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 _____	C 04/14/2025

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ 170257, 170547, 172201, 173065, 174274, 180063, 180317, 184231, Survey Date: 4/14/25 Census: 74 Sample: 21 + 3 closed records. 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		5/26/25

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

Electronically Signed | 05/08/2025

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.

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #: NJ184231 Based on interview, review of the closed medical record, and review of pertinent facility documents, it was determined that the facility failed to notify a resident's [redacted] after a change of condition. This deficient practice was identified for [redacted] The surveyor reviewed the closed medical record	F 580	Resident #178 is no longer at the facility. All residents experiencing a change in condition have the potential to be affected. In-service was immediately initiated with all licensed nurses by the [redacted] on the importance of [redacted] of residents change in condition. The DON or designee will audit ten (10) electronic medical records documentation for [redacted] of residents change	

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F 580	Continued From page 2 for Resident #178. A review of the Admission Record face sheet (admission summary) revealed the resident was admitted to the facility with diagnoses including; *NJ Ex Order 26. 4B1* [redacted]. A review of the Progress Notes revealed the following: On [redacted] at 6:09 AM, the resident was feeling *NJ Ex Order 26. 4B1* [redacted] There was no documentation that the *NJ Ex Order 26. 4B1* [redacted]. On [redacted] at 5:26 PM, the resident received *NJ Ex Order 26. 4B1* [redacted]. There was no documentation that the *NJ Ex Order 26. 4B1* [redacted]. On [redacted] at 10:38 AM, nursing received a call from the [redacted] stating the resident had a visitor that *NJ Ex Order 26. 4B1* [redacted] the resident was [redacted]. During an interview with the surveyor on 4/8/25 at 9:47 AM, the Licensed Practical Nurse (LPN #2) said that when there was a change in the resident's condition such as a temperature, a cough, a change in mental status, or any other symptom that would be different from the resident's normal, the *NJ Ex Order 26. 4B1* [redacted]. LPN #2 also said that the *NJ Ex Order 26. 4B1* [redacted] was documented in the resident's Progress Notes. During and interview with the surveyor on 4/8/25 at 10:01 AM, the *U.S. FOIA (b) (6)* [redacted] said	F 580	in condition weekly x 4 weeks, then monthly x 2 months to ensure that [redacted] are being notified of any change in residents' condition. All findings from the audits will be reported, reviewed by the DON or designee and submitted to the monthly Quality Assurance and Performance Improvement Committee (QAPI) for three (3) months in order to determine if further interventions are needed.	

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F 580	Continued From page 3 when there was a change in a resident's status, the [U.S. FOIA (b)] completed an assessment, called the [NJ Ex Order 26. 4B1], and documented in the Progress Notes. When asked if Resident #178's [NJ Ex Order 26. 4B1] of their change in condition in [NJ Ex Order 26.4(b)] [NJ Ex Order 26. 4B1], the [U.S. FOIA (b)] said she could not find any documentation that the [NJ Ex Order 26. 4B1] and confirmed they should have been. A review of a facility provided "Notification of Change" policy dated revised 1/2025, included... The facility must inform the resident, consult with the resident's family and or notify the resident's family member or legal representative when there is a change requiring such notification...	F 580		
F 690 SS=E	NJAC 8:39-13.1(c) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		5/26/25

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F 690	Continued From page 4 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that a.) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted]) care was consistently performed and documented in accordance with a physician order; b.) NJ Ex Order 26.4(b)(1) was consistently performed and documented in accordance with a physician order; c.) NJ Ex Order 26.4(b)(1) from NJ Ex Order 26.4(b)(1) was consistently monitored and documented according to physician orders; d.) NJ Ex Order 26.4(b)(1) from NJ Ex Order 26.4(b)(1) was consistently monitored and documented according to a physician order; and e.) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted]) was consistently changed to NJ Ex Order 26.4(b)(1) when the resident was out of bed according to a physician order. This deficient practice was identified for 2 of 3 residents reviewed for NJ Ex Order 26.4	F 690	Resident #1 *NJ Ex Order 26. 4B1* was assessed for signs and symptoms of infection. The [redacted] was NJ Ex Order 26.4(b)(1) *NJ Ex Order 26. 4B1* [redacted] as per order. Blanks in Resident #1 administration documentation cannot be signed retroactively. However, corrective measures were put in place. Resident #72 large *NJ Ex Order 26. 4B1* [redacted]. The facility is unable to retroactively correct NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 documentation omissions in Treatment Administration Record (TAR). However, as per facility protocol, the Director of Nursing (DON) investigated each omission and completed Medication/Treatment Error Report. Director of nursing (DON) educated	

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F 690	Continued From page 5 NJ Ex Order 26.4(b) (Resident #1 and Resident #72), and was evidenced by the following: 1. On 4/8/25 at 8:30 AM, the surveyor observed Resident #1 in bed during an *NJ Ex Order 26. 4B1* with a *U.S. FOIA (b) (6)* . The U.S. FOIA (b) exposed the NJ Ex Order which was noted to be NJ Ex Order 26.4(b)(1) A *NJ Ex Order 26. 4B1* was noted on the *NJ Ex Order 26. 4B1* . The NJ Ex Orde was labeled and dated appropriately. There was no dressing noted covering the *NJ Ex Order 26. 4B1* . The surveyor reviewed the medical record for Resident #1. A review of the Admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included; *NJ Ex Order 26. 4B1* . A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated a *NJ Ex Order 26. 4B1* . The MDS further included that the resident had an *NJ Ex Order 26. 4B1* . A review of the Order Summary Report (OSR) revealed the following active orders as of NJ Ex Order 26.4 - Cleanse around *NJ Ex Order 26. 4B1* started on NJ Ex Order 26.4(b)(1) - *NJ Ex Order 26. 4B1*	F 690	Licensed Practical Nurse (LPN #1) on the importance of changing NJ Ex Order NJ Ex Order 26. 4B1 when Resident #72 is NJ Ex Order 2 , and documenting NJ Ex Order 26. 4 NJ Ex Order 26 in the TAR as per physician's order. All residents who have an order for nephrostomy tubes and a foley catheter have the potential to be affected by this deficient practice. Staff education on the policy regarding nephrostomy care which includes flushing, urinary output, dressing change and appropriate documentation was initiated. DON will educate nurses and nurse aides about the importance of changing large foley catheter drainage bags to smaller leg bags when residents are OOB as well as about the importance of urinary output documentation in the TAR as indicated by physician's order. Furthermore, the facility policy titled "Management of Indwelling Catheter" was revised and updated to address drainage bag change and monitoring of urinary output. DON or designee will conduct weekly audits for 4 weeks, then monthly for 2 months. All findings from the audits will be reported and reviewed by the DON or designee and will be submitted to the monthly Quality Assurance and Performance Improvement Committee (QAPI) for three (3) months to determine if further interventions are needed.	

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F 690	Continued From page 6	F 690		

NJ Ex Order 26. 4B1 on 7:00 AM to 3:00 PM shift. Apply NJ Ex Order 26. 4B1 every day shift for NJ Ex Order 26. 4B1 care started on NJ Ex Order 26.4(b).
- Monitor NJ Ex Order 26 and NJ Ex Order 26. 4B1 every shift from NJ Ex Order 26. 4B1 every shift started on NJ Ex Order 26.4(b).
- Document NJ Ex Order NJ Ex Order 26 every shift started on NJ Ex Order 26.4(b) and revised on NJ Ex Order 26.4(b)

A review of the monthly Treatment Administration Record (TAR) for the months of NJ Ex Order 26.4(b) NJ Ex Order through NJ Ex Orde NJ Ex Order, revealed blanks in the documentation portion for the corresponding orders from the OSR and were not addressed in the progress notes:

- NJ Ex Order 26.4(b)(1), day shift had blanks on order for cleansing of NJ Ex Order 26. 4B1, and order to document NJ Ex Order NJ Ex Order 26.4
- NJ Ex Order 26.4(b), day shift had a blank on order for cleansing of NJ Ex Order 26. 4B1.
- NJ Ex Order 26.4(b)(1) day shift had blanks on order for cleansing of NJ Ex Order 26. 4B1, and order to document NJ Ex Order NJ Ex Order 26.4
- NJ Ex Order 26.4(b)(1), day shift had a blank on order for cleansing of NJ Ex Order 26. 4B1.
- NJ Ex Order 26.4(b)(1), day shift had a blank on order for cleansing of NJ Ex Order 26. 4B1.
- NJ Ex Order 26.4(b)(1) day shift had blanks on order for cleansing of NJ Ex Order 26. 4B1, and order to document NJ Ex Order NJ Ex Order 26.4
- NJ Ex Order 26.4(b), evening shift had a blank on order to document NJ Ex Order NJ Ex Order 26.4
- NJ Ex Order 26.4(b), day shift had blanks on order for cleansing of NJ Ex Order 26. 4B1, and order to document NJ Ex Order NJ Ex Order 26.4
- NJ Ex Order 26.4(b), day shift had blanks on orders for cleansing of NJ Ex Order 26. 4B1 of

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F 690	Continued From page 7 [redacted], and order to document [redacted] - [redacted] day shift had blanks on orders for cleansing of *NJ Ex Order 26. 4B1* [redacted], and order to document [redacted] - [redacted] day shift had a blank on orders to document [redacted] - [redacted], evening shift had a blank on order to document [redacted] - [redacted], day shift had blanks on orders for cleansing of *NJ Ex Order 26. 4B1* [redacted], and order to document [redacted] - [redacted] day shift had blanks on orders for cleansing of *NJ Ex Order 26. 4B1* [redacted], and order to document [redacted] A review of the individualized comprehensive care plan (ICCP) dated revised on [redacted], included a focus for risk of *NJ Ex Order 26. 4B1* [redacted] The goal was for the resident to be free from signs and symptoms of retention. Interventions included to administer the resident's medications per physician orders and to obtain laboratory tests as ordered and notify the physician. Another focus area the resident was at risk for infection due to the *NJ Ex Order 26. 4B1* [redacted] The goal for this focus was for the resident to be free from signs and symptoms of active infections. Interventions included [redacted], laboratory tests as ordered, and hand hygiene prior to and after care.	F 690		

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F 690	Continued From page 8 On 4/11/25 at 1:39 PM, during an interview with the survey team, the U.S. FOIA (b) (6) was asked by the surveyor what a blank in the administration record would indicate. The U.S. FOIA (b) stated that a "blank" in the administration records indicated that the nurse did not document it. The surveyor asked the U.S. FOIA (b) if a blank meant the order was not completed as ordered. The U.S. FOIA (b) stated, "Yes." The U.S. FOIA (b) was asked by the surveyor why it was important to do NJ Ex Order 26. 4B1 . The U.S. FOIA (b) replied that NJ Ex Order 26. 4B1 was important to monitor for infection. The U.S. FOIA (b) also stated that NJ Ex Order 26.4(b) was important to make sure the NJ Ex Order 26. 4B1 was functioning properly. The U.S. FOIA (b) was asked why it was important to monitor NJ Ex Order 26. NJ Ex Order 26.4(b)(1) and the U.S. FOIA (b) replied to make sure whatever was NJ Ex Order 26.4(b) was NJ Ex Order 26.4(b)(1); that it was adequate. A review of facility provided policy titled "Management of Indwelling Catheter" revised in January 2025, did not address NJ Ex Order 26.4(b)(1) care, NJ Ex Order 26.4(b)(1), and monitoring of NJ Ex Order 2. On 4/8/25 at 12:20 PM, the surveyor observed Resident #72 in the NJ Ex Order 26. 4B1 room. Resident #72 was observed to have their large NJ Ex Order 26 suspended beneath the seat of their wheelchair. The NJ Ex Order 26. 4B1 was observed to be inside of a blue NJ Ex Order 26. 4B1. The surveyor reviewed the medical record for Resident #72. According to the Admission Record, Resident #72	F 690		

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F 690	Continued From page 9	F 690		

was admitted to the facility with the following diagnoses: NJ Ex Order 26. 4B1 [redacted].

According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #72 had a Brief Interview for Mental Status score of [redacted] out of 15, which indicated NJ Ex Order 26. 4B1 [redacted]. A review of Section [redacted] revealed that Resident #72 was dependent on staff for [redacted]. A review Section H of the MDS revealed that Resident #72 had an NJ Ex Order 26. 4B1 [redacted]. A review of Section I revealed that Resident #72 had active diagnoses of NJ Ex Order 26. 4B1 [redacted].

A review of the Order Summary with an order date range of [redacted], revealed the following physician's order (PO) for Resident #72:

A PO dated [redacted] to change NJ Ex Order 26. 4B1 [redacted] every day shift when NJ Ex Order 26. 4B1 and change back to large NJ Ex Order 26. 4B1 at night, every shift.

A review of the ICCP included a focus area that the resident had an NJ Ex Order 26. 4B1 [redacted]. Interventions included to: change NJ Ex Order 26. 4B1 as needed/ordered, and report if there was a change in NJ Ex Order 26. 4B1 [redacted].

On 4/10/25 at 10:38 AM, Resident #72 was observed seated in a high back wheelchair in the NJ Ex Order 26. 4B1 attending an activity after completing NJ Ex Order 26. 4B1. Resident #72 had their large NJ Ex Order 26. 4B1 suspended from the frame under the seat of their wheelchair and

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F 690	Continued From page 10 enclosed in a large [NJ Ex Order 26. 4B1]. Resident #72 did not have a [NJ Ex Order 26. 4B1] as ordered on this observation when out of bed. On 4/10/25 at 1:39 PM, the surveyor observed Resident #72 seated in their wheelchair in the [NJ Ex Order 26. 4B1]. Resident #72 had a large [redacted] within a [NJ Ex Order 26. 4B1] suspended under the seat of their wheelchair. Resident #72 did not have a [redacted] when out of bed as per [U.S. FOIA (b) (6)] order on this observation. On 4/11/25 at 11:22 AM, the surveyor observed Resident #72 seated in their wheelchair in the [U.S. FOIA (b) (6)]. Resident #72 was doing an activity. The surveyor observed Resident #72's large [NJ Ex Order 26. 4B1] inside of a [NJ Ex Order 26. 4B1] and suspended from the seat of their wheelchair. No [redacted] was observed. On 4/11/25 at 11:25 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) assigned to Resident #72. LPN #1 told the surveyor that she had worked with Resident #72 a couple of times. The surveyor asked Resident #72 if they were supposed to have a [redacted] when out of bed. LPN #1 told the surveyor I assume it would be done by the [redacted]. I will check the order and see if it should be changed to a [redacted]. LPN #1 then went into the computer and checked the order for Resident #72. LPN #1 then told the surveyor, "Yes," they should have a [redacted] when out of bed. On 4/11/25 at 1:39 PM the surveyor conducted an interview with facility's Administration which included the [U.S. FOIA (b) (6)] [redacted]	F 690		

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CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 11	F 690		

U.S. FOIA (b) (6) in training. The surveyor asked the Administration if Resident #72 was to have a NJ Ex Order 26. 4B1 when out of bed. The U.S. FOIA (b) told the surveyor, "Yes," they should have had a NJ Ex Order 26. 4B1 if that was what the physician ordered.

3. On 4/8/25 at 9:26 AM, the surveyor conducted a record review for Resident #72. Resident #72 had the following active physician order:

Document NJ Ex Order 26. 4B1 every shift. Start date: NJ Ex Order 26. 4B1.

On 4/8/25 at 1:25 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #72.

A review of the NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR) revealed that the facility failed to document NJ Ex Order 26. 4B1 for Resident #72 on the following days and shifts: NJ Ex Order 26. 4B1 shift.

A review of the NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b)(1) TAR revealed the facility failed to document NJ Ex Order 26. 4B1 on the following days/shifts: NJ Ex Order 26. 4B1.

On 4/11/25 at 11:25 AM, the surveyor conducted an interview with LPN #1. LPN #1 told the surveyor she had worked with Resident #72 NJ. The surveyor told LPN #1 that Resident #72 had a physician's order to document NJ Ex Order 26. 4B1 every shift. The surveyor then asked LPN #1 when NJ Ex Order 26. 4B1 should be documented. LPN #1 told the surveyor, "NJ Ex Order 26. 4B1" LPN #1 further

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F 690	Continued From page 12 explained that she usually does it at the end of her shift. The surveyor asked LPN #1 if the TAR should have any blanks and LPN #1 responded, "No." On 4/11/25 at 1:39 PM, the surveyor conducted an interview with facility's Administration which included the U.S. FOIA (b) (6) [redacted] in training. The surveyor asked what a blank on the TAR would indicate? The [redacted] told the surveyor a blank on the TAR indicated that the nurse did not document it. The surveyor then asked the [redacted] if a blank would mean it was not completed as ordered. The [redacted] stated, "Yes." The surveyor then asked the [redacted] why it was important to monitor NJ Ex Order 26.4(b)(1). The [redacted] replied to make sure whatever was going in was coming out, and that it was adequate. On 4/14/25 12:28 PM, the surveyor reviewed the NJ Ex Order 26.4(b)(1) TAR. The TAR revealed that Resident #72 did not have [redacted] documented by nursing staff on the following shifts: NJ Ex Order 26. 4B1 [redacted] shift. A review of the facility's "Management of Indwelling Catheter" policy dated revised 1/2025. The policy did not include NJ Ex Order 26. 4B1 or monitoring [redacted]. NJAC 8:39-19.4(a)5; 27.1(a)	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		5/26/25

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F 695	Continued From page 13 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: Complaint #: NJ184231 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to a.) ensure there was a physician's order (PO) for NJ Ex Order 26.4(b)(1) and b.) administer NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) consistently according to the physician order. This deficient practice was identified for 2 of 3 residents reviewed for NJ Ex Order 26.4(b)(1) care and services(Resident #178 and Resident #44), and was evidenced by the following: A review of Resident #178's electronic Medical Record (EMR) revealed two progress notes. On NJ Ex Order 26.4(b)(1) at 10:45 AM, and on NJ Ex Order 26.4(b) at 11:00 AM, which indicated the resident was currently on *NJ Ex Order 26. 4B1*. A review of Resident #178's Admission Record face sheet (an admission summary) revealed they were admitted to the facility with diagnoses which included; *NJ Ex Order 26. 4B1*	F 695	Resident #178 *NJ Ex Order 26. 4B1* . The Facility cannot retroactively correct NJ Ex Order 26. 4B1 documentation omissions. However, the Director of Nursing (DON) investigated each omission and completed Medication error reports regarding the charting omissions identified for Resident #44 who has since *NJ Ex Order 26. 4B1* . All residents who receive nebulizer inhalation/treatment and have an order that requires a signature upon completion of medication or treatment administration have the potential to be affected by this deficient practice. All residents with the presence of oxygen administration have the potential to be affected by this deficient practice. The facility cannot retroactively correct the deficient practice. However, as needed (PRN) Batch orders for NJ Ex Order 26. 4B were created, are available and added to all residents if their *NJ Ex Order 26. 4B1* . The DON educated LPN/RNs on the policy on medication administration regarding charting omissions and the importance of signing MAR after nebulizer treatment administration.	

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F 695	Continued From page 14 A review of Resident #178's Order summary report dated [redacted], did not include a PO for [redacted]. During an interview with the surveyor on 4/8/25 at 9:47 AM, the Licensed Practical Nurse (LPN #2) said residents on [redacted] should have a physician's order. When asked about a resident in [redacted] LPN #2 said, if they do not already have an order for [redacted], they would used nursing interventions and placed the resident on [redacted] then call the doctor for further instructions and placed orders in the computer. During an interview with the surveyor on 4/8/25 at 10:01 AM, the [redacted] said that Resident #178 should have had an order for [redacted]. The [redacted] was unsure of when the resident was placed on [redacted] and after reviewing the resident's EMR she stated, [redacted]." A review of a facility policy titled "Oxygen Administration" with a revised date of 1/2025, revealed under... Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. On 4/7/25 at 10:06 AM, during the initial tour of the facility, the surveyor observed Resident #44's [redacted] on top of their bedside table. The	F 695	DON initiated education for all LPN/RN on the updated policy for oxygen administration and nebulizer therapy as well as the importance of obtaining physician order (PO) for oxygen treatment. The DON, Unit Manager and or designee will conduct daily audits on resident on all shifts for 8 weeks then monthly for 4 months to ensure that there are no charting omissions. DON or designee will audit five (5) residents who receive nebulizer treatment to ensure that nurses sign MAR after administration. The audit will be conducted weekly for four (4) weeks, then monthly for two (2) months. DON or designee will audit five (5) residents for the presence of oxygen and ensure orders are present. The audit will be performed weekly for four (4) weeks, then monthly for two (2) months. Audit findings will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) Committee for three (3) months. The QAPI Committee will determine if further actions are needed.	

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F 695	Continued From page 15	F 695		

resident stated that they used the [NJ Ex Order 26. 4B1] a couple of times a day.

The surveyor reviewed the medical record for Resident #44.

A review of the Admission Record face sheet revealed Resident #44 was admitted to the facility with diagnoses which included; [NJ Ex Order 26. 4B1] [redacted].

A review of the resident's most recent Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26] [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated a [NJ Ex Order 26. 4B1] [redacted]. The MDS also reflected that the resident received [NJ Ex Order 26. 4B1] [redacted].

A review of the [NJ Ex Order 26.4(b)(1)] Order Summary Report included the following orders:

[NJ Ex Order 26. 4B1] [redacted].

[NJ Ex Order 26. 4B1] [redacted].

A review of the corresponding Medication Administration Record (MAR) in [NJ Ex Order 26.4(b)(1)] revealed that [NJ Ex Order 26. 4B1] on the following dates

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F 695	Continued From page 16 and times was not signed administered: On [NJ Ex Order 26. 4B1] at 6:00 PM. On [NJ Ex Order 26. 4B1] at 12:00 AM. On [NJ Ex Order 26. 4B1] at 12:00 PM. A review of the individualized comprehensive care plan initiated on [NJ Ex Order 26.4(b)], reflected a focus for *NJ Ex Order 26. 4B1* [redacted]. The interventions included the resident required assistance to complete [NJ Ex Order 26. 4B1] [redacted]. On 4/11/25 at 1:36 PM, during an interview with the survey team, the *U.S. FOIA (b) (6)* stated that if the MAR was not checked then it was basically not done. A review of facility provided policy titled "Oxygen Administration" revised in January 2025, did not address *NJ Ex Order 26. 4B1*.	F 695		
F 756 SS=D	NJAC 8:39 - 27.1(a) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		5/26/25

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F 756	Continued From page 17 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to respond in a timely manner to the *U.S. FOIA (b) (6)* [redacted] monthly recommendations. This deficient practice was identified for 1 of 5 residents (Resident #16) reviewed for NJ Ex Order 26.4(b)(1) [redacted] and was evidenced by the following:	F 756	Resident #16 was assessed for presence of NJ Ex Order Resident #16's NJ Ex Ord management medications were re-evaluated by the prescriber, and sequenced as per pharmacist recommendations. Unit Manager/LPN #1 received individual education from the Director of Nursing (DON) on the importance of addressing pharmacist's recommendations in a timely manner.	

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F 756	Continued From page 18 On 4/10/25 at 10:40 AM, the surveyor observed Resident #16 in bed. The resident stated to the surveyor they were taking [redacted] medications because they had [redacted]. The resident further explained [redacted] usually did not work and after taking it, they would still be [redacted]. The resident had tried other [redacted] medications like [redacted]. The surveyor reviewed Resident #16's medical records. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included; [redacted]. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of 15, which indicated that the resident's [redacted]. A further review of the MDS revealed the resident in the [redacted] had received as needed [redacted] medication or had been offered and declined. In addition, during the [redacted] assessment interview, the resident revealed they frequently had [redacted]. A review of the Medications section of the MDS revealed the resident was taking [redacted] during the [redacted] since admission.	F 756	Residents on pain management regimen requiring multiple pain medications have the potential to be affected by this deficient practice. The DON will educate Unit Managers, supervisors, and floor nurses on the importance of addressing pharmacist's recommendations in a timely manner as well as sequencing multiple pain medications in the way to indicate mild, moderate or severe pain. The DON/Unit Manager or Designee will audit five (5) residents who use multiple pain medications for appropriate indication and sequencing of pain level. The audit will be completed weekly for four (4) weeks, then monthly for two (2) months. Audit results will be reported to the monthly Quality Assurance and Performance Improvement (QAPI) Committee will determine if further actions are needed.	

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F 756	Continued From page 19	F 756		

A review of the Order Summary Report (OSR) (physician's order sheet) with order date range of [redacted] to [redacted], revealed *NJ Ex Order 26. 4B1* [redacted]. A physician's order (PO) dated [redacted], for *NJ Ex Order 26. 4B1* [redacted]. A PO dated [redacted], for *NJ Ex Order 26. 4B1* [redacted]. A PO dated [redacted], for *NJ Ex Order 26. 4B1* [redacted].

A review of the [redacted], and [redacted] electronic Medication Administration Records (eMAR) revealed an order dated [redacted], for *NJ Ex Order 26. 4B1* [redacted]. An order dated [redacted] for *NJ Ex Order 26. 4B1* [redacted]. An order dated [redacted], for *NJ Ex Order 26. 4B1* [redacted].

A review of the *U.S. FOIA (b) (6)* [redacted] Consult to Physician" revealed the following recommendations:

On [redacted], the [redacted] recommended multiple as needed (PRN) medications were noted for the same or overlapping indications. Please sequence the following medication: [redacted],

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F 756	Continued From page 20 *NJ Ex Order 26. 4B1* [redacted].	F 756		

On 4/11/25 at 12:46 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1), who stated she received the monthly [redacted] recommendations from the [redacted] and she was responsible to ensure the recommendations were addressed. LPN/UM #1 stated if they were nursing recommendations, she addressed them, and if they were for the [redacted], she contacted the [redacted] for their response.

On 4/11/25 at 2:07 PM, the survey team met with the facility's Administration. The [redacted] stated the time it took to respond to the [redacted] recommendations was about ten days, but should definitely be addressed prior to the next [redacted] review. The [redacted] acknowledged the pain medication sequencing should have been addressed immediately after the [redacted] identified the issue and made their recommendation.

A review of the facility's undated "Pharmacy Consultant Policy and Procedure" policy revealed... The pharmacist will report any irregularities to the attending physician and the DON, and these reports must be acted upon... The pharmacist will provide the DON with pharmacy recommendation reports on an on-going basis each month. The DON will act upon these recommendations by bringing them to the attention of the attending physician and ensuring any changes are implemented in a timely manner.

NJAC 8:39-29.3

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F 761	Continued From page 21	F 761		
F 761 SS=D	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 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 pertinent facility documents, it was determined that the facility failed to ensure that all medications used in the facility were labeled and stored in accordance with professional standards to preserve their integrity. This deficient practice was observed in 1 of 2 medication storage rooms ([redacted]) inspected and was evidenced by the following:	F 761	The [redacted] were discarded immediately. Individual education on proper medication storage was provided to Unit Manager/LPN #1 by the [redacted]. Residents who have orders for [redacted] have the potential to be affected by this deficient practice.	5/26/25

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F 761	Continued From page 22 On 4/7/25 at 10:42 AM, the surveyor, in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM #1), inspected the [NJ Ex Order 26. 4B.] Medication Room. Observed on the counter was two one-liter opened and removed from the protective packaging Intravenous (IV) solutions for dextrose 5% with 0.45% normal saline (D5/1/2 NS). LPN/UM #1 stated they were for a resident who had been discharged and she was unsure how long the solutions were good for once removed from the protective overwrap. During inspection of the medication room refrigerator, an opened bottle of Tuberculin Purified protein derivative (PPD) 5 TU/0.1 ml (5 tuberculin units/0.1 milliliter) labeled "house stock" was dated opened 2/26/25. There was also an open bottle of "Patient's own" insulin aspart dated opened 1/18/25. When asked how long the bottles were good for once opened, LPN/UM #1 stated she believed the opened PPD and insulin should be discarded after 30 days. On 4/14/25 at 10:24 AM, the surveyor interviewed the [U.S. FOIA (b) (6)], who stated the insulin bottle should have been discarded after 28 days, and the PPD solution should be discarded after 30 days. On 4/14/25 at 12:22 PM, the surveyor interviewed the [U.S. FOIA (b) (6)], who stated that IV bags that were resident specific must be used by the date printed on the pharmacy label, and any IV bag without a label and not in the overwrap must be discarded. The [U.S. FOIA (b) (6)] acknowledged the IV bags and the opened vials found by the surveyor should have been removed from active inventory.	F 761	The DON will conduct education for licensed nursing staff regarding the policy and procedure for the storage of medications. Education focused on checking PPD and insulin solutions prior to use for a date opened on the bottle. If no date is noted on an opened bottle then it should be discarded immediately. PPD and insulin solutions must have a date added when initially opened and must be used within 30 days of the date opened or discarded, and 28 days for insulin. Additionally, IV fluid bags out of their original packaging should be returned to the pharmacy or discarded. Nurse Manager or designee will audit medication storage weekly for 4 weeks then monthly for 2 months. All findings from the audit will be reported, reviewed by the DON or designee and submitted to the monthly Quality Assurance and Performance Improvement (QAPI) Committee for three (3) months to determine if further interventions are needed.	

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	315294	A. BUILDING _____ B. WING _____	C 04/14/2025

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**

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F 761	Continued From page 23 A review of the facility's undated "Storage of Medications" policy included ... the facility shall not use discontinued, outdated, or deteriorated drugs or biological's. All such drugs shall be returned to the dispensing pharmacy or destroyed ...	F 761		
F 880 SS=D	NJAC 8:39-29.4(h) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		5/26/25

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F 880	Continued From page 24 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 25 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that staff wore the appropriate personal protective equipment (PPE) for residents on [NJ Ex Order 26.4(b)(1) redacted], to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of infection control practice. This was observed for 1 of 2 unsampled resident (Resident #39) reviewed for [NJ Ex Order redacted]. This deficient practice was evidenced by the following: Reference: "Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens." https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html On 4/9/25 at 10:59 AM, the surveyor observed a sign by the door of Resident #39 that the resident was on [NJ Ex Order redacted], and a PPE bin was outside the room by the doorway. The sign had instructions for staff to wear gown and gloves during high-contact resident care activities that included NJ Ex Order 26.4(b)(1) [redacted]. The surveyor went inside the room to interview a sampled resident and noted the roommate, Resident #39 being [NJ Ex Order 26. 4B1 redacted]. The surveyor asked Resident #39 if surveyor can	F 880	Resident #39 was evaluated and monitored for any signs and symptoms of infection, none noted. Individual education for CNA #1 and CNA #2 was provided by the DON immediately following the event on the importance of the use of proper PPE with residents on NJ Ex Order 26. 4B1 [redacted]. Residents on EBP have the potential to be affected by the deficient practice. The DON or IP Nurse will educate nursing staff on the EBP policy stressing the importance of the use of proper PPE including donning gowns and gloves with residents on EBP during high contact resident care. The DON or designee will conduct observational audits on five (5) residents on EBP to ensure staff compliance with PPE (gown and gloves) usage during high contact situations. The audit will be conducted weekly for four (4) weeks, then monthly for two (2) months. All findings from the audits will be reported, reviewed by the DON or designee and submitted to the monthly Quality Assurance and Performance Improvement (QAPI) Committee for three (3) months to determine if further interventions are needed.	

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F 880	Continued From page 26 observe them being [NJ Ex Order 26. 4B1] which the resident agreed to. The surveyor observed Certified Nursing Assistant (CNA) #1 cleansed the [NJ Ex Order] [redacted]. CNA #1 wore gloves but did not wear gown. When the resident was about to be turned to their side still [NJ Ex Order 26. 4B1], CNA #2 entered the room wearing gloves with no gown. CNA #2 assisted CNA #1 [NJ Ex Or] the resident to their [NJ Ex Order 26. 4B1]. A review of the Admission Record face sheet (an admission summary) revealed Resident #39 was admitted to the facility with diagnoses which included but were not limited [NJ Ex Order 26. 4B1] [redacted] A review of Resident #39's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Ex] out of 15, which indicated [NJ Ex Order 26. 4B1]. The MDS further revealed that the resident had an [NJ Ex Order 26. 4B1]. A review of the Order Summary Report (OSR) active as of [NJ Ex Order 26] included the following physician's orders: - [NJ Ex Order 26. 4B1] [redacted]. A review of the comprehensive care plans revised	F 880		

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F 880	Continued From page 27 on [NJ Ex Order 26.4(b)(1)], included a focus for the resident being at risk for infection requiring [NJ Ex Order 26. 4B1] [redacted]. The goal was for the resident to be free from signs and symptoms of active infection. The interventions included the following: [NJ Ex Order 26. 4B1] [redacted], use of gown and glove during *NJ Ex Order 26. 4B1* [redacted]. On 4/9/25 at 11:40 AM, during an interview with the surveyor, the *U.S. FOIA (b) (6)* [redacted] stated that staff had to wear gowns and gloves during *NJ Ex Order 26. 4B1* [redacted] when residents are on [NJ Ex Order] [redacted] to protect the residents with [NJ Ex Order 26. 4B1] [redacted]. The [U.S. F] [redacted] further stated that *NJ Ex Order 26. 4B1* [redacted]. A review of the facility-provided policy titled "Enhanced Barrier Precautions" revised in March 2024, reflected under Policy Statement the following: To minimize the transmission of germs transferring from residents to staff hands and clothing, staff will wear gown and gloves when providing care to residents that require significant physical contact and are at high risk of acquiring or spreading Multidrug-Resistant Organisms (MDRO). NJAC 8:39 - 19.4 (a)(5)	F 880		

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S 000	Initial Comments Complaint #: NJ 170257, 170547, 172201, 173065, 174274, 180063, 180317, 184231, 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ 172201, NJ 174274, NJ 180063, NJ 184231 Based on interviews and review of other 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 deficient practice was identified for 28 out of 70 day shifts and 1 out of 70 evening shifts reviewed.	S 560	The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls being made by the Staffing Coordinator or the shift Supervisor to fill the shift. The facility has documented evidence to reflect recruitment and retention efforts in its relentless attempts to comply with the staffing ratios. All residents have the potential to be	5/26/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/08/25

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S 560	Continued From page 1 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 nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One 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 as documented below: 1. For the week of Complaint staffing from 12/31/23 to 1/6/24, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts and	S 560	affected. Staffing Coordinator was re-educated by the Administrator on current staffing regulation and shift ratios. Recruitment and retention efforts continue to include: a. Daily staffing meetings and weekly Regional Labor Management reviews b. Training mentor program to support retention c. Employee Enrichment committee in place to improve and maintain staff morale d. Recruitment bonus and sign-on bonuses offered. e. Completive wage analysis DON/Staffing Coordinator/Administrator or designee will monitor and review staffing daily for 1 week, weekly for 3 weeks and monthly for 3 months. Results will be presented to the Quality Assurance and Performance Improvement (QAPI) team monthly for continued review and recommendations until substantial compliance is maintained.	

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S 560	Continued From page 2 deficient in total staff for residents on 1 of 7 evening shifts as follows: 1/1/24 had 6 total staff for 74 residents on the evening shift, required at least 7 total staff. 1/4/24 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. 1/6/24 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. 2. For the week of Complaint staffing from 3/3/24 to 3/9/24, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: 3/3/24 had 7 CNAs for 75 residents on the day shift, required at least 9 CNAs. 3/4/24 had 8 CNAs for 75 residents on the day shift, required at least 9 CNAs, 3/9/24 had 6 CNAs for 75 residents on the day shift, required at least 9 CNAs. 3. For the two weeks of Complaint staffing from 3/31/24 to 4/6/24, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: 3/31/24 had 6 CNAs for 81 residents on the day shift, required at least 10 CNAs. 4/3/24 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. 4/4/24 had 7 CNAs for 80 residents on the day shift, required at least 10 CNAs. 4/5/24 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. 4/6/24 had 7 CNAs for 80 residents on the day shift, required at least 10 CNAs. 4/13/24 had 8 CNAs for 82 residents on the day shift, required at least 10 CNAs. 4. For the week of Complaint staffing from	S 560		

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S 560	Continued From page 3 5/26/24 to 6/1/24, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: 5/26/24 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. 5/27/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. 5/28/24 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. 5/29/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. 5/30/24 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. 6/1/24 had 8 CNAs for 85 residents on the day shift, required at least 11 CNAs. 5. For the week of Complaint staffing from 11/3/24 to 11/9/24, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: 11/3/24 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. 6. For the week of Complaint staffing from 11/17/24 to 11/23/24, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: 11/17/24 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. 7. For the week of Complaint staffing from 1/19/25 to 1/25/25, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: 1/19/25 had 8 CNAs for 75 residents on the day shift, required at least 9 CNAs.	S 560		

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S 560	Continued From page 4 1/22/25 had 8 CNAs for 75 residents on the day shift, required at least 9 CNAs. 1/23/25 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. 1/24/25 had 7 CNAs for 78 residents on the day shift, required at least 10 CNAs. 1/25/25 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs. 8. For the two weeks of staffing prior to survey from 3/23/25 to 4/5/25, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: 3/23/25 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. 3/28/25 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. 3/29/25 had 8 CNAs for 78 residents on the day shift, required at least 10 CNAs. 4/5/25 had 8 CNAs for 75 residents on the day shift, required at least 9 CNAs. On 4/9/25 at 11:13 AM, the surveyor interviewed the Scheduling Coordinator (SC), and when asked if she was familiar with the minimum staffing requirements for CNAs. The SC responded yes, that the requirements were one CNA to eight residents on the day shift (7:00 AM until 3:00 PM); one CNA to ten residents on the evening shift (3:00 PM until 11:00 PM); and one CNA to 14 residents on the night shift (11:00 PM until 7:00 AM). When asked if the facility was meeting the requirements, the SC responded they were. The SC stated she was a CNA and often filled in as needed and used agency staff as well. On 4/9/25 at 11:28 AM, the surveyor interviewed the Licensed Nursing Home Administrator	S 560		

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S 560	Continued From page 5 (LNHA), who was aware of the minimum staffing ratio requirements, and stated the facility scheduled to meet those needs. The LNHA stated to meet the ratios, the facility offered bonuses to staff as well as used agency staff. A review of the facility provided "Sufficient Staffing Policy" dated revised 3/1/25, included ... The Facility will provide sufficient staffing to meet needed care and services for our resident population on a 24-hour basis. If required by the State where the Facility operates, those nursing staff ratio guidelines should be followed ... The facility will maintain adequate staffing on each shift to ensure that our resident's needs and services are met. An acceptable standard of care must be maintained when minimum staffing requirements are required. New Jersey Staffing Ratio 7-3 shift one CNA to eight residents, 3-11 one CNA to 10 residents and 11-7 one CNA to 14 residents ... When the staffing requirements are not met, the expectation is that good faith efforts are made to obtain the required staffing ... Good faith will be demonstrated by the offering of competitive salaries, the use of Personnel agencies and newspaper/Internet ads.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of:	S1680		5/26/25

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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
S1680	Continued From page 6 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060501	A. BUILDING: _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATIC	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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S1680	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the week of 3/23/25 to 4/5/25, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days. The required staffing hours and actual staffing hours are as follows: For the two weeks of AAS-12 staffing from 3/23/25 to 4/5/25, the facility was deficient in staffing for resident required services on 1 of 14 days as follows: For the week of 3/30/25 Required Staffing Hours: 209.50 4/5/25 had 208 actual staffing hours, for a difference of -1.50 hours. On 4/9/25 at 11:28 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who was aware of the minimum staffing ratio requirements, and stated the facility	S1680	The facility cannot retroactively correct the deficient practice. However the facility seeks to schedule staff based on the required staffing level to comply with the State of NJ staffing requirements. All residents have the potential to be affected. The Administrator initiated an in-service with the Director of Nursing (DON) and Staffing Coordinator on ensuring that the required staffing levels are provided and also reviewed the Sufficient Staffing policy. The DON and Staffing Coordinator will complete daily staffing sheets to ensure that the facility is meeting the required staffing levels per regulations. The DON, Staffing Coordinator, Administrator and or designee will monitor and review the daily Staffing Acuity Work Sheets weekly x 4 weeks and then monthly x 3 months to ensure that the daily required staffing levels were met. The results will be presented to will be	

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	060501	A. BUILDING: _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATIO	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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S1680	Continued From page 8 scheduled to meet those needs. The LNHA stated to meet the ratios, the facility offered bonuses to staff as well as used agency staff. A review of the facility "Sufficient Staffing" policy with a revised date of 3/1/25, included... The Facility will provide sufficient staffing to meet needed care and services for our resident population on a 24-hour basis... The Facility must have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment... The facility will designate a registered nurse (RN) who is responsible for overseeing total nursing activities within the facility on each tour of duty each day of the week.	S1680	reported, reviewed by the DON, Staffing Coordinator and or designee and submitted to the monthly Quality Assurance and Performance Improvement Committee (QAPI) for three (3) months in order to determine if further interventions are needed.	
S1690	8:39-25.2(d) Mandatory Nurse Staffing In facilities with 150 licensed beds or more, there shall be an assistant director of nursing who is a registered professional nurse. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure there was an Assistant Director of	S1690	The facility cannot retroactively correct the deficient practice. However, the facility has	5/26/25

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S1690	Continued From page 9 Nursing (ADON) who was a registered professional nurse (RN). This deficient practice has the potential to affect all residents, and was evidenced by the following: During entrance conference on 4/7/25 at 9:30 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) how many licensed beds the facility had. The LNHA stated the facility had 180 beds with a resident census of 74. On 4/11/25 at 2:09 PM, the surveyor interviewed the LNHA, who acknowledged an ADON was required if a facility had more than 150 licensed beds. The LNHA confirmed the facility was licensed for more 180 beds, and should have and did not have an ADON. The LNHA stated their ADON had quit in [redacted] of [redacted], and they were actively looking for an ADON.	S1690	designated and interim RN ADON while still actively seeking to hire a Registered Nurse (RN) Assistant Director of Nursing (ADON). All residents have the potential to be affected. Staffing Coordinator and Director of Nursing were educated by the Administrator on current staffing regulation and RN, ADON coverage for buildings licensed for 150 or more beds. DON/Staffing Coordinator/Administrator or designee will monitor and review staffing daily for 1 week, weekly for 3 weeks and monthly for 3 months to ensure that an ADON is staffed. All findings from the audits will be reported, reviewed by the DON or designee and submitted to the monthly Quality Assurance and Performance Improvement Committee (QAPI) for three (3) months in order to determine if further interventions are needed.	
S1695	8:39-25.2(e) Mandatory Nurse Staffing A registered professional nurse shall be on duty at all times in facilities with more than 150 licensed beds. This REQUIREMENT is not met as evidenced by:	S1695		5/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1695	Continued From page 10 Complaint: NJ180063 Based on interview and review of pertinent documents, the facility failed to ensure a registered professional nurse (RN) was on duty at all times in facilities with more than 150 licensed beds. This deficient practice was identified for 147 out of 231 shifts reviewed, and was evidenced by the following: During entrance conference on 4/14/25 at 9:30 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing Acting (DON) how many licensed beds the facility had. The LNHA stated the facility had 180 beds with a resident census of 74. A review of the AAS-11 (Nurse Staffing Report) completed by the LNHA revealed the following: 1. For the week of Complaint staffing from 12/31/23 to 1/6/24, the facility did not have a RN on duty for 13 out of 21 shifts. 2. For the week of Complaint staffing from 1/14/24 to 1/20/24, the facility did not have a RN on duty for 13 out of 21 shifts. 3. For the week of Complaint staffing from 3/3/24 to 3/9/24, the facility did not have a RN on duty for 14 out of 21 shifts. 4. For the week of Complaint staffing from 3/31/24 to 4/6/24, the facility did not have a RN on duty for 13 out of 21 shifts. 5. For the week of Complaint staffing from 4/7/24 to 4/13/24, the facility did not have a RN on duty for 13 out of 21 shifts.	S1695	The facility cannot retroactively correct the deficient practice. However, the facility actively seeks to hire Registered Nurses (RN), that all shifts are scheduled to comply with the requirement. The facility has documented evidence to reflect recruitment and retention efforts in it's relentless attempts to comply with the staffing ratios. All residents have the potential to be affected by this deficient practice. Staffing Coordinator and Director of Nursing were educated by the Administrator on current staffing regulations and RN coverage for buildings licensed for 150 or more beds. Recruitment and retention efforts to include: a. Daily staffing meetings and weekly Regional Labor Management reviews b. Training mentor program to support retention c. Employee Enrichment committee d. Collaboration with nursing schools DON/Staffing Coordinator/Administrator or designee will monitor and review staffing daily for 1 week, weekly for 3 months. Results will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for continued review and recommendations until substantial compliance is maintained.	

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S1695	Continued From page 11 6. For the week of Complaint staffing from 5/26/24 to 6/1/24, the facility did not have a RN on duty for 14 out of 21 shifts. 7. For the week of Complaint staffing from 11/3/24 to 11/9/24, the facility did not have a RN on duty for 12 out of 21 shifts. 8. For the week of Complaint staffing from 11/17/24 to 11/23/24, the facility did not have a RN on duty for 10 out of 21 shifts. 9. For the week of Complaint staffing from 1/19/25 to 1/25/25, the facility did not have a RN on duty for 11 out of 21 shifts. 10. For the two weeks of staffing prior to survey from 3/23/25 to 4/5/25, the facility did not have a RN on duty for 21 out of 42 shifts. On 4/9/25 at 11:28 AM, the surveyor interviewed the LNHA, who stated if a facility had more than 120 licensed beds, then a RN must be in the building for eight hours in a 24-hour period. A review of the facility "Sufficient Staffing" policy with a revised date of 3/1/25, included... The Facility will provide sufficient staffing to meet needed care and services for our resident population on a 24-hour basis... The Facility must have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility	S1695		

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S1695	Continued From page 12 assessment... The facility will designate a registered nurse (RN) who is responsible for overseeing total nursing activities within the facility on each tour of duty each day of the week.	S1695		

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
315294 Y1	A. Building B. Wing Y2	6/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580	Correction	ID Prefix F0690	Correction	ID Prefix F0695	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	05/26/2025	LSC	05/26/2025	LSC	05/26/2025
ID Prefix F0756	Correction	ID Prefix F0761	Correction	ID Prefix F0880	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	05/26/2025	LSC	05/26/2025	LSC	05/26/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/14/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315294 Y1	A. Building B. Wing Y2	6/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID Prefix F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 05/26/2025	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 05/26/2025	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

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FOLLOWUP TO SURVEY COMPLETED ON	
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060501 Y1	A. Building B. Wing Y2	6/13/2025 Y3

NAME OF FACILITY	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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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1680	Correction	ID Prefix S1690	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed	Reg. # 8:39-25.2(d)	Completed
LSC	05/26/2025	LSC	05/26/2025	LSC	05/26/2025
ID Prefix S1695	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-25.2(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/26/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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FOLLOWUP TO SURVEY COMPLETED ON	
4/14/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060501	A. Building B. Wing	6/13/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/26/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 05/26/2025	ID Prefix S1695 Reg. # 8:39-25.2(e) LSC	Correction Completed 05/26/2025
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
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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING **01** B. WING _____	**04/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments Crest Haven Nursing and Rehabilitation Center was in 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 04/09/2025 and 04/10/2025, and Crest Haven Nursing and Rehabilitation Center was found to be in non-compliance 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. Crest Haven Nursing and Rehabilitation Center is a 2-story building that was built in 1989, It is composed of Type I fire resistant construction. The facility is divided into 9- smoke zones. The facility has 2 generators, one 100 KW (Kilowatt) and one 600 KW (Natural Gas).	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the	K 222		5/26/25

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

Electronically Signed | 05/08/2025

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.

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CREST HAVEN NURSING AND REHABILITATION CENTER	**4 MOORE ROAD** **CAPE MAY COURT HOUSE, NJ 08210**

(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
K 222	Continued From page 1 clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315294	A. BUILDING 01 B. WING _____	04/14/2025

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

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility provided documentation and interview on 04/09/2025 and 04/10/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide 3 designated exit access/exit discharge doors within the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA 101, 2012 Edition, Section 7.2.1.6.1 (4), 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice had the potential to affect the 76 Residents, Visitors and Staff and was evidenced by the following: A review of the facility provided lay-out identified the facility is a single-story (1)building. The facility has twenty (20) Exit discharge doors in the facility. The facility has two outside enclosed (surrounded by the building) center courtyards. Observations on 04/09/2025 revealed the following: 1) At approximately 9:36 AM, the surveyor observed on the North Wing the one set of	K 222	The Maintenance Director (MD) immediately removed the metal tubing wrapped around the double door exit discharge handles on the North Wing preventing the exit discharge doors from opening. All double exit doors were checked to ensure they were readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA and all doors were found to be free of any obstructions or impediments. The Maintenance Director immediately disabled the keypad on one of the 2 locked exit access doors allowing a 2nd egress discharge back into the facility from the enclosed courtyard. All residents have the potential to be affected by the same deficient practice. The Administrator immediately in-serviced the U.S. FOIA (b) (6) [redacted] on ensuring all doors are readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA. In-service was initiated with all staff by the	

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	315294	A. BUILDING **01** B. WING _____	**04/14/2025**

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**

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K 222	Continued From page 3 double exit discharge (illuminated exit sign above the doors) doors that had metal tubing wrapped around the double doors handles preventing the exit discharge doors from opening. The [redacted] removed the tubing at the time and the door opened. A review of an emergency evacuation diagram posted in the corridor identified the door was the primary exit discharge door in the event of an emergency. 2) At approximately 10:20 AM, during an inspection of the enclosed center courtyard (larger courtyard), the surveyor observed that two (2) of the three (3) exit access doors were locked from the inside of the building. The third exit access door had a key pad to unlock the exit access door. In an interview at the time, the [redacted] confirmed the observations. The [redacted] were informed of the deficient practice during the Life Safety Code survey exit on 04/10/2025 at approximately 2:10 PM. NJAC 8:39 -31.2 (e)	K 222	Maintenance Director and/or designee on ensuring all doors are readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA. The Maintenance Director and/or designee will conduct weekly audits on all exit discharge doors for three (3) months, then monthly for two (2) months to ensure all doors are readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA. All findings from the audits will be reported and reviewed by the Maintenance Director and/or designee and will be submitted to the monthly Quality Assurance and Performance Improvement Committee (QAPI) for three (3) months to determine if further interventions are needed.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.	K 372		5/26/25

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	315294	A. BUILDING 01 B. WING	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 372	Continued From page 4 Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 04/09/2025 in the presence of facility [redacted] it was determined that the facility failed to maintain the integrity of smoke barrier partitions for two (2) of ten (10) smoke barrier walls in accordance with NFPA 101:2012 Edition, Section 19.3.6.2.3, 8.5.6,8.5.6.2,8.5.6.3. This deficient practice had the potential to affect the 76 residents and was evidenced by the following: A review of the facility provided lay-out identified the facility is a single-story (1)building. The facility is divided into nine (9) smoke compartments. Observations on 04/09/2025 revealed the following: 1) At approximately 10:18 AM, the surveyor observed above the ceiling tiles by the double corridor smoke doors next to the Activity storage room one (1) approximately 1-1/2 inch, one (1) approximately 3-inch and one (1) approximately 2-inch in diameter holes with wires running through the smoke barrier wall. These penetrations were observed on both sides of the smoke barrier wall indicating that it was not	K 372	The 1-1/2-inch, 3 inch and 2-inch holes with wires running the smoke barrier walls above the ceiling tiles by the double corridor smoke doors next to the Activity Storage room were sealed to prevent smoke, fumes and fire passing through to the other smoke compartment. The 1-1/2 inch, 1-inch and 2-inch holes with wires running through the smoke barrier wall above the ceiling tiles by the double corridor smoke doors next to resident room [redacted] were sealed to prevent smoke, fumes and fire passing through to the other smoke compartment. All residents have the potential to be affected by this deficient practice. The [redacted] and staff were in-serviced on the NFPA 101 requirements to maintain the integrity of smoke barrier partitions and prevent smoke, fumes and fire from passing through smoke compartments. The Maintenance Director and or Designee will conduct random monthly audits above ceiling tiles by double corridor smoke doors for 3 months then quarterly for 3 months in order to maintain the integrity of smoke barrier partitions are in accordance	

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K 372	Continued From page 5 1/2-hour fire rated and sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. 2) At approximately 11:43 AM, the surveyor observed above the ceiling tiles by the double corridor smoke doors next to Resident room [NJ Ex Order], one (1) approximately 1-1/2 inch, one (1) approximately 1-inch and one (1) approximately 2-inch in diameter holes with wires running through the smoke barrier wall. These penetrations were observed on both sides of the smoke barrier wall indicating that it was not 1/2 hour fire rated and sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. In an interview at the time, the [U.S. FOIA (b) (6)] confirmed the observations. The [U.S. FOIA (b) (6)] were informed of the deficient practice during the Life Safety Code survey exit on 04/10/2025 at approximately 2:10 PM. N.J.A.C 8:39-31.1(c), 31.2(e)	K 372	with NFPA 101 requirements. Any audit concerns will be corrected immediately. Audit findings will be provided to the Administrator for review. All findings will be submitted to the monthly Quality Assurance and Performance Improvement (QAPI) Committee to determine if further interventions are needed.	
K 531 SS=E	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	K 531		5/26/25

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K 531	Continued From page 6 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: Based on observations, interview and record review on 04/09/2025 and 04/10/2025 in the presence of the facility's *U.S. FOIA (b) (6)* [redacted], it was determined that the facility failed to maintain emergency communications in proper working condition for 1 of 1 elevators tested in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3 and ASME/ANSI A17.3. This deficient practice had the potential to affect Residents, Visitors and Staff who need to go to the second floor (Administrative offices on the 2nd. floor) and was evidenced by the following: In an interview on 04/09/2025 during the Life Safety Code survey entrance at approximately 9:01 AM, the facility's *U.S. FOIA (b) (6)* [redacted] stated that there was one (1) elevator in the facility. Observation and interview on 04/10/2025 revealed the following: On 04/10/2025 at approximately 10:37 AM, a test of elevator's emergency communication telephone was performed. When the surveyor	K 531	The service request work order to fix the elevator emergency communication telephone was approved as provided during the survey and the repair was completed on 4/30/2025. All residents, visitors and staff who need to go to the second floor (Administrative offices on the 2nd floor) have the potential to be affected by this deficient practice. The Administrator immediately in-serviced the *U.S. FOIA (b) (6)* [redacted] on the NFPA 101 and ASME/ANSI A17.3 requirement to ensure the elevator emergency communication telephone is always in proper working condition. The Maintenance Director and or designee will conduct random audits on the elevator emergency communication telephone 3x weekly for 4 weeks, then monthly for 2 months to ensure proper working conditions in accordance with NFPA 101 and ASME/ANSI A17.3. Any concerns will be corrected immediately. All findings from the audits will be provided to the Administrator for review. All findings will be submitted to the	

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K 531	Continued From page 7 attempted to use the emergency telephone, the U.S. FOIA (b) (6) told the surveyor that the emergency phone didn't work and the facility has a proposal to repair the emergency phone. Record review at approximately 10:58 AM revealed the following: 1) The Department of Community Affairs (DCA) annual elevator inspection dated 02/11/2025 read in part, "Emergency Signals and Communication-Unsatisfactory. Notice of Violation and Order to Terminate due date, 04/05/2025." 2) Proposal/ Estimate dated 04/08/2025 that read in part, "Install Dial Tone to Elevator Call Button. Have the line call the Nursing Stations and/or roll to Security Monitoring." In an interview at the time, the *U.S. FOIA (b) (6)* confirmed the findings of the record review and observations. The *U.S. FOIA (b) (6)* were informed of the deficient practice during the Life Safety Code survey exit on 04/10/2025 at approximately 2:10 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	monthly Quality Assurance and Performance Improvement (QAPI) Committee for three (3) months to determine if further interventions are needed.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		5/26/25

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K 712	Continued From page 8 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 04/09/2025 and 04/10/2025 in the presence of the facility *U.S. FOIA (b) (6)* [redacted], it was determined that the facility failed to conduct in-house fire drills at least Quarterly on each shift (every 3 months) in accordance with NFPA 101: 2012 Edition, Sections 19.7.1.4 through 19.7.1.7. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following: During the documentation review on 04/09/2025 the surveyor reviewed the following fire drills: 01/01/2024, 02:45 AM (11:00 PM to 07:00 AM shift.) 02/11/2024, 10:00 AM (07:00 AM to 03:00 PM shift.) 03/25/2024, 10:22 PM (03:00 PM to 11:00 PM shift.) 04/24/2024, 02:20 AM (11:00 PM to 07:00 AM shift.) 05/06/2024, 01:50 AM (07:00 AM to 03:00 PM shift) and 05/06/2024 no time (07:00 AM to 03:00	K 712	An outside company, Croker Fire Safety Corporation, was contracted in November of 2024 to conduct monthly fire drills which include review of Fire Safety protocols so participating staff are regularly educated on the proper procedures in case of a fire emergency. Drills have since been conducted at least quarterly on each shift (every 3 months) with the first drill conducted on 11/19/2024. All residents have the potential to be affected by this deficient practice. The *U.S. FOIA (b) (6)* was in-serviced on the NFPA 101 requirement to conduct in-house fire drills at least quarterly on each shift (every 3 months). Maintenance director and or Designee will perform quarterly audits for 3 quarters to ensure fire drills are conducted quarterly at least once on each shift (every 3 months). Any concerns found will be corrected immediately. Audit findings will be provided to the Administrator for review. All findings will be submitted to the	

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K 712	Continued From page 9 PM shift.) 06/24/2024, 08:08 PM (03:00 PM to 11:00 PM shift.) 07/18/2024, 02:33 AM (11:00 PM to 07:00 AM shift.) 08/28/2024, 01:10 AM (12:01 AM to 8:00 AM. shift.) 09/30/2024, 10:18 PM (04:00 PM to 12:00 PM shift.) 10/30/2024, 02:05 AM (12:01 AM to 08:00 AM shift.) 11/19/2024, 02:10 PM (07:00 AM to 03:00 PM shift.) 12/28/2024, 01:06 PM (07:00 AM to 03:00 PM shift.) 01/03/2025, 09:07 AM (07:00 AM to 03:00 PM shift.) 02/01/2025, 02:46 AM (11:00 PM to 07:00 AM shift.) 03/07/2025, 11:14 AM (07:00 AM to 03:00 PM shift.) The facility could not provide evidence of a 07:00 AM to 03:00 PM shift fire drill being performed between June 2024 and October 2024, five (5) months. The facility could not provide evidence of a 03:00 PM to 11:00 AM shift fire drill being performed between October 2024 and April 2025, seven (7) months. The facility conducted three (3) 03:00 PM to 11:00 AM shift fire drills in the 15 month window. In an interview at the time, the *U.S. FOIA (b) (6)* confirmed the record review.	K 712	quarterly Quality Assurance and Performance Improvement (QAPI) Committee meeting to determine if further interventions are needed.	

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K 712	Continued From page 10 The *U.S. FOIA (b) (6)* were informed of the deficient practice during the Life Safety Code survey exit on 04/10/2025 at approximately 2:10 PM. NJAC 8:39-31.2 (e)	K 712		

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
315294 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HAVEN NURSING AND REHABILITATION CENTER	4 MOORE ROAD CAPE MAY COURT HOUSE, NJ 08210

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 K0222	05/26/2025	LSC K0372	05/26/2025	LSC K0531	05/26/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0712	05/26/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/14/2025	☐ YES ☐ NO