STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Haven Nursing and Rehabilitation Center	4 Moore Road Cape May Court House, NJ 08210

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50919 Complaint #: NJ00179530 Based on interviews, review of the medical records, and other pertinent facility documents on 11/15/24, 11/18/2024, 11/21/2024, and 11/25/2024, it was determined that the facility failed to properly notify a Resident's (Resident #1) Primary Physician (RPP) of a need for increased supervision that was recommended by the Psychiatric Nurse Practitioner (PNP) on 11/6/2024. Resident #1 was on Q (Every) 15 minutes checks that was being done by the staff. The NP recommended 1:1 supervision for one week until the next evaluation because Resident #1 would not contract to safety during the meeting. On 11/9/2024, Resident #1 was found in adjoining in a bathroom standing up with a yellow plastic bag over their head and gripping strings tightly around their neck with their hands. The Resident was transferred to an Acute Care Hospital (ACH) for a crisis evaluation. This placed Resident #1 and all residents who are recommended for increased supervision at risk for harm, serious injury and or death for 1 of 5 residents reviewed. The Immediate Jeopardy (IJ) was identified on 11/21/2024 and the IJ template was provided to the facility on the same day at 4:45 pm. The IJ started on 11/6/2024 and continued until the facility sent a removal plan of action on 11/21/2024 with a completion date of 11/22/2024. The removal plan was reviewed and accepted on 11/22/2024. On 11/25/2024, the surveyors went onsite to validate that the removal plan was implemented. The facility implemented the removal plan, which included individual education for the involved Unit Manager, training for licensed nursing staff involved in receiving recommendations, notifications of changes in residents' status, and revision of physician notification policy. The noncompliance remained on 11/25/24 at a level G for actual harm that is not an IJ based on the facility staff have been educated on physician notification. The deficient practice was evidenced by the following: According to the admission record, Resident #1 was admitted to the facility with diagnoses which included but not limited to: Parkinson's Disease, Depression, and Alcohol Use. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Minimum Data Set (MDS), an assessment tool dated 10/29/24, indicated that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the Resident's cognition was intact. The MDS revealed that the Resident scored 10 in section D (this section address mood distress and social isolation. Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home) D0160 (The Total Severity Score, does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the resident's physician, other clinicians and mental health specialists for appropriate follow up) which indicated a total score of 10 (interpreted as moderate depression.) The MDS further revealed that Resident #1 was able to ambulate independently with or without an assistive device. A review of Order Summary Report, dated 10/29/24, revealed an order for Mirtazapine 7.5 mg, 1 tablet daily for Depression and Psychiatry/Psychology consult. A review of Resident #1's Baseline Care Plan, dated 11/3/24, revealed that the Resident to use plastic utensils, to be monitored every 15 minutes, and to remove all sharps and cords from the room. A review of Medication Administration Record, dated 11/2024, revealed on 1/3/24 at 12:49 p.m., Resident #1 was administered Xanax tablet 0.25 mg for anxiety. On 1/6/24 at 5:18 p.m., Resident #1 was administered Lorazepam tablet, 0.5 mg for Anxiety. A Review of Resident #1's progress notes (PN) revealed the following: On 11/3/2024 at 4:08 p.m., documented by Registered Nurse (RN #2), at 10:00 a.m. Resident #1's family member (FM) called who was upset and reported that the Resident was very anxious/depressed. pt states [she/he] worries about everything (i.e., clock stopped, eye dr. appt, finances, etc. [PMD was] aware, ordered [Xanax] 0.25mg bid [twice as needed,] observe for balance/gait and fall precautions. dose administered [at 12:45 p.m.] recheck pt appears calm [4:30 p.m. Resident #1] calls again stating .verbalized willingness to hurt [herself/himself] and has razors in the room. Room swept for dangerous items and removed. Initiated 15 min visual checks. [PMD] does not want crisis intervention, states .has always had episode of mania. Does not want to order [Urinalysis test] or labs to [to rule out Urinary Tract Infection]. Xanax [discontinued]. On assessment [Resident #1] denies any plan, states [she/he] agreed .nothing would happen tonight. [When] asked if it was to happen did he know what or think it thru, pt answered no. On 11/4/24 at 9:13 a.m., documented by UM/LPN #4, reached out to behavioral services at this time [related to] reports from weekend of pt having increased anxiousness and depression and statements about hurting himself .continues [every 15 minutes] as of this time. At 3:41 pm, documented by RN #4 .Mood appears anxious, sad, negative statements, tired/has little energy . At 10:05 p.m., documented by RN #1, .Mood appears anxious, tired/has little energy .currently on 1:1 care for suicidal ideations .talked about feelings and concerns. On 11/5/24 at 6:25 a.m., documented by LPN #5 .Mood appears anxious .talked about feeling and concerns. At 2:41 pm, documented by LPN#4 .Mood appears anxious, trouble concentrating . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/6/24 at 4:33 p.m., documented by UM/LPN #4, .recommendations received from the [PNP] are as follows following call .5. 1:1 supervision until face-to-face eval next visit .Spoke with [RPP] after speaking with [PNP] and [RPP] approved medication changes and new medication orders and gave orders to continue [every 15] minutes as of this time. [Resident #1] stated during telemed that if everything went well at [her/his] appointment on [Friday, 11/8/24, she/he] have a lot less anxiety and be able to 'relax.' Q15 minute checks to ensure [Resident #1's] safety continue as of this time. On 11/9/24 at 10:22 a.m., documented by the Supervisor/RN #2, resident found on floor in adjoining bathroom by another resident's family member with a yellow plastic bag over [her/his] head and gripping strings tightly around [her/his] neck. Visitor removed [her/his] hands and bag and notified staff. When asked what he was doing resident stated 'I'm trying to kill myself' .ems called for transport to ER for crisis evaluation . At 3:17 p.m., documented by LPN #3, nurse who was assigned to Resident #1 on 11/9/24 during 7:00 a.m. to 3:00 p.m. shift, the PN indicated Late entry for 0800 . At [9:40 a.m.] this writer was down another hallway when called by ancillary staff that resident was on floor, into bathroom of this resident to observe resident lying on floor and there was a visitor there also when the visitor stated my dad is in the next room and I wanted to check the bathroom and when i came in here I found this [woman/man] on the floor with a bag over [her/his] head and [her/his] hands around [her/his] neck . slurring [her/his] words when spoken to when this writer asked what happened resident stated, 'I want to Kill myself,' supervisor in room [ROOM NUMBER] activated, EMS, Paramedics arrived, and resident transported to local ER. Dr made aware and family notified. A Review of Resident #1's psychiatric notes dated 11/6/2024 from 2:00 p.m. to 3:00 p.m., revealed that Resident #1 had a video-conference with the PNP with the UM/LPN #4. The psychiatric notes indicated, . [Resident #1] made a comment to [FM] and staff feeling depressed about hurting [herself/himself]. [She/he] noted that [she/he] had razors as written. Harmful objects removed and [she/he] has been on every 15-minute checks. Patient seen with unit manager present. [She/he] appears quite anxious and hesitant to engage in formal until health assessment. Vaguely mentions a 'pickle' that [she/he] has gotten [herself/himself] into that [her/his] [wife/husband] does not know about. [She/he] is not agreeable to discuss in detail at this time. Admits [She/he] continues to feel hopeless and anxious. Significant depression. Reports sleep is variable. [She/he] openly admits that [she/he] is not able to contract for safety at this time but adamantly refuses inpatient psychiatric intervention. [She/he] denies any current suicide plan .The [Resident] reported feeling depressed, difficulty concentrating, no pleasures from life anymore, anxiety, insomnia, stress, and disturbing thoughts but no other psychiatric issues. The psychiatric notes indicated a plan included but not limited to: clinician suggested inpatient psychiatric hospitalization for severe depression, [she/he] declines at this time worried about [her/his husband/wife], I do not believe [she/he] meets criteria for commitment. Initiate suicide precautions, remove all dangerous objects from [her/his] room including cords, sharp objects and plastic trashcan liners, Styrofoam tray and plastic silverware only, 1:1 supervision until Face-to-face eval next week .Target behaviors include suicidal ideations, anxiousness, hopelessness, insomnia, ambivalence, apathy. Follow-up is needed . Review of RESIDENT MONITORING FORM from 11/6/24 to 11/9/24 indicated that the Resident was being monitored every 15 minutes. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview with the surveyor on 11/19/24 at 11:43 AM, the PNP stated that on 11/6/24 during the video-conference call, Resident #1 did not promise to contract for safety prior to face-to-face visit on 11/12/24. The NP further stated that Resident #1 was a danger of hurting herself/himself and required 1:1 supervision. During a telephone interview with the surveyor on 11/19/24 at 12:20 PM, RPP stated that on 11/6/24 he received a call from UM/LPN #4 and notified him of the PNP's recommendations. However, the UM/LPN did not mention that the Resident did not contract for safety. According to the RPP he agreed with the LPN that 15 minute checks be done because the UM/LPN #1 reported that the Resident was doing fine on every 15-minute checks instead of the 1:1 supervision. The Physician further stated, If I had been made aware that the resident did not contract to safety during the video-conference with the Psychiatric NP, I would have agreed with the 1:1 supervision instead of continuing every 15-minute checks. During an interview with the surveyor on 11/21/24 at 10:24 AM, UM/LPN #2 stated that during the video-conference call on 11/6/2024, Resident #1 was very anxious about an upcoming eye appointment and had expressed some financial concerns but would not elaborate. LPN#2/UM stated that she was aware that Resident #1 did not contract for safety during the video conference call. LPN#2/UM stated that during the video conference call, Resident #1 stated that she/he would not hurt self if all went well with eye appointment. LPN#2/UM confirmed that she called the RPP and notified him of the PNP's recommendations. However, the LPN#2/UM failed to mention that Resident #1 did not contract for safety when she called the RPP to notify him of the NP's recommendations. The LPN #2/UM stated that Resident #1 should have been placed on 1:1 supervision as recommended by the PNP on 11/6/24 instead of continuing every 15-minute checks to prevent the incident on 11/9/24. During an interview with the surveyor on 11/21/24 at 11:00 AM with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), the DON stated that she was aware of the PNP's recommendations for Resident #1. The DON further stated that she felt that Resident #1 did not need 1:1 supervision because the resident did not have a suicidal plan. The DON stated that the incident that occurred on 11/9/2024 with Resident #1 was unavoidable and could have happened even if Resident #1 was on 1:1 supervision. However, the DON stated that she was aware that Resident #1 could not promise to hurt herself/himself if the eye consult did not go well. The LNHA stated, I may have considered the 1:1 supervision as recommended by the PNP if I would have read her notes and recommendations made on 11/6/24. A review of the facility's policy titled Physician Notification, dated 2/2024, indicated Policy: This outlines the guidelines for when and how healthcare should contact a resident's physician to inform them of significant changes in their condition, critical test results, or other situation requiring medical attention, ensuring timely intervention, and coordinated care. Procedure: 1. Clearly define situations that necessitate notifying the physician, such as .Unexpected complications Significant changes in patient status .3. Provide the essential information to communicate when contacting the physician, including .Current condition and recent changes Relevant medical history .Any immediate actions taken .Information relayed .When calling the doctor .2. Collect relevant details about the patient's status .any significant changes .4. Provide a concise and accurate summary of the resident's condition . NJAC 8:39-13.1(d) (continued on next page)

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