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	10/30/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #2563285 Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to develop and implement an individualized comprehensive care plan (ICCP) for a resident who was non-compliant with receiving treatments and meals prepared in the facility. This deficient practice was identified for 1 of 3 residents sampled (Resident #1) and was evidenced by the following:On 10/30/2025 at 8:30 AM, the surveyor reviewed Resident #1's medical record.A review of the admission Record face sheet reflected the resident had diagnoses that included but not limited to pressure ulcer of the sacral region (stage 4), malignant neoplasm of the rectum (cancer of the rectum), and fracture of the right fibula. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 6/28/2025, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderately impaired cognition. The Resident Mood Interview indicated that the resident had little interest or pleasure in doing things. Further review of the MDS revealed the resident had one unhealed stage 4 pressure ulcer (severe form of skin damage from prolonged pressure).A review of the Order Summary Report (OSR) with orders active as of 7/9/2025, revealed the following: - Cleanse sacral wound with NSS (normal saline solution), pack with packing strip in NSS, and apply CDD (conventional daily dressing) every day and evening shift for wound care. Use until orders are in place for wound started on 6/25/2025.- Estrace vaginal cream 0.1 milligram/gram (Estradiol Vaginal), insert 0.5 gram vaginally at bedtime for itching for 3 Months.- Nystatin-Triamcinolone Cream 100000-0.1 unit/gram-%. Apply to labia majora and vulva topically every day and evening shift for itching for 2 months.- Monitor for refusals with ADLs, medication administration, treatments every shift for monitoring started on 6/28/25.A review of the Treatment Administration Record (TAR) for the month of June 2025, revealed the resident's refusal of the ordered treatments on the evening shift of 6/26/2025, morning and evening shifts on 6/28/2025, and on the morning shift of 6/29/2025. A review of the Treatment Administration Record (TAR) for the month of July 2025, revealed the resident's refusal of the ordered treatments on the day and evening shifts of 7/5/2025.A review of the nursing progress notes reflected the resident's refusal of the ordered treatments on the evening shift of 6/26/2025, morning and evening shifts on 6/28/2025, and on the morning shift of 6/29/2025, and on the day and evening shifts of 7/5/2025.A review of the nursing progress notes reflected the resident's refusal of meals specifically breakfast and lunch on 6/26/2025, lunch on 6/27/2025, and dinner on 6/27/2025. The nursing progress notes dated 6/26/2025 and 6/27/2025, revealed the resident's spouse notifying the nurses in charge about the resident's preference for home-cooked food.A review of Resident #1's comprehensive care plan did not include a focus addressing the resident's refusal of ordered treatments and preference for home-cooked meals. On 10/30/2025 at 12:38 PM, during an interview with the surveyor, the Director of Nursing (DON) stated that care plans are updated as things happen.A review of the facility-provided policy revised on August 2025, titled Care Plans, Comprehensive, Person-Centered included under Policy Interpretation: 7.c) The care planning process will incorporate the resident's personal and cultural preferences in developing the goals of care. 8.c.) Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. N.J.A.C. 8:39 - 11.2 (d)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to revise an individual Comprehensive Care Plan for a resident with a change in code status. This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed and was evidenced by the following:On [DATE] at 10:05 AM, the surveyor observed Resident #2 in the activities room lying in a recliner. The resident interview was not possible due to a diagnosis of dementia (memory loss). On [DATE] at 12:21 AM, the surveyor reviewed the medical record for Resident #2. A review of the admission Record (an admission summary) reflected The Resident was admitted to the facility with medical diagnoses that included but were not limited to; dementia, anxiety disorder, and protein-calorie malnutrition (inadequate intake of protein and calories). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of the Resident's care dated [DATE], indicated that Resident #2 had short and long-term memory deficits. The Resident was severely impaired for decision making and required maximum assistance for most activities of daily living (ADLs). A review of the resident's Order Summary Report (OSR), dated [DATE], included the following physician's orders (PO) to consult Serenity for evaluation and treatment, do not resuscitate (DNR), and do not intubate (DNI). A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area dated [DATE], for an Advanced Directive of Full Code. Interventions included: code status will be reviewed quarterly with a resident and/or responsible party, cardiopulmonary resuscitation (CPR), [a lifesaving technique to restart a person's heartbeat and breathing], will be performed as ordered, follow facility protocol for identification of code status, keep the family informed of change in condition, and provide emotional support as needed. The ICP was not updated to reflect the physician's order regarding the change in the Resident's code status from Full code to DNR and DNI. A review of the Progress Notes (PN) included a nurse's note (NN), dated [DATE] at 10:26 PM, which included that Resident #2 was admitted into Serenity Hospice Care with new orders, the Resident's son was notified and was agreeable with recommendations and that the doctor was made aware. On [DATE] at 12:05 PM, the surveyor interviewed the Certified Nursing Assistant (CNA), [NAME] Salfi, who stated that the Resident had recently change to hospice care and confirmed that the hospice staff provided care in the mornings. On [DATE] at 12:27 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), Jamirah Smiley, who confirmed that a change of code status for hospice care required updating the care plan to reflect changes so that staff can provide the appropriate care. On [DATE] at 12:44 PM, the surveyor interviewed the first floor Unit Manager (UM), [NAME] Kanderson, LPN, who explained that for hospice residents, a Physician Orders for Life Sustaining Treatment (POLST) {medical orders for preferences regarding life-sustaining treatment}, is completed with the resident and family and signed by the doctor. The UM stated that for a change of code status the Resident's care plan must be updated immediately to ensure that the correct care is administered should an emergency occur. The UM further explained that she was responsible for updating and ensuring the accuracy of ICCP when a resident code status changes. However, Resident #2's care plan was not updated. On [DATE] at 12:52 PM, the surveyor interviewed the Director of Nursing (DON), Mychelle [NAME], who confirmed that when an order is received for hospice and a change in code status, the care plan is immediately updated. However, Resident #2's, care plan did not reflect a change of code status as ordered on the OSR. The facility policy Care Plans, Comprehensive, Person-Centered, reviewed/revised date 8/2025, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39-27.1(a)