STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315353	A. BUILDING _____ B. WING _____	C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBURY CENTER	292 APPLEGARTH ROAD MONROE TOWNSHIP, NJ 08831

(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 A Recertification and Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ163678, NJ163732, NJ163934, NJ166804, NJ168708, NJ169714, NJ169741, NJ169884, NJ171609, NJ171653, NJ172222, NJ172606 Survey Dates: 06/11/24 through 06/14/24. Survey Census: 128 Sample Size: 34 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		8/12/24

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

Electronically Signed | 07/08/2024

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to maintain the residents' dignity when staff [NJ Ex Order] while [NJ Ex Order 26.4(b] residents [NJ Ex Order] in the dining room for one of 17 residents (Resident (R) 16) reviewed for [NJ Ex Order 26.4(b)(1)] of 34 sampled residents. This failure had the potential to result in an [NJ Ex Order 26.4(b)(1)] experience. Findings include: Review of R16's "Admission Record" located in	F 550	1. Immediate action was taken for resident found to have [NJ Exec Order 26.4b1] . The [U.S. FOIA] involved was given on the spot education on the proper procedure for maintaining resident dignity during mealtime. [U.S. FOIA] was educated on the correct practice of sitting down next to resident while assisting with feeding. 2. All residents requiring feeding assistance at mealtimes have the potential to be affected.	

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F 550	Continued From page 2 the electronic medical record (EMR) under the "Profile" tab, revealed NJ Exec was admitted to the facility on NJ Ex Order 26.4(b) with diagnoses to include NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Review of R16's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(b) located in R16's EMR under the "MDS" tab, revealed R16 had a "Brief Interview for Mental Status (BIMS)" score of NJ Ex O out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1). The MDS revealed R16 required a NJ Ex Order 26.4(b)(1). During an observation on 06/11/24 at 12:02 PM, the meal trays were delivered to 17 residents seated at four tables in the NJ Ex Order 26 dining room. During an observation on 06/11/24 at 12:06 PM, R16 was sitting in a wheelchair at the second table in the dining room with the lunch meal placed on the tray in front of NJ Exec O Continued observation revealed Licensed Practical Nurse (LPN) 3 walked over to R16, NJ Ex Order 26.4(b)(1) then NJ Ex Order 26.4(b)(1), while NJ Ex Order 26.4(b)(1). During an interview on 06/11/24 at 12:16 PM, LPN3 confirmed she was NJ Ex Order 26.4(b)(1) R16 while NJ Ex Order 26.4(b)(1) in the dining room. LPN3 stated that by NJ Ex Order 26.4(b)(1) R16 she didn't NJ Ex Order 26.4(b)(1). LPN3 also stated she could not find NJ Ex Order 26.4(b)(1), so she NJ Ex Order 26.4(b)(1) because she wanted NJ Ex Order 26 R16 while the NJ Ex Order 26.4(b)(1). During an interview on 06/14/24 at 8:53 AM, the U.S. FOIA (b) (6)) and US FOIA (b)(6)	F 550	3. All clinical staff involved in providing assistance at mealtimes have been in-serviced on the need to sit next to residents while assisting with feeding to ensure resident dignity is maintained. A validation checklist was performed for 5 random staff members that assist with meals. Findings reviewed with employees . Corrective action provided as needed. 4. The Director of Nursing , Assistant Director of Nursing and other Administrative Nursing staff will conduct observations weekly x2 for 4 weeks then monthly x3 months of staff observation during mealtime to ensure that staff are maintaining residents dignity during mealtimes in accordance with our facility policy and regulatory requirements. Observation reports and validation checklists will be reviewed by the Quality Assurance Committee monthly x3 or until consistent substantial compliance has been achieved as determined by the committee . The Social Service Director or designee will review the results of observation reports and any corrective measures taken with the resident council during their next monthly meeting for comments and suggestions .	

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F 550	Continued From page 3 U.S. FOIA (b) (6) stated they expected nursing staff to NJ Ex Order 26.4(b)(1) the resident while NJ Ex Order 26.4 to NJ Ex Order 26.4(b)(1). Review of the facility's policy titled, "Resident Rights Under Federal Law," revised on 02/01/23 and provided by the facility, revealed " ... Purpose To treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her self-esteem and selfworth ... 5. Respect and Dignity. The resident has a right to be treated with respect and dignity, including (refer lo Center Operations Policies and Procedures, Treatment: Considerate and Respectful) ...." NJAC 8:39-4.1(a)(12)	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		8/12/24

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F 584	Continued From page 4 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to ensure a homelike environment when staff delivered the lunch meal on a tray from the cart to the table and did not remove the food from the tray in the dining room for 16 of 55 residents that resided on Unit C (Residents (R) 16, R23, R39, R47, R49, R54, R56, R69, R70, R75, R80, R86, R90, R110, R113 and R123. This failure had the potential to result in an institutional dining experience. Findings include: During an observation on 06/11/24 at 12:01 PM, two staff members delivered the lunch meal trays	F 584	1) Immediate action taken for the residents found to have been affected: The CNAs involved were immediately in-serviced on the proper procedure for maintaining a safe homelike environment during mealtimes for all residents, including removing meals from trays. 2) Identification of other residents having the potential to be affected: All residents have potential to be affected by this practice. 3) What measures will be put in place or systemic changes made to ensure that	

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F 584	Continued From page 5 and sat them on the tables in front of R16, R23, R39, R47, R49, R54, R56, R69, R70, R75, R80, R86, R90, R110, R113 and R123. Continued observation revealed nursing staff in the dining room did not remove the food from the tray and place it on the table after the trays were delivered. During an interview on 06/11/24 at 12:13 PM, Certified Nursing Assistant (CNA) 5 verified she had worked at the facility since [NJ Ex Orde] and the food was not removed from the tray after it was placed on the table in the dining room on [NJ Ex Order 26] During an interview on 06/11/24 at 12:15 PM, CNA6 confirmed she had worked at the facility [NJ Ex Order 26.4(b)(1)] and resident's food was always served on trays and not removed from the tray after placed on the table in front of the residents in the dining room. During an interview on 06/11/24 at 12:16 PM, Licensed Practical Nurse (LPN) 3 acknowledged she had worked at the facility over [NJ Ex Order 26.4(b)(1)], and she had observed staff removing the meal trays from the cart, placing it on the table in front of the residents without removing the plates, bowls, drinks, and utensils from the tray. During an interview on 06/14/24 at 8:53 AM, the [U.S. FOIA (b) (6)]) and [U.S. FOIA (b) (6)] stated leaving food on the trays after being served in the dining room was a cafeteria setting and not a homelike environment. Review of the facility's policy titled, "Resident Rights Under Federal Law," revised on 02/01/23 and provided by the facility, revealed " ... 9. Safe Environment. The resident has the right to a safe, clean, comfortable and homelike environment,	F 584	the deficient practice will not recur: CNAs and other facility personnel involved in serving meal trays to residents were re-educated by the DON on the proper procedure on removing meals from the tray before serving the residents to maintain a safe homelike environment. Staff were re-educated on safe/ clean/comfortable /homelike environment for residents during mealtime which includes serving meals without trays. Audits will be done to ensure CNAs or facility personnel do not serve the residents meals on the tray. House wide audit was conducted weekly x 3 to ensure other residents were not affected by this deficient practice. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Nursing Services (DNS), or designee, will conduct observations weekly x2, for 4 weeks of staff during mealtimes over the next three (3) months to ensure staff are promoting and maintaining a safe homelike environment during mealtimes in accordance with our facility's practice guidelines and regulatory requirements. Observation reports and validation checklists will be reviewed by the Quality Assurance Committee monthly x 3, or until consistent substantial compliance has been achieved as determined by the committee. The Social Services Director, or designee, will review the results of observation reports and any	

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F 584	Continued From page 6 including but not limited to receiving treatment and supports for daily living safety ...." NJAC 8:39-31.4(a)	F 584	corrective measures taken with the Resident/Family Group Council during their next monthly meeting for comments and suggestion.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to follow a physician's order for a NJ Ex Order 26.4(b)(1) for one of one resident (Resident (R) 74) reviewed for NJ Ex Order 26.4(b)(1) of 34 sample residents. This failure could potentially cause NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26. in NJ Ex Order 26.4(Findings include:	F 688	1. Immediate actions were taken for resident #74. NJ Ex was re-evaluated by the U.S. FOIA (b) (6) and NJ Ex Orde was applied to NJ Ex Order 26.4(b)(1) as ordered by MD in order to prevent a NJ Ex Order 26. in NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). 2. All residents of the facility who require splints to prevent decline in ROM , according to person-entered care plans,	8/12/24

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F 688	Continued From page 7 Review of R74's "Admission Record" tab located in the electronic medical record (EMR), indicated R74 was admitted to the facility on [redacted] with diagnoses to include but not limited to, [redacted] and [redacted] following [redacted], and [redacted] Review of R74's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 which indicated R74 had [redacted]. Review of R74's "Care Plan," dated [redacted] and located in the EMR under the "Care Plan" tab, revealed " .... [R74] to use [redacted] during daytime for 6-8 hours ..." Review of the "Physician Orders," dated [redacted] and located in the EMR under the "Orders" tab, revealed R74 to "[redacted] daily for 6-8 hours (hrs.) during daytime ...Assistance for [redacted] was required every day and evening shift." During an observation and interview on 06/11/24 at 2:29 PM, R74 had a [redacted], which was [redacted], [redacted] across the room. an interview, R74 was asked about the [redacted] observation. R74 stated [redacted] was to [redacted] every day and proceeded to [redacted] from [redacted] and showed me [redacted], which was [redacted] R74 was asked why [redacted] was not [redacted] and R74 stated,	F 688	have the potential to be affected by this practice. 3. Audit of residents requiring the use of splint in accordance with care plan review was completed by the physical therapist. A log of residents requiring the use of splints was created by physical therapist and will be updated monthly. Copy of log was placed on each Nursing unit for quick lookback. Physical therapist will visualize splints monthly to ensure that all splints are intact and in use as ordered by MD. Nurse will check daily during shift to ensure that splints are applied as ordered. Nurses and CNAs were in-serviced on policy and procedure regarding use of splints and proper application of splints was demonstrated by physical therapist. 4. Physical therapist and ADON will conduct observations 3x/week times 4 weeks then monthly x2 months on residents requiring splints to ensure proper and consistent use of splints according to Physician's order. Observation reports will be reviewed by the Quality Assurance Committee monthly x3 or until consistent substantial compliance has been achieved as determined by the committee. Results of observation reports and any corrective measures will be reviewed during resident council for comments and suggestions.	

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F 688	Continued From page 8 "NJ Ex Order 26.4(b)(1)." During an observation on 06/12/24 at 9:12 AM, R74 was NJ Ex Order 26.4(b)(1) resting and observation of the NJ Ex Order 26.4(b)(1) was still lying on the dresser in the same position as observed on the previous day on 06/11/23. During an interview on 06/12/24 at 9:12 AM, Licensed Practical Nurse (LPN) 2 stated R74 NJ Ex Order 26.4(b)(1) should have been NJ Ex Order 26.4(b)(1), she NJ Ex Order 26.4(b)(1) R74's NJ Ex Order 26.4(b)(1). LPN2 was asked the importance of NJ Ex Order 26.4(b)(1) and the LPN2 stated, " NJ Ex Order 26 should be NJ Ex Orde as ordered and if not NJ Ex Order 26.4(b)(1) R74 could NJ Ex Or what NJ Ex Order 26.4(b)(1)." LPN2 further stated that R74 was not able to NJ Ex Order 26.4(b)(1) . During an interview on 06/12/24 at 2:19 PM, the U.S. FOIA (b) (6)) revealed her expectation of staff was that all physician orders were followed. During an interview on 06/12/24 at 3:17 PM, the facility U.S. FOIA (b) (6) revealed her expectation of staff was that physician orders were followed. Review of the facility's policy titled, "Activities of Daily Living (ADL)," dated 05/01/23, revealed "Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living (ADL) abilities are maintained or improved and do not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable ...assistive devices and adaptive	F 688		

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F 688	Continued From page 9 equipment are provided as needed. " NJAC 8:39-27.1(a)	F 688		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and facility policy review the facility failed to allow cooking vessels to completely air dry before being placed for storage in one of one kitchen. This failure has the potential to create an environment that would enable bacteria growth between the vessels which could cause illness among 127 of 128 residents. Findings include:	F 812	The pots and pans observed, that were not completely dry, were taken off of the rack and re-washed, and then taken to another area to air-dry. The rest of the kitchen was checked for this deficient practice and was found to be in compliance. This deficient practice has the potential to affect all residents.	8/12/24

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F 812	Continued From page 10 During an observation and interview on 06/11/24 at 10:10 AM with the U.S. FOIA (b) (6) buffet pans and other pans were stacked to be stored without reaching complete dryness. The U.S. FC was shown the multiple stacked pans, and the U.S. FC stated all the washed items should have been completely dried before stacking and storing. The U.S. FC then proceeded to take the stacks of wet items to the dishwasher room. During an observation and interview on 06/12/24 at 2:34 PM, with the U.S. FC and U.S. FOIA (b) (6)), buffet pans and other pans were stacked to be stored without reaching complete dryness. The U.S. FC and U.S. FOIA were shown the multiple stacks, and the U.S. FC stated all the washed items should have been completely dried before stacking and storing, and that the staff were educated on 06/11/24, the day before. The U.S. FC then proceeded to take the stacks of wet items to the dishwasher room to be recleaned. During an interview on 06/14/24 at 11:20 AM, the U.S. FOIA (b) (6) verified nesting pans stored for future use in the kitchen should have been completely dried before being stacked together. Review of the facility's policy titled, "Warewashing," revised 02/23 and provided by the facility, revealed "all dishware, service ware, and utensils will be cleaned and sanitized after each use." The policy continued to indicate, "all dishware will be air dried and properly stored." NJAC 8:39-17.2(g)	F 812	All kitchen staff were educated on wet-nesting. The FSD will conduct daily audits Monday-Friday x30 days and then monthly x2 of all pans to ensure complete dryness and that food procurement/storage/preparation is done according to professional standards. Results will be discussed in at the monthly QUAPI meeting x90 days to obtain substancial compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/12/24

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F 880	Continued From page 11 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 12 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow infection control and prevention guidelines to prevent cross-contamination when they did not follow NJ Ex Order 26.4(b)(1)) while performing NJ Ex Order 26.4(care for one of one resident (Resident (R) 103) reviewed for NJ Ex Order 26.4(b)(of 34 sampled residents. This failure had the potential to spread NJ Ex Order 26.4(b)(1) to the residents.	F 880	Immediate action was taken for resident #103. Resident was placed on NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) was used to NJ Ex Order 26.4(b)(1) . NJ Ex Ord sign was placed on door outside of resident□s room and stocked PPE cart was placed outside of room for use during care of resident All residents with chronic wounds and	

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F 880	Continued From page 13 Findings include: Review of R103's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R103 was admitted to the facility on NJ Ex Order 26.4(b with diagnoses that included NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1). Review of R103's comprehensive "Care Plan" located in the EMR under the "Care Plan" tab, revealed the following focus areas: "I, [R103] have a NJ Ex Order 26.4(b)(1) my NJ Ex Order 26.4(b)(1) r/t [related to] use of NJ Ex Order 26.4(b)(1) secondary to NJ Ex Order 26.4(b)(1) ," dated NJ Ex Order 26.4(b) , with no NJ Ex Orde interventions; "I, [R103] have NJ Ex Order 26.4(b)(1) present on admission NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1) s/p [status post] NJ Ex Order 26.4(b)(1) on Admission: NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex O , NJ Ex Order 26 ," dated NJ Ex Order 26.4(b)(1) with no NJ Ex Orde interventions; and "I, [R103] have a NJ Ex Order 26.4(b)(1) d/t [due to] NJ Ex Order 26.4(b)(1)," dated NJ Ex Order 26.4(b , with no NJ Ex Orde interventions. Review of R103's "Physician's Orders," dated NJ Ex Order 26.4(b , located in the EMR under the "Orders" tab, revealed orders as follows: "Perform NJ Ex Order 26.4(b)(1)) every day and evening shift, Observe NJ Ex Order 26.4(b)(1) every shift" and " NJ Ex Order 26.4(b)(1))	F 880	indwelling medical equipments have the potential to be affected as Enhanced Barrier Precautions helps to prevent cross contamination and the spread of multi drug resistant organism. Audit identifying residents with high contact patient care activities such as residents with chronic wounds , indwelling medical devices (central lines , GT , tracheostomy , urinary cather , colostomy etc.) was conducted to ensure compliance with infection control and prevention. Residents identified had PPE cart outside of room and sign posted on door. All Nursing staff were re-inserviced on Enhanced Barrier Precautions and indications to place a resident on EBP . Director of Nursing and Assistant Director of Nursing observed staff caring for residents on EBP. Special focus on proper donning, doffing of PPE, and handwashing per facility policy and infection control guidelines. Observations were completed on random residents daily x1 week, 3x/week x2 weeks, 1x/week x4 weeks, then monthly x3 months . Report of Observations will be reviewed by the Quality Assurance Committee monthly or until consistent substantial compliance has been achieved as determined by the committee . Results of observation reports and any corrective measures will be reviewed during resident council for comments and suggestions .	

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Apply NJ Ex Order 26.4(b)(1) every day and evening shift for NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4 , apply NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) , apply NJ Ex Order 26.4(b)(1) and d NJ Ex Order 26.4(b)(1) and apply NJ Ex Order 26.4(b)(1) as needed for NJ Ex Order 26. ***Change NJ Ex Order 26.4(b) if NJ Ex Order 26.4 ."

Observation on 06/11/24 at 10:18 AM revealed R103 lying in bed with the NJ Ex Order 26.4(b)(1) , the NJ Ex Order 26.4(b)(1) was not covered, and was attached to the bottom NJ Exec There was no NJ Ex Ord sign on the resident's door and no cart with personal protective equipment (PPE) near or outside of the resident's room. Interview with R103 at this time revealed staff were not wearing a gown when performing NJ Ex Order 26.4(or NJ Ex Order 26.4(b)(1) .

Observations on 06/11/24 at 10:39 AM, 12:32 PM, and 2:50 PM, revealed there was no NJ Ex Ord sign on R103's door and no PPE cart outside of the room.

During an interview and observation on 06/11/24 at 12:34 PM, Licensed Practical Nurse (LPN) 2 confirmed R103 did not have an NJ Ex Ord sign on the door and there was no PPE cart outside of the room or in the hallway.

During an interview on 06/11/24 at 12:34 PM, LPN3 verified R103 did not have an NJ Ex Ord sign on the door and there was no PPE cart outside of R103's room. LPN3 stated nursing staff were trained by the former U.S. FOIA (b) (6) on NJ Ex Ord a NJ Exec Order 26.4b1 ago and the NJ Ex Ord was used for residents with NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . LPN3 stated NJ Ex Ord were

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F 880	Continued From page 15 extra precautions that you took when providing NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) and should wear a gown and gloves when performing NJ Ex Order 26 and NJ Ex Order 26.4([redacted] During an interview on 06/11/24 at 12:40 PM, Certified Nursing Assistant (CNA) 4 stated she was trained by the former U.S. on NJ Ex Ord a NJ Exec [redacted] ago and should wear a gown and gloves when providing care to residents but she didn't know which residents should be on NJ Ex Orde CNA4 also stated residents on NJ Ex Ord would have an NJ Ex Ord sign on the outside of the door and a PPE cart would be placed outside of the door. CNA4 verified R103 did not have an NJ Ex Ord sign on the door or PPE cart in the hallway. CNA4 also stated she was assigned to R103 and had provided NJ Ex Order 26.4(care using gloves but not a gown. During an interview on 06/12/24 at 8:31 AM, the U.S. FOIA (b) (6) stated the U.S. would place an NJ Ex Ord sign on the door and PPE cart outside of the room if the resident had an NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4 The U.S. FOIA (b) (6) also stated R103 should have been placed on NJ Ex Ord when NJ Ex was readmitted on NJ Ex Order 26.4(b [redacted] but someone missed it. The U.S. FOIA (b) [redacted] indicated a gown, and gloves should be worn when the nursing staff were providing high touch activities for residents on NJ Ex Ord and that these precautions were implemented to protect residents and staff from spreading NJ Ex Order 26.4(b During an interview on 06/12/24 at 4:22 PM, CNA7 acknowledged R103 was not on NJ Ex Ord on NJ Ex Order 26.4(b [redacted] and did not know why the resident was on NJ Ex Order 26.4b1 today because he had not received report yet.	F 880		

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During an interview on 06/14/24 at 12:32 PM, the U.S. FOIA (b) (6) stated the former U.S. resigned NJ Exec O and trained the staff on NJ Ex Ord prior to her departure. The U.S. FOIA (b) (6) also stated the interim U.S. was at the facility most days of the week but not on the weekends and expected the admitting nurse to implement NJ Ex Ord and update the care plan when R103 was readmitted to the facility from the hospital on NJ Ex Order 26.4(b)(1)

During an interview on 06/14/24 at 1:16 PM, the interim U.S. acknowledged NJ Ex Ord was not implemented for R103 until NJ Ex Order 26.4(b) and she expected the admitting nurse to implement NJ Ex Ord and document NJ Ex Ord on the care plan after his readmission to the facility on NJ Ex Order 26.4(b) per the NJ Ex Ord policy. The interim U.S. stated the NJ Ex Ord signs were available on the floor at the nurses' station and nursing staff had access to the PPE carts during the week and on weekends. The interim U.S. also stated that the facility must implement NJ Ex Ord for residents with NJ Ex Order 26.4(but could use their discretion for residents with devices such as NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Orde

Review of the facility's policy titled, "Enhanced Barrier Precautions (EBP)," revised 04/01/24 and provided by the facility, revealed ". . . I. Prompt recognition of need: . . . c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is

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F 880	Continued From page 17	F 880		

not currently targeted by Center for Disease Control (CDC). b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a Multi- Drug Resistant Organisms MDRO) . . . 4. High-contact resident care activities include: . . . g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes . . ."

Review of the facility's policy titled, "Enhanced Barrier Precautions," revised 01/08/24 and provided by the facility, revealed "Policy In addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be used for novel or targeted multi-drug resistant organisms (MDROs) ... Purpose to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Refer to: Enhanced Barrier Precautions procedure ...."

Review of the facility's document titled, "Procedure: Enhanced Barrier Precautions," revised 05/01/24 and provided by the facility, revealed "1. Post the appropriate Enhanced Barrier Precautions (EBP) sign on the patient's room door ... 1.1 Enhanced Barrier Precautions (EBP) are to be utilized for the duration of the patient's stay ... 3. Follow the CDC [Centers for Disease Prevention and Control] guidance per table below ... Enhanced barrier applies to chronic wounds and/or indwelling medical

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F 880	Continued From page 18 devices (e.g., central line, urinary catheter, enteral feeding tube, tracheostomy, ventilator) regardless of MDRO colonization status. PPE used for these situations during high contact patient care activities: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, central line, urinary catheter, enteral feeding tube, tracheostomy, ventilator, wound care, any skin opening requiring a dressing ... Required PPE gown, gloves prior to high contact care activity (change PPE before caring for another patient) ... 4. PPE should be accessible and located outside of the patient's room ... 12. document: 12.1 type of precautions in care plan...." Review of the facility's staff in-service titled "New EBP Policy," dated 03/20/24 and provided by the facility, revealed nursing staff were trained on the new [redacted] guidelines. NJAC 8:39-19.4	F 880		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (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 review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. 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	S 560	1.) How the Corrective action will be accomplished for the residents found to have been affected The facility has contracted with staffing agencies to increase the volume of PRN, full time, and part time nurse and CNA hires. The facility will conduct Weekly Staffing calls with regional support team to review staffing schedules and recruiting strategies to ensure the facility meets minimum staffing requirements. 2.) How the facility will identify other residents having the potential to be affected	8/12/24

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

Electronically Signed | 07/08/24

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S 560	Continued From page 1 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 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. 1. For the 9 weeks of Complaint staffing from 01/01/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 59 of 63 day shifts and deficient in total staff for residents on 1 of 63 overnight shifts as follows: -01/01/23 had 4 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/02/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/03/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/04/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/06/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/07/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/08/23 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -01/09/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs.	S 560	All residents have the potential to be affected by this deficient practice 3.) What measures will be put into place or systematic changes made to ensure the deficient practice will not recur Facility Management were re educated on NJ staffing mandate. Facility will continue recruiting functions, which drive various forms of media to increase the number of applicants Forms external partnerships with schools to training Students and transitioning them into CNAs. ; and Converts temporary C.N.A.s into permanent C.N.A.s 4) How the facility will monitor its corrective actions to ensure compliance The DON, staffing coordinator and HR coordinator/designee will maintain a listing of current recruiting efforts, and document 3 days a week the results of these efforts. The Administrator and DON will audit these efforts twice weekly x 4 weeks, weekly x2 weeks then monthly x 2 to ensure the Center team is following up on all recruitment tasks. The Administrator/DON or Designee will report findings to the Performance	

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S 560	Continued From page 2 -01/10/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/11/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/13/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/14/23 had 8 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/15/23 had 6 CNAs for 104 residents on the day shift, required at least 13 CNAs. -01/16/23 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -01/19/23 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -01/20/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -01/21/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -01/22/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -01/23/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -01/24/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -01/25/23 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -01/26/23 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -01/27/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -01/27/23 had 7 total staff for 115 residents on the overnight shift, required at least 8 total staff. -01/28/23 had 7 CNAs for 115 residents on the day shift, required at least 14 CNAs. -01/29/23 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs. -01/30/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -01/31/23 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs.	S 560	Improvement Committee monthly for three months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061224	A. BUILDING: _____ B. WING _____	C 06/14/2024

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S 560	Continued From page 3 -02/01/23 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -02/02/23 had 9 CNAs for 118 residents on the day shift, required at least 15 CNAs. -02/03/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/04/23 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/05/23 had 7 CNAs for 106 residents on the day shift, required at least 13 CNAs. -02/06/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/07/23 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/08/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/09/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/10/23 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/11/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -02/12/23 had 4 CNAs for 102 residents on the day shift, required at least 13 CNAs. -02/13/23 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/14/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/15/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/16/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/17/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/18/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/19/23 had 7 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/20/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs.	S 560		

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S 560	Continued From page 4 -02/21/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/22/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/23/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/24/23 had 8 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/25/23 had 8 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/26/23 had 7 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/27/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/28/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -03/01/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -03/02/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -03/03/23 had 8 CNAs for 102 residents on the day shift, required at least 13 CNAs. -03/04/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of Complaint staffing from 04/23/2023 to 05/06/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -04/23/23 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -04/24/23 had 7 CNAs for 98 residents on the day shift, required at least 12 CNAs. -04/25/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -04/26/23 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -04/27/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs.	S 560		

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S 560	Continued From page 5 -04/28/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -04/29/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -04/30/23 had 7 CNAs for 99 residents on the day shift, required at least 12 CNAs. -05/01/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -05/02/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -05/03/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -05/04/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -05/05/23 had 8 CNAs for 105 residents on the day shift, required at least 13 CNAs. -05/06/23 had 6 CNAs for 104 residents on the day shift, required at least 13 CNAs. 3. For the 4 weeks of Complaint staffing from 07/30/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 28 of 28 day shifts as follows: -07/30/23 had 7 CNAs for 108 residents on the day shift, required at least 13 CNAs. -07/31/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/01/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/02/23 had 8 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/03/23 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/04/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/05/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/06/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs.	S 560		

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S 560	Continued From page 6 -08/07/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/08/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/09/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/10/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/11/23 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/12/23 had 7 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/13/23 had 5 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/14/23 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/15/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/16/23 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/17/23 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/18/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/19/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/20/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/21/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/22/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/23/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/24/23 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/25/23 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/26/23 had 5 CNAs for 109 residents on the day shift, required at least 14 CNAs.	S 560		

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S 560	Continued From page 7 4. For the 2 weeks of Complaint staffing from 10/15/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -10/15/23 had 8 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/16/23 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/16/23 had 9 CNAs to 21 total staff on the evening shift, required at least 10 CNAs. -10/17/23 had 8 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/18/23 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/19/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/20/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/21/23 had 6 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/22/23 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/23/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/24/23 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/24/23 had 10 total staff for residents on the evening shift, required at least 11 total staff. -10/25/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/26/23 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/27/23 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/28/23 had 8 CNAs for 116 residents on the day shift, required at least 14 CNAs.	S 560		

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S 560	Continued From page 8 5. For the 7 weeks of Complaint staffing from 11/26/2023 to 01/13/2024, the facility was deficient in CNA staffing for residents on 49 of 49 day shifts and deficient in total staff for residents on 2 of 49 overnight shifts as follows: -11/26/23 had 7 CNAs for 121 residents on the day shift, required at least 15 CNAs. -11/27/23 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -11/28/23 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -11/29/23 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -11/30/23 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs. -11/30/23 had 8 total staff for residents on the overnight shift, required at least 9 total staff. -12/01/23 had 9 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/02/23 had 8 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/03/23 had 9 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/04/23 had 6 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/05/23 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/06/23 had 9 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/07/23 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/08/23 had 8 CNAs for 135 residents on the day shift, required at least 17 CNAs. -12/09/23 had 9 CNAs for 134 residents on the day shift, required at least 17 CNAs. -12/10/23 had 9 CNAs for 134 residents on the day shift, required at least 17 CNAs. -12/11/23 had 9 CNAs for 134 residents on the	S 560		

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S 560	Continued From page 9	S 560		

day shift, required at least 17 CNAs.
-12/11/23 had 9 total staff for residents on the overnight shift, required at least 10 total staff.
-12/12/23 had 11 CNAs for 134 residents on the day shift, required at least 17 CNAs.
-12/13/23 had 9 CNAs for 134 residents on the day shift, required at least 17 CNAs.
-12/14/23 had 9 CNAs for 135 residents on the day shift, required at least 17 CNAs.
-12/15/23 had 8 CNAs for 135 residents on the day shift, required at least 17 CNAs.
-12/16/23 had 6 CNAs for 133 residents on the day shift, required at least 17 CNAs.
-12/17/23 had 7 CNAs for 133 residents on the day shift, required at least 17 CNAs.
-12/18/23 had 10 CNAs for 133 residents on the day shift, required at least 17 CNAs.
-12/19/23 had 9 CNAs for 130 residents on the day shift, required at least 16 CNAs.
-12/20/23 had 9 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-12/21/23 had 7 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-12/22/23 had 10 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-12/23/23 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs.
-12/24/23 had 9 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-12/25/23 had 9 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-12/26/23 had 8 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-12/27/23 had 8 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-12/28/23 had 8 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-12/29/23 had 7 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-12/30/23 had 6 CNAs for 129 residents on the

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S 560	Continued From page 10	S 560		

day shift, required at least 16 CNAs.
-12/31/23 had 6 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-01/01/24 had 9 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-01/02/24 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-01/03/24 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs.
-01/04/24 had 9 CNAs for 127 residents on the day shift, required at least 16 CNAs.
-01/05/24 had 11 CNAs for 127 residents on the day shift, required at least 16 CNAs.
-01/06/24 had 11 CNAs for 127 residents on the day shift, required at least 16 CNAs.
-01/07/24 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs.
-01/08/24 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs.
-01/09/24 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs.
-01/10/24 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs.
-01/11/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-01/12/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs.
-01/13/24 had 8 CNAs for 132 residents on the day shift, required at least 16 CNAs.

6. For the week of Complaint staffing from 02/18/2024 to 02/04/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-02/18/24 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs.
-02/19/24 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs.
-02/20/24 had 12 CNAs for 133 residents on the

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S 560	Continued From page 11 day shift, required at least 17 CNAs. -02/21/24 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -02/22/24 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -02/23/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -02/24/24 had 7 CNAs for 125 residents on the day shift, required at least 16 CNAs. 7. For the week of Complaint staffing from 03/17/2024 to 03/23/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/17/24 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs. -03/18/24 had 8 CNAs for 134 residents on the day shift, required at least 17 CNAs. -03/19/24 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/20/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -03/21/24 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs. -03/22/24 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs. -03/23/24 had 10 CNAs for 129 residents on the day shift, required at least 16 CNAs. 8. For the week of Complaint staffing from 03/31/2024 to 04/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/31/24 had 8 CNAs for 135 residents on the day shift, required at least 17 CNAs. -04/01/24 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -04/02/24 had 11 CNAs for 131 residents on the	S 560		

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S 560	Continued From page 12 day shift, required at least 16 CNAs. -04/03/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -04/04/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -04/05/24 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs. -04/06/24 had 11 CNAs for 130 residents on the day shift, required at least 16 CNAs. 9. For the 2 weeks of staffing prior to survey from 05/26/2024 to 06/08/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -05/26/24 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -05/27/24 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -05/28/24 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/29/24 had 11 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/30/24 had 14 CNAs for 129 residents on the day shift, required at least 16 CNAs. -05/31/24 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -06/01/24 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs. -06/02/24 had 10 CNAs for 122 residents on the day shift, required at least 15 CNAs. -06/03/24 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -06/04/24 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -06/05/24 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs. -06/06/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -06/07/24 had 11 CNAs for 121 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061224	A. BUILDING: _____ B. WING _____	C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBURY CENTER	292 APPLEGARTH ROAD MONROE TOWNSHIP, NJ 08831

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S 560	Continued From page 13 day shift, required at least 15 CNAs. -06/08/24 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315353 Y1	A. Building B. Wing Y2	9/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBURY CENTER	292 APPLEGARTH ROAD MONROE TOWNSHIP, NJ 08831

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 F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0688	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	08/12/2024	LSC	08/12/2024	LSC	08/12/2024
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	08/12/2024	LSC	08/12/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/14/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061224		9/12/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBURY CENTER	292 APPLEGARTH ROAD MONROE TOWNSHIP, NJ 08831

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 08/12/2024	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 6/14/2024	☐ 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
	315353	A. BUILDING **01** B. WING _____	**06/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBURY CENTER	**292 APPLEGARTH ROAD** **MONROE TOWNSHIP, NJ 08831**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 06/11/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 06/11/24 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Cranbury Center is a two-story building built in 1996 and is composed of Type II protected construction. The facility is divided into seven - smoke zones. The generator does approximately 40 % of the building per the Maintenance Director. The current occupied beds are 128 of 154.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type	K 161		8/12/24

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

Electronically Signed | 07/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315353	A. BUILDING **01** B. WING _____	**06/14/2024**

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K 161	Continued From page 1 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fireproofing was applied to the steel beams in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.1.6.1. This deficient practice had the potential to affect all 128 residents who resided at the facility.	K 161	The fireproofing for the steel beams in the electrical room were repaired on 7/8/24. The rest of the building was checked for a similar deficient practice and was found to be in compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315353	A. BUILDING **01** B. WING _____	**06/14/2024**

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K 161	Continued From page 2 Findings include: An observation on 06/11/24 at 12:30 PM of the main electrical room revealed the fireproofing was missing from one steel beam approximately 6 inches x 4 inches, from another beam approximately 10 inches x 3 inches and a third beam approximately 3 feet x 3 inches. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the fireproofing was missing from the steel beams in the main electrical room. NJAC 8:39-31.2(e)	K 161	This deficient practice can potentially affect all residents and staff, due to the fact that the items missing fireproofing can increase the spread of fire. Maintenance Department personnel will be educated on NFPA 101: Building Construction Type and Height. During daily rounds the maintenance department will inspect beams throughout the facility to ensure all steel beams remain fireproofed. To ensure compliance, Maitenance Director or Assistant Maintenance Director will inspect the fireproofing for the steel beams in the electrical room X30 days and then weekly x2 months and will report back to the QUAPI committee x3 months with any findings and/or corrections.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility	K 311	Both stairway exit doors were scheduled	8/30/24

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K 311	Continued From page 3 failed to ensure two out of four fire rated door assemblies of stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect all 128 residents who resided at the facility. Findings include: Observations on 06/11/24 at 1:17 PM and at 1:43 PM revealed the stairway exit door 6 on the first floor and the stairway exit door of the back hall of the "B" Wing were equipped with panic hardware and not the required fire exit hardware. This condition violated the listing of the rated fire door assemblies. During an interview at the time of observations, the U.S. FOIA (b) (6) confirmed the stairway doors were equipped with panic hardware. NJAC 8:39-31.2(e)	K 311	for repair. The rest of the building was checked for a similar difficiant practice and was found to be in compliance. This deficiant practice can potentially affect all residents and staff due to the fact that fire doors that are not properly assembled can increase the spread of fire. Maintenance department personnel will be educated on NFPA 101: Vertical Openings. During daily rounds the maintenance department will inspect all emergency exit doors throughout the facility to ensure the doors have the required fire exit hardware and to ensure proper operation , and condition. To ensure compliance, Maintenance Director or Assistant Maintenance Director will inspect all fire rated door assesmbles of stairway exit doors x30 days and then weekly for 2 months and report back to the QUAPI committee x3 months with supporting documentation with any findings or corrections.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		8/12/24

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	315353	A. BUILDING **01** B. WING _____	**06/14/2024**

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CRANBURY CENTER	**292 APPLEGARTH ROAD** **MONROE TOWNSHIP, NJ 08831**

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K 324	Continued From page 4 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the cooking facilities were not open to the corridor in accordance with NFPA 101, Life Safety Code (2012 Edition) Section 19.3.2.5.5. This deficient practice had the potential to affect all 128 residents who resided at the facility. Findings include: An observation on 06/11/24 at 12:42 PM revealed the kitchen door opened into the corridor and did not close and latch. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the kitchen door opened into the corridor and did not close. The U.S. FOIA (b) (6) stated when the	K 324	The kitchen door was repaired so that the door would latch properly. The rest of the building was checked for a similar difficiant practice and was found to be in compliance. This deficient practice can potentially affect all residents and staff due to the fact that fire doors that do not latch properly can increase the spread of fire. Maintenance Department Personnel will be educated on NFPA 101: Cooking Facilities. During daily rounds the maintenance director or Assistant Maintenance Director will inspect and ensure that the kitchen door positively latches and remains	

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K 324	Continued From page 5 dishwasher fan was on, the door would not close. The U.S. FOIA (b) (6) shut the power off to the dish washer and the door still did not close and latch. NJAC 8:39-31.2(e)	K 324	smoke tight. To ensure compliance, The Maintenance Director or Assistant Maintenance Director will inspect all kitchen doors x30 days and then weekly x2 months to ensure that the doors latch properly and remain smoke tight, and will report back to the QUAPI committee x3 months with supporting documentation with any findings or corrections.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) 8.5.2.2. This deficient practice had the potential to	K 372	The holes in the smoke barrier were repaired on 7/3/24 with fire barrier seilant. The rest of the building was checked for a similar deficient practice and was found to be in compliance.	8/12/24

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K 372	Continued From page 6 affect all 128 residents who resided at the facility. Findings include: Observations on 06/11/24 at 1:30 PM of the smoke barrier located near room 137, above the smoke barrier doors revealed a hole approximately 3/4" with eight wires going through it. Continued observation revealed a hole approximately 1/4" with two wires going through it. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the penetrations in the smoke barrier was not protected by a system or material capable of restricting the transfer of smoke. NJAC 8:39-31.2(e)	K 372	This deficient practice can potentially affect all residents and staff due to the fact that fire doors that due not latch properly can increase the spread of smoke. Maintenance department personell will be educated on NFPA 101: Smoke Barrier Construction. During daily rounds the maintenance department will inspect all smoke barrier walls throughout the facility to ensure that there are no penetrations and that previous penetrations are properly sealed with proper rated fire barrier sealant. To ensure compliance, The Maintenance Director or Assistant Maintenance Director will inspect all smoke barrier walls x30 days and then weekly x2 months to ensure that there are no penetrations and that previous penetrations are properly sealed with proper rated fire barrier sealant. and will report back to the QUAPI committee x3 months with supporting documentation with any findings or corrections.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with	K 511		8/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 511	Continued From page 7 NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the electrical outlet junction box was secured and the low voltage wiring under seven feet was in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 314.23 (B) and 760.130 (B) (1). This deficient practice had the potential to affect all 128 residents who resided at the facility. Findings include: An observation on 06/11/24 at 12:27 PM of the main electrical room revealed a junction box at the ceiling was not secured. An observation on 06/11/24 at 1:55 PM of the second-floor storage room, near the day room revealed low voltage wiring under seven feet for the fire alarm system was not protected in interior walls or in conduit. During an interview at the time of the observations, the U.S. FOIA (b) (6) verified the junction box was not secured and the low voltage wiring was not protected in the walls or in conduit. NJAC 8:39-31.2(e) NFPA 70	K 511	On 6/24/24 the junction box was secured to the ceiling in the electrical room. The low voltage wiring in the second floor storage room, was installed into the conduit and secured. This deficient practice can potentially affect all residents and staff due to the fact that not properly securing a junction box or protecting low voltage wiring poses a life safety hazard. Maintenance department personnel will be educated on NFPA 101: Utilities Gas and Electric. During daily rounds the Maintenance Director or Assistant Maintenance Director will monitor all wiring and boxes throughout the facility to ensure that they are secure and not exposed. To ensure compliance,the Maintenance Director or Assistant Maintenance Director will monitor all wiring and boxes x30 days and then weekly x2 months to ensure that they are secure and not exposed and will report back to the QUAPI committee x3	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 8	K 511	months with supporting documentation with any findings or corrections.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fire doors were inspected and deficiencies documented on the fire door reports by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 128 residents who resided at the facility. Findings include: Observations on 06/11/24 from 12:05 PM to 2:15 PM of the facility's stairway exit door 6 on the first floor and the stairway exit door of the back hall of	K 761	Both stairway exit doors were scheduled for repair and the kitchen door will be scheduled for an annual inspection. The rest of the building was checked for a similar difficiant practice and was found to be in compliance. This deficiant practice can potentially affect all residents and staff due to the fact that fire doors that are not inspected, can pose a life safety hazard. Maintenance Department Personnel will educated on NFPA 101: Inspection and Testing Doors. During daily rounds the maintenance department will inspect all	8/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315353	A. BUILDING **01** B. WING _____	**06/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBURY CENTER	**292 APPLEGARTH ROAD** **MONROE TOWNSHIP, NJ 08831**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 9 the "B" Wing were equipped with panic hardware and not the required fire exit hardware. Observations also revealed the door to the kitchen had not been inspected annually. A review of the facility's untitled fire safety binder provided by the facility revealed no deficiencies were noted on the fire door inspection reports. During an interview at the time of each observation, the U.S. FOIA (b) (6) confirmed the fire doors deficiencies were not noted on the reports and the kitchen door was not inspected annually. NJAC 8:39-31.2(e)	K 761	emergency exit doors throughout the facility to ensure the doors have the required fire exit hardware and to ensure proper operation , and condition. To ensure compliance, Maintenance Director or Assistant Maintenance Director will inspect all fire rated door assesmbles of stairway exit doors x30 days and then weekly for 2 months and report back to the QUAPI committee x3 months with supporting documentation with any findings or corrections.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315353 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBURY CENTER	292 APPLEGARTH ROAD MONROE TOWNSHIP, NJ 08831

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0161	08/12/2024	LSC K0311	08/30/2024	LSC K0324	08/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	08/12/2024	LSC K0511	08/12/2024	LSC K0761	08/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO