

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/05/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315451	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER The Elms Rehab and Healthcare Center of Cranbury		STREET ADDRESS, CITY, STATE, ZIP CODE 61 Maplewood Avenue 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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51143</p> <p>Complaint #: NJ00181255, NJ00181471</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documents on 12/17/2024, it was determined that the facility failed to ensure resident safety by using portable space heaters in resident rooms when the boilers became non-operational. The Maintenance Director (MD) stated he received a call on 12/8/24 from a staff member that a resident was complaining about the temperature being cold in their room. The MD stated he went to the facility and noticed that the boilers were not operational and supplemental heat was needed in certain areas of the facility. The MD notified the Licensed Nursing Home Administrator (LNHA) that the boilers were not operational and supplemental heat was required. The MD purchased the portable space heaters and placed them in the resident's rooms. The two non-operational boilers were replaced on 12/10/24. The facility discontinued using the portable space heaters on 12/11/2024. There were 38 cognitively impaired residents in the facility on 12/8/24 and there were 10 residents on oxygen on 12/8/24. The facility had knowledge that portable space heaters were being used in resident's rooms where the residents were cognitively impaired, and oxygen was being utilized despite being a fire hazard. This placed all residents at risk for an Immediate Jeopardy (IJ) situation.</p> <p>The Immediate Jeopardy was identified on 12/17/2024 at 6:06 PM and was reported to the LNHA and the Director of Nursing (DON). The LNHA and DON were presented with the IJ template that included information about the issue. The IJ began on 12/8/2024 and continued through 12/18/2024 when the facility submitted an acceptable Removal Plan.</p> <p>On 12/20/2024, the surveyors verified the implementation of the removal plan during an onsite revisit. The facility implemented the Removal Plan, which included education for the LNHA and MD on not using space heaters in the facility; education for all staff on not using the space heaters in the facility.</p> <p>The noncompliance remained on 12/20/24 as a level D based on that facility staff have been educated on not using space heaters in the facility. Audits that monitor compliance with space heaters not being used in the facility were conducted to ensure that they are being implemented.</p> <p>This deficient practice was identified for 48 of 48 residents and was evidenced by the following:</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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<p>A review of the facility's Facility Reported Event (FRE) records revealed: On Sunday 12/08/2024 at approximately 1 P.M., the Director of Maintenance notified the Administrator that both of the Water Source Heat Pump Boilers were not properly functioning and has caused an interruption of service for the heating units. The contracted boiler company was immediately contacted, and a representative was called on sight to inspect both boilers and begin working on the repairs. Ambient temperatures were still being maintained at this time in all resident living spaces. The entire Emergency Chain of Command was immediately notified including the contracted boiler repair company, corporate office, DOH (Department of Health), and NJLTCO (New Jersey Long Term Care Ombudsman). Two replacement boilers units were ordered and scheduled for delivery and install beginning 12/9/2024. During this time the Nursing Department and Maintenance Department are completing and maintain temperature check logs every two hours, and a Fire Watch is in effect with hourly monitoring. Substitute heat devices were in place where needed and extra blankets and comforters are being provided to all residents in need. Wellness checks are ongoing to ensure the comfort and safety of each resident.</p> <p>According to the Admission Record (AR), Resident #6 was admitted to the facility with diagnoses which included but were not limited to: Pulmonary Fibrosis (scarring and thickening of the tissue around and between the air sacs in the lungs), and Chronic Respiratory Failure (a serious condition that occurs when the lungs cannot take in enough oxygen).</p> <p>According to the Quarterly Minimum Data Set (MDS), an assessment tool dated 09/10/2024, Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated the resident's cognition was moderately impaired. The MDS further revealed that the resident was on oxygen therapy.</p> <p>A review of the facility's document titled Order Listing Report (OLR) revealed that Resident #6 had an order for 6 Liters of oxygen via nasal cannula at six liters per minute continuously.</p> <p>During a tour of the second-floor unit at 10:25 A.M., the surveyor observed Resident #6 wearing 6 Liters of oxygen via nasal cannula with an oxygen concentrator in his/her room.</p> <p>During an interview with the surveyor on 12/17/2024 at 10:25 A.M., Resident #6 stated he/she remembered there was a portable space heater in his/her room approximately a couple of weeks ago. Resident #6 stated the staff removed the portable space heater but was unsure of the date the heater was removed.</p> <p>According to the AR, Resident #4 was admitted to the facility with diagnoses which included but were not limited to: Iron Deficiency Anemia and Hypertension.</p> <p>According to the Quarterly MDS dated [DATE], Resident #4 had a BIMS score of 13 out of 15, which indicated the resident's cognition was intact.</p> <p>During an interview with the surveyor on 12/17/2024 at 10:27 A.M., Resident #4 stated approximately at the beginning of the month, the facility did not have heat because the boilers went down. Resident #4 stated staff brought a portable heater to his/her room. Resident #4 stated the heat did not operate for approximately four to five days. Resident #4 further stated I could not bear it, it was cold when the heat was not working. Resident #4 stated that the Maintenance staff removed the heaters, once the heat came back on but he/she was unsure of the exact date this had occurred.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<p>During an interview with the surveyor on 12/17/2024 at 10:34 A.M., the Licensed Practical Nurse Unit Manager (LPN/UM) stated that the boilers were not operating on the weekend of 12/08/2024. She stated that the residents were given portable space heaters and extra blankets. The LPN/UM stated that residents with oxygen were also provided with portable space heaters, but they were placed on the other end of the resident's room.</p> <p>According to the AR, Resident #5 was admitted to the facility with diagnoses which included but were not limited to: Chronic Obstructive Pulmonary Disease (a lung condition caused by damage to the airways usually from smoking or other irritants), and Peripheral Vascular Disease (a condition caused by narrowing, blockage, or spasms in the blood vessels).</p> <p>According to the Quarterly MDS dated [DATE], Resident #5 had a BIMS score of 10 out of 15, which indicated the resident's cognition was moderately impaired. The MDS further revealed that the resident was on oxygen therapy.</p> <p>A review of the facility's document titled Order Listing Report (OLR) revealed that Resident #5 had an order for 2 Liters of oxygen via nasal cannula at two liters per minute continuously.</p> <p>During a tour of the second-floor unit at 10:38 A.M., the surveyor observed Resident #5 wearing 2 Liters of oxygen via nasal cannula with an oxygen concentrator in his/her room.</p> <p>During an interview with the surveyor on 12/17/2024 at 10:38 A.M., Resident #5 stated he/she could not remember the date, but the heat was not working. Resident #5 stated the Maintenance staff brought a plug-in heater into his/her room. Resident #6 stated he/she told the staff they could not plug the heater in his/her room. Resident #5 stated the plug-in heater was left in the room even though he/she requested it be removed. Resident #5 stated the plug-in heater was eventually removed but he/she cannot remember when it was removed. Resident #5 stated that he/she did not use the plug-in heater.</p> <p>According to the AR, Resident #1 was admitted to the facility with diagnoses which included but were not limited to: Aftercare Following Joint Replacement right knee, Type 2 Diabetes (chronic disease that occurs when the body has difficulty using insulin, a hormone that regulates blood sugar levels), Hyperlipidemia (a condition where there are too many lipids (fats) in the blood).</p> <p>According to the Quarterly MDS dated [DATE], Resident #1 had a BIMS score of 15 out of 15, which indicated the resident's cognition was intact.</p> <p>During an interview with the surveyor on 12/17/2024 at 10:51 A.M., Resident #1 stated on 12/09/2024, he/she received a portable space heater in his/her room. Resident #1 stated the portable space heater operated for one night but was not connected to the red emergency outlet, which resulted in shutting off the lights in his/her room. Resident #1 stated the portable space heater was removed from his/her room on 12/10/2024.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	<p>During an interview with the surveyors on 12/17/24 at 1:15 P.M., the MD stated when he went to the facility on [DATE] around 6 P.M., he noticed the common area was a little chilly. He checked the boilers and noticed that the temperature was 52 degrees. He stated the normal temperature should have been 80 degrees. The MD stated that one boiler was not functioning properly, and the other boiler did not have enough output to keep the facility warm. The MD stated that the appropriate temperature for the resident's room should be between 71-81 degrees. The MD stated he toured the facility to assess which of the resident's rooms needed supplemental heat. He stated that some of the heating consoles in some of the resident's rooms were providing appropriate temperatures and therefore did not require supplemental heat. The MD stated that he was aware of the issues with the one boiler not being operational and the other two boilers needed to be repaired. He was obtaining quotes to have them repaired. The MD stated that he was aware that the portable heaters were a fire hazard, but this was an emergent situation and felt this was the best option to keep the residents comfortable at the time.</p> <p>During an interview with the surveyors on 12/17/24 at 2:41 P.M., the LNHA stated that he was notified on 12/8/24 by the MD that the boilers were not working properly. The LNHA stated he was aware that it was against regulations to use the portable space heaters because it was a fire concern. The LNHA stated it was not acceptable to not follow regulations regarding space heaters for the best interest of the residents. He stated this was an emergent situation and that his focus was the best interest of the resident's health and safety and to keep the residents comfortable. The LNHA stated that he would have considered evacuation if the problem with the boilers and no heat was a persistent problem.</p> <p>During a tour of the Physical Therapy aquatics room on 12/17/2024 at 5:11 P.M., the surveyor observed multiple portable space heater boxes. The MD confirmed that there were 46 boxes present during the tour.</p> <p>Review of the facility's Emergency Preparedness Plan for Fire Prevention dated 08/19/2024 revealed under Policy Statement, It is the policy of the facility that all personnel participate in methods of fire prevention and to report any condition (s) that could result in a potential fire hazard. Revealed under Procedure, fire prevention is the responsibility of all personal, residents, visitors, and public alike. Should a fire hazard, or other conditions that could develop into a fire hazard be discovered, it shall be reported to the Maintenance Director immediately. Hazardous conditions must be corrected as soon as practical. Any hazardous condition requiring more that twenty-four (24) hours to correct must be reported to the Administrator outlining what corrections shall be made, methods of correction, and when the hazardous condition is expected to be corrected.</p> <p>NJAC 8:39-31.2 (e)</p>		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 51143 Complaint #: NJ00181255, NJ00181471 Based on observations, interviews, medical record review, and review of other pertinent facility documents on 12/17/2024, it was determined that the Licensed Nursing Home Administrator (LNHA) failed to ensure the resident safety by allowing the use of space heaters in resident rooms while the boilers were not operational. The Maintenance Director (MD) notified the LNHA that the boilers were not operational and supplemental heat was required. The MD purchased the portable space heaters and placed them in the resident's rooms. The two non-operational boilers were replaced on 12/10/24. The facility discontinued using the portable space heaters on 12/11/2024. There were 38 cognitively impaired residents in the facility on 12/8/24 and there were 10 residents prescribed oxygen on 12/8/24. The facility had knowledge that portable space heaters were being used in resident's rooms where the residents were cognitively impaired, and oxygen was being utilized despite being a fire hazard. This placed all residents at risk for an Immediate Jeopardy (IJ) situation. The Immediate Jeopardy was identified on 12/17/2024 at 6:06 P.M. and was reported to the LNHA and the Director of Nursing (DON). The LNHA and DON were presented with the IJ template that included information about the issue. The IJ began on 12/8/2024 and continued through 12/18/2024 when the facility submitted an acceptable Removal Plan. On 12/20/2024, the surveyors verified the implementation of the removal plan during an onsite revisit. The facility implemented the Removal Plan, which included education for the LNHA and MD on not using space heaters in the facility; education for all staff on not using the space heaters in the facility. The noncompliance remained on 12/20/24 as a level D that is not an IJ based on that facility staff have been educated on not using space heaters in the facility. Audits that monitor compliance with space heaters not being used in the facility were conducted to ensure that they are being implemented. This deficient practice was identified for 48 of 48 residents and was evidenced by the following: (continued on next page)		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Facility Reported Event (FRE) records revealed: On Sunday 12/08/2024 at approximately 1 P.M., the Director of Maintenance notified the Administrator that both of the Water Source Heat Pump Boilers were not properly functioning and has caused an interruption of service for the heating units. The contracted boiler company was immediately contacted, and a representative was called on sight to inspect both boilers and begin working on the repairs. Ambient temperatures were still being maintained at this time in all resident living spaces. The entire Emergency Chain of Command was immediately notified including the contracted boiler repair company, corporate office, DOH (Department of Health), and NJLTCO (New Jersey Long Term Care Ombudsman). Two replacement boilers units were ordered and scheduled for delivery and install beginning 12/9/2024. During this time the Nursing Department and Maintenance Department are completing and maintain temperature check logs every two hours, and a Fire Watch is in effect with hourly monitoring. Substitute heat devices were in place where needed and extra blankets and comforters are being provided to all residents in need. Wellness checks are ongoing to ensure the comfort and safety of each resident.</p> <p>During an interview with the surveyors on 12/17/24 at 2:41 P.M., the LNHA stated that he was notified on 12/8/24 by the MD that the boilers were not working properly. The LNHA stated he was aware that it was against regulations to use the portable space heaters because it was a fire concern. The LNHA stated it was not okay to not follow regulations regarding space heaters for the best interest of the residents. He stated this was an emergent situation and that his focus was the best interest of the resident's health and safety and to keep the residents comfortable. The LNHA stated that he would have considered evacuation if the problem with the boilers and no heat was a persistent problem.</p> <p>During a tour of the Physical Therapy aquatics room on 12/17/2024 at 5:11 P.M., the surveyor observed multiple portable space heater boxes. The MD confirmed that there were 46 boxes present during the tour.</p> <p>Review of the facility's Emergency Preparedness Plan for Fire Prevention dated 08/19/2024 revealed under Policy Statement, It is the policy of the facility that all personnel participate in methods of fire prevention and to report any condition (s) that could result in a potential fire hazard. Revealed under Procedure, fire prevention is the responsibility of all personnel, residents, visitors, and public alike. Should a fire hazard, or other conditions that could develop into a fire hazard be discovered, it shall be reported to the Maintenance Director immediately. Hazardous conditions must be corrected as soon as practical. Any hazardous condition requiring more that twenty-four (24) hours to correct must be reported to the Administrator outlining what corrections shall be made, methods of correction, and when the hazardous condition is expected to be corrected.</p> <p>A review of the Administrator Job Description,dated May 2023 revealed under Major Duties and Responsibilities:</p> <ol style="list-style-type: none"> 1. Plans, develops, organizes, and implements, evaluates and directs the overall operation of the facility as well as its program and activities, in accordance with current state and federal laws and regulations. 2. Ensures delivery of compassionate quality care and services across an interdisciplinary team approach as evidenced by adequate, and competent facility staff, employee turnover, general cleanliness, physical plant condition, and optimal resident functioning-physically and psychosocially. 3. Follows appropriate safety and hygiene measures at all times to protect residents and themselves <p>(continued on next page)</p>		

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