| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315451 | A. Building<br>B. Wing | 11/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Elms Rehab and Healthcare Center of Cranbury | 61 Maplewood Avenue<br>Cranbury, NJ 08512 |

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) |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Complaint # 432327Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure that incontinence and hygiene care was provided to residents who were dependent on staff for activities of daily living (ADL) care. The deficient practice occurred for 1 of 2 residents (Resident #100) reviewed for ADL's and was evidenced by the following: Complaint #On 9/23/25 at 10:30 AM, the surveyor interviewed the Lead Certified Nurse Aide (CNA) regarding where the care provided was documented. The CNA informed the surveyor that all CNAs where to document the care provided on the Electronic Medical Record. The CNA was able to show to the surveyor where the care provided was documented. The CNA informed the surveyor that licensed staff had access and could print the document if needed. On 9/23/25 at 10:30 AM, the surveyor requested the above document from the Director of Nursing (DON). Upon review of the document, it was noted that on multiple shifts care was not signed as being provided nor that Resident #100 had refused care during their stay on 2/16, 2/17 and 2/21/25.On 9/23/25 at 12:30 PM, the surveyor reviewed the resident's clinical record. The admission Face Sheet reflected that Resident #100 was admitted to the facility with diagnoses which included, unspecified Dementia, chronic obstructive pulmonary disease, and muscle weakness. The admission Minimum Data Set ( MDS), an assessment tool, used by the facility to prioritize care dated 2/16/25, revealed that Resident #100 was moderately cognitively impaired. Resident #100 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS).Section GG of the MDS which addressed Functional Status, revealed that Resident #100 was totally dependent on staff for care, including bathing and incontinence care. Resident #100 had an ADL Self Care Performance Deficit related to deconditioning due to recent hospitalization initiated 2/9/25. The Goal was I will accept staff assistance regarding the performance of ADLs with maximum self-participation as able through the review date, 7/10/25. The interventions for Resident #100 included to receive the assistance of one person for bathing and hygiene and was a two person assist for mobility and transfer.A review of the Order Recap Report dated 2/1/25 to 2/28/25, reflected the following orders: Resume Bath/ shower/ nail care twice a week, and document any refusals and to see the shower assignment and schedule accordingly; every day shift every Tuesday and Friday for hygiene. On 9/23/25 at 11:30 AM, the surveyor requested the above document from the Director of Nursing (DON). On 9/23/25 at 12:29 PM, the DON provided a document titled, Documentation Survey Report v2. Upon review of the document the surveyor observed the following: thatOn 2/16/25 incontinence care was not documented as being offered/ provided during the 3:00 PM-11:00 PM shift and 11:00 PM-7:00 AM shift. Bowel Management was not documented for the 11:00 PM- 7:00 AM shift. Personal Hygiene was not documented as being offered/provided for 3:00 PM-11:00 PM shift and the 11:00 PM- 7:00 AM shift.On 2/17/25 Incontinence care was not documented as being offered/provided for the 7:00 AM-3:00 PM shift. Personal Hygiene/ shower/bath were not documented as being offered/provided during the 7:00 AM-3:00 PM shift. Bowel Management was not documented also for the 3:00 PM-11:00 PM shift and the 11:00 PM-7:00 AM shift. On 2/21/25 incontinence care, hygiene care, shower/bath were not documented as being offered/ provided. On 9/23/25 the surveyor reviewed the Point of Care document provided by the facility and observed that staff failed to document that incontinence care, hygienic care, shower/bath<br>(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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | were provided, on 2/16/25, 2/17/25 and 2/21/25 during the 7:00 AM -3:00 PM shift and 3:00 PM-11:00 PM shift. On 9/23/25 at 1:15 PM, a review of the nurse's progress notes from 2/16/25 to 2/17/25 revealed that the resident was at the facility and there was no rationale regarding why the care provided was not entered in the clinical record.On 9/24/25 at 12:30 PM, the surveyor reviewed the Documentation Survey Report for February 2025, with the DON. The DON confirmed that the care was not entered and could not be verified as having been provided. The surveyor then asked the DON if the facility had a system in place to review the care had been provided. The DON stated that staff would be educated, and that staff should notify their supervisors if they could not log-in to enter the data on the Point of Care.A review of the facility's policy titled, Activities of Daily Living (ADL), Supporting last revised April 2025, revealed the following:Policy Statement:Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).Residents who are unable to carry out of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. A review of the facility's policy titled, Charting and Documentation last revised July 2017, revealed the following:Policy Statement:All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. NJAC 8:39-27.2(f)(i).NJAC 8:39-35.2(d)16(g). |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on interview, review of the medical record and other facility documentation, it was determined that the facility failed to maintain Hospice Communication Records for 1 of 2 residents (Resident #95) reviewed for Hospice Services. This deficient practice was evidenced by the following:failed to ensure all residents medical record were readily accessible and available for review by the survey team. This deficient practice was identified for Resident #95, 1 of 2 residents reviewed for Hospice Services and was evidenced by the following: On 9/19/25 at 10:21 AM, the surveyor reviewed Resident #95's electronic medical record. The admission Face sheet, an admission summary reflected that Resident #95 was admitted to the facility with diagnoses which included but were not limited to; malignant neoplasm of unspecified part of the bronchus or lung (lung cancer), holiday relief care, secondary malignant neoplasm of the brain (brain cancer) and malignant neoplasm of the bone (bone cancer).The Nursing admission Evaluation dated 5/15/25, reflected that Resident #95 was unable to participate with the admission process. The resident was severely cognitively impaired and was unable to report the correct day, month or year. The initial plan of care listed clinical considerations as hospice or respite. The admission Evaluation also reflected that Resident #95 was admitted for palliative care under hospices services. A review of the individualized person-centered care plan included a focus area for hospice services, initiated 5/15/2025. Th goal was for Resident #95 to remain comfortable. The interventions included: Administer all medications as ordered, initiated 5/16/25. Encourage verbalization of thoughts/feeling or condition, hospice CNA (certified nursing assistant) visit per my care plan, hospice nurse visit at least once per week, notify hospice with any change in condition, other hospice staff (SS/clergy) visit as often as necessary, provide adequate rest periods between activities, initiated 5/16/25.A review of the Order Recap Report (ORR) dated 5/15/25 to 5/21/25, included an order for Do Not Hospitalize every shift for hospice code status with an original date of 5/17/25. A review of a progress notes dated 5/17/25 timed 4:09 PM, indicated the following: Hospice Nurse came to evaluate Resident #95. Recommendations given to change Morphine back to 0.5 milligrams (mg) every hour as needed and to change the code status to DNH as per the Resident Representative request. Hospice nurse at bedside monitoring the resident condition. On 9/24/25 at 10:20 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who completed the admission evaluation. The surveyor inquired regarding the process for hospice services. The LPN/UM stated if a resident was admitted for hospice services or if the resident was already on hospice, the hospice nurse would evaluate and make recommendations as needed. These recommendations would be communicated to the physician. Once approved by the physician, the hospice nurse would come as scheduled and communicate daily with the facility regarding the resident's care. The hospice nurse will enter in the hospice book any recommendation regarding medications and change in condition. The surveyor then requested the hospice recommendations for Resident #95. The LPN/UM did not provide any. The LPN/UM stated she was unsure where the communication log was for Resident #95. The LPN added that Resident #95 was discharged , and the facility could not locate the log.On 9/25/25 at 12:24 PM, the surveyor interviewed the Director of Nursing (DON) who stated when a resident was on hospice services the facility would provide a continuation of care. That's when the hospice service and the facility would get together and coordinate a plan of care for the resident. This would include a schedule for how frequently the nurses and aides would visit the resident. The DON acknowledged there was no documentation in the medical record that an interdisciplinary meeting had been held to discuss hospice services. She further acknowledged the facility staff was unable to locate any additional records on site. At that time the DON confirmed she did not have any of the hospice records. When asked how long the facility was required to maintain records at the facility, she stated five years. The DON acknowledged the hospice records should have been on the premises and available for review. A review of the Nursing<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Facility Services Agreement, effective 12/10/24 included.Hospice and Facility will jointly develop and agree upon a coordinated, interdisciplinary Plan of Care which is consist with the hospice philosophy and is responsive to the unique needs of the hospice patient and his or her expressed desire for hospice care. Hospice and the facility shall periodically conduct joint reviews of each plan of care as necessary to coordinate provision of facility services. The Plan of care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.A review of the Hospice Program policy with a revised date of July 2017 indicated.In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.NJAC 8:39-27.1(a) 35.2 (k) |