STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315451		11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMS OF CRANBURY, THE	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
F 000	INITIAL COMMENTS	F 000		
	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. Survey Date : 11/19/2021 Census : 116 Sample Size : 25 + 8 = 33			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		1/31/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2021

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 656	Continued From page 1 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and review of facility documentation, it was determined the facility failed to document on the Care Plan (CP) a residents use and refusal of a hearing aid. This deficient practice was identified for 1 of 25 residents, (Resident [redacted]) reviewed for CP. On 11/15/21 at 9:16 AM, the surveyor observed Resident [redacted] lying in bed, eyes closed. The resident did not respond to the surveyors greeting. On 11/16/21 at 9:59 AM, the surveyor observed the Certified Nursing Aide (CNA) enter the resident's room. The CNA spoke loudly to the resident. On 11/16/21 at 12:38 PM, the surveyor observed Resident #[redacted] in their room sitting in a wheelchair. The surveyor did not observe any [redacted] in either of the resident's [redacted].	F 656	1. Resident #[redacted] Care Plan was updated to include right hearing aid use and resident refusals. 2. All residents have the potential to be affected by this deficient practice and can identified by the resident roster. The Director of Nursing or designee will conduct an audit of current residents who have [redacted] and ensure they each have a patient centered care plan regarding use and refusals if applicable. 3. The Director of Nursing or designee will educate licensed staff to document on the Care Plan resident use and refusal of [redacted] The Interdisciplinary Care Team when reviewing Care Plans at the Initial, Quarterly, and Significant Reviews will ensure communication devices ([redacted] are care planned 4. The Director of Nursing or designee will conduct weekly random audits x 2 months to ensure compliance. Results of these audits will be reviewed at Quarterly	

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F 656	Continued From page 2 On 11/17/21 at 11:55 AM, the surveyor observed the resident in bed and did not observe any [redacted] in either ear. On 11/17/21 at 12:40 PM, the surveyor observed the resident in bed with lunch next to the bed. The surveyor observed no [redacted] in either ear. On 11/18/21 at 8:42 AM, the surveyor observed the resident in bed with breakfast next to the bed. The surveyor observed no [redacted] in either ear. Resident [redacted] was admitted to the facility with diagnoses which included but were not limited to [redacted] Review of the, Nursing Admission Screening/History, dated [redacted], revealed Resident [redacted] had a [redacted]t [redacted] in use. Review of the Admission Minimum Data Set (MDS - an assessment tool), dated [redacted], revealed Section [redacted] - that Resident [redacted] used a [redacted] or other [redacted] appliance; and that the resident required extensive assistance of a staff member for dressing and personal hygiene. The most recent Quarterly MDS, dated [redacted], revealed Section [redacted] - that Resident [redacted] used a [redacted] or other [redacted] appliance; that the resident scored an [redacted] Brief Interview for Mental Status (BIMS), which indicated [redacted]; and that the resident required extensive assistance of a staff member for dressing and personal hygiene.	F 656	QAPI Meeting.	

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F 656	Continued From page 3 Review of the facility provided 24 hour Report [redacted] Floor, revealed Resident [redacted]'s clinical needs which did not include [redacted] Review of Resident [redacted]'s facility provided, "Personal Effects Inventory", effective 7/10/21, revealed the resident had a [redacted] for [redacted] ([redacted] in box. Review of Resident [redacted]'s facility provided, "Personal Effects Inventory", effective [redacted], revealed the resident had a [redacted] with batteries. Review of Resident [redacted]'s CP revealed a focus area of [redacted] initiated [redacted] and revised on [redacted] with four interventions listed as follows: 1) speaker to adjust tone of voice, 2) speaker to [redacted] resident when speaking, 3) speaker to repeat as needed, and 4) speaker to talk to resident in quiet setting. Review of Resident [redacted]'s current CP provided by the facility, revealed a focus area of [redacted] initiated [redacted] (after readmission to the facility) with interventions that included but were not limited to [redacted] to [redacted] initiated on [redacted] On 11/16/21 at 9:59 AM, the CNA caring for Resident [redacted] stated that the resident was [redacted] so the staff would speak loudly. The CNA further stated the resident had [redacted] but she was not aware of any [redacted] On 11/16/21 at 12:38 PM, Resident [redacted] stated she/he had [redacted] but was not sure where they were or why they were not at the facility. The CNA entered the room and was interviewed at that time. The CNA stated that if a resident had	F 656		

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F 656	Continued From page 4 [redacted], the nurses would keep them in the medication cart and put them in the residents [redacted]. On 11/17/21 at 9:07 AM, Resident [redacted]s family member was interviewed via telephone and stated that the resident had a [redacted] at the facility but the staff never applied the [redacted]. The family member further stated that they never see the resident wearing the [redacted] but never remembered to ask staff why she/he was not wearing it. On 11/17/21 at 10:18 AM, the Registered Nurse (RN) caring for the resident stated that if a resident was able to put the [redacted] in themselves, they would keep their own [redacted] in the bedside table. The RN stated if the resident was unable, the nurses would keep the [redacted] in the medication cart and get an order to apply them. The RN stated the nurse would sign for the [redacted] on the medication administration record or the treatment administration record. The RN stated that there were only two residents she was aware of with [redacted] but did not mention Resident [redacted] as being one of them. On 11/17/21 at 10:24 AM, the Licensed Practical Nurse Unit Manager (LPN/UM) of the resident's unit, stated alert residents keep their own [redacted] but residents who were [redacted] would have the [redacted] locked in the medication cart. The LPN/UM stated there was no log or accountability sheet kept for [redacted] and the [redacted] would not be documented unless the staff were to put them in the resident's [redacted]. The LPN/UM stated if a resident was [redacted], the family would have to request an appointment	F 656		

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F 656	Continued From page 5 to have that checked and that he was unaware of any resident on the unit with [redacted] On 11/18/21 at 8:46 AM, the LPN MDS nurse stated she documented on the [redacted] MDS and would have obtained MDS information from the residents if able, the staff, the resident medical record and the Social Worker. The LPN MDS nurse stated Resident [redacted] was [redacted] and that she was able to interview the resident. LPN MDS nurse documented the resident use of a [redacted]. On 11/18/21 at 8:49 AM, a second MDS nurse stated she documented on the admission MDS and that she would have obtained the information from the hospital records, staff and resident. The second MDS nurse stated Resident [redacted] had a [redacted] On 11/18/21 at 8:51 AM, the LPN MDS nurse stated the [redacted] should have triggered and been added to the CP. She further stated it would be the responsibility of the nurse, unit manager and MDS to enter the [redacted] on the CP. The LPN MDS nurse reviewed the initial CP and the most recent CP in the presence of the second MDS nurse and the surveyor and acknowledged that the hearing aids were never entered on the CP. The LPN MDS nurse added the intervention of the [redacted] at the time the surveyor brought it to her attention. On 11/18/21 at 8:55 AM, the LPN/UM stated the nursing staff should refer to the 24 hour report, the CP, and the MDS to know what type of care a resident needed. The LPN/UM, in the presence of the surveyor, reviewed Resident [redacted]s admission and stated the staff should be encouraging the	F 656		

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F 656	Continued From page 6 use of the [redacted] instead of just speaking loudly to the resident. The LPN/UM acknowledged the 24 hour report should have had the [redacted] on the clinical information but did not. The LPN/UM and the surveyor went to Resident [redacted] s room to locate the [redacted] but the LPN/UM was unable to locate them. On 11/18/21 at 9:04 AM, the LPN/UM and surveyor approached the second RN who was caring for Resident [redacted] that day. The second RN showed the LPN/UM and surveyor the resident's [redacted] locked in the medication cart. The second RN stated the last time she tried to apply the resident's [redacted] was "a few months ago" and eventually the resident removed it. The second RN stated she had not tried again to put the [redacted] in. The second RN stated she was not sure if she had documented the resident refused the [redacted] at that time and stated she might have told someone but was unsure. The second RN stated the [redacted] should have been on the CP. On 11/19/21 at 11:19 AM, in the presence of the survey team, the facility regional nurse stated that the resident had a habit of taking out her/his [redacted] frequently. The facility was unable to provide documentation of the refusals by the resident. The surveyor asked if the residents refusal of the [redacted] should have been documented on the care plan? The Director of Nursing (DON) stated yes. On 11/19/21 at 11:23 AM, the Licensed Nursing Home Administrator stated that the [redacted] should have been documented on the care plan. Review of the facility provided, "Care	F 656		

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F 656	Continued From page 7 Plan-Baseline", policy revised 12/16, revealed the following: a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The interdisciplinary team will review the healthcare practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs including but not limited to initial goals based on admission orders; physician orders; dietary orders; therapy services; and social services. Review of the facility provided, "Care Plans, Comprehensive Person-Centered", revised 12/16, included but was not limited to the following. A comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The interdisciplinary team, resident and family or legal representative, develops and implements a comprehensive, person-centered care plan. The care plan interventions are derived from a thorough analysis of the information gathered in the comprehensive assessment. The care planning process will facilitate resident and/or representative involvement; and include an assessment of the resident's strengths and needs. The comprehensive person-centered care plan will (included but was not limited to) the following: describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; incorporate risk factors; reflect the resident's expressed wishes regarding care and goals; identify the professional services that are responsible for each element of care; and aid in preventing or reducing decline in the resident's	F 656		

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F 656	Continued From page 8 function level. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). Assessments are ongoing and care plans are revised as information about the residents and the residents' conditions change. The resident has the right to refuse to participate in medical and nursing treatments. Such refusals will be documents in the resident's clinical record in accordance with established policies. NJAC 8:39-11.2(d),(e)(1),(f),(g),	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility staff failed to: a) consistently follow a physician order for the application of a [redacted] (device to minimize risk of injury in the presence of [redacted], b.) ensure that a resident's [redacted] used to facilitate communication was applied as ordered by the physician, and c.) accurately following a Physician's Order (PO) to hold a medication ([redacted] according to [redacted] results. This deficient practice was identified for three of	F 658	1. Physician involved in the care of Resident [redacted] discontinued parameters to hold for [redacted] less than [redacted]. Resident's [redacted] have remained within normal baseline with no adverse symptoms. Resident [redacted] was discharged as planned. Residents [redacted] has [redacted] in place per physician's orders. Resident [redacted] has [redacted] in place as per physician's orders. 2. All residents have the potential to be affected by this deficient practice and can	1/31/22

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F 658	Continued From page 9 25 resident's, (Resident [redacted], [redacted] and [redacted]) reviewed for professional standards of nursing practice. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. According to the facility Admission Record, Resident #27 was admitted to the facility with diagnoses which included Dementia and a history of right hip arthroplasty the surgical reconstruction or replacement of a joint).	F 658	identified by the resident roster. The Director of Nursing or designee will conduct an audit of all current residents with [redacted], and [redacted] medications with parameters to ensure physician orders are being followed as ordered by visualizing that the [redacted] and [redacted] are in place and that blood pressure medications are administered within the ordered parameter by reviewing the medication administration record. 3. The Director of Nursing or designee will educate licensed staff on the importance of accurately following physician's orders for [redacted] medications with parameters, [redacted] and [redacted] application. 4. Director of Nursing or designee to conduct weekly random audits x 1 month, then monthly random audits x 2 months to ensure physician's orders are being followed for [redacted], [redacted], and [redacted] medications with parameters. Results of these audits will be reviewed at Quarterly QAPI Meeting.	

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F 658	Continued From page 10 The significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], revealed that the resident had [redacted] and needed assistance with all activities of daily living (ADLs). The MDS indicated the resident was at risk for [redacted]. Review of the Progress Notes revealed that Resident [redacted] sustained a [redacted] at the facility on [redacted] Review of the [redacted] Physician Order Sheet (POS) included a PO dated [redacted] for Resident [redacted] to have a hip protector on at all times. The [redacted] was to be removed during hygiene and checked for skin integrity. Review of the [redacted] Treatment Administration Record (TAR) confirmed the order and was plotted to be checked by all three shifts (7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, and 11:00 PM - 7:00 AM). During a tour of the [redacted] Unit on 11/10/2021 at 9:00 AM, the surveyor observed Resident [redacted] in bed. The resident attempted to get out of the bed unassisted with his/her [redacted] on the floor mat. The surveyor alerted the staff who went in and assisted Resident [redacted] back to bed. On 11/10/2021 at 12:27 PM, the surveyor observed Resident [redacted] in bed. Resident [redacted] removed the bed covers and was calling for help. The surveyor observed that Resident [redacted] did not have the [redacted] on. On 11/15/2021 at 8:51 AM, the surveyor observed the resident in bed, positioned on the left side, calling out for help, and no [redacted]	F 658		

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F 658	Continued From page 11 was in place. On 11/15/2021 at 10:07 AM, the surveyor observed Resident [redacted] in bed partly covered with blankets, the Certified Nursing Assistant (CNA) was at bedside and was assisting the resident with the breakfast meal. Resident [redacted] did not have a [redacted] on. At that time the surveyor interviewed the CNA who stated that Resident [redacted] was totally dependent on staff for all care. The surveyor returned to the resident's room at 12:27 PM, and observed Resident [redacted] in bed dressed for the day. The surveyor inquired about the [redacted]. The CNA went to the resident's room with the surveyor and verified that Resident [redacted] did not have a [redacted] on. The CNA accompanied the surveyor to the linen room and showed the surveyor a bin with several [redacted] available for use. The CNA told the surveyor all residents on fall precautions were to have [redacted] on. An interview with the nurse at 11:37 AM, revealed that the CNAs were responsible to apply the [redacted] and the nurses would signed the TAR. The nurse acknowledged that she did not verify that the [redacted] had been on before signing the TAR. The surveyor requested a copy of the [redacted] TAR for review. Review of the TAR indicated that on the following dates, 11/09, 11/10, 11/15 and 11/16, the nurses had signed that the [redacted] was on despite the surveyor observation and staff verification with that the [redacted] was not on the resident. 2) On 11/10/2021 at 9:08 AM, the surveyor	F 658		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMS OF CRANBURY, THE	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
F 658	Continued From page 12 observed Resident [redacted] seated in his/her wheelchair eating breakfast, Resident [redacted] did not have his/her [redacted] on. According to the facility Admission Record, Resident [redacted] was admitted to the facility with diagnoses which included [redacted] and [redacted]. A review of Resident [redacted]'s Physician Order Sheet (POS) dated [redacted] reflected a PO dated [redacted] for [redacted] to be applied every morning and evening shift. The order also indicated to remove [redacted] at bedtime. On 11/15/2021 at 11:45 AM, the surveyor observed the resident resting in bed and the resident's [redacted] were not on. The surveyor interviewed the resident's CNA who stated that Resident [redacted] was alert and could communicate his/her needs. On 11/17/2021 at 09:17 AM the surveyor observed Resident [redacted] sitting in the chair eating breakfast and the [redacted] were not on. On 11/17/2021 at 11:20 AM, the surveyor conducted an interview with the resident's representative who stated that the resident was very alert and able to communicate. The family member stated that he/she was very involved with the care and the resident required [redacted] on to be able to communicate. The resident representative expressed concerns over the staffs failure to ensure that the [redacted] were on. The resident representative	F 658		

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F 658	Continued From page 13 indicated that during visits, the staff had to be reminded to apply the [redacted] in the morning. On 11/17/2021 at 11:56 AM, the surveyor again went to the room and observed the resident did not have his/her [redacted] in place. The surveyor interviewed the resident's primary nurse at 12:57 PM who stated that the [redacted] were applied when the resident was out of his/her room. The surveyor reviewed the [redacted] POS and the resident's PO for the [redacted] with the nurse and the order read, "Apply [redacted] in the morning and removed at HS [Hour of sleep]. The nurse did not have any comment. During a conference meeting on [redacted], the facility was made aware of the above concerns. During a conference meeting on [redacted] at 11:30 AM, the Director of Nursing (DON) indicated that staff should ensure that the [redacted] were in place before signing the TAR. 3. On 11/10/21 at 10:28 AM, the surveyor observed Resident [redacted] sitting in a chair in the hallway with a walker nearby. The surveyor attempted to interview the resident, but the resident was unable to understand the surveyor and [redacted]. The surveyor reviewed the medical record for Resident #[redacted] A review of the resident's Transfer/Discharge Report revealed that the resident was admitted to	F 658		

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F 658	Continued From page 14 the facility on [redacted] with diagnoses that included [redacted]. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted], indicating that the resident had an [redacted] A review of the October and November 2021 electronic Medication Administration Record (EMAR) for Resident [redacted] reflected the physician's order (PO) dated 1[redacted] for '[redacted] (a medication used to treat [redacted]) [redacted] milligrams, give one tablet by mouth every eight (8) hours for [redacted]. Hold for [redacted]) (the [redacted]) less than [redacted] In addition, the EMAR reflected the administration of the Clonidine on the following dates and times with the corresponding [redacted] results that were less than [redacted] on 10/17/21 at 2:00 PM for a [redacted] of [redacted] on 10/19/21 at 10 PM for a [redacted] of [redacted]. on 10/20/21 at 2 PM for a [redacted] of [redacted]. on 10/20/21 at 10 PM for a [redacted] of [redacted]. on 10/29/21 at 2 PM for a [redacted] of [redacted] on 10/30/21 at 2 PM for a [redacted] of [redacted]. on 11/7/21 at 10 PM for a [redacted] of [redacted]	F 658		

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F 658	Continued From page 15 on 11/8/21 at 10 PM for a [redacted] of [redacted] on 11/10/21 at 2 PM for a [redacted] of [redacted]. on 11/12/21 at 10 PM for a [redacted] of [redacted] On 11/16/21 at 8:49 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who reviewed the resident's EMAR and verified that a check mark indicated that the medication was administered. The UM/LPN added that if a medication was not administered there would be a code number documented on the EMAR to indicate that the medication was held and thought there may also be a progress note. Another review of the resident's EMAR revealed that all the dates listed above had a check mark and there was no code numbers entered that corresponded to the medication being held. A review of the electronic progress notes (EPN) on the above dates and times revealed that there was no EPN indicating that the [redacted] was held. On 11/15/21 at 11:26 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the resident spoke some [redacted] at times but was [redacted] The CNA added that there had been times that the resident would get upset and would not [redacted] and would only [redacted]. The CNA added that there was several staff members that spoke the [redacted] as the resident. On 11/15/21 at 12:46 PM, the surveyor interviewed the Housekeeper (HK) who stated that she [redacted] as Resident [redacted] and was called at times [redacted] when the	F 658		

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F 658	Continued From page 16 resident became upset. The HK explained that the resident forgets why they had to come to the facility and that was what was causing distress. The HK stated that the resident does understand some [redacted] and can make needs known to the staff but [redacted]. On 11/16/21 at 11:29 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who verified her initials on the EMAR for the administration of [redacted] on 10/19 at 10 PM, 10/20 at 10 PM and 11/10 at 2 PM listed above. The LPN stated that she thought that she had not administered the medication. The LPN added that the computer system was difficult to "strike out" or change that the medication was not administered. The LPN stated that she would have to review and was unable to speak to the EMAR documentation of the [redacted] being administered. Further review of the resident's medical record revealed that there was no EPN on the above dates and times indicating that there was an error on the EMAR, and that the [redacted] was not administered. On 11/16/21 at 11:37 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurses were able to document in the electronic system if a medication was held or there was a change in a PO. The DON added that she would have to review the resident's EMAR for the [redacted] administration. On 11/17/21 at 8:39 AM, the surveyor, in the presence of the survey team, interviewed the physician (MD) who stated that he was very familiar with the resident and stated that the	F 658		

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F 658	Continued From page 17 resident had [redacted]) and was asked to speak with the survey team. The MD added that the nurses frequently called him about the resident's [redacted] and has instructed the nurses to administer the [redacted] even if the [redacted] was less than [redacted] The MD added that the resident was clinically assessed and had no concern with the [redacted] administration. The MD was unable to verify the specific dates or times that he gave permission for the [redacted] to be administered for a [redacted] less than [redacted]. The MD also acknowledged that when the nurses called him, and he gave permission there should have been documentation in the resident's progress notes to indicate the discussion. Further review of the resident's medical record revealed that there was no EPN documenting that the physician was contacted regarding the [redacted]. In addition, there was no documentation of a change in the PO for [redacted] on the above dates and times to allow the [redacted] to be administered when the [redacted] was less than [redacted]. On 11/17/21 at 9:30 AM, the surveyor interviewed the DON who stated that after reviewing the resident's EMAR for the [redacted] administration, she completed a Quality Assurance review with the nurses. The DON added that the nurses frequently called the physician but had not documented in the chart. On 11/17/21 at 12:20 PM, the surveyor interviewed the Registered Nurse (RN) who stated that she was familiar with Resident [redacted] because she administered medications to the resident. The RN added that she had to take a [redacted] prior to administering the [redacted] and if the	F 658		

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F 658	Continued From page 18 [redacted] was less than [redacted] then the medication should be held and documented in the EMAR. The RN acknowledged that she had signed the EMAR on 10/17 at 2 PM and 10/29 at 2 PM for the administration of [redacted] when the [redacted] was less than [redacted] The RN stated that she had made a mistake. The RN added that the physician was aware of the resident's fluctuating [redacted] On 11/18/21 at 1:28 PM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone. The CP acknowledged that the nurses were to follow a PO accordingly and to follow a hold order as instructed. The CP stated that the nurses frequently called the MD and would take a PO over the phone. The CP acknowledged that a PO would have had to be documented. The CP stated that the EMAR system allowed for documentation of medications being held and the nurses could also document in the EPN if there was a problem with medication administration. The CP also stated that he does review the EMAR for accurate medication administration according to a hold order. The CP added that if the documentation indicated that the medication was inaccurately being administered then he would notify nursing. On 11/19/21 at 12:01 PM, the survey team met with the Licensed Nursing Home Administrator, DON, Regional Clinical Nurse, and a DON from a sister facility. There was no further information provided regarding not following the standard of practice for the administration of [redacted] for the above listed dates and times. A review of the facility policy dated as revised April 2021 for "Administering Medications" provided by the DON reflected that medications	F 658		

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F 658	Continued From page 19 were to be administered as prescribed. The policy also reflected that if vital signs (important medical signs that indicate the status of the body's life sustaining functions such as [redacted]) were necessary then the vital signs were to be "checked/verified" prior to administering medications. In addition, the policy reflected that if a medication was withheld, refused or given at another time other than the scheduled time then the electronic health record would be appropriately documented. NJAC 8:39- 11.2(b), 29.2(d)	F 658		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review and review of the pertinent facility documentation it was determined the facility failed to: a.) ensure that [redacted] was appropriately labeled and dated, b.) the [redacted] was stored in a way to prevent bacterial microbial growth, c.) the [redacted] bottle was checked to ensure the appropriate water level for [redacted], and d.) the facility followed their Policy and Procedure for [redacted] Administration. This deficient practice was identified for three of four residents, (Resident [redacted], Resident [redacted], and Resident [redacted])	F 695	1. [redacted], [redacted] bottles, storage bags have been replaced and labeled with the current date for Resident #[redacted], [redacted], and [redacted] 2. All residents have the potential to be affected by this deficient practice and can identified by the resident roster. The Director of Nursing or designee will conduct an audit of all current residents receiving [redacted] Therapy to ensure [redacted], and [redacted] bottles are labeled with the current date and have a	1/31/22

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F 695	Continued From page 20 reviewed for [redacted] care and was evidenced by the following. 1. A review of Resident [redacted]'s Admission Record indicated Resident [redacted] was admitted with diagnoses which included but were not limited to [redacted]. Review of the resident's Physician Order Sheet (POS) dated [redacted] revealed a physicians order dated [redacted] for [redacted] to be administered via [redacted] as needed for [redacted]) or [redacted] less than [redacted] as needed related to [redacted] with [redacted]. On 11/09/2021 at 10:15 AM, the surveyor observed Resident [redacted] sitting in a wheelchair in the his/her room. Resident [redacted] did not speak to the surveyor. The [redacted] machine was observed next to the wheelchair. The surveyor observed that the [redacted] was in direct contact with the floor. On 11/10/2021 at 9:01 AM, the surveyor observed the [redacted] and the [redacted] in direct contact with the floor. On 11/15/21 at 10:07 AM, the surveyor observed the [redacted] machine running and titrated at [redacted]. The surveyor further observed that the [redacted] was dated 11/14/2021 and was in direct contact with the floor in the resident's room. Additionally, the [redacted] was not protected and was observed on the floor in the resident's room.	F 695	storage bag, and physician's order that includes a weekly change date for all [redacted], [redacted] bottles and storage bags 3. The Director of Nursing/designee to in-service current Nursing Staff on the policy and procedure for dating, labeling and storage of [redacted] and [redacted] bottles for residents receiving [redacted] therapy weekly, and to include a physician's order to change the [redacted] equipment and storage bags weekly. 4. The Director of Nursing or designee will conduct weekly random audits x 2 months to ensure compliance with the correct dating, labeling and storage of [redacted] and [redacted] bottles and physician's orders for residents receiving [redacted] therapy. The results of these audits will be reviewed at Quarterly QAPI Meeting.	

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F 695	Continued From page 21 On 11/16/21 at 9:34 AM, the surveyor observed Resident [redacted] seated in the wheelchair in his/her room. The [redacted] and [redacted] were both observed on the floor and dated [redacted]. During an interview with the Licensed Practical Nurse (LPN) on 11/15/2021 at 10:30 AM, the LPN stated that Resident [redacted]1 was on [redacted] and very confused. The LPN further stated that Resident [redacted] removed the [redacted] all the time. The surveyor observed the LPN enter the resident's room and place the [redacted] on the [redacted]. A review of the resident's Care Plan revised [redacted] reflected that the resident did not have a focus care area for the use of [redacted]. 2. A review of Resident [redacted] Admission Record revealed that the resident was admitted to the facility with diagnoses which included [redacted]. Review of the resident's POS dated [redacted] revealed an physicians order dated [redacted] for [redacted] to be administered at [redacted] every eight hours as needed. On 11/09/21 at 11:25 AM, the surveyor observed the [redacted] and the [redacted] on the floor in the resident's room. The [redacted] was dated [redacted]. The surveyor further observed that there was no water in the [redacted]. On 11/15/21 at 10:07 AM, the surveyor observed	F 695		

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F 695	Continued From page 22 the [redacted] at [redacted] The [redacted] Aide [redacted] was observed in the room. The [redacted] machine was on and running. The [redacted] was observed on the floor mat. The [redacted] stated that Resident [redacted] kept removing the [redacted] At that time, the surveyor observed the [redacted] remove the [redacted] from the floor mat and placed it on the resident's bed. The surveyor observed that the [redacted] and [redacted] bottle were labeled and dated 11/15/2021. On 11/16/21 at 9:01 AM, the surveyor observed Resident [redacted] in bed. The [redacted] was observed to be running. Resident [redacted] did not have the [redacted] on. The [redacted] was observed on the bed rail. Resident [redacted] 7 did not have her/his socks on. Resident [redacted] were [redacted] in color. Resident [redacted] was calling out. The surveyor left the room, located the nurse and informed her that Resident [redacted] needed help and was calling out. At 9:09 AM, the surveyor observed the nurse enter the room and apply the [redacted] that was on the bed rail. The surveyor observed Resident [redacted] in bed with the [redacted] The [redacted] was dated 11/15/2021. During an interview with the LPN on 11/16/2021 at 12:30 PM, the LPN stated that regarding the [redacted] being on the bed rails revealed that Resident [redacted] was very confused. The LPN further stated that Resident [redacted] removed the [redacted] all the time. The LPN stated that the 11:00 PM - 7:00 AM nurses were responsible for changing the [redacted] and the [redacted] bottle.	F 695		

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F 695	Continued From page 23 On 11/17/21 at 12:05 PM, the surveyor requested the policy for [redacted] care. The Director of Nursing (DON) told the surveyor she would look for the policy. The DON further stated, " It was the facility's practice to store the [redacted] in a plastic bag when not in use". This interview contradicted the surveyors observations. There was no plastic bag hung on the [redacted] or in the room to store the [redacted] when not in use. A review of the resident's undated Care Plan reflected a focus area that the resident had refused care and [redacted] therapy. The goal of the resident's Care Plan reflected that the resident's behaviors would not interfer with his/her activities of daily living. The interventions in the resident's Care Plan included to allow the resident to express self, have consistency with caregivers, and reassure the resident. 3. A review of Resident [redacted] Admission Record revealed that Resident [redacted] was admitted to the facility with diagnoses which included [redacted] Review of the resident's [redacted] POS revealed an physician's order dated [redacted] for [redacted] to be administered as needed for [redacted] that [redacted] On 11/09/2021 at 12:30 PM, the surveyor observed the [redacted] on and [redacted], there was no water in the [redacted] bottle. The surveyor further observed that the [redacted] was not labeled and dated.	F 695		

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F 695	Continued From page 24 On 11/10/2021 at 9:08 AM, the surveyor observed Resident [redacted] seated in a wheelchair, eating breakfast. The [redacted] was running. The [redacted] was observed on the bed rail. The [redacted] was observed on the floor. On 11/15/2021 at 8:20 AM, the surveyor observed Resident [redacted] in bed resting. The [redacted] was running at [redacted]. The surveyor observed that the [redacted] was not labeled or dated. On 11/15/21 at 11:45 AM, the surveyor observed Resident [redacted] sitting in his/her wheelchair leaning forward. The resident reported feeling lousy and wanted to go back to bed. The surveyor observed that the [redacted] was not labled or dated and the [redacted] was observed placed on the [redacted].The surveyor further observed that there was no bag attached to the [redacted] machine to store the [redacted]. On 11/17/21 at 12:05 PM, the surveyor shared the above observations with the Director of Nursing (DON) and inquired about a policy for [redacted] care treatment. The DON told the surveyor she would look for the policy. The DON also stated, " It was the facility's practice to store the [redacted] in a plastic bag when not in use". There was no plastic bag hung on the [redacted] machine or in the room to store the [redacted] when not in use during observations on the following dates: 11/09/2021, 11/10/2021,11/15/2021 and 11/16/2021. On 11/18/2021 the facility was asked to provide any in-services and further information regarding [redacted] therapy. No further information was	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315451		11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMS OF CRANBURY, THE	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
F 695	Continued From page 25 provided during the conference meeting on 11/19/2021. The facility policy titled, [redacted] Administration" revised October 2021, indicated that the purpose of this procedure is to provide guidelines for safe [redacted] administration. The procedure contained 17 steps that staff were to follow with [redacted] administration. Steps 8 of the procedure indicated the following: Be sure there is water in the [redacted] bottle if needed and that the water level is high enough that the water bubbles as [redacted] through. Steps 10 of the procedure read, Observe the resident upon setup and periodically thereafter to be sure [redacted] is being tolerated. Steps 11 Periodically re-check water level in [redacted] jar, change [redacted] g and supplies weekly. The [redacted] Administration Policy and Procedure did not include how the [redacted] supplies would be stored when not in use. NJAC 8:39-11.2(b); 27.1(a)	F 695		