STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062005	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK REHAB & HEALTHCARE CI	600 LINCOLN PARK EAST CRANFORD, NJ 07016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.	S 560	1. Currently conducting CNA classes start date 6/20/22 to 7/30/22. 2. The facility is actively recruiting license staff and certified nursing assistant by placing an ad and working directly with recruitment agency to cover the staffing requirements 3. The facility has instituted a sign-on bonus, and employee referral program. 4. The facility has instituted incentive programs for current staff to assist with covering staffing requirements. Identification	6/20/22

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

Electronically Signed | 06/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift	S 560	All residents have the potential to be affected by this deficient practice Systemic Changes 1. The Director of Nursing will work with the Staffing Coordinator in reviewing the Nursing/CNA Monthly Schedule to ensure appropriate staffing is in place. 2. The facility will continue to work closely with Staffing Agencies in utilizing agency staff ensuring monthly schedule for their staff. 3. Will continue to hold ongoing CNA class training. Monitoring 1. Human Resources designee will conduct monthly audits for callouts for 3 months then quarterly thereafter. Reports will be submitted to Administrator and discussed during quarterly meeting. 2. Human Resources will conduct a monthly Quality Assurance on hiring and retention specific to nursing staff monthly for 3 months then quarterly thereafter. Reports will be submitted to Administrator and discussed during QAPI/QA Meeting which takes place every three months.	

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S 560	Continued From page 2 begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 5/22/22 and 5/29/22 revealed the following: The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -05/22/22 had 8 CNAs for 70 residents on the day shift, required 9 CNAs. -05/28/22 had 8 CNAs for 69 residents on the day shift, required 9 CNAs. -05/29/22 had 8 CNAs for 66 residents on the day shift, required 9 CNAs. -05/30/22 had 8 CNAs for 66 residents on the day shift, required 9 CNAs. -06/04/22 had 7 CNAs for 68 residents on the day shift, required 9 CNAs. On 6/16/22 at 11:30 a.m., the surveyor discussed the staffing ratio concerns with the Administrator and the Director of Nursing.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed	S1405		6/20/22

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S1405	Continued From page 3 physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents it was determined that the facility failed to ensure that new employees received physicals within the required time frames. This was found with 2 of 5 employee files reviewed, employee # 3 and employee # 5. The deficient practice was evidenced by the following: On 6/15/22 at 10:00 AM, the surveyor reviewed 5 employee files for completeness. Of the 5 files reviewed it was found that 2 of the employees did not have a physical completed upon hire. Employee # 3 had a hire date of 4/11/22. The employee did not have a physical done upon hire. The file contained a copy of a physical that was done on 5/6/21 at another facility.	S1405	S1405 Mandatory Infection Control and Sanitation Plan of Correction 1. Corrective action for the residents affected by the alleged deficient practice 1. On June 16, 2022, Employee # 3 was seen and examined by a nurse practitioner and a health history was completed on the same day. 2. On June 16, 2022, Employee # 5 was seen and examined by a nurse practitioner and a health history was completed on the same day. 2. Corrective action taken for those	

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S1405	Continued From page 4 Employee # 5 had a hire date of 3/8/22. The employee did not have a physical done upon hire. The file contained a copy of a physical that was done on 12/15/21 at another facility. On 6/15/21 at 11:05 AM, the surveyor asked the Human Resources Manager if she was aware of the requirement to have a physical done upon hire. She said "Yes but it was missed. I apologize." On 6/16/22 at 9:00 AM the surveyor reviewed the facility's Policy and Procedure titled " Mantoux, Tuberculin Skin Test, Pre-employment, and New Hires Employee." The revision date on the policy was 1/14/22. The heading was "Hiring: Pre-employmeny Screening for new hires." Page two read "All of the following items must be completed once you have selected a candidate for employment and before the candidate actually starts work." Number 2 (a) read "Advise candidate to immediately: a) Set up appointment for madatory physical to be completed within 30 days of hire."	S1405	residents having the potential to be affected by the alleged deficient practice " Any resident in the facility has the potential to be affected by this alleged deficient practice 3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: A. The Human Resources Manager/Designee was reeducated with regards to the facility□s Policy and Procedure on completing the Physical Examination of a newly hired employee by an Advanced Practice Nurse/Physician 14 days prior of employment or 30 days of employment if a Registered Nurse performed the assessment on hire. 4. How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: 1. The Human Resources Manager will conduct an audit of all newly hired staff to check that these employees have a physical examination completed by a Physician or Advance Practice Nurse 14 days prior of starting work in the facility or 30 days of employment if a Registered Nurse performed the assessment on hire.. The audit will be conducted weekly x 4, then monthly x 3. All findings will be presented during the monthly QAPI committee meeting for review.	

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S1405	Continued From page 5	S1405	5. Date of Completion: June 20, 2022	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview, and review of facility documents it was determined that the facility failed to ensure that employees had 2 step	S1410	S1410 Mandatory Infection Control and Sanitation Plan of Correction	6/20/22

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S1410	Continued From page 6 tuberculin testing completed upon hire. This was found with 4 of 5 employee files reviewed, employee #,1, # 2, # 3, and # 4. The deficient practice was evidenced by the following: On 6/15/22 at 10:00 AM the surveyor reviewed 5 employee files for completeness. Of the 5 files reviewed it was found that 4 of the employees did not receive 2 step tuberculosis skin testing. Employee # 1 had a 1 step tuberculosis skin test done on 5/26/22. There was no second step. Employee # 2 had a 1 step tuberculosis skin test done on 3/25/22. There was no second step. Employee # 3 had no tuberculosis skin test. The file contained a copy of one tuberculosis skin test result dated 5/19/20 and one tuberculosis skin test result dated 5/4/21. These tests had been done at another facility. Employee # 4 had a 1 step tuberculosis skin test done on 5/16/22. There was no second step. On 6/15/21 at 11:05 AM, the surveyor asked the Human Resources Manager if she was aware of the requirement to have a two step tuberculosis skin test done upon hire. She said "Yes but it was missed. I apologize." On 6/16/22 at 9:00 AM the surveyor reviewed the facility's Policy and Procedure titled " Mantoux, Tuberculin Skin Test, Pre-employment, and New Hires Employee." The revision date on the policy was 1/14/22. The heading was "Hiring: Pre-employmeny Screening for new hires." Page	S1410	¿ Corrective action for the residents affected by the alleged deficient practice 1. On June 18 , 2022, Employee # 1 received the Step 2 Mantoux Test. 2. On June 18, 2022, Employee # 2 received the Step 2 Mantoux Test. 3. On June 18, 2022, Employee # 3 received the Step 1 Mantoux Test. 4. On June 18, 2022, Employee # 4 received the Step 2 Mantoux Test. ¿ Corrective action taken for those residents having the potential to be affected by the alleged deficient practice " Any resident in the facility has the potential to be affected by this alleged deficient practice ¿ Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: " The HR/Designee was reeducated with regards to the facility's Policy and Procedure on completing the First Step Mantoux Test of all newly hired employees prior to start and a Second Step two-three weeks thereafter if the first step was negative.	

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S1410	Continued From page 7 two read "All of the following items must be completed once you have selected a candidate for employment and before the candidate actually starts work." Number 2 (b) read "Advise candidate to immediately: b) Set up appointment for mandatory Mantoux [PPD skin test] (Note: Mantoux must be read 2-3 days after given. Make sure Mantoux is done at least 2 days (48 hours) prior to start date. Candidate cannot start work until after Mantoux is read.)"	S1410	¿ How will corrective actions be monitored to ensure the alleged deficient practice will not re occur: 1. The HR Manager will conduct an audit of all newly hired staff to check that these employees completed the First Step Mantoux Skin test prior to starting work in the facility and the second test two-three weeks after if the first sept was negative. The audit will be conducted weekly x 4, then monthly x 3. All findings will be presented during the monthly QAPI committee meeting for review. ¿ Date of Completion: June 20, 2022	
S2345	8:39-31.6(o) Mandatory Physical Environment (o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 6/13/22, it was determined that the facility failed to invite Local, County and State emergency management officials to their emergency drill(s) at least 10 days prior, as evidenced by the following:	S2345	Element One. On 6.18.22 the facility sent a invited local/state/ county OEM to the facility to our EP Drills. Element Two.	6/22/22

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S2345	Continued From page 8 A review of the facility's emergency preparedness records, fire drills, disaster drills and related records reviewed at 12:00 PM, revealed that the facility, did not have any documented evidence that indicated an invitation was extended to the Local, County and State emergency management officials to attend the disaster drills which were conducted on 10/7/21 and 9/2/21. The Maintenance Director indicated in an interview at 12:45 PM, that he did not recall if invitations were sent to emergency management officials and that no additional records were available. During the LSC exit conference on 6/14/22, the surveyor officially informed the Administrator and Regional Operations Director of this finding. NJAC 8:39-31.2(e)	S2345	All residents of the facility had the potential to be affected. Element Three. Maintenance Director received re-education regarding facility must invite 10 days prior local/state/ county OEM and to the drills and develop and maintain an emergency preparedness plan that must be [evaluated] and updated at least every 1 year. Element Four. The Maintenance Director or designee will complete audits on the facility emergency preparedness plan for four weeks and then monthly for three months and then quarterly basis. The results of these audits will be reported to the Administrator and QA Committee quarterly.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062005 Y1	A. Building B. Wing Y2	8/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK REHAB & HEALTHCARE CENTER	600 LINCOLN PARK EAST CRANFORD, NJ 07016

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix S1410	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. # 8:39-19.5(b)(1)	Completed
LSC	06/20/2022	LSC	06/20/2022	LSC	06/20/2022
ID Prefix S2345	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-31.6(o)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/22/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/16/2022	☐ YES ☐ NO