STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315451	A. BUILDING **01** B. WING ___	**11/19/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMS OF CRANBURY, THE	**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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/19/21,was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Elms of Cranbury is a 2-story building that was built in 90's, It is composed of Type II protected construction. The facility is divided into 4- smoke zones. The generator does approximately 50% of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 120 certified beds.	K 000		

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

Electronically Signed | | 12/07/2021

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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K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		1/31/22

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K 363	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/19/21, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close, and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 4 of 52 resident room doors during the building tour from 10:30 AM, to 02:30 PM, and was evidenced by the following: The following resident room door's, did not latch into its frame: 108, 213, 224 and 227. An interview was conducted with the Maintenance Director, who stated and confirmed that 4 of 52 resident room doors, did not latch into its frame. The Administrator was informed of the finding at the Life Safety Code exit conference on 11/19/21. NJAC 8:39-31.1(c), 31.2(e)	K 363	1. Rooms [redacted] and [redacted] doors repaired by tightening to ensure the doors latch properly. Doors were fixed on 11/19/21. 2. The residents in rooms [redacted] and [redacted] have the potential to be affected but had no negative outcome from doors not latching properly. 3. An audit will be conducted by the Maintenance Director/designee to ensure all doors throughout the building latch properly. Staff was educated to check and report immediately if any doors did not latch properly. 4. Monthly random audits X 2 to be conducted by the Maintenance Director/designee to ensure all doors latch properly. 5. Maintenance Director/designee to present results of these audits at Quarterly QAPI Meeting for review.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.	K 521		1/31/22

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K 521	Continued From page 3 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/19/21, in the presence of the facility Maintenance Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 21 of 52 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: 1. While touring the building on 11/19/21, from 10:30 AM, to 02:30 PM, the Surveyor and Maintenance Director observed that the ventilation in the following resident room bathrooms did not function: # [redacted] and [redacted] The surveyor requested that the Maintenance Director, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the Surveyor interviewed the Maintenance Director who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. The Administrator was informed of this deficiency	K 521	1. Resident Rooms [redacted], and [redacted] bathroom ventilation fans will be fixed by contracted HVAC Company. 2. The residents in rooms [redacted], [redacted], and [redacted] had the potential to be affected but there was no negative outcome related to bathroom ventilation fans not functioning properly. 3. An audit will be conducted by the Maintenance Director/designee in all resident bathrooms to ensure bathroom ventilation fans are functioning properly. Staff was educated to check and report immediately any bathroom ventilation fans that were not functioning properly. 4. The Maintenance Director/designee will conduct random monthly audits x 2 to ensure resident bathroom ventilation fans are functioning properly. 5. Maintenance Director/designee to present results of audits of bathroom ventilation fan findings at Quarterly QAPI Meeting for review.	

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K 521	Continued From page 4 at the Life Safety Code exit conference on 11/19/21. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation on 11/19/21, in the presence of the facility's Maintenance Director, it was determined that the facility failed to prohibit the use of highly flammable untreated decorations as evidenced by the following: The surveyor observed at 10:50 AM, 2 large dolls	K 753	1. Two large dolls made of dried straw and one bale of hay were removed from the facility on the same day it was identified by the Maintenance Director. 2. All Residents had the potential to be affected but no residents were affected by having combustible decorations inside the	11/20/21

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K 753	Continued From page 5 made of dried straw and 1-bale of hay (approximately 2' x 3') in the egress corridor, left of the the elevator on the 1st floor. An interview was conducted during the observations with the Maintenance Director, where he stated and agreed that the holiday decorations were not treated with approved fire-retardant coating, that is listed and labeled for observed product, and did not meet NFPA 701 requirements. The Administrator was informed of the observations, at the Life Safety Code exit conference. NJAC 8:39-31.2(e)	K 753	facility. 3. Maintenance Department/designee conducted facility wide inspection to ensure no flammable decorations are in the building. 4. Maintenance director/designee to in-service all current staff to only use non-combustible decorations in the facility that have been inspected by the Maintenance Department prior to use. 5. Maintenance Director/designee to conduct weekly rounds to ensure no flammable decorations are being used throughout the building x 2 months. Report of these rounds will be presented and reviewed at Quarterly QAPI Meeting.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		1/31/22

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K 923	Continued From page 6 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/19/21, the facility failed to provide storage of cylinders, so empty cylinders are segregated from full cylinders, or appropriately labeled full and empty in accordance with NPFA 99, 2012 Edition Sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. The deficient practice was evidenced for 1 of 1 O2 storage rooms observed by the following: The Surveyor and Maintenance Director, observed at approximately 11:10 AM, that the floor 2 oxygen storage closet by the unit manager office had 9 portable empty O2 tanks in the cart along with 1 full O2 bottle in the same cart. The wall sign indicated empty tanks. The cart of 10 full O2 tanks was stored to the right of the empty tank cart and there was no wall sign indicating full tanks.	K 923	1. Maintenance Director conducted an inspection of oxygen storage area, and all empty and full tanks were separated and placed in the appropriate designated rack one area labeled for empty and one area labeled for full tanks. 2. No residents were affected by oxygen tanks not being placed in the appropriate labeled storage rack. 3. The Maintenance Director or designee will in-service all current staff on returning oxygen tanks to storage area and to place them in the appropriate labeled rack. 4. Maintenance Director/designee to complete weekly random audits of oxygen storage areas to ensure full and empty oxygen tanks are stored in the appropriate labeled area. The results of these audits	

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K 923	Continued From page 7 An interview was conducted with the Maintenance Director at the time of the observations, where he stated and confirmed that the oxygen cylinders revealed full and empty cylinders were not segregated and not marked to identify which were full or empty. The Administrator was informed of the observations at the life safety code exit conference on 11/19/21. NJAC 8:39-31.2(e)	K 923	will be presented and reviewed at the Quarterly QAPI Meeting.	