

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Cranford Park Care		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Lincoln Park East Cranford, NJ 07016	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Complaint #NJ 00182926</p> <p>Based on interviews, medical records reviews, and review of other pertinent facility documentation, on 06/03/25, 06/05/25, and 06/19/25, it was determined that the facility failed to revise a care plan after an annual assessment for a cognitively impaired resident that needed assistance with meals. The facility also failed to follow its Care Plan policy. This deficient practice was identified for 1 of 3 residents (Resident #6) reviewed for care plans and was evidenced by the following:</p> <p>Resident #6 was not at the facility at the time of the survey. A closed record review was conducted.</p> <p>According to the admission Record (AR), Resident #6 was admitted to the facility with diagnoses which included but were not limited Alzheimer's Disease, Dementia, Muscle Weakness, Diabetes Mellitus and Encounter for Palliative Care.</p> <p>A review of the resident's annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 01/18/2025, revealed that Resident #6 had a Brief Interview of Mental Status (BIMS) score of 3 out of 15, which indicated that the resident had severe cognitive impairment. The MDS further indicated that Resident #6 required Substantial/ Maximum assistance with eating.</p> <p>A review of Resident # 6's Care Plan (CP) did not reveal the level of assistance the resident required when eating.</p> <p>A review of Resident #6 Progress Notes (PN) revealed a nursing note dated 01/12/25, at 10:56 P.M, that revealed that the resident, Requires complete total care with [Activities of Daily Living] at all times.</p> <p>Review of the IDCP (Interdisciplinary Care Planning)/Care Conference Note, dated 01/23/25 at 11:36 A.M., revealed that the Director of Nursing (DON), documented that the resident was a Max assist x1 with ADL .</p> <p>(continued on next page)</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/05/25 at 2:17 P.M, the DON stated that he and the Assistant Director of Nursing (ADON), were responsible for updating care plans. He stated that the CP was important because it showed that the needs of the resident were being addressed. He further stated, The MDS and the care plan should reflect the same information. In the presence of the surveyor, the DON reviewed Section GG of Resident #6's MDS and stated that the resident was a max assist related to eating. The DON also reviewed the IDCP/Care Conference note, and stated that, Max assist x1 with ADLs includes eating. He also reviewed Resident #6's CP and stated that the CP should have reflected the max assist for eating, and that he should have updated it.</p> <p>Review of the facility Care Plan policy, revised 2/21/25, revealed that, .all residents admitted to the facility will have comprehensive person-centered care plans that provide for their needs . The CP policy further revealed under section 10 that, Care plans will be updated in a timely manner and necessary revisions made when there are changes in conditions.</p> <p>NJAC: 8:39-11.1; 11.2(i); 27.1(a)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>COMPLAINT #NJ00179350, NJ00182926</p> <p>Based on interviews, medical record review, and review of other pertinent facility documents on 6/3/25, 6/5/25, and 6/19/25 it was determined that the facility failed to consistently document in the Documentation Survey Report on care provided to dependent residents according to facility policy and protocol for 3 of 3 residents (Resident #1, Resident #5, and Resident #6) reviewed for documentation. This deficient practice was evidenced by the following:</p> <p>1. According to the admission Record (AR), Resident #1 was admitted with diagnoses that included but were not limited to: Dementia, Muscle weakness, Diabetes Mellitus Type 2</p> <p>The surveyor reviewed Resident #1's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/10/25, which indicated that Resident #1 had a BIMS of 9 out of 15, indicating moderate cognitive impairment. The MDS further indicated that the resident required assistance with Activities of Daily Living (ADLs).</p> <p>A review of Resident # 1's Documentation Survey Report v2 (DSR) dated May 2025, for completion of ADL under Intervention / Task did not indicate that Personal Hygiene was documented at the following times:</p> <p>ADL- Personal Hygiene:</p> <p>During the 7:00AM to 3:00PM shift, the following days did not have documentation:</p> <p>5/3/25, 5/4/25, 5/7/25, 5/9/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/17/25, 5/18/25, 5/24/25, 5/25/25, 5/30/25.</p> <p>During the 3:00PM to 11:00PM shift, the following days did not have documentation.</p> <p>5/2/25, 5/5/25, 5/6/25, 5/9/25, 5/10/25, 5/11/25, 5/16/25, 5/17/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/30/25, 5/31/25.</p> <p>During the 11:00PM to 7:00AM shift, the following days did not have documentation:</p> <p>5/2/25, 5/3/25, 5/4/25, 5/9/25, 5/10/25, 5/15/25, 5/16/25, 5/17/25, 5/22/25, 5/23/25, 5/24/25, 5/30/25, 5/31/25.</p> <p>2. According to the AR, Resident #5 was admitted with diagnoses including but not limited to Seizures, Muscle weakness and difficulty walking.</p> <p>A review of the quarterly MDS, an assessment tool dated 5/21/25, revealed that Resident #5 had a BIMS score of 9 out of 15, indicating that Resident #5 had moderate cognitive impairment. The MDS further indicated that the resident required assistance with ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident # 5's DSR, dated May 2025, for completion of ADL under Intervention / Task did not indicate Personal Hygiene was documented at the following times:</p> <p>ADL- Personal Hygiene:</p> <p>During the 7:00AM to 3:00PM shift, the following days did not have documentation</p> <p>5/3/25, 5/4/25, 5/7/25, 5/9/25, 5/10/25, 5/11/25, 5/14/25, 5/16/25, 5/18/25, 5/20/25, 5/24/25, 5/25/25, 5/30/25, 5/31/25.</p> <p>During the 3:00PM to 11:00PM shift, the following days did not have documentation.</p> <p>5/2/25, 5/3/25, 5/5/25, 5/9/25, 5/10/25, 5/11/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/22/25, 5/24/25, 5/25/25, 5/30/25, 3/31/25.</p> <p>During the 11:00PM to 7:00AM shift, the following days did not have documentation.</p> <p>5/2/25, 5/3/25, 5/9/25, 5/10/25, 5/15/25, 5/16/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/30/25</p> <p>3. According to the AR, Resident #6 was admitted with diagnoses including but not limited to Alzheimer's Disease, Dementia, Muscle Weakness, Diabetes Mellitus and Encounter for Palliative Care.</p> <p>A review of the resident's annual MDS, an assessment tool used to facilitate the management of care, dated 01/18/2025, revealed that Resident #6 had a BIMS score of 3 out of 15, which indicated the resident had severe cognitive impairment. The MDS further indicated that the resident required assistance with ADLs.</p> <p>A review of Resident # 6's DSR, dated January 2025, for completion of ADL under Intervention / Task did not indicate that, Personal Hygiene, and Toilet Use were documented at the following times:</p> <p>ADL- Personal Hygiene:</p> <p>During the 7:00AM to 3:00PM shift, the following days did not have documentation</p> <p>1/1/25, 1/2/25, 1/3/25, 1/3/25, 1/4/25, 1/5/25, 1/6/25, 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/14/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25, 1/20/25, 1/22/25, 1/25/25, 1/26/25, 1/27/25, 1/28/25, 1/29/25, 1/30/25, 1/31/25</p> <p>During the 3:00PM to 11:00PM shift, the following days did not have documentation.</p> <p>1/2/25, 1/3/25, 1/3/25, 1/5/25, 1/6/25, 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/14/25, 1/15/25, 1/16/25, 1/17/25, 1/20/25, 1/21/25, 1/22/25, 1/23/25, 1/24/25, 1/25/25, 1/26/25, 1/27/25, 1/28/25, 1/29/25, 1/30/25, 1/31/25.</p> <p>During the 11:00PM to 7:00AM shift, the following days did not have documentation.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Activities of Daily Living policy, revised on 3/7/25, revealed that, The purpose of this procedure is to assist the nurse in gathering information about the overall condition of the resident and his or her performance of activity of daily living. It further revealed under the Documentation of Care Provided that the Certified Nursing Assistants (CNAs) document all the care they provided to the residents assigned to them during their shift in [the electronic medical record].</p> <p>NJAC: 8:39-27.1(a); 35.2(d)6</p>		