titled Dry Storage Areas, 2010 Becky Dorner & Associates, Inc. The following was revealed under Procedure:

7. "Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods."

The surveyor reviewed the facility provided checklist titled Sanitation Schedule Check Of (sic) List 7-3 Kitchen Cleaner, dated 8/21/2011. The checklist revealed that the "7-3 kitchen cleaner" is responsible for the cleaning of "Kitchen small appliances - coffee urn/steamer/robot coupe and blender machine/slicer."

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F 812	Continued From page 52 The surveyor reviewed the facility policy titled Labeling and Dating System Protocol, revised 11/12/19. The protocol revealed that "All Dried Spices (opened or un-opened) 1 year." A review of a facility provided Inspection, dated 5/21/21 revealed under General Kitchen Sanitation that "Fans & Vents Clean, free of dust" received a zero (0) response which indicated "No." A review of a facility policy with revision date 7/2021 titled Staff Hygiene revealed under the Procedure section: 1. Hair will be worn off of the shoulders and constrained in an approved hair net. N.J.A.C. 18:39-17.2(g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following: On 10/26/2021 from 9:36 AM to 9:43 AM the surveyor, accompanied by the Food Service Director (FSD), observed the facility's designated	F 814	The dumpster and the garbage container area were cleaned and free of garbage and debris 10/26/21. All residents have the potential to be affected by this deficient practice. Dietary staff, housekeeping staff, maintenance staff has been in-serviced on policy to maintain dumpster area. There is a cleaning schedule of the	11/26/21

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F 814	Continued From page 53 trash disposal area. The surveyor observed a trash compactor unit (closed unit) that the FSD stated was Utilized by the kitchen for waste. On the ground surrounding the compactor the surveyor observed clear plastic cups, Styrofoam cups, clear plastic bags, empty number 10 cans (can used in food service that hold approximately 109 oz of food product), an empty 1-gallon plastic jug of Italian dressing, plastic lids used for beverage cups, plastic spoons, used dish rags and other unidentifiable debris. When interviewed as to who was responsible for the maintenance of the designated garbage area the FSD responded, "I am responsible for the maintenance of the garbage area. I usually check it every morning, but I forgot today." During an interview with the facility Administrator on 10/26/2021 at 2:12 PM, the facility administrator told the surveyor that she did not have a policy and procedure that would cover who is responsible for maintenance of the facilities garbage area. The administrator stated, "Housekeeping, maintenance and the dietary department are responsible for the maintenance of the garbage area, but I don't have a policy for that." NJAC 8:39-19.3(c)	F 814	dumpster area and dietary, housekeeping and maintenance are all responsible to keep the area clean. The cleaning schedule is for daily cleaning of dumpster area. This will become part of our orientation education Dietary Director, Housekeeping Director, Maintenance Director will conduct visual audits of the dumpster area. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	
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. (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	F 842		11/26/21

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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 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 55 §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: Based on interview, review of medical record and other facility documentation, it was determined that the facility failed to ensure that the medical record was maintained with complete and accurate medical information for 2 of 35 sampled residents, (Resident #37 and Resident # 736). This deficient practice was evidenced by the following: 1. Resident # 37 was admitted to the facility with diagnoses of Parkinson's Disease and cerebral infarction. A review of review of the Nursing Admission Screening/History dated 10/9/21 revealed the only portion filled out was the weight dated 9/7/21, pulse dated 9/22/21, blood pressure dated	F 842	The two residents without completed admission assessments have been completed by 10/29/21. All residents have the potential to be affected by this deficient practice. Nursing staff has been in-serviced on completing the admission assessments properly and timely. This will become part of our orientation education for nursing staff. DON/ADON will audit all admissions to assure they have admission assessments completed. Audits will be completed weekly for the	

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F 842	Continued From page 56 9/22/21, blood glucose 217 dated 9/22/21. There was no further documentation to indicate Resident # 37's status upon admission to the facility. 2. Resident # 736 was admitted to the facility with diagnosis of Bipolar Disorder and Major Depressive Disorder. A review of Resident # 736's electronic and paper medical records revealed that a comprehensive nursing admission assessment was not completed. There was no further documentation to indicate Resident # 736's status upon admission to the facility. During an interview with the surveyor on 10/28/21 at 09:20 AM, the Licensed Practical Nurse (LPN # 6) said the nursing admission assessment should be completed for every resident upon admission within 24 hours. During an interview with the surveyor in the presence of a second surveyor on 10/28/21 at 11:24 AM, the Assistant Director of Nursing (ADON) who is also the acting Minimum Data Set Coordinator confirmed that Resident # 736 did not have a comprehensive nursing admission assessment completed upon admission. During an interview with the surveyor on 10/28/21 at 09:16 AM, the Director of Nursing (DON) said that admission assessments should be done when the resident comes into the facility. The nurse should start the assessments and depending on the time of arrival may be overlap	F 842	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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F 842	Continued From page 57 of shifts. She further stated the assessment should be completed within 24 hours. A review of an undated facility policy titled Daily Clinical Meeting revealed the daily clinical meeting is a review of the residents' clinical status events .... admissions ... The policy further indicated during the daily clinical meeting; the following occurs: Review of all admissions while utilizing the admission check off list. The policy also revealed The Director of Nursing responsibility: Review of all admissions in their entirety which includes documentation, assessments, as well as reviewing the medication reconciliation form. NJAC 8:39-35.2(d)(5)	F 842		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 14 of 14 day shifts and 3 of 14 night shifts reviewed. 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 at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	No residents were identified. All residents have the potential to be affected by this deficient practice. Director of Nursing, and Staffing coordinator were in-serviced on new minimum staffing requirements on 10/29/21. 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.	11/26/21

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

Electronically Signed | 11/12/21

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility for the weeks of 10/3/21 and 10/10/21, the staffing to residents' ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift, and was deficient for total staff for residents on 3 of 14 overnight shifts as follows: - 10/03/21 had 13 CNAs for 193 residents on the day shift, required 25 CNAs. - 10/04/21 had 14 CNAs for 191 residents on the day shift, required 24 CNAs. - 10/05/21 had 20 CNAs for 191 residents on the day shift, required 24 CNAs. - 10/06/21 had 21 CNAs for 191 residents on the day shift, required 24 CNAs. - 10/07/21 had 18 CNAs for 191 residents on the day shift, required 24 CNAs. - 10/08/21 had 14 CNAs for 191 residents on the day shift, required 24 CNAs. - 10/09/21 had 17 CNAs for 193 residents on the day shift, required 25 CNAs. - 10/10/21 had 12 CNAs for 193 residents on the day shift, required 25 CNAs. - 10/11/21 had 15 CNAs for 193 residents on	S 560	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, bus ticket bonus. 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. 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.	

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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 2 the day shift, required 25 CNAs. - 10/12/21 had 17 CNAs for 193 residents on the day shift, required 25 CNAs. - 10/13/21 had 20 CNAs for 193 residents on the day shift, required 25 CNAs. - 10/14/21 had 18 CNAs for 193 residents on the day shift, required 25 CNAs. - 10/15/21 had 18 CNAs for 193 residents on the day shift, required 25 CNAs. - 10/16/21 had 20 CNAs for 195 residents on the day shift, required 25 CNAs. - 10/05/21 had 13 total staff for 191 residents on the night shift, required 14 total staff. - 10/09/21 had 10 total staff for 193 residents on the night shift, required 14 total staff. - 10/10/21 had 11 total staff for 193 residents on the night shift, required 14 total staff. During an interview with the Staffing Coordinator (SC) on 10/26/21 at 01:30 PM, the SC said it is my responsibility to get the aides scheduled, putting them on schedule for the floors they work on, recording no shows and call outs and getting agency to work. The SC said Yes I am familiar with the requirements; 8 resident for day shift 12 residents for evening/3-11 shift and 15 residents for midnight shift. The SC said some days we meet the requirements and the Administrator and corporate would be responsible to make sure we meet the requirements. During an interview with the surveyor on 10/28/21 at 09:13 AM, the Director of Nursing said yes she is aware of requirements for CNA staffing as follows; 1 CNA-8 residents for day shift, 1 CNA-15 residents for evening shift, and 1 CNA-30 residents for night shift. She went on to say that she goes over the staffing with the SC daily and the majority of	S 560	We also recruit na's and send to school.	

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 _____	10/29/2021

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S 560	Continued From page 3 time we are meeting the requirements. The DON said it is between the DON and SC along with a corporate person who are responsible to make sure we are meeting the requirements for staffing. A review of an undated facility policy titled Staffing did not include information regarding the state mandated minimum direct care staff (CNA) to resident ratio.	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	1/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL SPRING CENTER LLC	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 F0584	Correction	ID Prefix F0636	Correction	ID Prefix F0638	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.20(c)	Completed
LSC	11/26/2021	LSC	11/26/2021	LSC	11/26/2021
ID Prefix F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0658	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	11/26/2021	LSC	11/26/2021	LSC	11/26/2021
ID Prefix F0689	Correction	ID Prefix F0695	Correction	ID Prefix F0761	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	11/26/2021	LSC	11/26/2021	LSC	11/26/2021
ID Prefix F0812	Correction	ID Prefix F0814	Correction	ID Prefix F0842	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	11/26/2021	LSC	11/26/2021	LSC	11/26/2021
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?
10/29/2021	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061501 Y1	A. Building B. Wing Y2	1/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL SPRING CENTER LLC	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 11/26/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/29/2021	☐ 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
	315125	A. BUILDING **01** B. WING _____	**10/29/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL SPRING CENTER LLC	**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) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/25/21 and 10/27/21,was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Crystal Lake is a 7- story building that was built in 1970's, It is composed of Type II unprotected construction. The facility is divided into 11 smoke zones from the plans provided by the Maintenance Director. The Maintenance Director stated the generator does approximately 40 % of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair,	K 000		

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

Electronically Signed | 11/12/2021

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 000	Continued From page 1 alterations or additions. The facility has 235 certified beds. At the time of the survey the census was 197 The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 10/25/21 to 10/27/21, the facility failed to provide stair thread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3. The deficient practice was observed in 4 of 4 stairwells in the facility by the following: While touring the facility on 10/27/21 from approximately 9:40 AM, to 2:00 PM, the Surveyor and Maintenance Director observed that the 4 egress stairwells identified as North, South, Main and Maintenance stairwell, revealed that marking stripes were not present on each step, floor	K 225	All four stairwells are now provided with stair thread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition. All residents have the potential to be affected by this deficient practice. Maintenance staff were educated on the NFPA code requiring stair thread marking stripes for each stairwell. Administrator/Maintenance Director/or designee will audit all stairwells to assure	11/26/21

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K 225	Continued From page 2 landing, and handrails. The findings were verified by the Maintenance Director at the times of the observation. The Administrator was informed of this finding during the Life Safety Code survey exit conference on 10/27/21. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	they meet this requirement. 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.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, and interview from 10/25/21 to 10/27/21, it was determined that the facility failed provide a battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 10/27/21 at 1:32 PM, the Surveyor and Maintenance Director observed in the basement electrical room, where the emergency generator transfer was located, that the room was not equipped with emergency lighting independent of the building's electrical system and emergency generator. This finding was verified by the facility's Maintenance Director at the time of inspection.	K 291	A battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1 has been installed. All residents have the potential to be affected by this deficient practice. Maintenance staff were educated on the NFPA code requiring a battery backup emergency light above the emergency generator□s transfer switch. This will become part of our orientation education	11/26/21

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K 291	Continued From page 3 The Administrator was notified of the above findings, at the Life Safety Code exit conference on 10/27/21. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	Administrator/Maintenance Director/or designee will audit all areas requiring battery backup emergency lights to assure compliance with this requirement. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months A monthly report will be given to the Administrator and the QAPI Committee.	
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	K 321		11/26/21

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K 321	Continued From page 4 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/27/21, in the presence of the Maintenance Director, it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous area 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 practice was evidenced by the following: At 10:47 AM, the surveyor observed in floor #1 storage room 114 that 50 plus combustible (filled) cardboard boxes and pieces of wood pallets were being stored. The room was approximately 50 square feet in size and required a door with a self-closing device. An interview was conducted with the Maintenance Director who stated that hazardous storage areas, must have a door with a self-closing device. The Administrator was informed of the finding, at the Life Safety Code exit conference on 10/27/21. NJAC 8:39-31.2(e)	K 321	A self closing door was provided and will be maintained to hazardous area 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. All residents have the potential to be affected by this deficient practice. Maintenance staff have been educated on the NFPA code requiring self closing door for hazardous areas. This will become part of our orientation education Administrator/Maintenance Director/or designee will audit areas requiring doors to have self closing hardware per NFPA code. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months A monthly report will be given to the Administrator and the QAPI Committee.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		11/26/21

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K 353	Continued From page 5 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 10/18/21 to 10/19/21, it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. The deficient practice was identified for all 7-floors of the building. This deficient practice was evidenced by the following: Ceiling tiles missing and/or holes in the ceiling tiles (sheetrock) and escutcheon plates missing and/or not in place in the following areas of the facility:	K 353	All ceiling tiles identified and escutcheon plates have been replaced and will be maintained in order to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. All residents have the potential to be affected by this deficient practice. Maintenance staff have been in-serviced on NFPA code requiring ceiling tiles and escutcheon plates to be maintained in order to maintain the sprinkler system, by	

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K 353	Continued From page 6 1. Resident room 717 Fire sprinkler head with an escutcheon plate with a bad ceiling tile cut leaving approximately an 1/4 to 1/2 gap. 2. Resident room 716 2-sections of ceiling tile missing, approximately 2" x 3". 3. Resident room 715 approximately 2' x 1" opening in the drop ceiling track 4. Outside resident room 705 ceiling tile gap around the sprinkler head 5. Outside resident room 705 the electrical conduit into the ceiling had gaps from the 2 conduit pipes, approximately 1" 6. Resident room 609 had a 2' x 4' ceiling tile drooping from its track, now leaving a large gap into the area above the tile. 7. Outside resident room 617 had a gap at the fire sprinkler head approximately 1" 8. floor 5 nurse station approximately 6" x 3" gap in the ceiling 9. Floor 5 exit sign and horn strobe had 2 conduit pipes into the ceiling with gaps 10. outside resident room 517 approximately 1/2 gap with low voltage wires into the ceiling tile 11. Resident room 517 corner fire sprinkler head with no escutcheon plate in place approximately 1/2 gap 12. Resident room 516 1 of 3 fire sprinkler heads	K 353	ensuring that the ceiling was smoke resistant and fire rated. This will become part of our orientation education Administrator/Maintenance Director/or designee will audit all areas with ceiling tiles to assure they are smoke resistant and fire rated per the NFPA code. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	

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K 353	Continued From page 7 with no escutcheon plate in place approximately 3/4 gap 13. Resident room 516 bathroom approximately 1" gap in the ceiling 14. Floor 4 Activity closet corner ceiling tile missing. 15. Resident room 414 above the door, broken ceiling tile (missing corner) approximately 2' x 1" 16. Floor 4 storage room escutcheon plate not in place, approximately 3/4 gap into the ceiling 17. Resident room 403 corner tile missing approximately 3" x 1" opening 18. Corridor outside resident room 304 approximately 2" x 1" gap 19. Corridor outside resident room 307 approximately 1" x 1" gap in the 4' x 2' ceiling tile 20. Corridor outside resident room 309, gap around the pipe into the ceiling 21. Morgue corridor hole in the 2' x 4' ceiling tile 22. Corridor outside the chart room approximately 1/2 gap at the fire sprinkler head 23. Corridor outside resident rooms 202 and 203 approximately 1" x 3" opening in the ceiling 24. Floor 1 outside the smoking area 2' x 4' ceiling tile not in place (drooping) leaving approximately 8" gap	K 353		

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K 353	Continued From page 8 25. Room 114 had an opening at the fire sprinkler head approximately 1" and 1 escutcheon plate not in place 26. The corridor outside Room 103 approximately 8" x 8" gap into the area above the ceiling 27. Floor 1, just above the entrance, the drop ceiling had many gaps that would delay the fire sprinkler heads and smoke alarms from activation until the area above the drop ceiling tiles filled with heat and smoke. The Maintenance Director confirmed the above findings during the building tour on 10/25/21 and 10/27/21. The Administrator was informed of the findings at the Life Safety Code exit conference.	K 353		
K 521 SS=F	NJAC 8:39-31.2(e) HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 10/25/21 to 10/27/21, in the presence of the	K 521	The 6 units identified with ventilation systems that were not adequately	11/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315125	A. BUILDING **01** B. WING _____	**10/29/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL SPRING CENTER LLC	**395 LAKESIDE BLVD** **BAYVILLE, NJ 08721**

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K 521	Continued From page 9 facility Maintenance Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 6 of 18 units and 1 of 5 shower rooms were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: 1. While touring the building on 10/25/21 to 10/27/21 from approximately 09:00 AM, to 02:00 PM, the Surveyor and Maintenance Director observed that the ventilation in the following resident room bathrooms did not function: # 605, 615, 616, 707, 714 and 715. 2. At 10:00 AM, the surveyor observed in the floor #3 south shower room across from resident room 320, that the self contained ventilation unit was not in working order. The surveyor requested that the Maintenance Director and Regional Plant Operations Director, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the Surveyor interviewed the Maintenance Director who confirmed that the exhaust vents in the above resident room bathrooms and shower room, were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 10/27/21.	K 521	maintained, in accordance with the NFPA 90 A, B, have been corrected. All residents have the potential to be affected by this deficient practice. Maintenance staff have been in-serviced on NFPA code requiring ventilation systems to be adequately maintained. This will become part of our orientation education Administrator/Maintenance Director/or designee will audit all ventilation systems to assure they are adequately maintained. Audits will be completed Weekly for the next 4 weeks and monthly for the next 3 months A monthly report will be given to the Administrator and the QAPI Committee.	

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	315125	A. BUILDING **01** B. WING _____	**10/29/2021**

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K 521	Continued From page 10 NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521		
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: 1. Based on interview from 10/25/21 and 10/27/21, the facility failed to ensure that elevators are inspected and tested monthly in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3, 9.4.6, 9.4.6.2 and ASME A17-1 Safety Code for Elevators and Escalators 2004 Edition Section 8.11.1.3 and Table N. This	K 531	Vendor has provided report that includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors. Also vendor has given a	11/26/21

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K 531	Continued From page 11 deficient practice was evidenced by the following: An interview was conducted on 10/27/21 with the Maintenance Director at the start of the building tour at approximately 09:00 AM,. The Maintenance Director stated that currently he did not have a record that Firefighter's Monthly Service test was performed and documented monthly. 2. Based on observation and interview from 10/25/21 to 10/27/21, in the presence of the Maintenance Director, it was determined that the facility failed to maintain elevator emergency communication for 2 of 3 passenger elevator telephones tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: The Surveyor had the Maintenance Director conduct a test of the emergency communication telephone system in the (3) facility's passenger/freight elevators. The emergency telephone did not function properly in elevator #1 and #2, at the time of the observation. The alarm bell was activated and worked properly during the observation. The Maintenance Director stated and confirmed elevator's #1 and #2, did not have emergency telephone communication at the time of the observations. The Administrator was informed of this finding at the Life Safety Code exit conference on 10/27/21. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	report regarding the phones in elevator working correctly. In addition the elevator phones have ring to the front desk. All residents have the potential to be affected by this deficient practice. Maintenance staff has been in-serviced on importance of having vendor provide report for Phase I key recall and smoke detector automatic recall, and Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors. This will become part of our orientation education Administrator/Maintenance Director/or designee will audit reports to assure we have Phase I and Phase II reports, audit fire reports and audit phones in elevators. Audit will be done weekly for the next four weeks and then monthly for the next three months. A monthly report will be given to the Administrator and the QAPI Committee.	

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	315125	A. BUILDING **01** B. WING _____	**10/29/2021**

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K 911	Continued From page 12	K 911		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/25/21, it was determined that the facility did not maintain the required clearance around electrical panels, electrical equipment and controls in accordance with NFPA 101, 2012 LSC Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26. This deficient practice was evidenced by the following: This deficient practice of not ensuring 36" in front of the electrical panels will prevent staff and emergency personnel from disconnecting the electrical power quickly. The Surveyor and Maintenance Director observed a yellow mop bucket stored under the electrical panel and wooden pole leaning on the panel. The electrical panel room was located on floor-5 by resident room #500. The observations were confirmed by the Maintenance Director during the tour of the electrical rooms in the facility. The Administrator was informed of the observations at the Life Safety Code exit conference on 10/27/21.	K 911	Facility removed the mop bucket and wooden pole leaning on the panel on 10/25/21 in order to maintain the required clearance around electrical panels, electrical equipment and controls in accordance with NFPA 101, 2012 LSC Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26. All residents have the potential to be affected by this deficient practice. Maintenance staff has been in-serviced on NFPA code requiring clearance around electrical panels, electrical equipment and controls. This will become part of our orientation education. Administrator/Maintenance Director/or designee will audit electrical panels and electrical equipment and controls to assure there is proper clearance per	11/26/21

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K 911	Continued From page 13 NJAC 8:39-31.2(e) NFPA 70, 99	K 911	NFPA code. Audits will be completed weekly for the next 4 weeks and monthly for the next 3 months. A monthly report will be given to the Administrator and the QAPI Committee.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview from	K 920	Microwaves and refrigerators are now	11/26/21

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K 920	Continued From page 14 10/25/21 to 10/27/21, the facility failed to prohibit the use of power strips beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity and the proper use of power strips in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. 1. At 12:07 PM, the Surveyor and Maintenance Director observed on floor #7 that in the Nurses lounge, a refrigerator and microwave were plugged into a multi-outlet power strip. The power strip was then plugged into the duplex wall outlet. 2. At 10:55 AM, the Surveyor and Maintenance Director observed in the Physical Therapy room on floor #1, that a microwave was plugged into a multi-outlet power strip. The power strip was then plugged into the duplex wall outlet. The findings were verified by the Maintenance Director at the time of the observations. The Administrator was notified of the findings at the Life Safety Code exit conference on 10/27/21. NJAC 8:39-31.2(e)	K 920	plugged into wall outlets and not in power strips in both the nurses lounge and the physical therapy room All residents have the potential to be affected by this deficient practice. Maintenance staff have been in-serviced on NFPA code requiring refrigerators and microwaves to not be used for non-PCREE (e.g., personal electronics). This will become part of our orientation education. Administrator/Maintenance Director/or designee will audit offices, nursing stations and non-resident room areas to assure personal electronics are not plugged into power strips. Audits of areas with refrigerators and microwaves will be completed weekly for the next 4 weeks and monthly for the next 3 months after that to assure any microwave or refrigerator is not plugged into a power strip. Audits will be on-going to prevent this deficient practice. A monthly report will be given to the Administrator and 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
315125 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL SPRING CENTER LLC	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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0225	11/26/2021	LSC K0291	11/26/2021	LSC K0321	11/26/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	11/26/2021	LSC K0521	11/26/2021	LSC K0531	11/26/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0911	11/26/2021	LSC K0920	11/26/2021	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?
10/29/2021	☐ YES ☐ NO