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	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranford Park Care	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. COMPLAINT #2728237 Based on interviews, review of medical records and other pertinent facility documentation on 5/26/26, it was determined that the facility failed to: a) appropriately reconcile a resident's medication at time of admission and b) administer an antibiotic treatment in a timely manner in accordance with professional standard of practice. This deficient practice was identified for 1 of 2 residents (Resident #6) reviewed for medication reconciliation and was evidenced by the following:Resident #6 was not at the facility at the time of the survey. A closed record review was conducted. A review of Resident #6's admission Record revealed that the resident was admitted with diagnoses that included but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, hemiplegia affecting left dominant side, type II diabetes, and convulsions. A review of Resident #6's comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated 11/14/25, revealed a Brief Interview of Mental Status (BIMS) of 13 out of 15, which indicated that the resident's cognition was intact. A review of Resident #6's care plan (CP) indicated that Resident #6 had a focus related to the resident receiving, [Intravenous] antibiotic therapy (Vancomycin), due to an infection. The focus included an intervention that revealed that medications were to be administered as ordered. A review of Resident #6's After Visit Summary dated 11/8/25, revealed that the resident was to start taking Vancomycin 1.25 gram/250 mL in sodium chloride 0.9% daily on 11/9/25. A review of Resident #6's Medication Administration Record (MAR) for November 2025 revealed a Vancomycin Intravenous Solution was to be administered daily to treat Sepsis arthritis ordered to start on 11/9/25. A review of the 11/9/25 MAR box revealed that a 9 was entered in the box for that day, by the Licensed Practical Nurse (LPN #1), which indicated that the antibiotic was not administered as ordered. Further review of the MAR showed the medication was first administered on 11/10/25 at 3:12 PM. A review of Resident #6's progress notes (PN) revealed nursing notes as follows:-11/8/25 at 8 PM, nursing note revealed that the resident arrived at the facility and that their medications were reviewed, created by LPN #1.-11/9/25 at 6:35 AM, nursing note revealed that a message was left for the Nurse Practitioner (NP) inquiring if the [Vancomycin] should continue and they were awaiting a call back.-11/9/25 at 2:01 PM, an administration note that indicated that the pharmacy was contacted related to the Vancomycin and that it would arrive in the second delivery.-11/9/25 at 6:07 PM, nursing note created by LPN #1, that revealed that the resident had an order for Vancomycin that was to start on 11/9/25 and that the order had not been entered into the computer. LPN #1 reached out to the nurse practitioner and obtained an order to enter the medication and was told to obtain the medication from the backup. The note further indicated that LPN #1 did not have access to the back-up, and the script was sent to the pharmacy. An interview was conducted on 5/26/26 at 2:09 PM with LPN #1 who confirmed that she was the admitting nurse for Resident #6 on 11/8/25. In the presence of the surveyor, she reviewed the PN from 11/8/25, the medication reconciliation, and Resident #6's MAR. She stated that resident was admitted late in the shift, and that she expected that the next shift staff was responsible for the medication reconciliation. She stated that when she returned the next day, she realized that the Vancomycin was not on the medication list, so she contacted the NP to obtain the order. She further stated that the medication was not in the facility back-up box, and that she sent the script to 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy. Whew the surveyor asked why she wrote in the PN that she reviewed the resident's medications on 11/8/25. LPN #1 stated that she reviewed the medications but that she expected the next shift staff to reconcile them. She further stated that the resident had an infection that was being treated with Vancomycin and that the purpose of the medication was to prevent the infection from worsening, and the resident should have received it on 11/9/25. An interview was conducted on 5/26/26 at 4:25 PM with the Nursing Supervisor (NS) who stated that it was the responsibility of the admitting nurse to reconcile medications and that the NS was to verify that medications were reconciled for each new admission. In the presence of the surveyor, the NS reviewed the above documentation related to Resident #6. The NS stated that he could not recall what happened on that day, but he considered the incident a delay in treatment. He further stated that the resident should have started Vancomycin at the facility on 11/9/25. An interview was conducted on 5/26/26 at 4:43 PM with the Director of Nursing (DON) who reviewed the above documentation for Resident #6 in the presence of the surveyor. She stated that the resident should have started the medication on 11/9/25. She further stated that this medication is normally kept in the back-up box, and it should have been there. N.J.A.C. 8:39-27.1(a)

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Complaint #2966196, 2955245Based on interviews, record review, and review of other pertinent facility documents it was determined that the facility failed to a) ensure that care and services for a resident's colostomy was provided and b) resident's behaviors related to care and services of the colostomy were monitored and documented in the medical record. This deficient practice was identified for 1 of 2 closed medical records reviewed (Resident #2) for ostomy care.Resident #2 was no longer at the facility. A closed medical record review was conducted. According to the admission record, Resident #2 was admitted to the facility with diagnoses including but not limited to: encounter for attention to ileostomy (a surgical procedure that reroutes waste out of your body by connecting the lowest part of the small intestine (the ileum) to an opening in your abdominal wall, called a stoma); need for assistance with personal care; long term use of immunosuppressive biologic (medication that reduces the activity of the immune system); dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to); and heart transplant status. The quarterly Minimum Data Set (MDS) an assessment tool dated 03/12/2026 was reviewed. The MDS revealed that Resident #2 had a Brief Interview for Mental Status Score of 15 out of 15 which indicated that the resident's cognition was intact. Review of the MDS further revealed that Resident #2 had an ostomy (surgical procedure that creates an opening in the body for the discharge of body wastes) and required partial or moderate assistance with ostomy hygiene. Review of the Care Plan (CP) for Resident #2 revealed a Focus with an initiation date of 08/31/2026 revealed Resident #2 had anxiety related to fear of ileostomy leakage and availability of ostomy supplies. Interventions related to this goal included but were not limited to monitoring the resident for signs and symptoms of discomfort, with an initiation date of 10/30/2025; reassurance and clear communication about ostomy supply management, with an initiation date of 02/26/2026; and patient teaching about ileostomy care and bag emptying, with an initiation date of 02/26/2026. Review of the Order Summary Report for Resident #2 revealed the following physician orders (POs):Change ileostomy bag every three days and as needed (PRN). The order start date was 12/17/2025.Change ileostomy bag every three days and PRN on night shift. The order start date was 12/18/2025.Change pouching system every three to five days and immediately if leaking. First, apply Cavilon Advanced (a protectant for damaged or at-risk skin) to peristomal skin (area of skin immediately surrounding an abdominal stoma) and allow to air dry; second, apply Coloplast SenSura Mio Convex light ostomy barrier (skin barrier that adheres around the stoma, protects skin and secures the ostomy pouch); third, apply Coloplast SenSura Mio flex high ostomy output pouch (medical device used to collect stool through an abdominal opening called a stoma); fourth, apply Coloplast Bed Drainage Bag (a separate waste collection container connected to the ostomy bag by a long, flexible drainage tube) one time a day every three days for ostomy care. The order start date was 01/25/2026.Change the dry sterile dressing (DSD) to the small stormy (stoma) area above the ileostomy every three days. Monitor for target behaviors for use of alprazolam every night shift: crying, fidgeting with her ileostomy, inability to sleep, and restlessness. Number of behaviors noted: 0 = NA (not applicable), 1 = 1, 2 = 2, 3 = 3 or more. Nondrug interventions: 0 = NA, 1 = redirection, 2 = support/reassurance 3 = reduced stimulation, 4 = 1:1 with staff, 5 = diversional activities, 6 food/snack. Outcome/Result: 0 = NA, 1 = effective, 2 = ineffective. The order start date was 01/15/2026. Complete monthly psychotropic medication review every 17th day of each month. Go to evaluations, initiate drop down, click and Monthly Psychotropic Medication Review then complete review and summarize resident's behaviors in the past month. Every night shift starting on the 17th and ending on the 17th every month. The order start date was 01/17/2026. Review of the medication administration records (MAR) and treatment administration records (TARs) for January, February, and March 2026 revealed that the orders for ileostomy bag changes and the instructions for Resident #2's ileostomy care did not appear on the MARs or TARs. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes (PNs) for Resident #2 showed behaviors directed toward their ileostomy bag on the following dates: 02/06/2026, 02/17/2026, 02/26/2026 and 03/02/2026. Review of the February and March MARs for Resident #2 revealed that no behaviors, non-drug interventions, or outcomes were documented related to the resident's ileostomy on the aforementioned dates and no evidence of interventions provided by staff to address the behaviors. The OSR and MARs and TARs for Resident #2 were reviewed with the Director of Nursing (DON) during an interview on 05/26/2026 at 3:54 PM. The DON stated that the pouch system changes for Resident #2 should have been documented on the Resident's MARs or TARs. The DON stated that the treatment orders should have been transcribed to the MARs or TARs by the nurse who received the order. The DON further stated that if touching and fidgeting with the ileostomy bag was documented in the progress notes it should have been documented in the behavior monitoring section of the MAR. The facility Physician Medication/Treatment Order Transcription policy, with a revision date of 03/22/2026, was reviewed. Under Policy: the facility policy revealed Registered and Licensed Practical Nurses shall transcribe the physician's orders from the Physician's Order Sheet onto the resident's Medication Administration Record or Treatment Record accurately, efficiently and within a timely basis. NJAC 8:39-27.1 (a)