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 06/23/2025

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 Complaint #: NJ187234 Survey Date: 06/23/2025 Survey Census: 100 Sample Size: 3 THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG-TERM CARE FACILITIES.	F 000		

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

Electronically Signed | 07/01/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061224	A. BUILDING: _____ B. WING _____	C 06/23/2025

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 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ187234 Based on review of facility documents on 06/23/2025, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. 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	S 560	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. All residents have the potential to be affected by this deficient practice. Facility Management were re-educated on NJ staffing mandates. The facility will continue recruiting functions, which drive	7/30/25

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

Electronically Signed | 07/01/25

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 06/23/2025

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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. For the 2 weeks of staffing prior to the complaints survey from 06/08/2025 to 06/21/2025, the facility was deficient in CNAs for resident care on 14 of 14 day shifts as follows: On 06/08/25 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 06/09/25 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. On 06/10/25 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. On 06/11/25 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. On 06/12/25 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. On 06/13/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs.	S 560	various forms of media to increase the number of applicants, form external partnerships with schools to train Students and transition them into CNAs and convert temporary C.N.As into permanent C.N.As. 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 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.	

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	061224	A. BUILDING: _____ B. WING _____	C 06/23/2025

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 2 On 06/14/25 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. On 06/15/25 had 7 CNAs for 99 residents on the day shift, required at least 13 CNAs. On 06/16/25 had 7 CNAs for 99 residents on the day shift, required at least 13 CNAs. On 06/17/25 had 8 CNAs for 99 residents on the day shift, required at least 13 CNAs. On 06/18/25 had 9 CNAs for 99 residents on the day shift, required at least 13 CNAs. On 06/19/25 had 8 CNAs for 99 residents on the day shift, required at least 13 CNAs. On 06/20/25 had 9 CNAs for 99 residents on the day shift, required at least 13 CNAs. On 06/21/25 had 10 CNAs for 99 residents on the day shift, required at least 13 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061224 (Y1)	A. Building B. Wing (Y2)	7/5/2025 (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 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 07/30/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/23/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

EVENT ID: MZKV12

STATE FORM: REVISIT REPORT (11/06)