STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315451	A. BUILDING _____ B. WING _____	C 12/22/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 #: NJ159278, 159279, 159280 Census: 98 Sample Size: 6 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint 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 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	F 609		2/9/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/28/2023

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 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 #: NJ159278, 159279, 159280 Based on interviews and record review, as well as review of pertinent facility documents on 12/20/22, 12/21/22, and 12/22/22 it was determined that the facility failed to report injury of unknown origin to the New Jersey Department of Health (NJDOH) and to follow the facility policy on "Abuse Investigation and Reporting" for 2 of 6 residents (Resident #1 and Resident #3). This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)" form, Resident #1 was admitted to the facility on [redacted], with diagnoses that included but were not limited to [redacted]. The Minimum Data Set (MDS), an assessment tool dated 10/7/22, showed that Resident #1's cognition was [redacted] and required [redacted] from staff in Activities of Daily Living (ADL). The care plan (CP), undated, revealed that Resident #1's cognition wa [redacted] The facility's investigation report (IR) dated 10/17/22 at 10:22 am indicated that the facility investigated an incident involving Resident #1. The IR revealed that Certified Nursing Assistant (CNA #1) saw Resident #1's [redacted],	F 609	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected by the deficient practice. Resident #1 & #2 incidents were reported to NJDOH with the proper paperwork 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents were reviewed to ensure injuries of unknown origin were reported accordingly. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All staff were in-serviced on F609 reporting guidelines. The director of nursing and or administrator will review all reported incidents to make sure those that require reporting under the guidelines of F609 are reported accordingly. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: Audits will be conducted 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	

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F 609	Continued From page 2 EX Order 26 § 4b1 during care and reported to the nurse on duty. The IR further revealed that the NP assessed Resident #1 and ordered an Xray of the EX Order 26 § 4b1 and the Xray result was pending. The IR indicated the Resident was unable to explain what happened and there were no witnesses. On 12/18/22, the IR concluded by the Director of Nursing (DON) that there was no evidence of intentional mishandling. Included in the IR was a written statement from CNA #1 which indicated that she notified the nurse when she observed the EX Order 26 § 4b1 . Also included in the IR was a written statement for Registered Nurse (RN #1) verified she was notified by CNA #1 of the Resident's change in status. The RN indicated the Resident was and unable to express what happened. A Physician's progress note (PPN) dated 10/17/22 at 8:38 am, documented by the NP revealed that Resident #1 was evaluated for the EX Order 26 § 4b1 and other medical problems. The PPN further showed that Resident's was EX Order 26 § 4b, and the Resident was complaining of EX Order 2. Review of the Radiology Results Report (RRR) indicated that on 10/17/22 at 3:38 pm, X-ray was performed to EX Order 26 § 4b1 to ruled The PPN dated 10/18/22 indicated that it was unclear if Resident #1 had and that the result of the X-ray was .	F 609	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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Review of Resident #1's progress note (PN), on 10/17/22 at 5:36 pm, documented by RN #1 reflected the incident on the IR.

The surveyor conducted an interview with CNA #1 on 12/21/22 at 1:53 pm. The CNA confirmed what she wrote on her aforementioned statement. She remembered the Resident was [redacted] on the [redacted], she assisted the Resident to the bathroom. When she removed the Resident's gown, she noticed the Resident's EX Order 26 § 4b1 was bigger than before, and that the Resident was [redacted] of EX Order. CNA #1 further stated that she was unable to explained how it happened and the Resident was unable to tell her what happened to the EX Order 26 § 4b1.

The surveyor conducted an interview with RN #1 on 12/22/22 at 1:53 pm. The RN confirmed what she wrote on her aforementioned statement. RN #1 stated that she immediately reported the incident on 10/17/22 to the Director of Nursing (DON) and did not report it to the NJDOH.

During the post survey telephone interview with the NP on 12/28/22 at 2:08 pm, the NP stated that she received a report from one of the nurses stating that Resident #1's EX Order 26 § 4b1 and [redacted] was EX Order 26 § 4b, Resident #1 was cooperative and was not [redacted] during the assessment, Resident #1 had [redacted] when she/he lifted her/his [redacted] The NP further stated that an Xray was ordered to make sure that there was no [redacted] to Resident's EX Order 26 § 4b1, she was unable to conclude what happened to the EX Order 26 § 4b1 without the Xray result.

The surveyor conducted an interview with the DON on 12/21/22 at 3:51 pm. The DON

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confirmed the incident was not reported to the NJDOH because it was a "known origin" and the CNA was able to explain what happened. The DON further stated that the Resident acquired the injury from [redacted]. The DON confirmed that if a resident was unable to explain, the facility will report to the NJDOH within 2 hours.

2. According to the AR form, Resident #3 was admitted to the facility on [redacted], with diagnoses that included but were not limited to: EX Order 26 § 4b1 [redacted]

The MDS, dated 10/7/22, revealed that Resident #3's cognition was moderately impaired and required extensive assistance from staff in ADL.

The CP, undated, indicated that the Resident was at risk for complications, injury related to EX Order 26 § 4b1 and behaviors. The CP further revealed that Resident #3 had EX Order 26 § 4b1 EX Order 26 § 4b1.

The facility's IR dated 10/24/22 at 11:00 am, revealed that the facility investigated an incident involving Resident #3. The IR indicated that the Hospice CNA (CNA #3) reported a EX Order 26 § 4b1 next to Resident's EX Order 26 § 4b1. The investigation further indicated that Resident #3 was unable to explained what happened and there was no witness to explain how the EX Order 26 § 4b1 next to the Resident's EX Order 2 happened. The IR noted the incident was reported to the NJDOH on 10/27/22 at 1:11 pm which was not according to their policy.

Additionally, the IR included a verbal statement from Licensed Practical Nurse (LPN #1) dated

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10/24/22 signed and documented by the DON. The statement indicated that LPN #1 reported a [redacted] to Resident #3's [redacted]. On 10/24/22 LPN #1 also stated that on 10/21/22 Resident #3 threw his/her breakfast tray on the floor, fluids flew in the air. The Resident was [redacted] where the [redacted] was located.

A PN dated 10/21/22 at 3:23 pm, documented by LPN #1 indicated that CNA #4 (who was passing breakfast tray on 10/21/22) reported that Resident #3 threw breakfast tray on the floor and the Resident was [redacted]. LPN #1 walked into the room and asked Resident #3 what happened, the Resident did not say what happened and asked the LPN to leave the room. The PN had no documented evidence that the Resident was having [redacted] as indicated on the statement by DON on 10/24/22.

The surveyor conducted an interview with the DON on 12/21/22 at 3:51 pm, the DON confirmed the aforementioned IR and verbal statement from LPN on 10/24/22. The DON stated that incident was not reported to the NJDOH because it was a "known origin" and added that LPN #1 was able to explain what happened on 10/21/22. The DON confirmed that if a resident was unable to explain how it happen, the facility will report the occurance to the NJDOH within 2 hours.

During the post survey telephone interview with LPN #1 on 12/27/22 at 1:27 pm. The LPN stated that on 10/21/22 in the morning, when CNA #4 was passing tray, the CNA reported that the Resident became [redacted], threw breakfast tray on the floor and all over the place. LPN #1 further stated that she did not witness that Resident

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threw the tray, when she walked into the room the tray was already on the floor, Resident #3 was calm and had asked the LPN to leave the room. The LPN confirmed what she documented on the PN dated 10/21/22 at 3:23 pm.

During the post survey telephone interview with CNA #4 on 12/27/22 at 2:14 pm. The CNA stated that on 10/21/22, Resident #3 refused breakfast and reported to LPN #1. CNA #4 further added that the Resident was [redacted], however, the Resident did not swing his/her hands and did not hit his/her face.

The surveyor conducted an interview with the Administrator on 12/22/22 at 1:31 pm, who stated that injuries of unknown origin must be investigated according to policy and are to be reported within 2 hours to NJDOH.

The facility's policy titled "Accidents and Incidents - Investigating and Reporting", dated 7/2017 showed "All accidents or incidents involving residents... occurring on our premises shall be investigated and reported to the administrator..."

The facility's policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program", dated 4/2021 showed "... residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restrain not required to treat the residents symptoms...8. identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report

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F 609	Continued From page 7 any allegations within time frames required by federal requirements..." NJAC 8:39-9.4(f)	F 609		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		2/9/23

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F 842	Continued From page 8 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C# NJ100159278, 159280 Based on interviews, medical record review, and	F 842	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 842	Continued From page 9 review of other pertinent facility documents on 12/20/22, 12/21/22, and 12/22/22, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" the Activities of Daily Living (ADL) status and care provided to the resident. In addition, the facility staff failed to follow the facility's policy titled "Guidelines for Charting and Documentation" for 4 of 4 residents (Resident #1, #2, #3, and #4) reviewed for documentation. This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [EX Order 26 § 4b] with diagnosis that included but was not limited to [EX Order 26 § 4b1]. The Minimum Data Set (MDS), an assessment tool, dated 10/7/22, revealed a Brief Interview for Mental Status (BIMS) score of [EX] which indicated that the Resident's cognitive status was [EX Order 26 § 4b1] [redacted]. The MDS also indicated that the Resident required extensive assistance from staff for ADLs. The surveyor reviewed the Documentation Survey Report (DSR), an ADL record documented by the Certified Nursing Assistant (CNA) during their assigned shift for September 2022. The DSR revealed the following: The DSR forms had assigned ADL care tasks which included but were not limited to Bed Mobility, Behavior Symptoms, Dressing, Personal Hygiene, Skin Observation, Toilet Use, Transferring, Turning and Repositioning, and Eating and percentage of amount eaten. Review of Resident #1's ADL record included an	F 842	All residents have the potential to be affected by the deficient practice. The charts of residents #1, #2, #3, and #4 were audited to ensure no negative outcomes occurred from the deficient practice. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents charts were immediately audited for potential omission from the deficient practice 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All certified nursing assistants were in-serviced immediately and on on-going basis (by the director of nursing, regional director of nursing, and nurse supervisors) on the center's procedure for documenting ADL's. Random audits will be conducted by the director of nursing and or administrator / designee to ensure ADLs documentation is completed. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: Audits will be conducted 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 director of nursing and or designee.. 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	

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area for the CNAs to document the Resident's self-performance and support provided by staff. There was no documentation completed for the aforementioned ADL care tasks for the following dates and shifts: Day shifts on 9/1/22, 9/4/22, 9/11/22, 9/18/22, and 9/25/22. Evening shifts on 9/24/22. Night shifts on 9/2/22, 9/12/22, 9/16/22, 9/21/22, 9/26/22, and 9/30/22. Eating and percentage of amount eaten for breakfast and lunch on 9/1/22, 9/4/22, 9/11/22, and 9/25/22. Additionally for breakfast on 9/18/22, and dinner on 9/24/22.

Review of Resident # 1's Progress Notes revealed no documentation of the aforementioned ADL care.

2. According to the AR, Resident #2 was admitted to the facility on 10/12/22 with diagnosis that included but was not limited to [redacted].

The MDS dated 10/19/22, revealed a BIMS score of [redacted] which indicated that the Resident's cognitive status was [redacted]. The MDS also indicated that the Resident required extensive assistance from staff for ADLs.

Review of Resident #2's ADL record in the DSR form for October 2022 revealed the following:

There was no documentation completed for the aforementioned ADL care tasks for the following dates and shifts: Day shifts on 10/25/22 to 10/28/22, and 10/31/22. Evening shifts on 10/14/22, 10/23/22, 10/24/22, 10/26/22, 10/28/22, and 10/31/22. Night shifts on 10/12/22, 10/17/22, 10/20/22, and 10/22/22. Eating and percentage of amount eaten for breakfast and lunch on 10/25/22 to 10/28/22, and 10/31/22. Additionally

members.

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F 842	Continued From page 11 for dinner on 10/3/22, 10/23/22, 10/24/22, 10/26/22, 10/28/22, and 10/31/22. Review of Resident # 2's PN revealed no documentation of the aforementioned ADL care. 3. According to the AR, Resident #3 was admitted to the facility on [redacted] with diagnosis that included but was not limited to [redacted] The MDS dated 9/27/22, revealed a BIMS score of [redacted] which indicated that the Resident's cognitive status was moderately [redacted]. The MDS also indicated that the Resident required extensive assistance from staff for ADLs. Review of Resident #3's ADL record in the DSR form for December 2022 revealed the following: There was no documentation completed for the aforementioned ADL care tasks for the following dates and shifts: Day shifts on 12/4/22, 12/7/22, 12/9/22, 12/13/22, and 12/16/22. Evening shifts on 12/4/22, 12/9/22, and 12/18/22. Night shifts on 12/3/22, 12/5/22, 12/10/22, 12/17/22 and 12/19/22. Eating and percentage of amount eaten for breakfast and lunch on 12/4/22, 12/7/22, 12/9/22, 12/13/22, and 12/16/22. Additionally for dinner on 12/4/22, 12/9/22. Review of Resident # 3's PN revealed no documentation of the aforementioned ADL care. 4. According to the AR, Resident #4 was admitted to the facility on 1/10/18 with diagnosis that included but was not limited to [redacted].	F 842		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315451	A. BUILDING _____ B. WING _____	C 12/22/2022

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 842	Continued From page 12	F 842		

The MDS dated 11/17/22, revealed that BIMS was [redacted] and rarely understood which indicated that the Resident's cognitive status was [redacted]. The MDS also indicated that the Resident required extensive assistance from staff for ADLs.

Review of Resident #4's ADL record in the DSR form for November 2022 revealed the following:

There was no documentation completed for the aforementioned ADL care tasks for the following dates and shifts: Day shifts on 11/13/22 and 11/20/22. Evening shifts on 11/4/22, 11/9/22, 11/13/22, 11/14/22, 11/17/22, 11/20/22, 11/28/22, and 11/29/22. Night shifts on 11/1/22, 11/6/22, 11/7/22, 11/10/22, 11/14/22, 11/16/22, 11/19/22, 11/21/22, and 11/29/22. Eating and percentage of amount eaten for breakfast on 11/13/22 and 11/20/22, and for lunch on 11/4/22, 11/9/22, 11/13/22, 11/14/22, 11/17/22, 11/20/22, 11/28/22, and 11/29/22. Additionally for dinner on 11/1/22, 11/6/22, 11/7/22, 11/10/22, 11/14/22, 11/16/22, 11/19/22, 11/21/22, 11/21/22, and 11/29/22.

Review of Resident # 4's PN revealed no documentation of the aforementioned ADL care.

During an interview with the surveyor on 12/21/22 at 1:53 PM, CNA #1 stated that CNAs are responsible for entering the ADL care provided to residents in the POC kiosk and must be completed by the end of the shift.

During an interview with the surveyor on 12/22/22 at 12:10 PM, CNA #2 stated that CNAs are responsible for documenting the ADL care into the kiosk. She further stated that all tasks must be answered as these reflected the resident's

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	315451	A. BUILDING _____ B. WING _____	C 12/22/2022

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

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F 842	Continued From page 13	F 842		

status and the ADL care provided. She could not explain why there were blanks in the sampled resident's ADL records but stated that they should have been completed.

During a telephone interview with the surveyor on 12 /22/22 at 12:35 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that CNAs are expected to complete the ADL care in the kiosk at the end of their shift. She stated that it was her responsibility to ensure that the tasks are documented timely and accurately, however, she could not explain why there were blanks in the ADL records for the sampled residents.

During a conference with the DON and Administrator on 12/21/22 at 4:00 PM, the DON stated that CNAs are expected to document the ADL care provided to the residents into the kiosk by the end of their shift. The DON could not explain why there were blanks in the sampled Resident's ADL records but stated that they should have been completed.

Review of the "Job Description" titled" Certified Nursing Assistant" under "Main Duties" revealed "Support the facility's philosophy of care ...Carry out assignments for resident care including (but not limited to) a.) bathing b.) dressing ...e.) feeding ...Complete assignment ...at the end of every shift."

Review of the facility's policy titled "Guidelines for Charting and Documentations" indicated "The purpose of charting and documentation is to provide: 1. A complete account of resident's care .....the progress of the resident's care. 3. The facility ....a tool for measuring the quality of care provided to the resident. 5. Assistance in the

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

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F 842	Continued From page 14 development of a Plan of Care" ...under "General Rules for Charting and Documentation" indicated "6. Document assessments, interventions, treatments, etc..7. Chart all entries legibly. 8. All entries must reflect the date, the time, and the signature and title of the person recording the data". NJAC 8:39-35.2 (a)(g)1	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061211	A. BUILDING: _____ B. WING _____	C 12/22/2022

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	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: C #: NJ00159278, NJ00159279, NJ00159280 Based on interviews and review of pertinent facility documentation on 12/20/22, 12/21/22, and 12/22/22, 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 for 9 of 14 days reviewed. This deficient practice was evidenced by the following: 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. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (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	S 560	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 nine shifts that were identified. All residents have the potential to be affected by the deficient practice. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Director of Nursing/designee reviewed the last 30 days of the CNA staffing report. The interdisciplinary team reviewed grievance logs and care conference meetings and no care issues were identified. All residents have the potential to be affected by the deficient practice. 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. Recruitment efforts are in place to assist the facility in recruiting. CNAs receive sign on bonuses, referral bonuses,	2/9/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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. The "Nurse Staffing Report" completed by the facility for the weeks of 12/4/22 and 12/11/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift. The facility was deficient in CNA staffing for 9 of 14 day shifts as follows: 12/04/2022 had 7 CNAs for 102 residents. Staffing should have been 13 12/07/2022 had 8 CNAs for 102 residents. Staffing should have been 13 12/08/2022 had 10 CNAs for 102 residents. Staffing should have been 13 12/09/2022 had 9 CNAs for 102 residents. Staffing should have been 13 12/10/2022 had 10 CNAs for 103 residents. Staffing should have been 13 12/11/2022 had 7 CNAs for 106 residents. Staffing should have been 13 12/13/2022 had 7 CNAs for 105 residents. Staffing should have been 13 12/14/2022 had 5 CNAs for 103 residents. Staffing should have been 13 12/16/2022 had 10 CNAs for 102 residents. Staffing should have been 13 During an interview with the Administrator and the Staffing Coordinator (SC) on 12/22/22 from 1:05 pm to 1:31 pm, they stated that the facility was aware of the staffing ratios and they were trying to meet the requirements. NJAC 8:39-5.1(a)	S 560	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 findings of the audits will be presented at the Quarterly Quality Assurance Performance Improvement (QAPI) meetings x3 three meetings or until a timeframe determined by the QAPI members.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	2/17/2023

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 02/09/2023	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 02/09/2023	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 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	
12/22/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO