STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315010	A. BUILDING _____ B. WING _____	01/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

(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: 1/6/2021 Census: 148 Sample: 21 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 and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=E	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	F 880		2/6/21

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

Electronically Signed | 01/15/2021

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

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F 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) ensure personal protective equipment (PPE) was easily and readily available to all Transmission-Based Precaution (TBP) rooms and ensure used personal protective equipment receptacles were covered and emptied to prevent overflow. This was identified for 16 of 16 TBP rooms; b.) utilize appropriate personal protective equipment (PPE) and follow infection control practices to prevent the potential spread of infection in accordance with the U.S. Centers for Disease Control and Prevention (CDC). This was identified for 1 of 7 staff members on 1 of 2 units; and c.) ensure residents were socially distanced during the lunch meal observation. This was identified for [redacted] residents in the dining room on [redacted]. This deficient practice was identified during the COVID-19 Focused Infection Control survey conducted on 1/6/21 and was evidenced by the following: The New Jersey Communicable Disease Services (CDS) and New Jersey Department of Health, "Considerations for Cohorting COVID-19 Patients in Post-Acute Facilities," dated	F 880	F880 SS-E 1) 1) TBP Units were rounded to ensure sufficient PPE was available. PPE was made available within close proximity to the rooms. 2) Large Receptacles with lids were purchased and placed in TBP rooms. Receptacles from the hallways were removed. 3) Overflowing bins were emptied immediately. 4) Markings for social distancing were placed in dining rooms. 5) Disposable tray was properly disposed and the food truck was sanitized immediately. 6) CNA #3 was re-educated regarding the disposable lunch tray system and appropriate infection control practices for meals. In addition CNA #3 was re-educated on the use of PPE including the N95 Respirator.	

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F 880	Continued From page 3 10/22/2020, revealed New or Re-admissions: This cohort consists of all persons from the community or other healthcare facilities who are newly or re-admitted. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be compatible with COVID-19. According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Responding to Coronavirus (COVID-19) in Nursing Homes, updated 04/30/2020, included, "Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown...All recommended COVID-19 PPE [personal protective equipment] should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e. goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement... However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE." 1. On 1/6/21 at 9:30 AM, during the entrance conference with the Director of Nursing (DON), the DON stated that the Executive Order 26, 4.b. unit on the Executive Order 26, 4.b. were the dedicated Executive Order 26, 4.b. . (This	F 880	7) The recreation aide and Unit Manager were re-educated regarding maintaining social distancing during meals. 2) All residents can be affected by this deficient practice. There were no negative outcomes to the residents. 3) Root Cause Analysis was done and the conclusion was A) In regards to Social distancing, disposing of disposable trays and proper PPE use the staff have received education on using PPE related to droplet precaution including demonstration and knowledge check testing. Staff have received education on social distancing. Despite all of this human error occurred. Staff was in-serviced again with regard to PPE related to Droplet precaution and Social distancing. B) All TBP rooms had Garbage bins in the room but they were missing lids to prevent overflow. Bins with lids were put in all TBP rooms. C) PPE was accessible on TBP units and in order to make it more readily accessible bins with PPE were placed throughout the Unit. 1) All Top line staff/Infection preventionist were in-serviced on infection prevention and control program.	

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F 880	Continued From page 4 [redacted]	F 880	2) All front line staff were in-serviced on Keeping Covid out! via CDC Video 3) All front line staff were in-serviced on Use PPE correctly for Covid-19 via CDC video. 4) All staff were In-serviced in regard to Donning and Doffing PPE. 5) All staff were in-serviced on proper disposal of disposable trays. 6) All staff were in-serviced on maintaining social distance during meals. 7) All staff were in-serviced in regard to the use of proper PPE in TBP rooms. 8) Large receptacles with lids were purchased and placed in TBP rooms. 9) Markings for social distance were placed in dining rooms. 4) DON, ADON, ICP or designee will randomly audit TBP units weekly x 4 weeks then monthly x 3 months to ensure proper donning and doffing PPE, proper disposal of disposable trays, proper use of PPE for TBP rooms, and maintaining social distance in dining rooms. DON or designee will report outcome off all audits to the QA and Interdisciplinary team at the Quarterly Quality Assurance Performance Improvement Meeting.	

[redacted]

At 12:10 PM, the surveyors toured the [redacted] unit with the Registered Nurse/Unit Manager (RN/UM). The surveyors observed [redacted] TBP rooms that did not have PPE within close proximity to the rooms. At that time, the surveyors observed two large black plastic garbage bins with a lid in the middle of each hallway. The [redacted] TBP rooms did not have a designated container to dispose of PPE inside the rooms.

At 12:13 PM, in the presence of the RN/UM, Certified Nursing Assistant (CNA) #1, the surveyors interviewed CNA #2 who stated that the black garbage bins were used to dispose only cloth isolation gowns. She stated that the facility's process was to obtain PPE from the clean utility closet. At that same time, CNA #2 showed the surveyors the clean utility closet which was located diagonally across from the nurses station. CNA #2 stated that before you enter an "isolation room" you have to go to the closet to get your PPE, put it on and enter the room. She then demonstrated and stated that there were clean and clear plastic garbage bags kept inside each residents dresser drawer to be used when disposing PPE. She then removed the clear plastic bag from the dresser drawer and placed it ontop of a dresser and explained that after doffing the cloth gown, the plastic bag is tied, removed from the room and placed into the black plastic garbage bin that had been observed in the hallway.

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F 880	Continued From page 5 At that same time, CNA #1, CNA #2, and the RN/UM all acknowledged that when the clean plastic bag was placed onto the dresser it would become contaminated from the environment in the TBP room and should not be taken out into the hallway. At 12:20 PM, the surveyors interviewed the DON regarding accessibility and disposal of PPE. The DON stated "this has been our system for many years. We've never had a problem before." A short time later, the surveyor opened one of the black plastic bins and observed two cloth gowns that were not inside a plastic bag. At that same time, neither the RN/UM, CNA #1 and CNA#2 could not speak to how or why the two cloth gowns were not bagged. On that same day at 12:42 PM, the surveyors toured [Executive Order 28] and observed 10 TBP rooms that did not have PPE within close proximity to the rooms. The surveyors observed two large black plastic garbage bins with a lid in the middle of each hallway. At 12:44 PM, the surveyor, in the presence of another surveyor, observed two TBP rooms with multiple blue used disposable gowns stuffed into the small open trash can next to the doorway. Both open trash cans were overflowing with PPE causing the used gowns to touch the floor within the room. There was no designated container to dispose of PPE inside the rooms. At 12:50 PM, the surveyor interviewed the housekeeper who stated that all the rooms have a small open trash can for garbage only and not	F 880		

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F 880	Continued From page 6 for PPE. She said that PPE was supposed to be bagged and taken out of the room. At 12:55 PM, the surveyor interviewed CNA #3 who stated "I disposed my gown and gloves in the garbage can inside the room before coming out" and could not speak to why the trash cans in both rooms were overflowing with PPE. At 1:50 PM, the surveyors interviewed the Infection Control Preventionist (ICP) who acknowledged that if a clean plastic bag was placed on a surface inside a TBP room the bag would become contaminated. He further acknowledged that in an emergency PPE would not be readily and easily available to staff prior to entering a TBP room. The ICP could not speak to the two opened trash cans overflowing with PPE on [redacted] At 3:30 PM, the surveyors met with the Administrator, DON, and the ICP to discuss the above observations and concerns. The Administrator and the ICP acknowledged that PPE should have been readily available to all TBP rooms. 2. On 1/6/21 at 12:50 PM, the surveyor observed CNA #3 walking toward the food truck in the hallway carrying a disposable lunch tray without gloves. The surveyor observed CNA #3 place the disposable lunch tray onto the food truck in the hallway. At that same time, the surveyor interviewed CNA #3 who stated the lunch tray was disposable because it belonged to a resident who was on isolation for Droplet precautions. The CNA showed the surveyor the room she came out of. The room had a stop sign and a droplet	F 880		

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F 880	Continued From page 7	F 880		

precaution sign on the door. The CNA #3 stated that all residents on isolation have disposable meal trays. The CNA #3 could not speak to whether or not the disposable lunch tray was contaminated. The CNA #3 could not speak to why she removed the disposable lunch tray from a TBP room without wearing gloves. In addition, the CNA #3 also could not speak to what the proper method was for discarding disposable trays in a TBP room was.

At that same time, the surveyor observed that the CNA #3 was wearing a KN95 mask. The surveyor interviewed the CNA #3 regarding the KN95 mask. The CNA #3 stated "I should be wearing an N95 mask and the KN95 over the N95 mask.

At 12:55 PM, the surveyors interviewed the 2 North Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that CNA #3 should have been wearing a N95 mask and should not have removed the soiled disposable lunch tray from a droplet precaution room.

At 1:50 PM, the surveyors interviewed the ICP who stated that CNA #3 should have been wearing an N95 mask and should not have removed the soiled disposable lunch tray from a droplet precaution room.

At 2:00 PM, in the presence of the ICP, the surveyors interviewed the DON who stated that CNA #3 should have been wearing an N95 mask and should not have removed the soiled disposable lunch tray from a droplet precaution room.

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F 880	Continued From page 8 3. On 1/6/21 at 12:35 PM, the surveyors observed the dining room on [redacted] during the lunch meal. There were 10 residents in the dining room. Four residents were seated at their own table and socially distanced from others. The surveyors observed six residents who were seated two at a table less than six feet apart. Residents were wearing masks until which time their lunch was delivered. At 12:52 PM, the surveyor interviewed the Recreation Aide (RA) and the LPN/UM who stated that there were extra residents in the [redacted] dining room relocated from the [redacted] dining room. The RA and the LPN/UM could not speak to how the facility was able to ensure that residents were socially distanced six feet apart when seated across from each other at a dining room table. There were no markers observed on the floor to indicate six foot distancing. At 1:50 PM, the surveyors interviewed the ICP who also could not speak to how the facility was able to ensure that residents were socially distanced six feet apart when seated across from each other at a dining room table. At 3:30 PM, the surveyors met with the Administrator, DON, and the ICP to discuss the above observations and concerns. There was no additional information provided. Review of the facility's policy for cohorting COVID-19 patients revised indicated that an N95 respirator should be worn for cohort 4 (all new and readmissions) which includes contact and droplet precautions.	F 880		

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F 880	Continued From page 9 Review of an undated facility document titled "COVID-19 Infection Control Recommendations" indicated that six foot distancing social guidelines were to be maintained while facemask removed. The facility did not provide a policy related to social distancing at meal times. The facility did not provide a policy related to the proper method to discard a disposable tray for TBP rooms. A review of the facility's Outbreak Response Plan included that PPE is an essential element to prevent the spread of an infectious disease (including COVID-19)...and the facility trains all employees and other healthcare personnel on proper use of PPE on an ongoing basis in accordance with applicable Governmental Guidelines and Directives. A review of an undated facility document titled "COVID-19" indicated that a fit tested N-95 mask is utilized for contact and droplet precautions...and maintain social distancing (6 ft apart) for environment controls. NJAC 8:39-19.4(a)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315010 (Y1)	A. Building B. Wing (Y2)	2/26/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 02/26/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
1/6/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO