PRINTED: 02/26/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		315451	B. WING		I .	C / <b>20/2024</b>
	PROVIDER OR SUPPLIER	THCARE CENTER OF CRANBU	RY	STREET ADDRESS, CITY, STATE, ZIP CO 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512		2012027
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS	F 0	00		
	Complaint #: NJ00	181255, NJ00181471				
	Survey Dates: 12/1	7/2024				
	Census: 101					
	Sample Size: 48					
	COMPLIANCE WIT 42 CFR PART 483,	NOT IN SUBSTANTIAL ITH THE REQUIREMENTS OF SUBPART B, FOR LONG LITIES BASED ON THIS TO BE TO SUBPART ON THIS				
	F689					
	record review, and facility documents of determined that the resident safety by president rooms who non-operational. The stated he received member that a resident the temperature be stated he went to the boilers were not opheat was needed in The notified the operational and supplies the purchased and placed them in non-operational boil 12/10/24. The facility of the state of the s	ions, interviews, medical review of other pertinent on 12/17/2024, it was a facility failed to ensure using portable space heaters in the boilers became the boilers became a call on 12/8/24 from a staff dent was complaining about ing cold in their room. The serational and supplemental in certain areas of the facility.  EU.S. FOIA (b)(6)  That the boilers were not opplemental heat was required. If the portable space heaters the resident's rooms. The two illers were replaced on ty discontinued using the ters on 12/11/2024. There				
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

01/21/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C	
		315451	B. WING _			20/2024
	IDER OR SUPPLIER	ALTHCARE CENTER OF CRANBU	RY I	STREET ADDRESS, CITY, STATE, ZIP CODE 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
terrissus facions pre known impons Rei leve an edu facions page 183	ility on scribed scribed weed that por scribed weed in residents were we see idents were were placed all respond (IJ) situated a placed all respond (IJ) situated in the scribe week in	and there were 10 residents on Section 10 and there were 10 residents on Section 10 and there were 10 residents on Section 10 and Section 10				

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		315451	B. WING			I .	0
	PROVIDER OR SUPPLIER	THCARE CENTER OF CRANBUR		s 6	TREET ADDRESS, CITY, STATE, ZIP CODE 1 MAPLEWOOD AVENUE CRANBURY, NJ 08512	1 <i>211</i>	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 000	facility documents of determined that the resident safety by a heaters in resident not operational. The notified the special to operational and supplies and placed The two non-operationable space heatwere NJ Exec Ordinary on Special and that portable space resident's rooms will Exec Order 26.4bf utilized despite being the space of the space	review of other pertinent on 12/17/2024, it was U.S. FOIA (b)(6) failed to ensure the allowing the use of space rooms while the boilers were	F	000			
	12/17/2024 at 6:06 U.S. FOIA (b)(6) we template that includissue. The IJ began	ppardy was identified on PM and was reported to the ere presented with the IJ ded information about the n on 12/8/2024 and continued when the facility submitted an al Plan.					
	implementation of t onsite revisit. The f Removal Plan, which	e surveyors verified the the removal plan during an acility implemented the ch included education for the not using space heaters in the					

facility; education for all staff on not using the

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM			PLETED			
		315451	B. WING		12/2	20/2024
	PROVIDER OR SUPPLIER	THCARE CENTER OF CRANBUF	,   (	STREET ADDRESS, CITY, STATE, ZIP CODE S1 MAPLEWOOD AVENUE CRANBURY, NJ 08512		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	level D that is not an have been educated in the facility. Audits space heaters not be conducted to ensuring implemented.  Free of Accident Harce of Accident Sets of Accident Harce of Accident Sets of Accidents.  This REQUIREMENT by:  Complaint #: NJ00  Based on observation of Accident Sets of Accident	e facility.  e remained on 12/20/24 as a in IJ based on that facility staff don not using space heaters is that monitor compliance with being used in the facility were e that they are being azards/Supervision/Devices 1)(2)  Its. sure that - resident environment remains hazards as is possible; and aresident receives adequate sistance devices to prevent in IS not met as evidenced 181255, NJ00181471  ons, interviews, medical review of other pertinent on 12/17/2024, it was facility failed to ensure sing portable space heaters in the boilers became	F 689	·	will be ound to	1/22/25
	stated he went to the	ing cold in their room. The left facility and noticed that the erational and supplemental certain areas of the facility.  U.S. FOIA (b)(6)		Resident six was Ty Exec Order 28.461.  2. Address how the facility will ider other residents having the potential affected by the same deficient pract	to be	

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		315451	B. WING			12/2	20/2024
	PROVIDER OR SUPPLIER	THCARE CENTER OF CRANBUR	RY	6	TREET ADDRESS, CITY, STATE, ZIP CODE  1 MAPLEWOOD AVENUE  RANBURY, NJ 08512		
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F 689	operational and sup The state and placed them in non-operational boi 12/10/24. The facility portable space hea were state of a cility on state of a cility of a cility of a cility of a cility; education of the cility; education for space heaters in the cility of a cility; education for space heaters in the cility of a cility; education for space heaters in the cility of a cility; education for space heaters in the cility of a cility; education for space heaters in the cility of a cility; education for space heaters in the cility of a cility; education for space heaters in the cility of a cility; education for space heaters in the cility of a cility; education for space of a cility; education for space heaters in the cility of a cility; education for space of a cility of a cility; education for space of a cility of a cility.	that the boilers were not oplemental heat was required. If the portable space heaters the resident's rooms. The two illers were replaced on ty discontinued using the sters on 12/11/2024. There der 26.4b1 residents in the land there were residents in the land there were was being used in the heaters were being used in the heaters were being used in the heaters were was being a fire hazard. This placed all an Immediate Jeopardy (IJ) opporting was identified on PM and was reported to the ere presented with the IJ ded information about the non 12/8/2024 and continued when the facility submitted an all Plan.  The surveyors verified the the removal plan during an accility implemented the chincluded education for the not using space heaters in the or all staff on not using the	F	689	All residents have the potential to be affected. No residents were identificated.  3. Address what measures will be into place or systemic changes may ensure that the deficient practice werecur:  The Regional Director of Clinical Sceducated the US FOIA (b)(6) and US FOIA (b)(6) on not use space heaters in the facility. This we completed on 12/17/24. After that we completed, The NHA or Maintenand Director began in-servicing staff on using space heaters in the facility. began on 12/17/2024. All facility stain-serviced as of 12/20/24. Newly he staff and agency staff will receive the in-servicing in orientation when the hired prior to working on the floor.  4. Indicate how the facility plans to monitor its performance to make so solutions are lasting:  The NHA will conduct audits to ensist space heaters are not used in the faudits will continue daily for one we then weekly for three weeks, then refor three months. The results will be reviewed in the facility Squality Assurance and Performance Improvement (QAPI) meetings.	ed as  put de to ill not ervices sing as vas ce not This aff were ired ne y are  ure that ure acility. eek, monthly	

heaters not being used in the facility were

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		ATE SURVEY DMPLETED
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	PROVIDER OR SUPPLIER	LTHCARE CENTER OF CRANBU	JRY	STREET ADDRESS, CITY, STATE, ZIF 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512		LIZUIZUZ-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	conducted to ensure implemented.  This deficient practive residents and was A review of the fact (FRE) records reveat approximately 1 Maintenance notifice of the Water Source properly functioning interruption of service contacted, and a resight to inspect both the repairs. Ambier maintained at this spaces. The entire Command was improperly functionally for the properties of the spaces. The entire Command was improperly functionally for the properties of the spaces. The entire Command was improperly functionally for the properties of the spaces. The entire Command was improperly functionally for the properties of the spaces. The entire Command was improperly functionally for the properties of the spaces. The entire Command was improperly for the properties of the spaces. The entire Command was improperly functionally for the properties of the spaces. The entire Command was improperly functionally functional	tice was identified for 48 of 48 evidenced by the following: ility's Facility Reported Event ealed: "On Sunday 12/08/2024 P.M., the Director of ed the Administrator that both be Heat Pump Boilers were not g and has caused an ince for the heating units. The company was immediately expresentative was called on the boilers and begin working or not temperatures were still being time in all resident living and Emergency Chain of mediately notified including the expair company, corporate rompany, corporate rompany corporate rompany and install beginning this time the Nursing laintenance Department are antain temperature check logs and a Fire Watch is in effect with Substitute heat devices were in ed and extra blankets and ang provided to all residents in ecks are ongoing to ensure the of each resident."	n gg	589		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	ALTHCARE CENTER OF CRANBU	RY	STREET ADDRESS, CITY, STATE, ZIP CO 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512		ILOILOL4	
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F 689	Continued From p	•	F 6	89			
	(MDS), an assess Resident #6 had a Status (BIMS) sco indicated the resid	Quarterly Minimum Data Set sment tool dated NJ Exec Order 20.451, a Brief Interview for Mental pre of NJ Exec Order 20.451, which dent's NJ Exec Order 26.451  OS further revealed that the J Exec Order 26.451					
	Listing Report" (C	cility's document titled "Order DLR) revealed that Resident #6 NJ Exec Order 26.4b1					
		ne second-floor unit at 10:25 r observed Resident #6 wearing 5.451 in his/her room.					
	12/17/2024 at 10: he/she remember heater in his/her r weeks ago." Resi	w with the surveyor on 25 A.M., Resident #6 stated red there was a portable space oom approximately a "couple of dent #6 stated the staff removed e heater but was unsure of the as removed.					
	the facility with dia	AR, Resident #4 was admitted to agnoses which included but b: NJ Exec Order 26.4b1					
	NJ Exec Order 26.4b1, Resid	Quarterly MDS dated dent #4 had a BIMS score of or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 689	During an interview 12/17/2024 at 10:2 approximately at the facility did not have down. Resident #4 heater to his/her roheat did not operated days. Resident #4 stated on but he/she was had occurred.  During an interview 12/17/2024 at 10:3 boilers were not op 12/08/2024. She sigiven portable span The US FOIA (DID) state were also provided but they were placeresident's room.  According to the A the facility with diagonal materials.	w with the surveyor on 27 A.M., Resident #4 stated he beginning of the month, the e heat because the boilers went stated staff brought a portable from the heat was not working. If that the Maintenance staffers, once the heat came back unsure of the exact date this with the surveyor on 34 A.M., the U.S. FOIA (b)(6) stated that the perating on the weekend of tated that the residents were ce heaters and extra blankets. If with portable space heaters, ed on the other end of the	F 689			
	NJ Exec Order 26.4b1, Reside	euarterly MDS dated ent #5 had a BIMS score of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	THCARE CENTER OF CRANBUR	RY	STREET ADDRESS, CITY, STATE, ZIP COD 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512		ZUZUZ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	A review of the facil Listing Report" (OL had an order for NJ  During a tour of the A.M., the surveyor of NJ Exec Order 26.4  During an interview 12/17/2024 at 10:38 he/she could not re was not working. Re Maintenance staff to his/her room. Resident #5 left in the room eve be removed. Resident was eventual remember when it was tated that he/she of According to the AF the facility with diag were not limited to.	ity's document titled "Order R) revealed that Resident #5  Exec Order 26.4b1  NJ Exec Order 26.4b1 at 10:38 observed Resident #5 wearing in his/her room.  with the surveyor on A.M., Resident #5 stated member the date, but the heat esident #5 stated the brought a plug-in heater into lent #6 stated he/she told the plug the heater in his/her stated the plug-in heater was in though he/she requested it ent #5 stated the plug-in ally removed but he/she cannot was removed. Resident #5 did not use the plug-in heater.  R, Resident #1 was admitted to moses which included but NJ Exec Order 26.4b1	F 68	39		
	NJ Exec Order 26.4b1, Reside	nt #1 had a BIMS score of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315451	B. WING		1	20/2024
	PROVIDER OR SUPPLIER	LTHCARE CENTER OF CRANBU	RY 6	TREET ADDRESS, CITY, STATE, ZIP CODE  1 MAPLEWOOD AVENUE  CRANBURY, NJ 08512	1212	20/2024
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F 689	During an intervier 12/17/2024 at 10:3 in his/her re NJ Exec Order 26. was not connected which resulted in stroom. Resident #7 remove 12/17/24 at 1:15 F went to the facility he noticed the corchecked the boile temperature was normal temperature degrees. The functioning proper have enough outp The stated that for the resident's register of the supplemental heat heating consoles were providing ap therefore did not resident's stated that he	dicated the resident's with the surveyor on 51 A.M., Resident #1 stated on e received a with the ereceived a with the end on end of the red emergency outlet, shutting off the lights in his/her is stated the with the surveyors on end of the moneyor of the end of th	F 689			
	obtaining quotes t stated that he was heaters were a fire	d to be repaired. He was o have them repaired. The was aware that the portable hazard, but this was an and felt this was the best				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X2) M IDENTIFICATION NUMBER: (X2) M A. BUI		TIPLE CONSTRUCTION ING	CON	(X3) DATE SURVEY COMPLETED C	
		315451	B. WING			/20/2024	
	PROVIDER OR SUPPLIER	LTHCARE CENTER OF CRANBU	RY	STREET ADDRESS, CITY, STATE, ZIP OF 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	option to keep the time.  During an interview 12/17/24 at 2:41 P. was notified on 12/were not working p was aware that it were the portable space concern. The state of the best interesting was an emergence was the best interesting was an emergence was the best interesting was the best interesting at the evacuation if the property of the facility observed multiple property of the facility that a methods of fire precondition (s) that contained the prevention is the residents, visitors, hazard, or other contained the property of the facility that a methods of fire precondition (s) that contained the prevention is the residents, visitors, hazard, or other contained the prevention is the residents, visitors, hazard, or other contained the prevention is the residents of the facility that a methods of fire precondition (s) that contained the prevention is the residents, visitors, hazard, or other contained the prevention is the residents of the facility that a methods of fire precondition is the residents, visitors, hazard, or other contained the prevention is the residents of the facility that a methods of fire precondition is the residents of the facility that a methods of fire precondition is the residents.	residents comfortable at the with the surveyors on .M., the stated that he 8/24 by the stated that the boilers properly. The stated he was against regulations to use heaters because it was a fire stated it was not acceptable ations regarding space heaters to fithe residents. He stated ent situation and that his focus est of the resident's health and the residents comfortable. The ne would have considered roblem with the boilers and no ent problem.  Physical Therapy aquatics 24 at 5:11 P.M., the surveyor portable space heater boxes. That there were 46 boxes		89			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		E SURVEY IPLETED
		315451	B. WING			C <b>20/2024</b>
	PROVIDER OR SUPPLIER	THCARE CENTER OF CRANBUR	RY	STREET ADDRESS, CITY, STATE, ZIP CODE 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512	1 12/	2012024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	be reported to the corrections shall be	our (24) hours to correct must .S. FOIA (b)(6) outlining what a made, methods of correction, rdous condition is expected to	F 6	39		
F 835 SS=J	Administration CFR(s): 483.70  §483.70 Administra A facility must be acceptable it to use its efficiently to attain of practicable physical well-being of each of this REQUIREMED by: Complaint #: NJ00  Based on observation record review, and facility documents of determined that the resident safety by a heaters in resident not operational. The purchased and placed them in non-operational boin 12/10/24. The facility portable space heat were were NJ Exec Order.	dministered in a manner that resources effectively and or maintain the highest I, mental, and psychosocial resident.  NT is not met as evidenced 181255, NJ00181471  cons, interviews, medical review of other pertinent on 12/17/2024, it was IJS. FOIA (b)(6)  I) failed to ensure the allowing the use of space rooms while the boilers were be IJS FOIA (b)(6)  That the boilers were not opplemental heat was required the portable space heaters the resident's rooms. The two lers were replaced on the ty discontinued using the ters on 12/11/2024. There is 12/11/2024.	F 83	1. Address how corrective action accomplished for those residents have been affected by the deficient practice:  No residents were found to be affected by the same deficient practice by the same deficient practice.  All residents have the potential to affected. No residents were idential to affected. No residents were identically being affected.  3. Address what measures will into place or systemic changes mensure that the deficient practice recur:  The Regional Director of Clinical educated the US FOIA (b)(6)	found to nt rected.  dentify al to be actice: be ified as rece put ade to will not	1/22/25

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F 835	knowledge that pobeing used in residents were cogwas being utilized. This placed all res Jeopardy (IJ) situated. The Immediate Je 12/17/2024 at 6:06 U.S. FOIA (b)(6) U.S. FOIA (b)(6) We template that inclusions and through 12/18/202 acceptable Remove On 12/20/2024, the implementation of onsite revisit. The Removal Plan, who U.S. FOIA (b)(6) on facility; education is space heaters in the The noncompliance level D that is not a have been educated in the facility. Audit space heaters not conducted to ensuring the conducted to ensuring	rtable space heaters were dent's rooms where the gnitively impaired, and oxygen despite being a fire hazard. idents at risk for an Immediate ition.  opardy was identified on one of P.M. and was reported to the Impaired with the IJ ded information about the in on 12/8/2024 and continued 4 when the facility submitted an inval Plan.  e surveyors verified the the removal plan during an facility implemented the included education for the not using space heaters in the for all staff on not using the	F 83	on not using space heaters in This was completed on 12/1  4. Indicate how the facility monitor its performance to not solutions are lasting:  The Regional Director of Clinor designee will conduct audity space heaters are not used. Audits will continue weekly for the nevery other week for the sund then monthly for two more results will be reviewed in the Quality Assurance and Perform Improvement (QAPI) meeting.	plans to make sure that nical Services dits to ensure in the facility. For one week, ree weeks onths. The le facility sormance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	THCARE CENTER OF CRANBU	RY	STREET ADDRESS, CITY, STATE, ZIP CODE 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COI	(X5) MPLETION DATE
F 835	of the Water Source properly functioning interruption of service contracted boiler of contacted, and a resight to inspect bot the repairs. Ambier maintained at this to spaces. The entire Command was immontracted boiler resoffice, DOH (Depart (New Jersey Long replacement boilers scheduled for deliving 12/9/2024. During the Department and Macompleting and man every two hours, are hourly monitoring. Splace where needed comforters are being need. Wellness checomfort and safety  During an interview 12/17/24 at 2:41 P. was notified on 12/2 were not working powas aware that it withe portable space	e Heat Pump Boilers were not g and has caused an ice for the heating units. The ompany was immediately expresentative was called on h boilers and begin working on at temperatures were still being ime in all resident living Emergency Chain of mediately notified including the expair company, corporate the theory of Health), and NJLTCO Term Care Ombudsman). Two is units were ordered and ery and install beginning this time the Nursing aintenance Department are intain temperature check logs and a Fire Watch is in effect with Substitute heat devices were in d and extra blankets and ing provided to all residents in ecks are ongoing to ensure the				
	best interest of the an emergent situati best interest of the and to keep the res stated that he woul	egarding space heaters for the residents. He stated this was ion and that his focus was the resident's health and safety idents comfortable. The description of the hoilers and no heat was a				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  IG	COM	COMPLETED	
		315451	B. WING _		I	20/2024	
	PROVIDER OR SUPPLIER	LTHCARE CENTER OF CRANBU	JRY	STREET ADDRESS, CITY, STATE, ZIP CODE 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512	, .2.20,232.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 835	During a tour of the room on 12/17/202 observed multiple. The confirmed present during the Review of the facil. Plan for Fire Preverevealed under "Proof the facility that a methods of fire precondition (s) that of hazard." Revealed prevention is the residents, visitors, hazard, or other coafire hazard be distinguished by the Maintenance E Hazardous conditions as practical. Any homore that twenty-fibe reported to the corrections shall be and when the hazard be corrected."  A review of the "Ac Description," dated "Major Duties and 1. Plans, develoevaluates and direct facility as well as it accordance with coand regulations.  Ensures deliverage and services.	e Physical Therapy aquatics 24 at 5:11 P.M., the surveyor portable space heater boxes. If that there were 46 boxes tour.  Ity's Emergency Preparedness ention dated 08/19/2024 olicy Statement", "It is the policy all personnel participate in evention and to report any could result in a potential fire I under "Procedure", "fire esponsibility of all personnel, and public alike. Should a fire onditions that could develop into scovered, it shall be reported to Director immediately. Ons must be corrected as soon azardous condition requiring our (24) hours to correct must Administrator outlining what e made, methods of correction, ardous condition is expected to diministrator Job		95			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	СОМ	E SURVEY PLETED	
315451			B. WING _		C <b>12/20/2024</b>		
	PROVIDER OR SUPPLIER	THCARE CENTER OF CRANBUF	RY	STREET ADDRESS, CITY, STATE, ZIP CODE 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 835	competent facility s general cleanliness optimal resident fur psychosocially. 3. Follows approp	taff, employee turnover, , physical plant condition, and nctioning-physically and riate safety and hygiene es to protect residents and	F 83				

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New Jersey Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		061211	B. WING		12/20/2024	
	PROVIDER OR SUPPLIER  IS REHAB AND HEAL	THCARE CENTE 61 MAP	ADDRESS, CITY, Lewood Ave Ury, NJ 0854			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE	
S 000	Initial Comments		S 000			
S 560	standards in the Ne 8:39, standards for Facilities. The facili Correction, includin deficiency and ensuimplemented. Failu result in enforceme the provisions of the Code, Title 8, chapt licensure regulation 8:39-5.1(a) Mandat	re to correct deficiencies may nt action in accordance with e New Jersey Administrative ter 43E, enforcement of as.	S 560		1/22/25	
		NT is not met as evidenced		. No residents were identified to be affected by this deficient practice.		
	documents on 12/1 the facility failed to met for 7 of 14 day	s and review of facility 7/2024, it was determined that ensure staffing ratios were shifts reviewed. This deficien tential to affect all residents.		Identify those individuals who could affected by the deficient practice: All residents have the potential to be affected by this deficient practice.		
	(NJDOH) memo, da with N.J.S.A. (New 30:13-18, new mini nursing homes," ind	ersey Department of Health ated 01/28/2021, "Compliance Jersey Statutes Annotated) mum staffing requirements fo dicated the New Jersey to law P.L. 2020 c 112,		What corrective action will be accomplished for those residents a by the deficient practice: The Administrator, Director of Nurs and Staffing Coordinator were ree on the minimum staffing requirement. The facility has contracted with mustaffing agencies to supplement the	ing, ducated ents. Itiple	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 01/21/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OI CORRECTION	IDENTIFICATION NOMB	LK.	A. BUILDING:	LDING:		LILD
		061211		B. WING		12/2	; 0/2024
NAME OF I	PROVIDER OR SUPPLIER	S	TREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
THE ELN	IS REHAB AND HEAL	THCARE CENTE		WOOD AVE RY, NJ 0851			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 560	Continued From pa	ige 1		S 560			
3 300	codified as N.J.S.A established minimu nursing homes. The effective on 02/01/2 One Certified Nurse residents for the damember to every 10 shift, provided that shall be CNAs and be signed into work shall perform nurse care staff member in night shift, provided member shall sign in perform CNA duties. For the two weeks 0 12/01/2024 to 12/14 deficient in CNA staday shifts as follows.	. 30:13-18 (the Act), whom staffing requirements of following ratio (s) were 2021:  The Aide (CNA) to every expensive shift. One direct care to residents for the even no fewer of all staff ments as a certified nurse aid of each direct staff members as a certified nurse aid of each direct care so to every 14 residents for that each direct care so in to work as a CNA and so considered to survey 14/2024, the facility was affing for residents on 7	es in esight staff ning mbers per shall de and direct or the staff d	3 900	for the missing shifts in an effort to the staffing ratios.  Measures or systemic changes to that the deficiencies will not recur:  "The administrator/designee w participate in a weekly call for 3 m with a recruitment team to review positions and recruitment tactics to improve hiring outcomes to meet to required staffing ratio.  "The Administrator/designee w the staffing sheets daily to ensure compliance with the staffing ratios.  "The administrator/designee w the minutes from resident council determine whether any concerns regarding care and services are idmonthly for three months and ther quarterly.  "Results of audit will be review Monthly Quality Assurance Meetin Quarterly over the duration of the process.	ensure iill onths open o the iill review to lentified o ed at the g and	
	CNAs. On 12/02/24, the fa residents on the da CNAs.	cility had 10 CNAs for 1 y shift, required at least	103 t 13				
	residents on the da CNAs. On 12/07/24, the fa	cility had 12 CNAs for a y shift, required at least cility had 12 CNAs for a y shift, required at least	t 13 106				
	residents on the da CNAs. On 12/09/24, the fa	icility had 12 CNAs for for shift, required at least cility had 12 CNAs for for shift, required at least	t 13 106				

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	:			
061211		B. WING			C <b>12/20/2024</b>		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE ELM	IS REHAB AND HEAL	THCARE CENTE	LEWOOD AVE URY, NJ 0851				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
S 560	Continued From pa	ige 2	S 560				
S 560	CNAs. On 12/14/24, the fa	icility had 12 CNAs for 101 y shift, required at least 13	S 560				
ı							

		POST-C	ERIII	FICATION	N REVISIT F	REPORT		
	R / SUPPLIER		ISTRUCTIO	N			DATE (	OF REVISIT
315451	CATION NUMBI	ER A. Building Y1 B. Wing					Y2 2/4/202	25 <sub>Y3</sub>
NAME OF	FACILITY	•			STREET ADDRESS, C	CITY, STATE, ZIP CO	DE	
THE ELN	AS REHAB AN	ID HEALTHCARE CENT	ER OF CR	RANBURY	61 MAPLEWOOD AVE			
					CRANBURY, NJ 08512	2		
program, corrected provision	, to show those d and the date	ed by a qualified State su e deficiencies previously such corrective action v the identification prefix o	reported o	on the CMS-256 plished. Each d	7, Statement of Defici leficiency should be fu	encies and Plan of ally identified using	Correction, that either the regula	t have been ation or LSC
ITEI	М	DATE	ITEM		DATE	ITEM		DATE
Y4		<b>Y</b> 5	Y4		Y5	Y4		<b>Y</b> 5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.25(d)(1)(2)	Completed	Reg. #	483.70	Completed	Reg. #		Completed
LSC		01/22/2025	LSC		01/22/2025	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		_
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Reg. # Completed		Reg. #		Completed	Reg. #		Completed	
LSC			LSC			LSC		-
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE	SIGNATU	JRE OF SURVEYOR		DATE	
REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/20/2024			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO					

#### STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building 2/4/2025 B. Wing 061211 **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 61 MAPLEWOOD AVENUE THE ELMS REHAB AND HEALTHCARE CENTER OF CRANBURY CRANBURY, NJ 08512 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE **Y4 Y5** Y4 Y5 Y4 Y5 ID Prefix S0560 **ID Prefix ID Prefix** Correction Correction Correction 8:39-5.1(a) Reg. # Completed Reg. # Completed Reg. # Completed LSC 01/22/2025 LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction 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 **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) DATE TITLE DATE REVIEWED BY **REVIEWED BY** CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

Page 1 of 1 EVENT ID:

YES NO

0X7I12

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

12/20/2024