STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315451	A. BUILDING ______ B. WING ______	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELMS REHAB AND HEALTHCARE CENTER OF CRANBURY	**61 MAPLEWOOD AVENUE CRANBURY, NJ 08512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ #159517, #161104, #161105, #161107, #163603, #166090, #166352, #166620, #167003, #168446 Survey Date: 3/7/24 Census: 89 Sample: 22 + 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		4/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/18/2024

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 609	Continued From page 1 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint NJ #161104 Based on record review, interviews and other facility documentation, it was determined that the facility failed to notify the Board of Nursing (BON) (evaluates license applications, issues licenses, renews licenses, and takes disciplinary action in response to professional misconduct) for a Licensed Practical Nurse/Supervisor (LPN/S #1) who was under investigation for misappropriation of Residents' [NJ Exec Order 26] medication. This deficient practice was identified for one of one investigation reviewed. This deficient practice was evidenced by the following: On 02/21/24 at 2:40 pm, the Director of Nursing (DON #1) provided the survey team with a file for an investigation dated [NJ Exec Order 26.4b]. A review of the file revealed a "Reportable event [Resident's name redacted] [NJ Exec Order 26.4b] Summary and	F 609	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No Residents were affected. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents had the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 100% of the staff were in-serviced on F609 reporting guidelines. The Administrator will review all incidents to make sure those that require reporting under the guidelines of F609 are reported accordingly.	

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F 609	Continued From page 2 Conclusion": On NJ Exec Order 26.4b, the nurse assigned to [name redacted] went to administer his/her NJ Exec Order 26.4b1 around 9am. The nurse went to the declining inventory form (a record used to keep accurate count of controlled substances) for [name reacted] NJ Exec Order 26.4b1 The nurse observed three signatures timed 10a, 12p, and 2:20 p for NJ Exec Order 26.4b This nurse was also the nurse that worked this assignment on NJ Exec Order 26.4b 7a-3p. The three signatures were not her signature. The nursing supervisor (LPN/S #2) notified the Director of Nursing (DON #2) and the U.S. FOIA (b) (6) The signatures could not be identified." Further review of the investigation identified 2 other residents that had unidentified signatures on their declinining inventory sheets. "Based upon the investigation and review of statements, the supervisor (LPN/S #1) who worked 3p-11p on NJ Exec Order 26.4b was the only nurse that had access to all three residents that had unidentifiable signatures on their declining inventory sheets ...She was suspended pending investigation." Further review revealed that "on NJ Exec Order 26.4b, the U.S. FOIA (b) (6)) reached out to the supervisor (LPN/S #1) to come in and meet with administration." A meeting was scheduled for NJ Exec Orde. "The supervisor (LPN/S #1) did not show up for the meeting. The U.S. FOIA called her, but she did not answer." Further review of the investigation file revealed a certified letter dated NJ Exec Order 26 sent to the LPN/S #1, "On Tuesday NJ Exec Order 26.4b at 1:30 pm you had a meeting scheduled at this facility with [name redacted] U.S. FOIA and me to discuss the outcome of an investigation. Since you did not attend this meeting, we are considering this a voluntary resignation." This letter was signed by the U.S. FOIA (b	F 609	4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Administrator will conduct the audits weekly times four (4) weeks, then biweekly times four (4) weeks, then monthly times three (3) months. Any areas of concern identified will be addressed by the Administrator. The findings of the audits will be presented at the Quality Assurance Performance Improvement (QAPI) meetings x three (3) meetings or until a timeframe determined by the QAPI members.	

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F 609	Continued From page 3	F 609		

Additional review of the investigation file revealed that the police and the DEA (Drug Enforcement Administration) were notified. It did not reveal evidence that the Board of Nursing had been notified.

On 02/22/24 at 8:45 AM, in the presence of the survey team, the U.S. FOIA (b) (6) confirmed that the facility did not report the U.S. FOIA (b) to the Board of Nursing because they did not have NJ Exec Order 26.4b1 , but she (the U.S. FOIA (b)) was the only one who had access to all of the carts (medication carts). She then stated that the DEA and the police were notified.

On 02/22/24 at 10:48 AM, the U.S. FOIA (b) , the U.S. FOIA (b) (6)), DON#1 and the U.S. FOIA (b) (6)) met with the survey team to review the above-mentioned investigation. The U.S. FOIA (b) (6 who confirmed at the time of the incident she was the DON #2, acknowledged that the investigation was completed and reported to the Department of Health, the police, and the DEA. She stated that "it is fair to say yes we believe that [name redacted] (the LPN/S #1) was the common denominator, she had access to all the carts" but "I did not send a report to the BON." The U.S. FOIA (b) stated that the purpose of reporting to the BON was "so that they are aware of a situation, something that that nurse did, so they could investigate it." The administrative team all acknowledged that the incident should have been reported.

On 02/23/224 at 10:22 AM, the U.S. FOIA provided the survey team with the incident report, dated

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NJ Exec Order 26.4b at 12:00 PM. Review of the report, revealed "Agencies/People Notified: State Agency (DEA), Office of Ombudsman, Department of Health, and Physician."

On NJ Exec Order 26 at 1:50 PM the U.S. FOIA (b) provided the survey team with copy of a report that the above incident was submitted to the BON, dated NJ Exec Order 26

A review of the facility's policy "Incident and Accidents" revised 7/17/23, revealed: Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Definitions: An "incident" is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member. Policy Explanation: The purpose of incident reporting can include Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements; Meeting regulatory requirements for analysis and reporting incidents and accidents. Compliance Guidelines: 4. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the facility's abuse policy. 8. The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events.

A review of the facility's policy "Abuse, Neglect and Exploitation" revised 7/2023, revealed: VII. Reporting/Response: A. the facility will have written procedures that include: 1. Reporting of all

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F 609	Continued From page 5 alleged violations to the Administrator, state agency, ...all other required agencies. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. A review of the facility's policy " Controlled Substance Administration & Accountability" revised 5/20/23, revealed Policy: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. 9. Discrepancy Resolution: e. Any discrepancies which cannot be resolved must be reported immediately as follows: iii. The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities. NJAC 8:39-13.4(c)(2)(v)	F 609		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		4/15/24

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F 640	Continued From page 6 (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents it was	F 640	1. Address how corrective action will be accomplished for those residents found to	

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determined that the facility failed to complete and submit a Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with the federal guidelines of the MDS 3.0 Resident Assessment Instrument (RAI) for 1(Resident #33) of 1 resident reviewed for hospitalizations.

This deficient practice was evidenced by the following:

On 02/14/24 at 11:30 AM, the surveyor observed Resident #33 in his/her room lying in bed. Resident #33 was NJ Exec O and NJ Exec Order 26.4b1, the resident was NJ Exec Order 26.4b1 The surveyor interviewed Resident #33, in reference to his/her hospitalizations. Resident #33 stated that he/she was admitted to NJ Exec Order 26.4b1 however he/she was NJ Exec Order 26.4b1 or NJ Exec O he/she was admitted and readmitted from the hospital since admission to the facility.

The surveyor reviewed the medical record of Resident #33.

Review of the Admission Record (an admission summary) reflected that Resident #33 was admitted to the facility with diagnoses which included but are not limited to: NJ Exec Order 26.4b1

F 640

have been affected by the deficient practice
Resident 33 was not affected. The MDS Coordinator completed the entry and discharge for R 33 on NJ Exec Order 26.4b1.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents had potential to be affected.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
The US FOIA (b)(6) was in-serviced by the Regional Director of Nursing on MDS completion guidelines on 3/18/24. The NHA/designee will conduct audits on MDS completion guidelines.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting
The NHA/designee will conduct audits on MDS completion. The audits will be conducted on three random residents weekly times four (4) weeks, then biweekly times four (4) weeks, then monthly times three (3) months. The findings of the audits will be presented at the Quality Assurance Performance Improvement (QAPI) meetings x three (3) meetings or until a timeframe determined by the QAPI members.

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A review of the electronic medical record (EMR) under the section titled census, revealed that Resident #33 was admitted to the hospital on NJ Exec Order 26.4b, readmitted to the facility on NJ Exec Order 26.4 and sent back to the hospital again on NJ Exec Order 26.4.

A review of the MDS tracking records (a record which documented the resident's entry and discharge into and out of the facility) which revealed the following: NJ Exec Order 26.4b1 (Discharge Return Anticipated); NJ Exec Order 26.4b1 (Entry); NJ Exec Order 26.4b1 (Discharge Return Anticipated) and NJ Exec Order 26.4b1 (Entry).

A review of the EMR progress notes revealed the following:

"NJ Exec Order 26.4b1 14:2 Nursing Note Text: patient arrived from NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 noted VS (vital signs) NJ Exec Order 2 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 , U.S. FO notified, NJ Exec Order 26.4b1 treatment given, continue to monitor, call bell within reach."

"NJ Exec Order 26.4b1 17:04 Nursing Note Text: oncoming nurse rounded on resident noticed he was in NJ Exec Order 26.4b1, reported to U.S. FOIA (b) (6), upon arrival to room resident noted to be NJ Exec O, NJ Exec Order 26.4b1, VS NJ Exec Order 26 NJ Exec Order 26.4 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, U.S. FO contacted order to send back to NJ Exec O for evaluation."

"NJ Exec Order 26.4b1 08:37 Nursing Note Text: Resident was admitted to NJ Exec O with dx (diagnosis): NJ Exec Order 2"

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On 02/20/24 at 10:16 AM, the surveyor interviewed the U.S. FOIA (b) (6), who explained to the surveyor that she was informed of the facility admissions and discharges through morning meetings, utilization review meetings (review of subacute resident's discharge status), emails, and the discharge calendar. She stated that she completed the entry tracking and discharge records the day the resident was admitted, re-admitted, or discharged if she was in the building or the next day. She further stated that if there was an admission, re-admission, or discharge on the weekend, that she completed the tracking assessment on Monday.

The U.S. FOIA (b) (6) reviewed Resident #33's MDS tracking record in the presence of the surveyor. The U.S. FOIA (b) (6) acknowledged that she did not see the entry and discharge tracking record for the date of NJ Exec Order 26.4. She stated, "I will look into why the entry and discharge tracking were not completed for NJ Exec Order 26.4b1

On 02/20/24 at 11:08 AM, the U.S. FOIA (b) (6) acknowledged that the above mentioned MDS records were not completed for NJ Exec Order 26.4. She informed the surveyor that she completed and submitted the MDS entry/discharge tracking record after surveyor inquiry.

A review of the facility policy titled "MDS 3.0 Completion," date reviewed/revised 9/18/23 included the following: "a. Entry Tracking i. Complete and submit with every entry into the facility no later than entry date + 7 calendar days." "F. Discharge Assessment-completed using the discharge date as the Assessment Reference

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F 640	Continued From page 10 Date (ARD). Must be completed within 14 days of the discharge date/ARD." NJAC 8:39-11.2 (3)(i)	F 640		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 ensure the medication error rates were not 5% or greater. During the morning medication administration observation on 2/20/24, the surveyor observed two (2) nurses administer medications to four (4) residents. There were 37 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 5.41%. This deficient practice was identified for one (1) of four (4) residents, Resident# 83, that was administered medications by one (1) of the two (2) nurses that were observed. The deficient practice was evidenced by the following: On 2/20/2024 from 9:23 AM to 9:40 AM, during the medication administration, the surveyor observed the U.S. FOIA (b) (6)) prepare and administer medications to Resident # 83 which included:	F 759	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident 83 was not affected. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents had potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Licensed nurse education was completed by the Director of Nursing on the facility□s Administering Medications and Treatments policy. The policy was reviewed with all facility licensed nurse staff. New licensed nurse hires will continue be educated during their new-hire orientation.	4/15/24

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THE ELMS REHAB AND HEALTHCARE CENTER OF CRANBURY	61 MAPLEWOOD AVENUE CRANBURY, NJ 08512

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F 759	Continued From page 11 (i) NJ Exec Order 26.4b1 oral capsule NJ Exec NJ Exec Order 26.4b1 (ii) NJ Exec Order 26.4b1 oral tablet NJ Exec Order 26.4b1 The surveyor asked the U.S. FOIA if the resident had breakfast and the U.S. FOIA stated, "the resident has not eaten yet." The U.S. FOIA opened up resident's room door to show the surveyor that his/her breakfast tray was on the tray table, which was positioned away from the resident's bed and further stated, "the resident is waiting for [his/her] NJ Exec O to bring [him/her] breakfast from home." At 10:00 AM, the surveyor reviewed Resident #83's Electronic Medication Administration Records (eMARs), which included special directions for these medications: (i) NJ Exec Order 26.4b1 capsule by mouth two times a day for NJ Exec Order 26.4b1 (ii) NJ Exec Order 26.4b1 - Give 2 tablet by mouth two times a day NJ Exec Order 26.4b1 . Please ensure given 12 hrs. (hours) apart and with food in the stomach and also with food. At 1:25 PM, the surveyor asked the U.S. FOIA when the resident ate last and the U.S. FOIA stated, "the resident had food last night." At that time the surveyor requested the U.S. FOIA to review the eMARs and read the directions for the above medications, "Give with meals" and "Please ensure given 12 hrs. apart and with food in the stomach and also with food." After reviewing the	F 759	4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting The Director of Nursing (D.O.N.) or a designated nurse will complete random medication pass audits on a licensed nurse weekly times four (4) weeks, then biweekly times four (4) weeks, then monthly times three (3) months. The findings of the audits will be presented at the Quality Assurance Performance Improvement (QAPI) meetings x three (3) meetings or until a timeframe determined by the QAPI members.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315451	A. BUILDING ______ B. WING ______	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELMS REHAB AND HEALTHCARE CENTER OF CRANBURY	61 MAPLEWOOD AVENUE CRANBURY, NJ 08512

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F 759	Continued From page 12	F 759		

directions, the U.S. FOIA stated, "I should've HOLD the medications."

A review of facility's policy, "Medication Administration," revised on 5/30/23, included the following:
"14. Administration medication as ordered in accordance with manufacturer specifications.
a. Provide appropriate amount of food and fluids."

A review of an undated policy titled "PharmACCURATE Medication Pass," which was provided by the U.S. FOIA (b) (6) on 2/23/24, included the following instructions under the subsection titles, "Medication Timing":

-"Medication ordered with food may be administered up to 15 minutes after a meal or given with 4 ounces of milk and 2 graham crackers (or similar items)."

-"Applesauce is not food."

-"Medication ordered with meals should be given with the meal (i.e., Metoprolol)."

-"Milk and crackers do not constitute a meal."

N.J.A.C 8:39-29.2 (d)

New Jersey Department of Health

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	061211	A. BUILDING: ______ B. WING ______	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELMS REHAB AND HEALTHCARE CENTER OF C	**61 MAPLEWOOD AVENUE CRANBURY, NJ 08512**

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to a). notify the Clearing House Coordinator of a Licensed Practical Nurse/Supervisor (LPN/S) who had resigned her position while under investigation for drug diversion as mandated by the State of New Jersey. This deficient practice was identified for one of one investigation reviewed and b). accurately post staffing information to include the staff-to-resident ratio on the resident care staffing report for Registered Nurses (RN), LPNs, and Certified Nurses Aides(CNA) who provide direct resident care. This deficient practice was evidenced by the following:	S 560	F560 Mandatory Access to Care CFR(s): 8:39-5.1(a) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: There were no care issues reported on the shifts that were identified. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents had potential to be affected. The Nursing Home Administrator /designee reviewed the last 30 days of the CNA staffing report. The interdisciplinary team reviewed grievance logs and care	4/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 03/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELMS REHAB AND HEALTHCARE CENTER OF C	**61 MAPLEWOOD AVENUE CRANBURY, NJ 08512**

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S 560	Continued From page 1 1. Reference: New Jersey Administrative Code Title 13 Law and Public Safety Chapter 45E Health Care Professional Reporting Responsibility. Subchapter 3: 13:45E-3.1 Notification to the Clearing House Coordinator by a Health Care Entity a) Except as provided in (c) below, a health care entity shall file a report with the Clearing House Coordinator concerning a health care professional who is employed by, under contract to render professional services to, has clinical privileges granted by that health care entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry if: 1) For reasons relating to health care professional's impairment, incompetency or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety, the health care entity; i) Summarily or temporarily revokes or suspends or permanently reduces, suspends or revokes the health care professional's full or partial clinical privileges or practice; ii) Removes the health care professional from the list of eligible employees of health services firm or staffing registry; iii) Discharges the health care professional from the staff of the health care entity; or iv) Terminates or rescinds a contract with the health care professional to render professional services;	S 560	conference meetings and no care issues were identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Administrator in-serviced the Staffing Coordinator regarding the requirement for S560 to ensure C.N.A. staffing needs are reviewed daily and addressed as needed to meet the staffing requirement and logged on the correct form. Recruitment efforts are in place to assist the facility in recruiting. CNAs receive sign on bonuses, referral bonuses, reimbursement for C.N.A. tuition, and transportation service from certain locations. Facility also has contracts with agencies to recruit C.N.As. Director of Nursing/designee also reviews staff attendance records to ensure that excessive absences are addressed accordingly. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting Administrator/designee will have weekly meetings with the staffing coordinator to review staffing schedules, needs, and the efficacy of the systems in place to fill needs. The NHA/designee will audit the staffing form weekly times four (4) weeks, then biweekly times four (4) weeks, then monthly times three (3) months. The findings of the audits will be presented at the Quality Assurance Performance Improvement (QAPI) meetings x three (3) meetings or until a timeframe determined by the QAPI members. The findings of the	

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S 560	Continued From page 2 On 02/21/24 at 2:40 pm, the Director of Nursing (DON #1) provided the survey team with a file for an investigation dated NJ Ex Order 26.4b1. Review of the file revealed "Reportable event [Resident's name redacted] NJ Ex Order 26.4b1; Summary and Conclusion"... "Based upon the investigation and review of statements, the supervisor (LPN/S) who worked 3p-11p NJ Ex Order 26.4b1 was the only nurse that had access to all three residents that had unidentifiable signatures on their declining inventory sheets (a record used to keep accurate count of controlled substances) ...She (LPN/S) was suspended pending investigation." Further review revealed that "on NJ Ex Order 26.4b1 the Human Resource Director (HRD) reached out to the supervisor (LPN/S) to come in and meet with administration." A meeting was scheduled for NJ Ex Order 26. "The supervisor (LPN/S) did not show up for the meeting. The HRD called her, but she did not answer." Additional review of the investigation file revealed a certified letter dated NJ Ex Order 26.4 sent to the LPN/S, revealed: "On Tuesday NJ Ex Order 26.4b1 at 1:30 pm you had a meeting scheduled at this facility with [name redacted] DON and me to discuss the outcome of an investigation. NJ Ex Order 26.4b1 ." This letter was signed by the HRD. On 02/22/24 at 8:45 AM, in the presence of the survey team, the Regional Director of Clinical Services (RDCS) stated they (the facility) did not have NJ Ex Order 26.4b1 that she (LPN/S) NJ Ex Order 26.4b but she was the only one who had access to all of the carts (medication carts). The RDCS confirmed that the facility did notify the DEA (Drug Enforcement Administration) and the	S 560	audits will be presented during at the monthly Quality Assurance Performance Improvement (QAPI) meetings.	

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police.

On 02/22/24 at 10:48 AM, the Regional Director of Clinical Services (RDCS), the Regional Director of Operations (RDO), DON #1 and the Licensed Nursing Home Administrator (LNHA) met with the survey team to review the above-mentioned investigation. The RDCS, who confirmed at the time of the incident she was the DON #2, confirmed that the investigation was completed and reported to the Department of Health, the police, and the DEA. She stated that "it is fair to say yes we believe that [name redacted] (the LPN/S) was NJ Ex Order 26.4b1 to all the carts." The surveyor asked the administrative team if they were familiar with the Healthcare act, they all acknowledged that they were. When the surveyor asked if the purpose of the Healthcare act was to avoid staff going facility to facility or hospital to hospital? The administrative team all acknowledge "yes."

On 02/23/24 at 10:22 AM, DON #1 provided the surveyor with the incident report for the above mentioned incident, dated NJ Ex Order 26.4b1 at 12:00 PM. A review of the report revealed "Agencies/People Notified: State Agency (DEA), Office of Ombudsman, Department of Health, and Physician."

On 02/23/24 at 12:55 PM during exit conference with the survey team, the LNHA, DON #1, and the RDCS, the RDO confirmed that the administrative team did not have any additional information to present.

A review of the facility's policy "Controlled Substance Administration & Accountability" revised 5/20/23, revealed Policy: It is the policy of

New Jersey Department of Health

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this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. 9. Discrepancy Resolution: e. Any discrepancies which cannot be resolved must be reported immediately as follows: iii. The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities.
2. On 02/14/24 at 12:22 PM, the surveyor observed the resident care staffing report information posted on the first floor in the facility lobby alongside an administrative office in a picture frame on the wall. The Resident Care Staffing Report was posted as follows:

02/14/2024
Shift Hours: 07:00AM-03:00PM
Current Resident Census:89

Staff Category	#of Staff	Start and End Times
Registered Nurse (RN)	2	7:00AM-3:00PM
Licensed Practical Nurse (LPN)	8	7:00AM-3:00PM
Certified Nurse's Aide (CNA)	10	7:00AM-3:00PM

Shift Hours: 03:00AM-11:00PM Current Resident Census:89

Staff Category	#of Staff	Start and End Times
Registered Nurse (RN)	0	3:00AM-11:00PM
Licensed Practical Nurse (LPN)	5	3:00AM-11:00PM
Certified Nurse's Aide (CNA)	10	3:00AM-11:00PM

Shift Hours: 11:00PM-07:00PM Current

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S 560	Continued From page 5 Resident Census:89 Staff Category #of Staff Start and End Times Registered Nurse (RN) 0 11:00PM-7:00AM Licensed Practical Nurse (LPN) 5 11:00PM-7:00AM Certified Nurse's Aide (CNA) 7 11:00PM-7:00AM On 02/15/24 at 09:00AM, the surveyor observed the Resident Care Staffing Report information posted on the first floor in the facility lobby area alongside an administrative office in a picture frame on the wall. The Resident Care Staffing Report was posted as follows: 02/15/2024 Shift Hours: 07:00AM-03:00PM Current Resident Census:89 Staff Category #of Staff Start and End Times Registered Nurse (RN) 2 7:00AM-3:00PM Licensed Practical Nurse (LPN) 8 7:00AM-3:00PM Certified Nurse's Aide (CNA) 11 7:00AM-3:00PM Shift Hours: 03:00AM-11:00PM Current Resident Census:89 Staff Category #of Staff Start and End Times Registered Nurse (RN) 0 3:00AM-11:00PM Licensed Practical Nurse (LPN) 5 3:00AM-11:00PM Certified Nurse's Aide (CNA) 10 3:00AM-11:00PM	S 560		

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S 560	Continued From page 6	S 560		

Shift Hours: 11:00PM-07:00PM Current Resident Census:89
Staff Category #of Staff Start and End Times
Registered Nurse (RN) 0 11:00PM-7:00AM
Licensed Practical Nurse (LPN) 5 11:00PM-7:00AM
Certified Nurse's Aide (CNA) 7 11:00PM-7:00AM

On 02/16/24 at 09:00AM, the surveyor observed the Resident Care Staffing Report information posted on the first floor in the facility lobby area alongside an administrative office in a picture frame on the wall. The Resident Care Staffing Report was posted as follows:

02/16/2024

Shift Hours: 07:00AM-03:00PM Current Resident Census:90
Staff Category #of Staff Start and End Times
Registered Nurse (RN) 2 7:00AM-3:00PM
Licensed Practical Nurse (LPN) 8 7:00AM-3:00PM
Certified Nurse's Aide (CNA) 10 7:00AM-3:00PM

Shift Hours: 03:00AM-11:00PM Current Resident Census:90
Staff Category #of Staff Start and End Times
Registered Nurse (RN) 1 3:00AM-11:00PM
Licensed Practical Nurse (LPN) 5 3:00AM-11:00PM
Certified Nurse's Aide (CNA) 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 7	S 560		

3:00AM-11:00PM

Shift Hours: 11:00PM-07:00PM Current Resident Census:90
Staff Category #of Staff Start and End Times
Registered Nurse (RN) 0 11:00PM-7:00AM
Licensed Practical Nurse (LPN) 4 11:00PM-7:00AM
Certified Nurse's Aide (CNA) 6 11:00PM-7:00AM

On 02/22/24 at 12:58 PM, the surveyor interviewed the staffing coordinator in the presence of the regional human resource director. He explained to the surveyor that he was responsible for completing the resident staffing care report. He stated that the information that should be included in the resident staffing care report was the census, date, and the hours of the registered nurse's (RN), licensed practical nurses (LPN), and Certified Nurse Aide's (CNA). He further explained that he followed the state regulations to staff the building. He stated that the state ratio was (day shift 1:8; 3-11 shift 1:10; and 11-7 shift 1:14). The surveyor inquired if the staff ratio should be included in the resident staffing care report and he stated, "yes."

Review of the facility policy titled "Nurse Staffing Posting Information," which was reviewed/revised on 9/6/23, included the following guidelines: "(1.) The Nurse Staffing Sheet (Resident Care Staffing Report) will be posted on a daily basis and will contain the following information: (a.) Facility name, (b.) The current date, (c.) Facility's current resident census, (d.) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly

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S 560	Continued From page 8 responsible for the resident care per shift: (i.) Registered, (ii.) Licensed Practical Nurses/Licensed Vocational Nurses, (iii.) Certified Nurse's Aides." The policy did not include posting for staff to resident ratios.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315451	A. Building B. Wing	5/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELMS REHAB AND HEALTHCARE CENTER OF CRANBURY	61 MAPLEWOOD AVENUE CRANBURY, NJ 08512

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 04/30/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/7/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315451	A. Building B. Wing	5/1/2024

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 04/30/2024	ID Prefix F0640 Reg. # 483.20(f)(1)-(4) LSC	Correction Completed 04/15/2024	ID Prefix F0759 Reg. # 483.45(f)(1) LSC	Correction Completed 04/15/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/7/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT Y3
061211		5/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELMS REHAB AND HEALTHCARE CENTER OF CRANBURY	61 MAPLEWOOD AVENUE 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/15/2024	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/7/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061211 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELMS REHAB AND HEALTHCARE CENTER OF CRANBURY	61 MAPLEWOOD AVENUE CRANBURY, NJ 08512

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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 3/7/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315451	A. BUILDING **01** B. WING ___	**03/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELMS REHAB AND HEALTHCARE CENTER OF CRANBURY	**61 MAPLEWOOD AVENUE** **CRANBURY, NJ 08512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by CertiSurv, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/07/2024 and The Elms Rehab and Healthcare Center of Cranbury was found to be in 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 Occupancies. The Elms Rehab and Healthcare Center of Cranbury is a 2-story with a partial basement Type II (111) construction that was built in the 1920s with two additions in 2001 and 2005. The facility has 6 smoke zones.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2024

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.