STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ #: 163930; 166007 STANDARD SURVEY: 9/15/2023 CENSUS: 68 SAMPLE SIZE: 17 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 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.	F 584		9/21/23

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

Electronically Signed | 09/21/2023

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss 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 observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain the resident's living environment in a clean, comfortable, homelike manner. This deficient practice was identified on 3 of 3 nursing units, (A-unit, B-unit, and C-unit) reviewed for environmental concerns and for 1 of 1 resident, (Resident #63) reviewed for [redacted]. This deficient practice was evidenced by the following:	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment Plan of Correction ¿ ¿ Corrective action for the residents affected by the deficient practice. a. Rooms C-5, C-6 and A 109 were cleaned, renovated, and painted. b. Room B-211, the towel under the Air Conditioner was removed, the room was painted. c. Room B-205, the wall was repaired	

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F 584	Continued From page 2 1. On 09/06/23 at 12:11 PM, the surveyor toured the C-unit, entered room C5 and observed that the white molding on the bottom of the wall which was in contact with the floor was stained with yellow and black discolorations. In addition, the top of the molding behind the bed's headboard that was positoned on the same wall as the door entryway was chipped off, exposing discolored brownish-black wood. The surveyor further observed green privacy curtains throughout room. Two of the privacy curtains were observed with brown and red stains throughout. The doors between the connecting hallway between rooms C5 and C6 were observed with white and black indentations along the bottom half of the door. Further observations in room C5 identified that the tile in the room closest to the molding was discolored with black scratches and indentations. On 09/06/23 at 1:20 PM, the surveyor entered room C6 on the C-unit and observed a bed on the right-hand side of the room. The bed was pushed up against the wall and was placed in front of a shut door. The doorknob and call bell system were observed to be protruding from the wall and were positioned over the center of the resident's bed. The surveyor further observed brownish-black discoloration on the tile next to the wall behind the door, an apple sized hole was observed in the shades, and there were multiple scratches and indentations throughout the molding on the wall by the floor. On 09/07/23 at 8:46 AM, the surveyor observed on the A-unit in room 109, the headboard to the resident's bed was pressed up against the wall to the left of the entryway door. The length of the bed was against the wall and under the window. The surveyor observed the walls surrounding the	F 584	and painted. d. The privacy curtains in Rooms C-5 and C6 were washed and cleaned. e. The bed in Room C-6 was moved so that it is not pushed against the wall behind the door, the doorknob and the call bell were repositioned so as not to protrude from the wall. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " . All residents have the potential to be affected by these deficient practices. " All other residents and rooms were assessed. " No other residents were observed to have been affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur: " The Administrator/designee educated the housekeeping director with regards to: A. Identifying and locating all medical equipment in every unit that requires daily cleaning. B. Assign a consistent housekeeping staff on each unit to clean rooms and all equipment daily. C. Develop a routine daily cleaning schedule in each unit to ensure that every	

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F 584	Continued From page 3 bed had a long rectangular area that exposed unsanded white spackle which was uneven with the wall's exterior. The surrounding wall was painted a light-colored green. On 9/7/23 at 9:08 AM, the surveyor observed on the B-unit in room 211 a white towel underneath the air conditioner in the resident's room. In addition, the surveyor observed in front of the resident's bed, unsanded white spackle on the wall, with green paint surrounding the area. On 9/7/23 at 9:50 AM, the surveyor observed on the B-unit in room 205 a hole in the wall, exposing white plaster underneath the light socket. On 09/08/23 at 11:50 AM, the surveyor observed on the C-unit in room C5, reddish and brown stains throughout the privacy curtains. On 09/13/23 at 2:28 PM, the surveyor interviewed with Housekeeping Director (HD) who stated that he had a schedule in place to change the privacy curtains in the resident's rooms. The HD further stated that when the privacy curtains in the resident's rooms were observed to be stained, they could be changed right away by staff. The HD told the surveyor that he made rounds everyday after his housekeeping staff cleaned the resident's room to check on their work, but some days could, "miss something". The HD then stated to the surveyor, "Honestly, I would not expect the housekeeping staff to clean the privacy curtains daily." This contradicted the HD previous statement. The surveyor asked the HD why he would not have that expectation from staff. At that time, the HD stated that he focused more on cleaning the bottom of the tray tables in the resident's rooms, bed rails, and topical	F 584	room in a unit is cleaned each week. D. Housekeeping staff assigned to a certain unit will be educated by the housekeeping manager to observe and report rooms that require repair, renovation, and painting. E. Educate housekeeping staff to check the privacy curtains for cleanliness while cleaning the assigned room that day. If curtains are observed to be soiled, these curtains will be washed immediately. F. Develop a routine monthly schedule to washing all privacy curtains in each unit to ensure that all privacy curtains in the unit are completely washed/cleaned on a monthly basis. This will be done regardless of the curtains being soiled or not. " The administrator/designee educated the Maintenance Director with regards to: A. Perform weekly rounds to assess residents□ rooms and beds for repairs and repainting. B. Conduct weekly rounds to check the walls, presence of towels in the Air conditioning System, if beds are pushed against the wall behind the door and corners, to check for chipped paints, doorknobs and call bells that are protruding from the walls. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur:	

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F 584	Continued From page 4 surfaces. On 09/14/23 at 10:36 AM, the surveyor observed on the C-unit in room C6, brown splatter above the bed next to the window and on the wall at the head of the resident's bed. The brown splatter was observed to be in a circular formation. The surveyor further observed next to the same bed that an air conditioner unit was placed in the window. Next to the window the surveyor observed a brown piece of wood covering the window. There was a brown piece of wood covering up the portion of the window that would have been exposed to the outside. The wood was surrounded by white caulk and spackle. The surveyor further observed that the windowsill had grey and brown debris on top of it. On 09/14/23 at 10:47 AM, the surveyor interviewed the Maintenance Director (MD) who stated that he made rounds throughout the facility regularly and inspected the resident's rooms. The MD told the surveyor that he would keep a running list of things that needed to be fixed, would go to Home Depot, get supplies, and then fix the issue. The MD then gave the example that the rooms needed to be painted. The MD further explained that before painting the walls, the walls needed to be spackled, sanded, and then painted so that the wall was even. The MD could not speak to why the resident's room with exposed white plaster were not sanded and painted. On 09/14/23 at 11:04 AM, the surveyor conducted a follow up interview with the MD who stated that the white material surrounding the brown piece of wood was caulking and he was supposed to come in to paint the wood but did not yet. The MD did not speak to time frames of how long the	F 584	1. The Administrator /designee will conduct a weekly audit/round in each unit to check resident□s walls, sills, and corners for areas in need of repairs, painting or renovating. 2. The Administrator /designee will conduct a weekly audit of rooms in each unit with medical equipment to ensure that the equipment is clean and has no stains over them. 3. The Administrator /designee will conduct weekly audit of random rooms in each unit to ensure that the rooms and Privacy Curtains are clean. " The audit will be conducted weekly x 4 weeks, then monthly x 3 months. " All findings will be presented during the monthly QAPI committee meeting for review.	

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wood was left exposed in the resident's room.

On 09/15/23 at 9:57 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that since he took over the facility in NJ Exec Order 26.4b1, he had renovated multiple rooms throughout the facility, hired a new MD, purchased new beds and over bed tables. The LNHA further stated that the MD was in the process of plastering the walls and painting over them. The LNHA stated that the HD was also replacing the privacy curtains in the resident's rooms.

2. On 09/06/23 at 11:37 AM, 09/07/23 at 10:30 AM, and 09/08/23 at 11:31 AM, the surveyor observed Resident #63 in his/her room with a NJ Exec Order 26.4b1 attached to a NJ Exec Order 26.4b1 that was NJ Exec Order 26.4b1 that was attached to an NJ Exec Order 26.4b1. There were several areas of NJ Exec Order 26.4b1 observed on the NJ Exec Order 26.4b1 which was consistent with the NJ Exec Order 26.4b1 that was used for the resident's NJ Exec Order 26.4b1.

The surveyor reviewed the medical record for Resident #63.

Review of Resident #63's Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1.

Review of Resident #63's Quarterly Minimum

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Data Set (MDS), an assessment tool utilized to facilitate the management of care dated NJ Exec Order 26.4b, revealed that the resident's Brief Interview for Mental Status (BIMS) score of NJ E out of 15, which indicated the resident had NJ Exec Order 26.4b1 . The MDS also revealed that the resident was NJ Ex Order 26.4b1 activities of daily living and NJ Exec Order 26.4b1.

Review of Resident #63's Order Summary Report revealed a physician order dated NJ Exec Order 26.4b for NJ Exec Order 26.4b1 for 16 hours or until NJ Exec Order 26.4b1

Review of Resident #63's NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected the above physician's order and was documented as administered.

On 09/08/23 at 11:43 AM, the surveyor interviewed the Registered Nurse (RN) caring for Resident #63. The RN stated the resident NJ Exec Order 26.4b1 and that NJ Exec Order 26.4b1 The RN stated that it was the housekeeper's responsibility to NJ Exec Order 26.4b1 and NJ Exec Order but that she would clean them if they were dirty. The RN further stated that any time that she worked, and the equipment needed to be cleaned, that she would clean them. The surveyor escorted the RN to the resident's room and observed the NJ Exec Order 26.4b1 and NJ Exec Order. The RN acknowledged the NJ Exec Order 26.4b and stated it should not have been there and that she would wash it. The RN stated that it was important to keep resident equipment clean for infection control.

On 09/08/23 at 11:55 AM, the surveyor

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interviewed the Housekeeper (HK) who stated his responsibility was to clean resident rooms daily and wipe equipment daily. The surveyor provided three days of photos of Resident #63's [redacted] and [redacted]. The HK stated the [redacted] and [redacted] should not have been dirty and stated that it should have been, "clean, spotless, and wiped down," to keep the resident safe and for the prevention of cross contamination.

On 09/08/23 at 12:07 PM, in the presence of the Director of Nursing (DON), the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that it was the nurse's responsibility to wipe down the [redacted] and [redacted] if it was visibly soiled and that once the resident no longer needed the equipment, the HK cleaned it and stored it in the supply closet on the unit. The surveyor provided three days of photos of Resident #63's [redacted] and [redacted]. The LPN/IP acknowledged that the [redacted] and [redacted] were dirty and stated that if the equipment was soiled that it was the nurse's responsibility to wipe it and that it was important to keep the equipment clean to avoid germs and contamination.

On 09/13/23 at 2:29 PM, the surveyor interviewed the HD who stated that the Housekeeping Department would clean [redacted] when they were noticeably soiled and that he would make rounds after staff and then would make a cleaning schedule when he observed that the [redacted] needed to be cleaned. The HD then stated that he would not expect his HK staff to clean the [redacted] daily because the staff focused more on cleaning the bottom of the

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eating tables, the bed rails, and topical surfaces. He further stated that he performed rounds every day but some days he could "miss something".

Review of the facility policy, "Daily cleaning resident rooms," with a revision date of 9/8/23, revealed Purpose: To maintain a clean and safe resident care environment in accordance with commonly accepted infection control practices and criteria for cleaning and disinfection. Procedure: 1. Daily cleaning of resident rooms includes but is not limited to the following: cleaning and sanitizing high touch areas ...cleaning any identified spills other dirty surfaces. 7. Visibly dirty surfaces and non-critical medical equipment may be cleaned with mild detergent followed by application of EPA approved disinfectants.

A review of the facility policy, "Cleaning and storage of non-critical medical equipment," with a review date of March 9, 2023, revealed Purpose: To maintain a clean and safe resident care environment in accordance with commonly accepted infection control practices and criteria for cleaning and disinfection. Procedure: 6. Visibly dirty surfaces and non-critical medical equipment may be cleaned with mild detergent followed by application of EPA approved disinfectants.

Review of the facility's In-Service Education Attendance Sheet dated 09/11/23, reflected that staff were in-serviced on Disinfection of the Environment and Equipment and the facility's Cleaning and storage of non-critical medical equipment Policy and Procedure reviewed 03/09/23. The facility's Cleaning and storage of non-critical medical equipment Policy and Procedure indicated, "To maintain a clean and

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safe resident care environment in accordance with commonly accepted infection control practices and criteria for cleaning and disinfection: 1. Non-critical medical equipment is defined as equipment which can be safely cleaned and disinfected by use by others. Examples of such equipment are nebulizers, concentrators and IV pumps."

Review of the facility's In-Service Education Attendance Sheet dated 09/12/23, reflected that staff were in-serviced on the facility's Daily Cleaning Resident Rooms Policy and Procedure dated 09/08/23. The Daily Cleaning Resident Rooms Policy and Procedure indicated that daily cleaning of the resident rooms included, but were not limited to, "cleaning and sanitizing high touch areas, like bedrails, bed side tables, doorknobs, toilet handles, and light switches. Collecting and removing trash bags, sweeping, and mopping the floors. Cleaning any identified spills other dirty surfaces. Cleaning a disinfecting bathroom toilets, sinks, tubs, and showers. The Daily Cleaning Resident Rooms Policy and Procedure further indicated, "Visibly dirty surfaces and non-critical medical equipment may be cleaned with mild detergent followed by application of EPA approved disinfectants."

Review of the facility's Environmental Policy, Resident dated 03/20/23, indicated, "It is the goal of Cranford Park RHCC to provide cheerful home-like environment while ensuring the safety of the residents, staff and equipment at the facility."

Review of the facility's Maintenance Policy and Procedure dated 03/22/23, indicated, "It is the goal of Cranford Park RHCC to provide cheerful

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F 584	Continued From page 10 home-like environment while ensuring the safety of the residents, staff and equipment at the facility." Review of the undated Housekeeping Assistant Job Description indicated, "The primary purpose of this job is to perform the day-to-day activities of the Housekeeping Department in accordance with current federal, state, and local standards, guidelines and regulations governing the facility, and as may be directed by the Administrator and/or the Director of Housekeeping, to assure that the facility is maintained in a clean, comfortable, and safe manner. Review of the undated Maintenance Director Job Description indicated, "The primary purpose of this position is to maintain the orderly functioning of all equipment in the facility including laundry, heating, air conditioning, and elevators as well as purchasing necessary supplies for repairs, maintenance, and emergencies within budgetary guidelines." The MD Job Description further reflected that the MD was to perform all repairs that did not fall under the purview of the housekeeping staff, to maintain up-to-date knowledge of any Federal, and State regulations, modify department policies and assure compliance, and supervise repairs and routine maintenance of the building and all the departmental equipment.	F 584		
F 640 SS=B	NJAC 8:39 - 31.4(a)(f) Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement-	F 640		9/20/23

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§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that

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CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

(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 640	Continued From page 12 does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit the discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for a resident that was discharged from the facility. This deficient practice was identified for 1 of 1 unsampled resident, (Resident #31) reviewed in the Resident Assessment Task for MDS record NJ Exec Order 26.4b1 [redacted] The deficient practice was evidenced by the following: On 09/13/23 at 1:06 PM, the surveyor reviewed Resident #31's MDS history in the presence of the Minimum Data Set Coordinator (MDSC). The surveyor and MDSC reviewed the resident's medical record and identified that the MDS history did not reveal that the resident was discharged from the facility. The surveyor independently reviewed the medical record for Resident #31. Review of the resident's Admission Record indicated that the resident was admitted to the facility in late NJ Exec Order 26.4b1 and had diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]	F 640	F 640 Encoding/Transmitting Resident Assessments Plan of Correction ¿ ¿ Corrective action for the residents affected by the deficient practice. " The MDS assessment for resident # 31 was completed on NJ Exec Order 26.4b1, and was transmitted to and accepted by CMS on NJ Exec Order 26.4b1. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. 1. All residents have the potential to be affected by this deficient practice. 2. The MDS assessments for all other residents were audited for completeness, accuracy and timely submission to CMS. 3. No other residents were observed to have been affected by this deficient practice. ¿ Measures/Systemic changes put in	

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F 640	Continued From page 13 NJ Exec Order 26.4b1 . Review of the resident's Progress Notes (PN) reflected a PN dated NJ Exec Order 26.4b at 11:18 AM, which indicated that the resident was sent to the hospital. On 09/14/23 at 12:13 PM, the surveyor interviewed the MDSC who stated that she forgot to complete the discharge MDS for Resident #31. On 09/15/23 at 10:00 AM, the surveyor interviewed the Director of Nursing who stated that the discharge MDS was required to be completed within three days of discharge. Review of the facility's Education Attendance Sheet, dated NJ Exec Order 26.4b, indicated that the MDS Coordinator was educated on timely submission of MDS's. Review of the facility's undated Job Description for MDS Coordinator indicated, "Monitor Medicare assessment schedules and nursing documentation to ensure accurate and timely submission." NJAC 8:39-11.1	F 640	place to assure the deficient practice does not re occur: " The Director of Nursing/designee educated the MDS Coordinator that MDS assessments should be completed within 14 days of a resident□s change of condition, admission, readmission, or discharge. " The Director of Nursing/designee educated the MDS Coordinator that completed MDS assessments of residents who had a change of condition, a new admission, readmission, or discharge should be submitted to CMS within 14 days. " The Director of Nursing/designee educated the MDS Coordinator make a weekly list of residents who had a change in condition, who were newly admitted/readmitted or discharged whose MDS assessments should be completed within 14 days. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Director of Nursing /designee will conduct a weekly audit of residents who were new admissions, readmissions or discharged or had a change in condition, whose MDS assessments are due for completion to check that the MDS	

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F 640	Continued From page 14	F 640	assessments were completed within 14 days. 2. The Director of Nursing /designee will conduct a weekly audit of residents who were new admissions, readmissions or discharged or had a change in condition whose MDS assessments were completed to check that the MDS assessments were submitted to CMS within 14 days of completion. 3. The audit will be conducted weekly x 4 weeks, then monthly x 3 months. 4. All findings will be presented during the monthly QAPI committee meeting for review.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code a resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 1 of 20 resident's, (Resident #8) reviewed for accurately coding the MDS. The deficient practice was evidenced by the following:	F 641	F 641 Accuracy of Assessments Plan of Correction ¿ ¿ Corrective action for the residents affected by the deficient practice. " The MDS assessments for Resident # 8 were corrected and updated with the note from the NP/MD stating that a [NJ Exec Orde] of the [NJ Exec Order 26.4b1] medication [NJ Exec Order 26.4b1] is [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b1] and submitted to	9/20/23

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F 641	Continued From page 15 On 09/06/23 at 12:06 PM, the surveyor observed Resident #8 seated in his/her reclining chair in the main dining/activity room on the [redacted]. The resident was observed bopping their head to music that was playing in the background. The surveyor reviewed the medical record for Resident #8. Review of the resident's Admission Record indicated that the resident had resided at the facility[redacted] and had diagnoses which included but were not limited to [redacted] Review of the resident's [redacted] Order Summary Report reflected a physician's order dated [redacted], for the [redacted] give one (1) tablet by mouth at bedtime for [redacted]. Review of the resident's Psychiatric Progress Note (PPN) dated [redacted], reflected that a [redacted] of the resident's medication [redacted] was clinically [redacted] Review of the resident's quarterly MDS dated [redacted] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident had [redacted]. A further review of the resident's quarterly MDS, [redacted] - [redacted] Medication Review reflected that [redacted] had been documented by a physician as clinically [redacted] The date the physician had	F 641	and accepted by CMS of [redacted] ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. 1. . All residents who are receiving antipsychotic medications have the potential to be affected by this deficient practice. 2. The MDS assessments for all other residents on antipsychotics were audited. 3. No other residents on antipsychotics were affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Director of Nursing/designee educated the MDS Coordinator about different Antipsychotic medications, their actions and side effects. 2. The director of nursing/designee educated the MDS Coordinator to identify all residents receiving anti-psychotic medications in the facility. 3. The Director of Nursing/designee educated the MDS Coordinator that the Physician Notes are uploaded in each	

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F 641	Continued From page 16 documented that the NJ Exec Orde was clinically NJ Exec Order 26.4b1 on the MDS was blank. Review of the resident's PPN dated NJ Exec Order 26.4b, further reflected that a GDR of the resident's medication, NJ Exec Order 26.4b1 was clinically NJ Exec Order 26.4b1 Review of the resident's annual MDS dated NJ Exec Order 26.4b, reveled that the resident had a BIMS score of NJ Exe out of 15 which indicated the resident had NJ Exec Order 26.4b1. A further review of the resident's annual MDS, NJ Exec Order 26.4b1 - NJ Exec Order 26.4b1 Medication Review reflected that NJ Exec Order 26 had been documented by a physician as clinically NJ Exec Order 26.4b1. The date the physician had documented that the NJ Exec Or was clinically NJ Exec Order 26.4b1 on the MDS was blank. On 09/13/23 at 11:16 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident NJ Exec Order 26.4b, had NJ Exec Order 26.4b1, and was seen by a NJ Exec Order 26.4b1. The CNA further explained that there was NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b and that one minute the resident would be NJ Exec Order 26.4b1 and the next minute the resident NJ Exec Order 26.4b. The CNA told the surveyor that when she identified that the resident's NJ Exec Order 26.4b1 and the resident NJ Exec Order 26.4b1, she would notify the nurse. On 09/13/23 at 11:27 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident had a diagnosis of NJ Exec Order 26.4b1, was NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, was NJ Exec Order 26.4b1, and at times would present with	F 641	resident□s profile each time they are seen by the provider. 4. The Director of Nursing/designee educated the MDS Coordinator to print and review the latest Physician Notes to verify if a resident requires or does not require a Gradual Dose Reduction as documented by the provider prior to completing Section N in the resident□s MDS assessment to ensure the accuracy of MDS data submitted for residents receiving antipsychotics. 5. The Director of Nursing/designee educated the MDS Coordinator to review the latest Physician Notes whether a resident requires a gradual dose reduction or not and the date it was completed by the Physician to ensure that the date is accurately documented in the Section N of the resident□s assessment. 6. The Director of Nursing/designee educated the MDS Coordinator about dating all assessments completed for accuracy of data submitted. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Director of Nursing /designee will conduct a weekly audit of MDS submissions of residents who are on Psychotropic medications to check for accuracy of section N of the MDS assessments.	

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F 641	Continued From page 17 NJ Exec Order 26.4b1. The LPN further stated that at times the resident would have NJ Exec Order 26.4b1 but was easily redirected by staff and NJ Exec Orde on his/her medications. On 09/14/23 at 12:00 PM, the surveyor interviewed the Minimum Data Set Coordinator (MDSC) who stated that Resident #8's quarterly and annual MDS were filled out correctly because the doctor documented that NJ Exec Order 2 was clinically NJ Exec Order 26.4b1 and since NJ Exec Order 2 was not performed, it was not required to be documented on the MDS. The surveyor reviewed the CMS's RAI Version 3.0 Manual in the presence of the MDSC who stated that she coded the resident's quarterly and annual MDS correctly. On 09/15/23 at 10:01 AM, the surveyor interviewed the Director of Nursing who stated the resident's medications should have been accurately coded on the MDS's and were not. Review of CMS's RAI Version 3.0 Manual Section N: Medications indicated that the intent of the antipsychotic medication review was to assist facilities to evaluate the use and management of medications. The RAI Manual further explained that each aspect of antipsychotic medication use and management had important associations with quality of life and quality of care for the resident. Section N0450: Antipsychotic Medication Review indicated in the steps for assessment to review the resident's medical record to see if a GDR had been attempted and if a GDR had not been attempted to review the resident's medical record to determine if the physician documented that a GDR was clinically contraindicated. Review of the facility's Education Attendance	F 641	2. The Director of Nursing /designee will conduct a weekly audit of MDS submissions of residents who are on Psychotropic medications to check that these completed assessments were dated prior to submission. 3. The audit will be conducted weekly x 4 weeks, then monthly x 3 months. 4. All findings will be presented during the monthly QAPI committee meeting for review.	

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F 641	Continued From page 18 Sheet dated [NJ Exec Order 26.4b], indicated that the MDS Coordinator was educated on the correct procedures for filling out Section N - Medications. Review of the facility's undated Job Description for MDS Coordinator indicated that the MDS Coordinator was responsible for completing and assuring the accuracy of the MDS process for all residents. NJAC 8:39-11.1	F 641		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to clarify a Physician's Order (PO) for the dosage of a medication on the electronic Medication Administration Record (eMAR) for several months. This deficient practice was identified during the medication pass observation for 1 of 6 residents, (Resident #16) reviewed and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential	F 658	F 658 Services Provided Meet Professional Standards Plan of Correction ¿ ¿ Corrective action for the resident affected by the deficient practice. 1. Resident # 16□s medication orders were reviewed to check for other issues with transcription, none was noted. 2. Resident # 16 was assessed for any adverse reactions caused by this deficient practice, none was observed. 3. The order for the [NJ Exec Order 26.4b1] was clarified with the Physician and	9/20/23

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F 658	Continued From page 19 physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 09/07/23 at 09:40 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare medications for Resident #16 at the medication cart. The surveyor reviewed the NJ Exec Order 26.4b1 eMAR in the presence of the LPN which reflected a PO dated NJ Exec Order 26.4b1, for the medication NJ Exec Order [redacted] with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 26.4b1. At the time of dispensing the NJ Exec Order 26.4b1, the surveyor observed the LPN pour the NJ Exec Order 26.4b1 into a NJ Exec Order [redacted] plastic medicine cup, take the NJ Exec Order [redacted] cup and pour the NJ Exec Order 26.4b1 into a NJ [redacted] plastic cup. The surveyor further observed the LPN fill the NJ Exec Order [redacted] plastic cup a second time with NJ Exec Order 26.4b1 and pour it into the NJ Exec [redacted] plastic cup. This indicated there was now NJ Exec Order [redacted] of NJ Exec Order 26.4b1 in the NJ Exec [redacted] plastic	F 658	rewritten to indicate the dosage/amount that the resident should receive. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. 1. All residents have the potential to be affected by this deficient practice. 2. All other residents were assessed, no other resident was adversely affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Director of Nursing/designee educated the licensed nursing staff about carrying out orders from prescriptions of compounded medications that residents receive from consults outside the facility. 2. The Director of Nursing/designee educated the licensed nursing staff about clarifying with the Physician or with the Pharmacy if a prescription does not specify the dosage of the medication to be given. 3. The Director of Nursing/designee educated the licensed nursing staff that transcribing medications should include the route of the medication, the form of	

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F 658	Continued From page 20 cup. The LPN then stopped and stated that she would have to call the resident's physician to review the PO because she did not think it was the correct dose of the medication. At 09:54 AM, the surveyor reviewed the NJ Exec Order 26.4b1 eMAR with the LPN. The PO indicated, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1 . Please dispense NJ Exec Order 26 At that time, The LPN stated that the dose (amount) of the medication was missing from the PO and was not displayed on the eMAR. The LPN further stated that the dose of the medication was required within the PO, so the nurse knew the accurate amount of the medication to dispense for the resident. At 09:56 AM, the surveyor reviewed the NJ Exec Orde medication bottle in the presence of the LPN which indicated a dose of NJ Exec Ord on the bottle. At that time, the LPN stated that the dose for the NJ Exec Order 26.4b1 should have been clarified within the PO on the eMAR. The surveyor reviewed the medical record for Resident #16. Review of the resident's Admission Record indicated the resident had resided at the facility for NJ Exec Order 26.4b1 and had diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]	F 658	the medication, the time the medication should be administered, the right indication or diagnosis for using the medication and the dose of the medication to be given. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Director of Nursing/designee will work with the consultant Pharmacist to ensure that the facility has an outside oversight in reviewing all physician□s orders for all residents. 2. The Director of Nursing /designee will conduct a weekly audit to review all medication orders to ensure that medications are written with right indication, right dose, right form, and right route. 3. The audit will be conducted weekly x 4 weeks, then monthly x 3 months. 4. All findings will be presented during the monthly QAPI committee meeting for review.	

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F 658	Continued From page 21	F 658		

Review of the resident's NJ Exec Order 26.4b1 Order Summary Report revealed a PO dated NJ Exec Order 26.4b for NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 26.4b. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Order 26.4b at 0900 (9:00 AM), 1200 (12:00 PM), 1700 (5:00 PM), and 2100 (9:00 PM) from NJ Exec Order 26.4b to NJ Exec Order 26.4b.

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 26.4b. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Order 26.4b at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b.

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 26.4b. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Order 26.4b at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication,

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F 658	Continued From page 22	F 658		

NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 2. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Ord NJ Exec Order 26.4b at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 2. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Ord NJ Exec Order 26.4b at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b.

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 2. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Ord NJ Exec Order 26.4b at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b.

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 2. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Ord NJ Exec Order 26.4b at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b

Review of the resident's NJ Exec Order 26.4b1 eMAR

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	315390	A. BUILDING _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658		F 658		

Continued From page 23

revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 26. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Orde at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b.

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please NJ Exec Order 26.4b1. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Orde at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b

Review of the resident's NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26.4b for the medication, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 four times a day NJ Exec Order 26.4b1. Please dispense NJ Exec Order 26. A further review of the NJ Exec Order 26.4b1 eMAR reflected that the nurses were signing for the administration of the NJ Exec Orde at 0900, 1200, 1700, and 2100 from NJ Exec Order 26.4b to NJ Exec Order 26.4b.

On 09/08/23 at 10:40 AM, the surveyor interviewed the facility's Medical Director (MD) who stated that the eMAR should reflect the dosage of the medication, so the nurse knew the amount of medication to dispense. The MD further stated that if the PO did not reflect the correct dosage, the nurse should have called the physician to clarify.

On 09/08/23 at 11:19 AM, the surveyor

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F 658	Continued From page 24 interviewed the Director of Nursing (DON) who stated that nurses were to administer medication based off the six rights of medication administration which included: the right resident, the right medication, verify the indication for usage of the medication, the right dose of the medication, the right time, and the right route. The DON further stated that if the PO did not reflect that on the eMAR, the process would be to call the resident's physician and clarify the order. NJAC 8:39-29.2(a),(d)	F 658		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		9/18/23

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F 732	Continued From page 25 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the Nursing Home Resident Care Staffing Report daily. This deficient practice was evidenced by the following: On 09/05/23 at 9:00 AM, the surveyor entered the facility (on the Tuesday after Labor Day weekend) and observed that the Nursing Home Resident Care Staffing Report posted in the front lobby was dated 09/01/23 (Friday). On 09/13/23 at 12:21 PM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that the Staffing Coordinator (SC) was responsible for posting the daily staffing Monday through Friday. The LPN/IP told the surveyor that on weekends the Supervisor or Receptionist would post the daily staffing.	F 732	F 732 Posted Nurse Staffing Information Plan of Correction ¿ Corrective action for the residents affected by the deficient practice. " The Nurse staffing report was posted on the designated area daily since this concern was brought to the facility□s attention. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " Any resident in the facility has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur:	

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F 732	Continued From page 26 At 12:27 PM, the surveyor interviewed the SC who stated that she posted the daily staffing report in the front lobby of the facility every day, Monday through Friday. The SC told the surveyor that she would print out the weekend staffing report on Friday for the Supervisor that was on duty to post in the front lobby over the weekend. At 2:20 PM, the surveyor interviewed the Receptionist who stated that she would sometimes post the daily staffing in the front lobby over the weekends, but not all the time. The Receptionist further told the surveyor that she worked the weekend prior to September 5th and had not posted the daily staffing report. At 2:24 PM, the surveyor interviewed the facility's Licensed Nursing Home Administrator (LNHA) who stated that the daily staffing report was posted in the front lobby daily to be compliant State and Federal regulations. On 09/15/23 at 10:02 AM, the LNHA stated that the SC left copies for the daily staffing report to be posted over the weekend on the Receptionist desk and the Receptionist did not post the daily staffing report over the Labor Day weekend. Review of the facility's New Jersey Department of Health Nursing Home Resident Care Staffing Report Policy and Procedure dated 09/14/23 indicated, "Staffing Coordinator will complete staffing report daily and submit electronically to the New Jersey Department of Health." The facility's Policy and Procedure further indicated, "A copy of the report will be posted on the wall inside of the front entrance which is visible to all residents and visitors. Weekend reports will be completed on Friday by the staffing coordinator	F 732	1. The Director of Nursing/Designee educated the staffing coordinator that Nursing Staffing Report should be posted daily in a prominent place readily accessible to residents and visitors. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Director of Nursing/Designee will conduct a random weekly audit to check that the Nurse Staffing is posted daily. 2. The audit will be conducted weekly x 4, then monthly x 3. 3. All findings will be presented during the monthly QAPI committee meeting for review.	

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F 732	Continued From page 27 and put in the binder on the wall behind Friday's report. Any corrections will be made the following Monday. The weekend receptionist will remove the prior day report and make sure the current report is visible. In the event the staffing coordinator is out, the Human Resource manager will complete the report and assure that it is posted accordingly." NJAC 8:39-41.2	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		9/20/23

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F 761	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to: a.) appropriately label, date and store biologicals and b.) discard medications after the manufacturer specified use by date. This deficient practice was identified during 2 of 2 medication storage room (B-unit medication storage room and C-unit medication storage room) inspections and was evidenced by the following: 1. On 09/05/23 at 11:54 AM, the surveyor inspected the medication storage room on the B Unit. The surveyor observed one unlabeled clear orange pill bottle which contained an unidentified clear liquid. The surveyor interviewed the Licensed Practical Nurse (LPN) at the time of inspection who stated that she could not identify what type of liquid was being stored in the clear orange pill bottle on the counter of the medication storage room. On 09/08/23 at 12:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Clinical Nursing Registered Nurse Liaison who were all in agreement that unlabeled clear orange pill bottles containing unidentified substance should not to be stored in the medication storage room. The LNHA and DON reviewed the picture that the surveyor took of the unlabeled pill bottle which contained an unidentified clear liquid and the DON stated that they do not have any pill bottles that look like that in the facility and that it must be a staff member's personal pill bottle, however it should not be	F 761	F 761 Label/Store Drugs and Biologicals Plan of Correction ¿ ¿ Corrective action for the residents affected by the deficient practice. 1. No resident was adversely affected by this deficient practice. 2. The expired Tubersol Vial was removed from Unit C Medication Refrigerator and disposed of accordingly on Sept 8, 2023. 3. The unlabeled clear orange pill bottle which contained an unidentified clear liquid was removed from Unit B Medication Storage Room and disposed of accordingly on Sept 5, 2023. 4. All medication carts and medication rooms/storages/refrigerators in all units were audited on September 14, 2023. All unlabeled and undated drugs and biologicals found were removed and disposed of accordingly. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " . All residents have the potential to be affected by this deficient practice.	

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F 761	Continued From page 29 stored in the medication storage room. 2. On 09/08/23 at 11:41 AM, the surveyor inspected the C-unit medication storage room and observed in the refrigerator the medication, Tubersol, which was opened and dated 08/05/23. At that time, the surveyor interviewed the LPN who stated that Tubsersol was to be discarded 30 days after the medication was opened. On 09/13/23 at 2:38 PM, the surveyor interviewed the facility's Consultant Pharmacist (CP) over the telephone who stated that all medications and containers stored in a medication room that were not appropriately labeled, dated, and identified should have been thrown away. The CP further stated that the medication Tubersol was to be discarded 30 days after opening per the manufacturer recommendations. On 09/15/23 at 10:04 AM, the surveyor interviewed the DON who stated that nothing should have been left open in the medication room and medications that were in the medication room needed to be appropriately labeled and dated. The DON further stated that the medication Tubersol was only good for 30 days after opening and should have been discarded. Review of the facility's Education Attendance Sheet dated 09/14/23, reflected the educational topic, "Medication Storage - No unlabeled medications should be kept in the medication rooms or medication carts. Review of the facility's Medication Storage Policy and Procedure, dated 03/23/23, indicated that,	F 761	¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur: a. The Director of Nursing/designee educated the licensed nursing staff that all medications stored in the medication carts, medication rooms and medication refrigerators should be labeled. b. The Director of Nursing/designee educated the licensed nursing staff that all medications and biologicals should be dated upon opening. c. The Director of Nursing/designee educated the licensed nursing staff that all medications that are not properly labeled and dated should be removed from the medication cart, medication storage rooms and refrigerators and disposed of accordingly. d. The Director of Nursing/designee educated the licensed nursing staff that all medications that are expired should be removed from the medication cart/medication room storages and refrigerators and disposed of accordingly. e. The Director of Nursing/designee educated the licensed nursing staff that all medications and biologicals stored in the refrigerators should be logged when it was stored, when it was opened and when is	

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F 761	Continued From page 30 "Medications will be stored in a manner that maintains the integrity of the product, ensures the safety of the customers, in accordance with state Department of Health guidelines and are accessible only to licensed nursing and pharmacy personnel. The facility's Medication Storage Policy and Procedure further indicated, "Medications will be stored in the original, labeled containers received from the pharmacy. No medication is to be transferred from one container to another. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy." NJAC 8:39-29.4(a)1.2.3.4.5.6.7.8.9.10.(f)	F 761	the expiration date after opening. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Director of Nursing /designee will conduct a weekly audit of the medication carts, medication refrigerators and medication storage areas in each unit for any unlabeled and expired medications. 2. The Director of Nursing /designee will conduct a weekly audit of refrigerator logs for completeness of documentation to ensure that there are no unlabeled, undated, or expired medications in the refrigerators. 3. The audit will be conducted weekly x 4 weeks, then monthly x 3 months. 4. All findings will be presented during the monthly QAPI committee meeting for review.	
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	F 812		9/21/23

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F 812	Continued From page 31 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 on observation, interviews and review of facility documentation it was determined that the facility failed to: a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was observed and evidenced by the following: On 09/05/23 at 10:25 AM, the surveyor toured the kitchen in the presence of the Food Services Director (FSD) and observed the following: 1. On a metal rack in the refrigerator, there was an opened box labeled bacon with the inner plastic bag open and the bacon visible and exposed to air. The FSD acknowledged that the bacon should not have been exposed to air and stated that it was important to make sure the bacon was covered properly to avoid sickness. 2. On the bottom shelf on a metal rack in the freezer, there were four (4) five-pound freezer	F 812	F812 - Food Procurement, Store, Prepare, Serve, Sanitary Plan of Correction ¿ Corrective action for the residents affected by the deficient practice " The frozen meat was dated as of delivery date. " The opened box of bacon was disposed of accordingly. " The meat slicer was washed, disinfected, and securely covered with plastic. " The open coffee filters were placed in a sealed container. " ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " . All residents have the potential to be affected by these deficient practices. ¿ Measures/Systemic changes put in	

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F 812	Continued From page 32 sealed bags of dark reddish chunks of meat with no label and no dates. The FSD identified the meat as cubed beef and acknowledged that the packages were not labeled and dated. The FSD stated that the packages should have been labeled and had an orange sticker with the pull date marked. On the same shelf was one (1) ten-pound package marked cooked corned beef with no use by date. The FSD acknowledged the package was undated and stated that it was important for all the food to be labeled and dated so that the staff were aware when it should have been used to avoid sickness. 3. The meat slicer was observed covered with a black plastic bag. The FSD stated that once the slicer was used that it was cleaned and covered. The FSD removed the black plastic bag and there was white debris on the base and brown debris on the slicer blade, which the FSD acknowledged. The FSD stated that it was important for the equipment to be kept clean because if bacteria had grown, it could have caused illness. 4. On the second shelf in the coffee area, there were three (3) piles of unwrapped, exposed coffee filters resting directly on the shelf. The FSD acknowledged the coffee filters were not stored properly and stated that they should have been stored in a box for the prevention of contamination. A review of the undated facility policy, "Food Storage," revealed, Procedure: 7. C. Food should be dated as it is placed on the shelves ...d. Date marking to indicate the date or day by which a ready-to-eat, time/temperature control for safety food should be consumed, sold or discarded will	F 812	place to assure the deficient practice does not re occur: " The Administrator/designee educated the Kitchen director in regard: A. Ensuring that all meats stored in the refrigerator is labelled and dated when opened. B. All coffee filters should be in safely sealed container C. The meat slicer should be cleaned after every use and securely covered with plastic for infection control. D. Bacon should be securely sealed and stored and not exposed to air. Once opened, it needs to be dated. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator /designee will conduct a random weekly audit of the kitchen to check that all meats stored in the refrigerator are sealed, labelled and dated if previously opened. 2. The Administrator /designee will conduct a random weekly audit of the kitchen to check that coffee filters are stored appropriately in a sealed container. 3. The Administrator /designee will conduct a random weekly audit of the kitchen to ensure that the meat slicer is clean and covered appropriately. 4. The Administrator /designee will conduct a random weekly audit of the kitchen to ensure that bacon is securely sealed and stored in the refrigerator.	

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F 812	Continued From page 33 be visible on all high-risk food.14. Refrigerated food storage: f. All foods should be covered, labeled, and dated. 15. Frozen foods: c. All food should be covered, labeled, and dated. A review of the facility policy, "Cleaning Instructions: Coffee, Beverage, Juice, Frozen Yogurt or Ice Cream Machines," dated 2017, revealed, Procedure: Coffee Machines: 2. All paper products should be stored in a dry location and handled properly. NJAC 8:39-17.2(g)	F 812	5. The audit will be conducted weekly x 4, then monthly x 3. 6. All findings will be presented during the monthly QAPI committee meeting for review.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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;	F 880		9/20/23

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F 880	Continued From page 34 §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: (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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

(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 880	Continued From page 35 §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, interviews, and review of facility documentation, it was determined that the facility failed to follow appropriate infection control practices and perform hand hygiene as indicated during dining observation for 1 of 3 units, (B unit). The deficient practice was evidenced as follows: On 09/07/23, the surveyor observed the following during lunch meal pass on the B-unit: At 12:36 PM, in the pantry room, a Recreation Aide (RA) removed the ice scoop from the wall holder and scooped ice from a cooler, poured the ice into a cup, replaced the ice scoop to the holder, placed the cup on a meal tray and placed the tray on Resident #16's bedside table in his/her room. The RA returned to the pantry and retrieved a meal tray and placed it on Resident #46's side table in his/her room. In the same room, the RA then pulled the privacy curtain around Resident #57, turned, and rested her left hand on Resident #46's pillow that was behind his/her head while the resident was seated in a recliner chair. The RA pulled the recliner chair to reposition the resident in the room, moved the bedside table in front of the resident, touched the resident's shoulder with her right hand, retrieved the meal tray from the side table and placed the meal tray on the bedside table in front of Resident #46, then used the handle on the side of the bedside table to lower the table in front of the resident. The RA removed the food lid, removed the silverware from the plastic bag, placed the	F 880	F 880 Infection Control Hand Hygiene Plan of Correction ¿ Corrective action for the residents affected by the deficient practice 1. All staff who were observed not utilizing the correct hand hygiene practice in between distributing resident s food tray were immediately educated about the proper policy and procedure of hand washing. 2. The staff handing out food trays were reeducated and made to perform a return demonstration of appropriate handwashing technique. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " Any resident in the facility has the potential to be affected by these deficient practices ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur:	

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	315390	A. BUILDING _____ B. WING _____	C 09/15/2023

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CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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F 880	Continued From page 36 fork in the resident's food, pulled up a chair next to the resident and sat down. The RA then picked up the resident's fork and fed the resident a bite of meat, placed the fork on the tray, opened their milk carton, picked up the fork and fed the resident a bite of meat, went to the air conditioning unit and pressed a button, retrieved the power cord and plugged it into the electrical outlet, then again pressed a button on the air conditioning unit, returned to the resident and picked up his/her fork and fed the resident a bite of food. No hand hygiene (HH) was observed at any time during the observation. On 09/07/23 at 12:46 PM, the surveyor interviewed the RA who stated she was also a Certified Nursing Assistant (CNA) and that her role was to assist to feed the resident. She stated during meal tray pass that staff performed handwashing before entering the pantry room, if they touched anything, or if they performed a task for the resident. The surveyor made the RA aware of the meal pass observation. The RA acknowledged that she did not perform HH correctly and stated that it was important to perform proper HH during the meal pass to prevent illness from germs. On 09/07/23 at 12:55 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that staff performed HH before and after the whole meal tray pass and was unsure if HH should have been done between passing each tray. The surveyor made the LPN aware of the meal pass observation. The LPN stated that the RA should have performed HH when she left the first resident's room, after the resident was touched, after plugging in the air conditioning unit, when the curtain was touched, and when the	F 880	1. The Director of Nursing/Designee re-educated all the staff in the facility who handle food distribution during meals with regards to the facility□s infection program with a focus on utilizing the correct way of hand washing in between serving residents during meals. 2. The Director of Nursing /Designee re-educated all staff in the facility regarding appropriate handwashing technique when providing care to residents. Any employee who is found to be noncompliant with this program will receive progressive disciplinary action up to termination. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Director of Nursing/Designee will conduct a random weekly audit by observing staff if they wash their hands between residents while distributing meal trays during meal times. The audit will be conducted weekly x 4, then monthly x 3. All findings will be presented during the monthly QAPI committee meeting for review.	

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F 880	Continued From page 37	F 880		

table was touched. The LPN further stated that it was important to perform HH correctly to prevent passing bacteria.

On 09/08/23 at 09:50 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that HH was performed between each meal tray pass. The surveyor made the LPN/IP aware of the meal pass observation from 09/07/23. The LPN/IP stated that HH was not performed correctly and that HH was important for infection control.

On 09/08/23 at 11:05 AM, the surveyor interviewed the Director of Nursing (DON) who stated that HH was performed in between each resident and when objects were touched. The surveyor made the DON aware of the meal pass observation from 09/07/23. The DON acknowledged that HH was not performed correctly and that HH was important for infection control.

On 09/14/23 at 12:17 PM, the Licensed Nursing Home Administrator and administrative team were made aware of the 09/07/23 B unit RA meal tray pass observation.
On 09/07/23 at 12:30 PM, the surveyor observed the lunch dining observation on the B Unit dining room. The surveyor observed multiple staff members passing out food trays to the residents sitting at the tables in the dining room. The surveyor observed that staff were obtaining the food tray from the cart, would provide the resident the tray, set up the tray (open containers, cut up food etc.), then would immediately go back out to the cart and obtain another tray for another resident and then would set that other resident up

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F 880	Continued From page 38	F 880		

for lunch. The surveyor did not observe any employee in the dining room performing hand hygiene in between distributing resident meals.

On 09/07/23 at 12:41 PM, the surveyor interviewed the Staffing Coordinator/CNA (SC) who was observed by the surveyor distributing resident food trays and setting up residents for their meals in the B Unit dining room. The SC explained to the surveyor that after you set the residents up and prepare the food tray you for one resident then you would proceed to get the next tray and set the next resident up for lunch. She then admitted to the surveyor that she did not sanitize her hands after setting up resident after resident for meals. She stated that it would have been important to sanitize hands between residents' meal distribution to prevent the spread of infection.

On 09/08/23 09:49 AM, the surveyor interviewed the LPN/IP who explained that when staff are distributing food trays to the residents, they should be performing hand hygiene between each resident. She stated that the importance of performing hand hygiene was to not spread germs or infection.

Review of facility documentation, "Competency Validation, Handwashing Technique," dated 09/15/22, revealed the RA passed the return demonstration.

Review of facility documentation, "Hand Hygiene Competency Validation," dated 02/09/23, revealed the RA was competent with return demonstration.

Review of facility documentation, "In-Service

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F 880	Continued From page 39 Education Attendance Sheet," dated 03/20/23, revealed the RA attended the 30-minute hand hygiene in-service. Review of facility policy, "Handwashing, Staff," with a revision date of 03/21/23, revealed, Policy: To prevent the transmission of infections diseases, all personnel working in the facility are required to wash their hands before and after resident contact, before and after performing any procedure ...before handling food and when hands become soiled. NJAC 8:39-19.4 (m)(n)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062005	A. BUILDING: _____ B. WING _____	C 09/15/2023

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S 000	Initial Comments Complaint NJ #: 163930 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ#: 163930 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey. This deficient practiced was evidenced by the following: The facility was 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	S 560	Currently conducting CNA classes start date 10/1/23 to 11/30/23. The facility is actively recruiting license staff and certified nursing assistants by placing an ad and working directly with recruitment agency to cover the staffing requirements. The facility has instituted a sign-on bonus, and employee referral program. The facility has instituted incentive programs for current staff to assist with covering staffing requirements. Identification All residents have the potential to be affected by this deficient practice Systemic Changes	9/20/23

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

Electronically Signed | 09/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062005	A. BUILDING: _____ B. WING _____	C 09/15/2023

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S 560	Continued From page 1 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. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: For the week of Complaint staffing from 12/18/2022 to 12/24/2022, there were no deficient practices for staffing identified as submitted.	S 560	1. The Director of Nursing will work with the Staffing Coordinator reviewing the Nursing/CNA Monthly Schedule to ensure appropriate staffing is in place. 2. The facility will continue to work closely with Staffing Agencies in utilizing agency staff ensuring monthly schedule for their staff. 3. Will continue to hold ongoing Class training. Monitoring 1. Human Resources designee will conduct monthly audits for callouts for 3 months then quarterly thereafter. Reports will be submitted to the Administrator and discussed during quarterly meeting.2. Human Resources will conduct a monthly Quality Assurance on hiring and retention specific to nursing staff monthly for 3 months then quarterly thereafter. Reports will be submitted to the Administrator discussed during QAPI/QA Meeting which takes place every three months.	

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S 560	Continued From page 2 For the week of Complaint staffing from 04/30/2023 to 05/06/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -05/01/2023 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. For the week of Complaint staffing from 07/23/2023 to 07/29/2023, there were no deficient practices identified for staffing as submitted. For the 2 weeks of staffing prior to survey from 08/20/2023 to 09/02/2023, there were no deficient practices identified for staffing as submitted. On 09/13/23 at 12:26 PM, the surveyor interviewed the Staffing Coordinator who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for 10 residents on the 3:00 PM - 11:00 PM shift, and one CNA for 14 residents on the 11:00 PM - 7:00 AM shift. On 09/08/23 at 12:59 PM, the surveyor interviewed the facility's Licensed Nursing Home Administrator who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for 10 residents on the 3:00 PM - 11:00 PM shift, and one CNA for 14 residents on the 11:00 PM - 7:00 AM shift.	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
315390 Y1	A. Building B. Wing Y2	10/19/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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 F0584	Correction	ID Prefix F0640	Correction	ID Prefix F0641	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	09/21/2023	LSC	09/20/2023	LSC	09/20/2023
ID Prefix F0658	Correction	ID Prefix F0732	Correction	ID Prefix F0761	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	09/20/2023	LSC	09/18/2023	LSC	09/20/2023
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	09/21/2023	LSC	09/20/2023	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	
9/15/2023	☐ 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)
062005		10/19/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/20/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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
9/15/2023

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
062005	A. Building B. Wing	10/19/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/20/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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
9/15/2023

☐ 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
	315390	A. BUILDING **01** B. WING _____	**09/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

(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 000	INITIAL COMMENTS NJ Exec Order 26.4b1 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/12/23 and 9/13/23, 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 This Facility is a 3-story building that was certified in 90's, It is composed of Type I fire resistant construction. The facility is divided into 11- smoke zones. The exterior 30 KW natural gas generator does approximately 80 % of the facility. The facility has 2-elevators: dumb waiter and inclined platform lift. The facility has 100 certified beds. At the time of the survey the census was 68. The completed FSES (fire safety evaluation system) dated 8/4/2022 (as of a result of the 6/16/22 survey) indicated that: Cranford Park Rehabilitation & Health Care Center, provider # 31-5390 is comprised of 3-buildings: Nursing Home (two stories and basement); Annex Section (two stories); and C-unit (three stories and basement). *The facility Administrator was informed that a new FSES needs to be conducted for the 2023 recertification survey.	K 000		
K 161	Building Construction Type and Height	K 161		11/2/23

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

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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
	315390	A. BUILDING **01** B. WING _____	**09/15/2023**

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K 161 SS=F	Continued From page 1 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 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,	K 161		

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K 161	Continued From page 2 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 on 9/13/23, in the presence of the Maintenance Director (MD) and Administrator in Training (AIT), it was determined that the facility failed to comply with the construction requirements of NFPA 101:21012 as evidenced by the following: During a tour of the Annex section of the building from 9:30 AM to 1:00 PM, in the presence of the facility's MD and AIT, the Surveyor observed that it was a 2-story wood-frame structure, exceeding the 1-story height requirement for wood-frame structures. The condition noted above was confirmed by the facility's Administrator, Maintenance Director and Administrator in training during the Life Safety Code exit conference on 9/13/23. The facility's Administrator was informed to conduct an on-site Fire Evaluation System (FSES) survey for this recertification. NJAC 8:39-31.2(e)	K 161	¿ Corrective action for the residents affected by the deficient practice. " The facility conducted a Fire Safety Evaluation System on 8/4/2022 for compliance with NFPA 101A-20123. The FSES equivalency calculation passed the Fire Safety Evaluation System (FSES). The facility requested a new FSES and it will be conducted on November 2,2023. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " Any resident in the facility has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator/Designee will train staff extensively every quarter on enhanced level of safety concerning the annex section for the evacuating of residents, fire hazards, electrical hazards, sprinkler system and fire alarm section operations. 2. The facility requested a new FSES. The FSES will be conducted on 11/2/2023	

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K 161	Continued From page 3	K 161	3. The Administrator/Maintenance Director upon receipt, will forward the result of the FSES to department of health ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator/Designee will monitor the building while the corporate physical plant will be monitored monthly. All findings will be presented during the monthly QAPI committee meeting for review.	
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by:	K 252	¿	11/2/23

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K 252	Continued From page 4 Based on observation and interview on 9/13/23, in the presence of the Maintenance Director (MD) and Administrator in Training (AIT), it was determined that the facility failed to provide 2 acceptable exits from each floor or fire section of the building as evidenced by the following: During a tour of the building from 9:30 AM to 1:30 PM, in the presence of the facility's MD and AIT, the surveyor observed the following conditions: 1. The stairway leading from the 3rd floor of the older section of the building was of a winding design. Also, the basement stairway was of a winding design. 2. The 2nd exit/means of egress from the 3rd floor was through a dining room leading to a fire escape. The above conditions were confirmed in an interview with the facility's Maintenance Director and Administrator in Training, at 11:35 AM, both indicated that the issues identified in this section of the building was previously allowed through approved NJDOH and CMS waivers. The facility's Administrator was informed to conduct an new on-site Fire Evaluation System (FSES) survey for this recertification as the last FSES was conducted: 8/4/2022. NJAC 8:39-31.2(e)	K 252	¿ Corrective action for the residents affected by the deficient practice " The facility requested a new FSES, which is scheduled to be completed on November 2, 2023. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " Any resident in the facility has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. The Administrator/Designee will train staff extensively every quarter on enhanced level of safety concerning the annex section for the evacuating of residents, fire hazards, electrical hazards, sprinkler system and fire alarm section operations. 2. The facility requested a new FSES which is scheduled for November 2, 2023. 3. The Administrator/Maintenance Director upon receipt, will forward the result of the FSES the Department of Health	

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K 252	Continued From page 5	K 252	¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: The Administrator/Designee will monitor the building while the corporate physical plant will be monitored monthly. All findings will be presented during the monthly QAPI committee meeting for review. ¿ Date of Completion: Awaiting response from Cranford Fire Department	
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 observation and interview on 9/13/23, in the presence of the Maintenance Director (MD) and Administrator in Training (AIT), it was determined that the facility failed to ensure that	K 311	¿ Corrective action for the residents affected by the deficient practice. " The facility requested a new FSES	11/2/23

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K 311	Continued From page 6 vertical openings between floors were enclosed with 1-hour fire-rated construction as evidenced by the following: During a tour of the building from 9:30 AM to 1:00 PM, in the presence of the facility's MD and AIT, the surveyor observed the stairway connecting the first and second floors in the C Unit were not enclosed with 1-hour fire rated walls on both sides and a fire-rated door at the bottom. This condition was confirmed by the facility's Administrator, Administrator in Training, and Maintenance Director, during the Life Safety Code exit conference on 9/13/23. The facility's Administrator was informed to conduct an on-site Fire Evaluation System (FSES) survey for this recertification. NJAC 8:39-31.2(e)	K 311	which has been scheduled for November 2, 2023. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " Any resident in the facility has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. The Administrator/Maintenance Director train staff on safety programs for evacuating residents via this stairway. 2. The Administrator/Maintenance Director will provide additional training for fire and evacuation drills. 3. The Administrator/ Maintenance Director will ensure that the stairway is free of obstructions. 4. The facility requested a new FSES which will be conducted on 11/2/2023.. 5. The Administrator/Maintenance Director upon receipt, will forward the result of the FSES to the Department of Health	

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K 311	Continued From page 7	K 311	¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator/ Maintenance Director will conduct an audit to ensure that the stairway is free of obstruction. The monitoring will be done weekly x 4 weeks, then monthly x 3 months. All audit findings will be presented during the monthly QAPI committee meeting for review.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321	¿	9/20/23

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K 321	Continued From page 8 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/13/23, in the presence of the Administrator in Training (AIT) and Maintenance Director (MD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were labeled in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 3 of 9 hazardous storage room doors observed and was evidenced by the following: 1. At 11:03 AM, the surveyor observed the door to the annex outside resident room A-4, that the door was provided with a fire resistance rating label, but the label was painted and the rating could not be varified. 2. At 11:28 AM, the surveyor observed that the red fire door in the old basement, was not provided with a fire rating, as the door was observed to be unlabeled.	K 321	¿ Corrective action for the residents affected by the alleged deficient practice " On 9/20/2023, the Maintenance Director installed fire resistance rating labels on the door to the annex out Room A-4. " On 9/20/2023, the Maintenance Director installed fire resistance rating labels on the red fire door in the old basement. " On 9/20/2023, the Maintenance Director installed fire resistance rating labels on the medical storage room door. Photographic documentation of this has been forwarded to and received by Marie Chapman ¿ Corrective action taken for those residents having the potential to be affected by the alleged deficient practice	

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K 321	Continued From page 9 3. At 11:32 AM, the surveyor observed that the medical records storage room door, was not provided with a fire resistive label to determine the rating of the door. The MD and AIT both confirmed the finding's during the observations. The Administrator was informed of the finding's at the Life Safety exit conference on 9/13/23. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321	" Any resident in the facility has the potential to be affected by this alleged deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. The Administrator educated the Maintenance Director that all Fire-Rated Doors should have fire resistant levels. 2. The Administrator educated the Maintenance Director not to paint the labels on Fire Rated doors. 3. All staff were educated that all Fire-Rated Doors shall have fire resistant levels. ¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: 1. The Administrator/ Maintenance Director will conduct an audit to ensure all Fire-Rated Doors shall have fire resistant levels. 2. The monitoring will be done weekly x 4 weeks, then monthly x 3 months. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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K 321	Continued From page 10	K 321		
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 facility documentation, observation and interview on 9/13/23, in the presence of the Maintenance Director (MD) and Administrator in Training (AIT), it was determined the facility failed to inspect all fire-rated door assemblies for proper operation as required by National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives. This deficient practice was evidenced for 2 of 15 fire doors observed. 1. At 11:41 AM, the surveyor observed the	K 761	¿ ¿ K 761 Maintenance, Inspection $ Testing - Doors Plan of Correction ¿ Corrective action for the residents affected by the deficient practice " On 9/20/2023, the Maintenance Director installed a door closer on the Gym Area Door. " On 9/20/2023, the Maintenance	9/27/23

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K 761	Continued From page 11 fire/smoke door from the stairway (by the time clock) on floor #1 to the identified gym area on the floor plan (currently the conference room), it was observed that the wooden door would not fully close into its frame and latch. The MD and AIT confirmed the finding, during the observation. 2. At 12:15 PM the surveyor observed the illuminated exit sign above the exit door in the gym (currently the conference room), that was on the evacuation plan as a designated evacuation exit, was observed in the closed position. The surveyor attempted to open the door, but the exit door was stuck into the frame and required the full body weight of the surveyor to fully pull the door open. The Maintenance Director confirmed the finding during the observation. The Administrator was informed of the finding's at the life safety code exit conference on 9/13/23. NJAC 8:39-31.2(e) NJAC 8:39-31.6	K 761	Director repaired the exit door in the conference room. ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " Any resident in the facility has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator educated the Maintenance Director and staff that all doors should doors should open easily when opened. 2. The Administrator educated the Maintenance Director and staff that all doors should be easily opened. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator/ Maintenance Director will conduct an audit to ensure all doors close easily when closed. 2. The Administrator/ Maintenance Director will conduct an audit to ensure all	

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K 761	Continued From page 12	K 761	doors should open easily opened. 3. The audit will be done weekly x 4 weeks, then monthly x 3 months. All audit findings will be presented during the monthly QAPI committee meeting for review. ¿	

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{K 000}	INITIAL COMMENTS The facility was found to be not in compliance with their POC upon offsite/paper review on 11/03/2023, specifically K161, K252 and K311.	{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 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	{K 161}		11/6/23

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

Electronically Signed | 11/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01** B. WING _____	R **11/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

(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 161}	Continued From page 1 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: The facility submitted an FSES report to show equivalency to the Life Saftey Code. Based on review of the FSES report, the report is incomplete. An email was sent to the facilty Administrator for revisions.	{K 161}	Corrective action for the residents affected by the deficient practice. " The facility conducted a Fire Safety Evaluation System on 10/27/23 for compliance with NFPA 101A-20123. The FSES equivalency calculation passed the Fire Safety Evaluation System (FSES). ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " Any resident in the facility has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the deficient practice does not re occur: 1. The Administrator/Designee will train staff extensively every quarter on enhanced level of safety concerning the annex section for the evacuating of residents, fire hazards, electrical hazards, sprinkler system and fire alarm section	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01** B. WING _____	R **11/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{K 161}	Continued From page 2	{K 161}	operations. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator/Designee will monitor the building while the corporate physical plant will be monitored monthly. All findings will be presented during the monthly QAPI committee meeting for review.	
{K 252} SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: The facility submitted an FSES report to show equivalency to the Life Saftey Code. Based on review of the FSES report, the report is incomplete. An email was sent to the facilty Administrator for	{K 252}	Corrective action for the residents affected by the deficient practice " The facility conducted a Fire Safety Evaluation System on 10/27/23 for compliance with NFPA 101A-20123. The	11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01** B. WING _____	R **11/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

(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 252}	Continued From page 3 revisions.	{K 252}	FSES equivalency calculation passed the Fire Safety Evaluation System (FSES). ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice " Any resident in the facility has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. The Administrator/Designee will train staff extensively every quarter on enhanced level of safety concerning the annex section for the evacuating of residents, fire hazards, electrical hazards, sprinkler system and fire alarm section operations. 3. The Administrator/Maintenance Director upon receipt, will forward the result of the FSES the Department of Health	
{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	{K 311}		11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING **01** B. WING _____	R **11/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

(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 311}	Continued From page 4 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: The facility submitted an FSES report to show equivalency to the Life Saftey Code. Based on review of the FSES report, the report is incomplete. An email was sent to the facilty Administrator for revisions.	{K 311}	Corrective action for the residents affected by the deficient practice. " The facility conducted a Fire Safety Evaluation System on 10/27/23 for compliance with NFPA 101A-20123. The FSES equivalency calculation passed the Fire Safety Evaluation System (FSES). ¿ Corrective action taken for those residents having the potential to be affected by the deficient practice. " Any resident in the facility has the potential to be affected by this deficient practice. ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: 1. The Administrator/Maintenance Director train staff on safety programs for evacuating residents via this stairway. 2. The Administrator/Maintenance	

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	315390	A. BUILDING **01** B. WING _____	R **11/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{K 311}	Continued From page 5	{K 311}	Director will provide additional training for fire and evacuation drills. 3. The Administrator/ Maintenance Director will ensure that the stairway is free of obstructions. ¿ How will corrective actions be monitored to ensure the deficient practice will not re occur: 1. The Administrator/ Maintenance Director will conduct an audit to ensure that the stairway is free of obstruction. The monitoring will be done weekly x 4 weeks, then monthly x 3 months. All audit findings will be presented during the monthly QAPI committee meeting for review.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315390	A. Building 01 - MAIN NURSING BUILDING B. Wing	11/3/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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 Reg. # NFPA 101 LSC K0321	Correction Completed 09/20/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 09/27/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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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	
9/15/2023	☐ 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
	315390	A. BUILDING **01** B. WING _____	R **11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	**600 LINCOLN PARK EAST** **CRANFORD, NJ 07016**

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{K 000}	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/12/23 and 9/13/23, 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 This Facility is comprised of 3-buildings: Nursing Home (two stories and basement) composed of Type V (000); Annex Section (two stories) composed of Type V (000); and C-unit (three stories and basement), composed of Type II (111)that was certified in 90's. The facility is divided into 10- smoke zones. The exterior 30 KW natural gas generator does approximately 80 % of the facility. The facility has 2-elevators: dumb waiter and inclined platform lift. The facility has 100 certified beds. At the time of the survey the census was 68. The facility submitted an FSES report that indicts equivalency.	{K 000}		

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

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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315390	A. Building 01 - MAIN NURSING BUILDING B. Wing	11/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK CARE	600 LINCOLN PARK EAST CRANFORD, NJ 07016

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 Reg. # NFPA 101 LSC K0161	Correction Completed 11/06/2023	ID Prefix Reg. # NFPA 101 LSC K0252	Correction Completed 11/06/2023	ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 11/06/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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 9/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO