STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315353	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranbury Center	292 Applegarth Road Monroe Township, NJ 08831

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interviews, review of medical records, and review of other pertinent facility documents on 05/28/2026, it was determined that the facility failed to maintain an environment free from the use of physical restraint for Resident #2.This deficient practice was identified for 1 of 6 residents (Resident #2) reviewed for restraint.During the survey, a tour was conducted by the surveyor, there was no restrictive device noted for any resident.On 05/23/2026, during the 7:00 AM-3:00 PM shift, the Registered Nurse (RN#1) who was assigned to Resident #2 stated the resident was experiencing respiratory distress. RN#1 administered a respiratory treatment by nebulizer mask. RN#1 stated during the treatment Resident #2 became combative and pulled off the mask from their face. RN#1 stated she then used a pillowcase, wrapped it around Resident #2's left hand and tied it to their side rail to ensure Resident #2 received their respiratory treatment. At approximately 10:20AM, Resident #2 was found by their Hospice Nurse with a restraint to left hand. The hospice nurse called and requested the Manager on Duty (MOD) to immediately come to the facility. The MOD arrived at the facility at approximately 11:00AM and went to Resident #2's room. The MOD untied Resident #2's left hand from their side rail and assessed for injury and bruises with none documented.RN#1 who was assigned to Resident #2 on 05/23/2026, restrained the resident during a respiratory treatment and failed to follow the facility Use of Restraint policy, which led to an Immediate Jeopardy situation.The IJ began on 05/23/2026, and ended on 05/25/2026 when the facility self-corrected the deficient practice. The Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) were informed of the F604 IJ and were provided with the IJ template on 05/28/2026 5:02 P.MThe facility self-corrected and put themselves back in compliance to prevent serious harm from occurring or reoccurring by immediately completing the following:On 05/23/2026, the MOD (Manager on Duty) immediately removed the restricting device from Resident #2. A full body assessment was completed with no injuries noted. The Medical Doctor and Legal Guardian were notified. The Police were called and were onsite for a report. Both nurses working on the unit were immediately suspended pending an investigation.On 05/23/2026, the MOD conducted an audit on all residents living on the unit to ensure no restrictive devices were in place.On 05/23/2026, an In-service initiated with all staff by the DON/LNHA on abuse, restraints and reporting.On 05/24/2026, the DON/ Designee started unannounced rounding on all residents to ensure residents are free of any restrictive devices daily on off shifts.The IJ is Past Non-Compliance. The surveyor verified the implementation of the facility's Removal Plan (RP) while onsite on 5/28/26, and determined that there is sufficient evidence that the facility corrected the noncompliance on 05/25/2026, and is in substantial compliance at the time of the current survey for the specific regulatory requirements for F604. The evidence was as follow.A review of the facility's policy titled Use of Restraint, with a review and revision date of 09/15/2025, under Policy revealed: Patients have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the patient's medical symptoms. Under definitions revealed: Physical Restraint refers to any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: Is attached or adjacent to the patient's body, cannot be removed easily by the patient, and restricts the (continued on next page)

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.

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

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	patient's freedom of movement or normal access to their body.A review of the Facility Reportable Event (FRE) dated 05/24/2026, submitted to the New Jersey Department of Health (NJDOH) included the following:On 05/23/2026, Resident #2's left upper extremity was observed secured to the enabler (side rail) by a pillowcase. An assessment was performed on the resident, and no injuries were noted. Staff involved were suspended immediately pending investigation.The facility provided a summary of the investigation related to the FRE, which stated that RN#1 who was assigned to Resident #2 admitted to looping Resident #2's left hand to the enabler (side rail) using a pillowcase while attempting to administer a nebulizer treatment.According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia (significant, progressive decline in memory), major depression (a serious mood disorder characterized by persistent feeling of sadness), respiratory failure (a critical life threatening condition that occurs when respiratory system cannot adequately perform its essential gas exchange functions), and functional quadriplegia (the complete inability to move due to severe physical disability or frailty).According to the Minimum Data Set (MDS), an assessment tool dated 03/17/2026, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated that the resident's cognition was severely impaired.Resident #2's CP included the following:Under Focus, date initiated 10/17/2024: I [Resident #2] am resistive /combative with care related to: Cognitive Loss/Dementia. Under Goal: I [Resident #2] will have no more than 30 episodes of (i.e. (that is) resisting care/being combative with care) by the review date. Under Interventions: If resident/patient becomes combative or resistive, postpone care/activity and allow time for the resident to regain composure.A review of Resident #2's 05/2026 Order Summary Report (OSR) revealed the following physician's orders (PO): Ipratropium-Albuterol 3 milliliter orally every 6 hours as needed for shortness of breath or wheezing.On 05/28/2026 at 10:44 A.M., a telephone interview was conducted with RN#1 who was assigned to Resident #2. She stated that on 05/23/2026, Resident #2 was experiencing respiratory distress. RN#1 attempted to administer Resident #2's respiratory treatment by mask. Resident #2 was combative and removed their mask. RN#1 then used a pillowcase, wrapped it around Resident #2's left hand and tied it to their side rail. RN#1 stated she should have called the resident's Medical Doctor for refusal and document the refusal. On 05/28/2026 at 12:31 P.M., an interview was conducted with the DON in the presence of the LNHA. The [NAME] stated the nurse did not follow the facility's policy for restraint. The facility self-corrected and put themselves back in compliance to prevent serious harm from occurring or reoccurring by immediately completing the following:On 05/23/2026, the MOD (Manager on Duty) immediately removed the restricting device from Resident #2. A full body assessment was completed with no injuries noted. The Medical Doctor and Legal Guardian were notified. The Police were called and were onsite for a report. Both nurses working on the unit were immediately suspended pending an investigation.On 05/23/2026, the MOD conducted an audit on all residents living on the unit to ensure no restrictive devices were in place.On 05/23/2026, an In-service initiated with all staff by the DON/LNHA on abuse, restraints and reporting.On 05/24/2026, the DON/ Designee started unannounced rounding on all residents to ensure residents are free of any restrictive devices daily on off shifts.The IJ is Past Non-Compliance. The surveyor verified the implementation of the facility's Removal Plan (RP) while onsite on 5/28/26, and determined that there is sufficient evidence that the facility corrected the noncompliance on 05/25/2026, and is in substantial compliance at the time of the current survey for the specific regulatory requirements for F604. N.J.A.C:8:39-4.1 (6)