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	12/04/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure the code status for a resident (Resident # 61) was accurately documented in the electronic medical record (EMR) that correctly identified their wishes in the event of a medical emergency. This deficient practice was identified for 1 out of 37 residents (Resident # 61). Resident # 61 wished to be a Do Not Resuscitate (DNR; do not perform cardiopulmonary resuscitation (CPR) if a person's heart stops or they cease breathing). A review of the resident's EMR revealed that Resident # 61's code status was documented as DNR/Full Code (all resuscitation procedures will be provided when a person stops breathing or their heart stops beating). An interview with staff on [DATE], revealed that during an emergency response, staff would initiate CPR while another staff member called the resident's family to verify their wishes. The facility's failure to ensure Resident # 61's code status was correct during an emergency response to ensure their wishes were followed, posed the likelihood of serious harm or death for the resident by receiving an incorrect emergency response. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on [DATE], when a second Physician's Order (PO) was written for a DNR code status and the first PO dated [DATE], for a full code was not discontinued in the resident's EMR. This led to two contradicting code status' in the resident's EMR. The facility Administration was notified of the IJ on [DATE] at 7:25 PM. The facility submitted an acceptable Removal Plan (RP) on [DATE] at 8:27 AM. The survey team verified the implementation of the RP during the continuation of the on-site survey on [DATE] at 6:59 PM. Findings include:A review of the facility's policy titled OPS422 Code Status Orders, revised [DATE], included code status communicates to the clinical staff whether the patient desires cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest. Patient identification mechanisms and information about each patient's code status will be easily accessible to the clinical staff for all patients. Code status orders include Full Code and Do Not Resuscitate (DNR). All patients require a code status order as soon as possible upon admission/re-admission, a change in patient preference, or a significant change in patient condition. If the patient's wishes are different from the admission orders, immediately document the patient's wishes in the medical record, notify the physician and obtain the correct order. A review of Resident # 61's Face Sheet, located in resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE], and was listed as a Full Code/DNR status. A review of Resident # 61's banner in the [name redacted] in the EMR revealed the resident was listed as a Full Code/DNR status. A review of Resident # 61's Physician Orders located in the resident's EMR under the Orders tab, revealed two active orders; one dated [DATE], for full code and the second order dated [DATE], for DNR. The full code order was not discontinued on [DATE], when the new order was entered. Which led to two contradicting code statuses in the EMR. A review of Resident # 61's paper chart located on the second-floor nurses station revealed a Physician Order for Life-Sustaining Treatment (POLST; a form that enable residents to indicate their preferences regarding life-sustaining treatment) dated [DATE], for DNR.During an interview on [DATE] at 4:16 PM, the Registered Nurse (RN#1) and the Licensed Practical Nurse (LPN#4) stated that when a (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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident coded, they looked in the EMR [name redacted] at the dashboard where the advanced directives were listed or the physician's orders. During an interview on [DATE] at 4:25 PM, LPN#2 stated that she used the EMR [name redacted] dashboard to identify the code status of a resident. During an interview on [DATE] at 4:27 PM, LPN#1 confirmed that upon admission, the advance directives were listed on the dashboard in the EMR, and that the document was in the resident's chart. LPN#1 stated in addition, there was a physician's order for either a DNR or Full Code, and if there was a change, the order needed to change as well. During an interview on [DATE] at 4:30 PM, LPN#3 stated she would use the EMR [name redacted] dashboard to identify the code status of a resident. During an interview on [DATE] at 4:30 PM, RN#2 stated if there was not a code status listed or if there were two code statuses listed, she would initiate CPR while someone attempted to contact the family.During an interview on [DATE] at 9:49 AM, the Infection Preventionist/Licensed Practical Nurse (IP/LPN) stated that he was the nurse who verified the physician's order for Resident #61. The IP/LPN stated he put in the DNR order on [DATE], and that the order for Full Code was not discontinued by the physician at that time. The IP/LPN stated it was his responsibility to request an order to discontinue the Full Code status from the physician, but he was unsure if he did that. The IP/LPN stated if he did make that request, it would have been documented in progress notes in the EMR, but there was no documentation related to it. The IP/LPN stated it was the responsibility of every staff who reviewed the resident's chart to notice the discrepancy in the code status and alert management and the physician to correct it. During an interview on [DATE] at 11:44 AM, the Director of Nursing (DON) stated she expected when a resident was admitted to the facility, that staff verified the resident's code status and ensured the physician's order was correct and reflected the correct code status. The DON stated if there was a change in code status, she expected the old order to be discontinued when the new order was put in. An acceptable Removal Plan (RP) was received on [DATE] at 8:27 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the immediacy including; the conflicting orders for Resident #6l were immediately clarified with the attending physician and responsible party on [DATE]. The correct code status of DNR was verified for Resident #61, the previous Full Code order was discontinued leaving a single active order in the EMR. The banner bar on the EMR reflected only one active code status of DNR for Resident #61. An audit of all active residents was completed on [DATE], by the DON, the Assistant Director of Nursing (ADON), and the unit manager. Chart reviews were completed to ensure there were no conflicting code status orders and that documentation matched the care plan and the POLST, Advanced Directive, and or provider notes. No other mismatches were identified during the initial audit. All findings from the initial audit were documented on an audit tracking tool spreadsheet. The DON and ADON were educated and trained by the Market Clinical Advisor on all areas listed below on [DATE]. All licensed nurses, the Admissions Director, the Medical Records, therapy staff and social services were educated by the ADON between [DATE] and [DATE], either in person or via telephone if not present in the facility, on how to verify code status during admissions and readmissions. All licensed nurses were also educated by the ADON between [DATE] and [DATE], on new physician's orders stop and verify protocol: nurses must confirm that whenever a new Code Status order is entered, no contradicting orders remain to confirm accuracy of code status on the shift-to-shift report daily. The survey team verified the implementation of the Removal Plan on-site on [DATE] at 6:59 PM, and determined the immediacy was removed.NJAC 8:39-4.1(a)(2)NJAC 9.6

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and facility policy review, the facility failed to ensure areas in the kitchen remained sanitary including sanitation buckets remaining at the correct Parts Per Million (PPM) level, the outside of the ice machine was cleaned, dry storage was properly labeled and dated, broken equipment was not used and covers for the steam table were clean when in use. This failure had the potential to affect the spread of food borne illness for 100 of 101 total sampled residents. Findings include:During the initial kitchen tour on 12/01/25 at 10:30 AM with the Dietary Manager (DM), the following observations were made: 1. The sanitary bucket used for wiping cloths, located on the shelf near the floor, was tested and revealed 0 PPM of sanitizer. 2. The lower front of the ice machine was covered in splattered food and water stains. 3. Four ingredient bins, located in the dry storage room, were not labeled or dated. There was one bin with flour, one with breadcrumbs, one with sugar and one with rice. 4. Two plastic containers that held cups and small desert bowls with lids. The lids on both containers had a dirty film and sticky crumbs. Inside the container was a bowl that had dried pudding inside. 5. There was a large coffee urn that had approximately six inches of packing tape at the bottom. The DM stated it had broke but they were continuing to use it until the new coffee urn arrived.6. The cover for one of the steam table pans had hard gravy drippings approximately 4 inches long and 1/2 inches wide. During an interview on 12/01/25 at 10:30 AM, the DM stated she had a cleaning schedule, but it was not in writing. She stated that the containers that held flour, breadcrumbs, sugar and rice, should be labeled and dated. She stated the red buckets that hold the sanitizer wash should be changed every two hours and should always have the required PPM to be effective. The DM stated only clean dishes should be stored and containers that hold dishes should also be clean. She stated that broken equipment should be thrown away and replaced.During an interview on 12/04/25 at 3:07 PM, the Administrator stated that kitchen sanitation policies should be followed. She stated if something is broken it should be thrown away and replaced. Review of the facility's policy titled, Environment, revised 06/2025, revealed All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The Dining Services Directory will ensure that the kitchen is maintained in a clean and sanitary manner . All food contact surfaces will be cleaned and sanitized after each use . The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas and surfaces. NJAC 8:39-17.2(g)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that four residents (R70, R11, R77, and R20) out of 37 residents sampled had a Minimum Data Set (MDS) that accurately reflected their Preadmission Screening and Resident Review (PASRR) Level II status. This had the potential to affect all residents who qualified for a PASRR Level II. Findings include:1.Review of R70's admission Record located in the Profile tab of the electronic medical record (EMR) revealed a re-admission to the facility on [DATE]. Review of R70's annual MDS under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 06/29/25, revealed no indication of a Mental Illness or Level II services. Review of R70's PASARR I located under the Resident Documents tab in the EMR dated 04/03/18 revealed the resident was referred for a level II. During an interview on 12/04/25 at 9:17 AM the Minimum Data Set (MDSC) nurse stated that all the MDS assessments in section A of the Level II PASARR Conditions were done incorrectly per the Resident Assessment Instrument (RAI) manual, and she would need to modify them. She stated all the residents should have had PASRR level II indicated on section A of their comprehensive assessments. During an interview on 12/04/25 at 11:44 AM the Director of Nursing (DON) said she expected MDS assessments to be completed accurately. 2. Review of the admission Record, located in the profile tab of the EMR indicated that R11 was admitted to the facility on [DATE] with a diagnosis of bipolar and major depressive disorder. Review of Level 2 PASRR, dated 03/12/25, located under the tab document in the EMR, indicated.has a mental health treatment needs that can be met in a nursing facility. The following recommendations are being made for the client: psychiatric consultation upon admit to the nursing facility, routine follow up visits with primary and psychiatrist, medication monitoring, supportive counseling, routine lab testing, formulate and implement a behavioral modification plan to address any behavioral disturbances, provide education on medication to client and family on mental illness and medication, and develop a crisis intervention/safety plan with the client.Review of R11's annual MDS with and ARD of 03/31/25 revealed there was no level 2 PASSR noted on the MDS. 3. Review of the admission Record, located in the profile tab of the EMR indicated that R77 was re-admitted to the facility on [DATE] with a diagnosis of schizophrenia. Review of Level 2 PASRR, dated 05/26/21, located under the tab document in the EMR, indicated .has a mental health treatment needs that can be met in a nursing facility. The following recommendations are being made for the client: psychiatric consultation upon admit to the nursing facility, routine follow up visits with primary and psychiatrist, medication monitoring, supportive counseling, routine lab testing, formulate and implement a behavioral modification plan to address any behavioral disturbances, provide education on medication to client and family on mental illness and medication, and develop a crisis intervention/safety plan with the client.Review of R77's significant change MDS assessment with ARD 02/23/25 revealed there was no level 2 PASRR noted.During an interview on 12/04/25 at 10:35 AM, the MDSC confirmed that both of the MDSsfor R11 and R77 were coded incorrectly. 4. Review of R20's Face Sheet located in the EMR under the Profile tab revealed an admission date of 01/19/25 with medical diagnosis of bipolar disorder.Review of R20's annual MDS located in the EMR under the MDS tab with an ARD of 01/24/25 revealed the resident was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. Review of R20's Care Plan located in the EMR under the Care Plan tab, with a revised date of 10/15/25, revealed the focus was [R20] meets PASRR II Level of Determination secondary to: dx (diagnosis) of Serious Mental Illness. The goal was for R20 to Be appropriately evaluated and re-evaluated for specialized services as needed and per state requirements. Interventions included Arrange for PASRR re-evaluation if there is a significant change in status that results in new evidence of possible mental disorder, intellectual disability and/orrelated condition.During an interview on 12/04/25 the MDSC stated R20's MDS was inaccurate and she would be submitting a correction. During an interview on 12/04/25 at 3:07 PM, the Administrator stated that all MDSs should be accurate upon submission. NJAC 8:39-33.2(d)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility reported incident (FRI), and review of the facility policy, the facility failed to ensure one (Resident (R) 46) of four residents reviewed for abuse out of a total sample of 37 residents was free from abuse. This had the potential for an injury to the resident. Findings include:1.Review of R85's admission Record, located in the profile tab of the electronic medical record (EMR) indicated the resident was re-admitted to the facility on [DATE] with severe dementia with agitation. An attempt was made to interview R85 however he did not respond to questions. 2. Review of R46's admission Record, located in the profile tab of the EMR indicated that R46 was re-admitted to the facility on [DATE] with bipolar and adjustment disorder with mixed anxiety and depressed mood. Review of R46's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/24/25 revealed that R46 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating she was moderately impaired cognitive function. During an interview on 12/03/25 at 5:40 PM, R46 revealed R85 got upset when he told him to go away and R85 hit him on the chin. R46 denied that R85 had ever hit him prior to this. Review of the unlabeled, undated Facility Reported Incident (FRI) summary (5-day) revealed that on 11/26/25, a staff member witnessed R85 approach R46. R46, told him [meaning R85] to go away and R85 hit R46 on his [meaning R46] chin. Both residents were immediately separated. Skin assessments were performed on both residents, and no apparent injuries were noted to either resident. R85 did not recall the incident; however, R46 stated that R85 hit him on his chin because he told him to go away. The team feels that when R46 told R85 to go away, he [R85] became agitated and retaliated due to his declining cognitive status. R46 was offered and accepted a room change on the opposite side of the unit. However, later in the shift, he requested to return to his old room. R46 revealed they felt safe in the facility. During an interview on 12/03/25 at 1:15 PM, the Director of Nursing (DON) stated this was an isolated occurrence. During an interview on 12/04/25 at 3:15 PM, the Administrator indicated that this was an isolated occurrence and there had not been another occurrence since then. Review of a policy document titled Abuse Prohibition, revised 11/14/25 indicated Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient property, and exploitation for all patients.This includes, but is not limited to, freedom from.and any physical. NJAC 8:39-4.1(a)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and facility policy review, the facility failed to identify targeted behaviors, conduct behavior tracking and monitor the side effects of antipsychotic medications for two of five sampled residents (Resident (R) 80 and R6) reviewed for unnecessary medications out of a total sample of 37 residents. These failures placed the residents at risk for not obtaining the intended therapeutic goal of the antipsychotic medication and the potential for serious adverse effects from the antipsychotic medications.Findings include: 1.Review of R80's undated Resident Face Sheet, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was re-admitted to the facility on [DATE] with diagnoses including schizophrenia. Review of R80's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/09/25 and located in the EMR indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated R5 was cognitively intact. The assessment indicated the resident exhibited verbal behaviors one to three days, but no other behaviors were indicated. Review of R80's Physician Order Report dated 09/16/25 and found in the EMR under the Orders tab, indicated R80 was to receive Zyprexa 10 milligrams (mg), one tablet by mouth in the evening for schizophrenia. Review of R80's Medication Administration Record (MAR), dated October, November and December 2025 and found in the EMR under the Orders tab, revealed no documented evidence to show which specific behaviors or side effects were associated with the administration of the resident's antipsychotic medications and required routine monitoring. Review of R80's "Nurse's Notes" located in the EMR under the "Notes" tab for October, November and December 2025 revealed no documented behaviors related to a diagnosis of schizophrenia. During an interview on 12/03/25 at 3:25 PM Licensed Practical Nurse (LPN)4 stated they do not have a does not list specific side effects or behaviors to look forDuring an interview on 12/03/25 at 4:00 PM Registered Nurse (RN)1 stated if they see any behaviors they will document that. But they have never been instructed to look for specific behaviors for each medication or been told which specific side effects for each medication to look for. She was unable to state which specific side effects to look for related to R80's medication. During an interview on 12/04/25 at 11:44 AM the Director of Nursing (DON) said she was unaware that nursing staff were not monitoring target behaviors or side effects and she expected them to. 2.Review of R6's undated Face Sheet, located in the EMR under the Profile tab, revealed R6 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia. Review of R6's annual MDS with an ARD of 10/13/25, located in the EMR under the MDS tab, revealed R6 had a BIMS score of 15 out of 15, which indicated R6 was cognitively intact. R6 did not exhibit any behaviors within the review period. R6 received an antipsychotic medication routinely during the lookback review period of Risperidone 1mg (milligrams) twice dailyReview of R6's comprehensive Care Plan, updated 09/13/25, located in the EMR under the Care Plan tab, documented [R6] is at risk for complications related to the use of psychotropic drugs . Resident has a hx (history) of paranoia, screaming and curing at others, hallucinations and punching others, racial slur toward staff.Review of R6's Physician's Orders, dated 01/2023, located in the EMR under the Orders tab, revealed R6 received Risperidone (an antipsychotic) 1mg twice daily, with a start date of 05/08/23. Further review failed to reveal orders for behavior tracking and to monitor the side effects of antipsychotic medications. Review of R6's Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 11/2025 and 12/2025, located in the EMR under the Orders tab, revealed Chart behaviors every shift. The MARS failed to reveal the specific behaviors staff should track. orders for tracking specific behaviors and tracking medication side effects when monitoring antipsychotic medications.During an interview on 12/03/25 at 11:01 AM, the Director of Nursing (DON) stated even though the behaviors are on the care plan, there are no orders for the specific behaviors. She stated risks of taking an (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antipsychotic should also be in the MAR for monitoring.During an interview on 12/03/25 at 1:45 PM, Licensed Practical Nurse (LPN) 1 stated that R6 did not have targeted behaviors documented in his physician orders on the MAR but should be.During an interview on 12/04/25 at 3:07 PM, the Administrator stated she expected staff to ensure targeted behaviors and risks of medications were identified and monitored. Review of a facility document titled, Psychotropic Drug Use, dated 10/31/18, documented Each customer [resident] receiving an antipsychotic medication for organic mental disorders .is observed for 1. Episodes of the behavioral symptoms being treated and/or manifestations (s) of the disordered thought process. 2. Adverse reactions and side effects. 3. Appropriateness of drug selection and dosage. NJAC 8:39-27.1(a)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to report an allegation of verbal abuse within two hours for two of three residents (Resident (R) 80 and R46) reviewed for abuse out of a total of 37 residents. his had the potential for continued abuse of the residents.Findings include:1. Review of R80's undated Resident Face Sheet, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was re-admitted to the facility on [DATE] with diagnoses including schizophrenia. 2. Review of R46's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included anxiety disorder and bipolar disorder. Review of the Nurse's Note dated 08/23/25 and located under Progress Notes tab in the EMR revealed During the 3-11 shift, R80 had reportedly threatened R46 in stating he was going to blow his head off, if he doesn't give him a cigarette while cursing and causing a disturbance in the hallway. That episode had been managed at the time.During an interview on 12/03/25 at 9:43 Registered Nurse (RN)4 stated that earlier in the day after that last smoking break during the 3-11 shift R46 came upstairs and told her that R80 threatened to shoot him because he would not give him a cigarette. She stated that she did not witness this interaction and that R80 denied saying it. She said R46 stated he was not afraid and that R80 had verbal outburts at times. She stated she did not talk to any of the staff who supervised smoking or any other residents, and she did not report it, but she should have. During an interview on 12/04/25 at 11:44 AM, the Director of Nursing (DON) was not made aware of the incident that occurred on 08/22/25, until the next morning on 08/23/25. She stated she did not feel the need to report it since she spoke with R46, and he denied anything occurred and he felt safe. Review of the Facility's policy titled OPS300 Abuse Prohibition revised 11/14/25, revealed Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following: Report allegations involving abuse (physical. verbal. sexual. mental) not later than two hours after the allegation is made. NJAC 8:39-9.4(f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to thoroughly investigate allegations of verbal and physical abuse for two residents (Resident (R) 46 and R85) out of five residents reviewed for abuse out of a total sample of 37 residents. This had the potential for continued abuse of the residents.Findings include:1. Review of R80's undated Resident Face Sheet found in the electronic medical record (EMR) under the Profile tab, indicated the resident was re-admitted to the facility on [DATE] with a diagnosis of schizophrenia. Review of R46's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included anxiety disorder and bipolar disorder. Review of the Nurse's Note dated 08/23/25 and located under Progress Notes in the EMR revealed During the 3-11 shift, R80 had reportedly threatened R46, stating he was going to blow his head off, if he doesn't give him a cigarette while cursing and causing a disturbance in the hallway. That episode had been managed at the time.Review of Soft File undated revealed the Director of Nursing (DON) was made aware of the incident that occurred on 08/22/25 on 08/23/25. Further review revealed no staff who supervised smoking were interviewed or other staff other than Registered Nurse (RN)4 and no residents were interviewed including R46 and R80. During an interview on 12/03/25 at 9:43 RN4 stated that earlier in the day after that last smoking break during the 3-11 shift R46 came upstairs and told her that R80 threatened to shoot him because he would not give him a cigarette. She stated that she did not witness this interaction and that R80 denied saying it. She said R46 stated he was not afraid and that R80 had verbal outburts at times. She stated she did not talk to any of the staff who supervised smoking or any other residents and she did not report it but she should have. During an interview on 12/04/25 at 11:44 AM the Director of Nursing (DON) said she spoke with R46 who stated nothing occurred and he was not fearful and therefor she did not feel the need to interview other residents or staff. She stated since R46 felt safe they were satisfied that there was no concern. 2.Review of R85's admission Record, located in the profile tab of the electronic medical record (EMR) indicated the resident was re-admitted to the facility on [DATE] with severe dementia with agitation. An attempt was made to interview R85 however he did not respond to questions. Review of the undocumented, undated summary (5-day) revealed that On 11/26/25, a staff member witnessed R85 approach R46. R46, told him [meaning R85] to go away and R85 hit R46 on his [meaning R46] chin. Review of the Facility Reported Incident (FRI), there was evidence of only one staff being interviewed and no residents being interviewed regarding the abuse allegation. During an interview on 12/02/25 at 3:00 PM, the DON stated that there was only one staff member that had direct knowledge of the incident, so that is the only staff interview that was obtained. Confirming that there were no resident interviews obtained. The DON said that there were no residents involved. Review of the Facility's policy titled OPS300 Abuse Prohibition revised 11/14/25 revealed, initiate an investigation within 24 hours of an allegation of abuse that focuses on: whether abuse or neglect occurred and to what extent; clinical examination for signs of injuries. if indicated, causative factors; and interventions to prevent further injury. The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnessed interviews is included. NJAC 8:39-4.1(a)NJAC 8:39-9.4(f)NJAC 8:39-27.1(a)

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	12/04/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure one resident (Resident (R) 5) of 37 residents reviewed was invited to their care plan conference. The facility further failed to hold a care plan conference for R119. This had to potential to cause the residents to be not informed regarding their care. Findings include:1.Review of R5's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed an admission date of 08/18/23 with medical diagnosis of chronic kidney disease.Review of R5's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an assessment reference date (ARD) of 09/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R5 was cognitively intact. Review of the Care Conference Notification Letter dated 06/04/25 located in the EMR under the Documents tab revealed, Care plan conference for (R5) on Thursday June 12th at 1:00 PM. The letter was addressed to R5's family members. There was no documentation to support that R5 received notification. Review of the Progress Note dated 06/12/25 located in the EMR under the Progress Notes tab revealed the care plan meeting was held and the resident or family did not attend. Review of the Care Conference Notification Letter dated 08/25/25 located in the EMR under the Documents tab revealed, Care plan conference for (R5) on Thursday, September 4th at 1:00 PM. The letter was addressed to R5's family members. There was no documentation to support that R5 received notification.Review of the Post admission Patient-Family Conference located in the EMR under the Assessments tab, dated 09/08/25 revealed attendees included resident's family, Social Services, Nurse Unit Manager, and Director of Rehab. There was no documentation indicating why R5 did not attend.During an interview on 12/01/25 at 1:35 PM, R5 stated she was not aware of any care conference, nor had she attended a care conference. She stated she would like to attend.During an interview on 12/04/25 at 11:40 AM, the Medical Records Specialist (MRS) stated if a resident did not have family or a responsible party she would give the care conference notice to the resident. If the resident did have family she would give the notice to the family member. She stated she thought the family would then notify the resident. During an interview on 12/04/25 at 11:01 AM, the Director of Nursing (DON) stated residents should always be invited to their care plan meeting. During an interview on 12/04/25 at 3:07 PM, the Administrator stated the resident should always be invited to the care conference and encouraged to attend.2. Review of the admission Record, located in the profile tab of the EMR indicated that R119 was admitted to the facility on [DATE] with diagnoses of anxiety, chronic pain syndrome, cerebrovascular accident (CVA), depression, epilepsy, muscle spasms, and polyneuropathy. Review of the Progress Notes located it the Progress Notes tab of the EMR revealed no evidence of care planning meeting being held quarterly for R119. During an interview on 12/04/25 at 1:50 PM, the MDS Coordinator (MDSC) indicated that prior to January 2025 there was no process in place to determine who gets invited to the care plan meetings and when they were scheduled. The MDSC confirmed that R119 had one in-progress for 06/18/24, otherwise no record for care conferences were found in the medical record for R119. Review of the facility's policy titled Person Centered Care Plan dated 09/15/25 revealed, Care plan meetings: The center has the responsibility to assist patients to participate by extending invitation to pertinent and representatives sent in advance; holing care planning meetings at the time of day when the patient is functioning best, facilitating the inclusion of the patient/representative(s) to attend; and incorporating the patient's personal and cultural preferences in developing goals of care. NJAC 8:39-11.2(e)(f)(h)