

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2022
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 02/12/2021
NAME OF PROVIDER OR SUPPLIER ELMS OF CRANBURY, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS Survey date: 2/12/2021 Census: 91 Sample: 18 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to	F 880		3/11/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/23/2021

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.

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F 880	<p>Continued From page 1</p> <p>§483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and</p>	F 880			

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F 880	<p>Continued From page 2</p> <p>transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that the visiting Physician adhered to the facility policy and procedures put in place to prevent infection spread. This deficient practice was identified for 1 of 1 Physician visiting the facility as evidenced by the following:</p> <p>On 2/12/21 at 9:45 AM, the surveyors observed a temporary movable separation barrier at the end of the hallway. The surveyor noted the temporary barrier with signage that read, "STOP Report to Nurse Before Entering." The surveyors were informed by the Facility Administrator that behind the barrier was the resident [REDACTED] unit. The Administrator added that all entry and exit from the [REDACTED] unit is accessed through a separate outside door by all staff. The separate outer door leads directly in and out of the [REDACTED] unit. The Administrator added that no one accesses the [REDACTED] unit through the temporary barrier separation.</p> <p>On 2/12/21 at 10:00 AM, the surveyor observed the facility Physician walk through the [REDACTED] Unit, move the temporary barrier separation, and access the [REDACTED] unit.</p> <p>On 2/12/21 at 10:15 AM, the surveyor observed the facility Physician leave the [REDACTED] unit via the</p>	F 880	<ol style="list-style-type: none"> 1. No resident was specified in the [REDACTED] because the physician did not assess or have contact with any residents after exiting the [REDACTED] wing. 2. All residents are at potential risk for exposure if a staff member or contractor does not follow proper procedure and enters their room after seeing patients in the designated [REDACTED] area. The facility held a QAPI meeting as per the DPOC to perform a Root Cause Analysis and the 5 Whys to determine why the physician entered through the barrier and how the facility's practices can be modified to prevent further occurrences. The Root Cause Analysis determined that the physician entered the barrier because he did not believe the protocol established for entry into the [REDACTED] wing applied to him. 3. As per the DPOC, the Executive Leadership Team completed Module 1 of the Infection Prevention & Control Program and all facility staff was required to watch Keep Covid Out. The physician was reprimanded for not following facility protocol for entering and exiting the [REDACTED] Wing. The facility policy will be modified for urgent or emergency situations by permitting a practitioner or 		

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F 880	<p>Continued From page 3</p> <p>barrier separation and stand at the [REDACTED] Nursing Station.</p> <p>On 2/12/21 at 10:30 AM, the surveyor interviewed the [REDACTED] (Registered Nurse) [REDACTED], who stated that the Physician should not have accessed the [REDACTED] unit via the separation barrier. The ICP informed the surveyor that the Physician should access the [REDACTED] unit only through the outside door access.</p> <p>On 2/12/21 at 10:45 AM, the surveyor interviewed the Physician, who was wearing an N95 mask with a surgical mask on top. The Physician stated that he did access the [REDACTED] unit through the separation barrier to see a resident in the [REDACTED] Unit after doffing full PPE (Protective gown, gloves, N95, surgical mask, and face shield). The Physician could not explain why he accessed the [REDACTED] unit via the restricted barrier wall and then left the [REDACTED] area via the [REDACTED] Unit. The Physician informed the surveyor that he was exiting the building.</p> <p>On 2/12/21 at 1:30 PM, the surveyor received a [REDACTED], which documented information regarding the procedure for the [REDACTED] Unit "Barrier has yellow stop sign; Designated entrance. No employees may cross the barrier!"</p> <p>The facility supplied no additional information.</p> <p>NJAC 8:39-19.4 (a)</p>	F 880	<p>staff member who must return to the regular units to don a new N95 and a new face shield prior to doing so.</p> <p>4. Any attempt to breach the policy will be prevented by the [REDACTED] Nurse and reported to the Infection Preventionist. The Infection Preventionist will conduct random observations of the entrance and exit of the [REDACTED] wing for compliance for three months or until the covid wing is discontinued(if less than three months). The Infection Preventionist will report findings to the Infection Control QA Committee meeting monthly for three months.</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315451	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 3/30/2021	Y3
NAME OF FACILITY ELMS OF CRANBURY, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 61 MAPLEWOOD AVENUE CRANBURY, NJ 08512		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0880	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	03/30/2021	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 _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/12/2021		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		