STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. BUILDING ______ B. WING ______	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANFORD PARK REHABILITATION & HEALTHCARE CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 11/15/19 CENSUS: 80 SAMPLE SIZE: 18 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	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 §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:	F 880		12/9/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/03/2019

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	Continued From page 1 (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. 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:	F 880		

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F 880	Continued From page 2 Based on observation, interview, and record review, it was determined that the facility failed to a) follow appropriate handwashing practices during the medication administration observation for 1 of 3 nurses observed during medication administration; and, b) maintain proper infection control practices during a Executive Order treatment observation for Ex of Exec residents (Resident Executive). This deficient practice was evidenced by the following: 1. During the medication administration observation on Executive Order 26, 4.b. the surveyor observed that the paper towel dispenser was broken. Licensed Practical Nurse #2 (LPN #2) entered Resident Executive Or room and stated, "I have to use another sink." At that time, LPN #2 went into the Executive Order 2 room to perform hand hygiene but had to leave because there was no soap in the dispenser. In the Executive Order 26, 4.b., the surveyor observed LPN #2 wash her hands for 63 seconds without wetting her hands prior to applying liquid soap. On that same day and time, LPN #2 stated, "I should have wet my hands first before getting the soap."She further said, "I'm sorry. I was so nervous." Afterward, LPN #3 checked Resident Executive Or blood pressure with her bare hands and did not perform hand hygiene after direct contact with resident. LPN #2 then applied a new pair of gloves without first performing hand hygiene prior to sanitizing the blood pressure apparatus.	F 880	Element One: Nurse involved was re-educated on proper treatment procedure and soiled dressing disposal Signs were placed on Biohazards waste rooms for easy identification Soap dispenser filled with soap and checked for proper functioning Hand towel dispenser was filled and checked for functioning All hand towel dispensers in the facility filled and checked for functioning Element Two: Potentially can affect all residents Element Three: 11/13/19 Handwashing in-service and competencies given by Infection Preventist Nurse with nurse involved and all facility staff Inservice given by Infection Preventist Nurse related to proper Executive Order 2 treatment technique and disposal of soiled dressing with nurse involved and all facility staff Biohazards waste rooms identified, and nurse involved and all facility staff in serviced by Infection Preventist Nurse Paper towel holders will be checked daily by housekeeping for functioning and that they are filled Housekeeping staff in serviced on importance of checking soap dispensers daily for functioning and that they are filled with soap Maintenance Director will be made aware of malfunctioning soap dispensers	

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F 880	Continued From page 3 At that time, LPN #2 did not perform hand hygiene after removing gloves and directly prepared and administered Resident [Executive Or] medications. During the observations as mentioned above, the surveyor questioned LPN#2 regarding proper hand hygiene and protocol. LPN #2 replied, "I should have washed my hands after direct contact with the resident, and before and after removing gloves." On 11/13/19 at 12:06 PM, in the presence of the survey team, the Administrator, Director of Nursing (DON) were made aware of the above observations and concerns. On 11/14/19 at 9:26 AM, the surveyor interviewed the Infection Control Nurse, who informed the surveyor that hand washing should be done after direct contact with residents, before and after glove removal, and after cleaning equipment. She stated that during hand washing, staff should wet hands before applying soap and should lather for 20 seconds or more. A review of the Centers for Disease Control and Prevention handwashing information regarding how to wash hands, updated March 7, 2016, indicated, "Wet hands with clean, running water, and apply soap. Lather hands by rubbing them together with soap. Be sure to lather the backs of your hands between fingers and under nails. Scrub hands for at least 20 seconds. Rinse hands well under clean, running water. Dry hands using a clean towel or air dry them." A review of the facility policy on Handwashing	F 880	and malfunctioning paper towel dispensers for repair Element Four: Director of Nursing or Designee will conduct monthly audits x 6 months then annually that proper [Executive Order 2] technique is performed with disposal of soiled dressings. Infection Preventist Nurse will conduct monthly audits x 6 months then annually that all staff proper handwashing protocol is followed DON or Designee will conduct monthly audits and to inspect that paper towel dispensers are filled and functioning properly and soap dispensers are filled and functioning properly x 6 months Results of audits will be reported to Administrator and at QAPI meeting quarterly. This will ensure that 100% compliance is reached and maintained	

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F 880	Continued From page 4	F 880		

provided by the Administrator with a revision date of 5/11/19, indicated: "To prevent the transmission of infectious diseases, all personnel working in the facility are required to wash their hands before and after resident contact, before and after performing any procedure, after smoking, applying cosmetics, sneezing or blowing noses, after using the toilet, before handling food and when hands become soiled," and "Procedure: wet hands/wrists thoroughly; apply liquid soap; lather hands and wrists; use a rotary motion to clean all surfaces for 20 seconds; wash under nails; hold hands lower than forearms; rinse under running water; dry hands, wrists, and arms thoroughly with a paper towel; discard towel in waste receptacle; turn off faucet with a clean paper towel; discard towel in waste receptacle."

A review of the facility policy on Medication Administration provided by the Administrator with a revision date of 5/14/18 indicated, "Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice."

2) On 11/6/19 at 1:40 PM, the surveyor observed Resident [Executive] awake in bed with his/her family member at the bedside. The resident smiled at the surveyor but did not speak. Resident [Executive Or] family member stated that the resident was admitted from the hospital with a [Executive Order] on the resident's [Executive Order 26, 4.b.]

The surveyor reviewed the admission record, which reflected that Resident [Executive] was admitted to the facility on [Executive Order 26] with a diagnosis that included Executive Order 26, 4.b.

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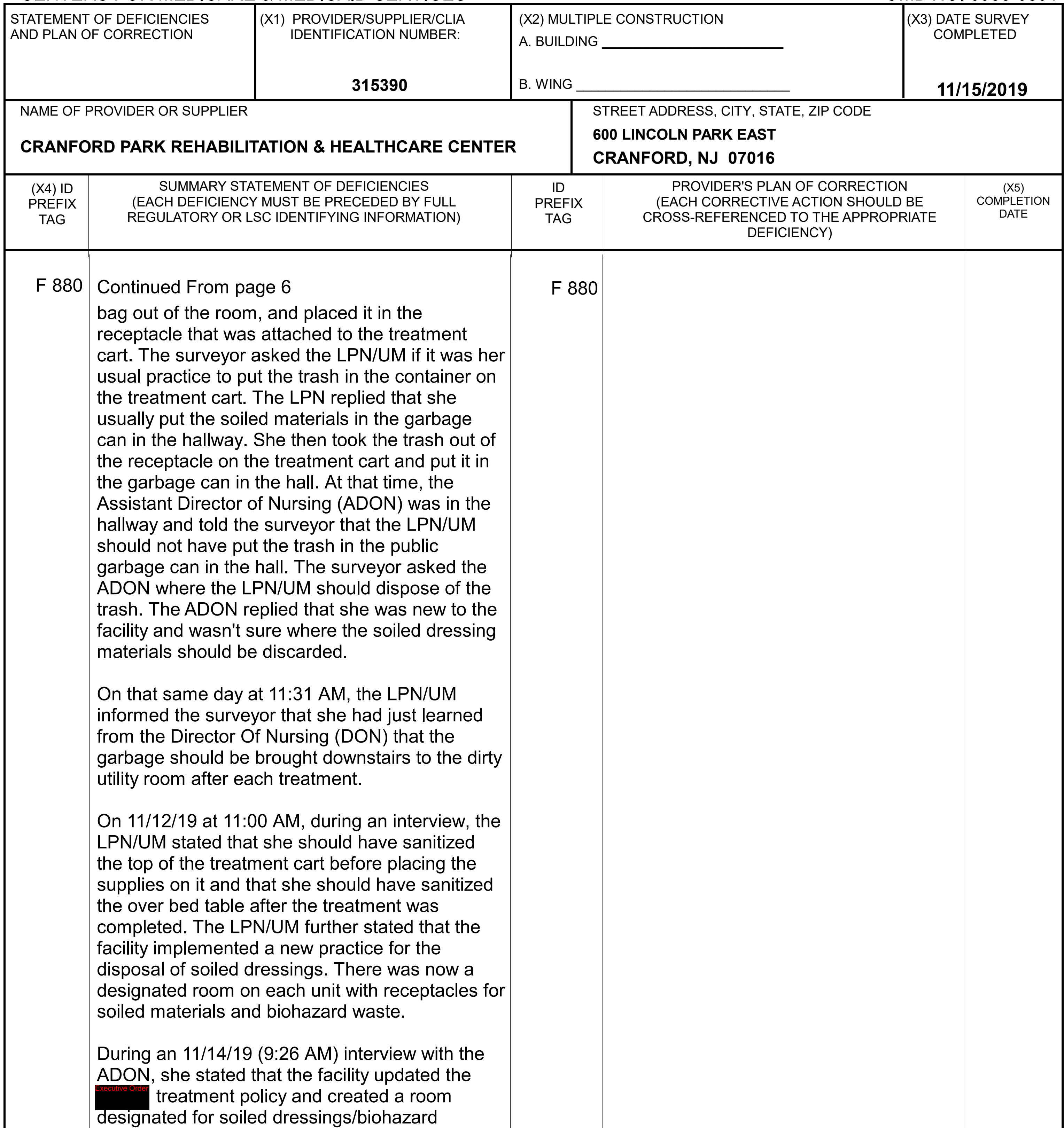
F 880	Continued From page 5 Executive Order 26, 4.b. On 11/8/19 at 10:53 AM, during a Executive Order treatment observation, the surveyor observed the Licensed Practical Nurse/Unit Manager (LPN/UM) perform a Executive Order treatment to Resident Executive Or Executive Order 26, 4.b.. On that same day and time, the LPN/UM accompanied by the surveyor reviewed the Executive Order 26, 4.b. Physician's Order Sheet (POS). The POS reflected an order dated Executive Order 26, 4 to cleanse the Executive Order 26, 4.b. with Executive Order 2 Executive Order 26, 4.b. apply a Executive Order 26, 4.b. with Executive Order 26, 4.b. at the base of the Executive Order 26 pack with an Executive O moistened gauze and cover the Executive Order with a dry dressing. The Physician's order was transcribed onto Resident Executive Or Executive Order 26, 4.b. Executive Ord Treatment Administration Record (TAR). The LPN/UM cleansed Resident Executive Or overbed table with a disinfectant wipe. The LPN/UM gathered supplies on top of the treatment cart without first disinfecting the surface. The LPN/UM then covered the overbed table with a clean barrier and put all the supplies from the non-sanitized treatment cart onto the clean barrier on the overbed table. The LPN/UM washed her hands and performed the Executive Order treatment according to the physician's order. The LPN/UM did not disinfect the overbed table after she completed the treatment. The LPN/UM described the soiled dressing as being saturated with Executive Order 26, 4.b. She put the soiled dressing, and all the other used supplies into a plastic trash bag, brought the	F 880		



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F 880	Continued From page 6 bag out of the room, and placed it in the receptacle that was attached to the treatment cart. The surveyor asked the LPN/UM if it was her usual practice to put the trash in the container on the treatment cart. The LPN replied that she usually put the soiled materials in the garbage can in the hallway. She then took the trash out of the receptacle on the treatment cart and put it in the garbage can in the hall. At that time, the Assistant Director of Nursing (ADON) was in the hallway and told the surveyor that the LPN/UM should not have put the trash in the public garbage can in the hall. The surveyor asked the ADON where the LPN/UM should dispose of the trash. The ADON replied that she was new to the facility and wasn't sure where the soiled dressing materials should be discarded. On that same day at 11:31 AM, the LPN/UM informed the surveyor that she had just learned from the Director Of Nursing (DON) that the garbage should be brought downstairs to the dirty utility room after each treatment. On 11/12/19 at 11:00 AM, during an interview, the LPN/UM stated that she should have sanitized the top of the treatment cart before placing the supplies on it and that she should have sanitized the over bed table after the treatment was completed. The LPN/UM further stated that the facility implemented a new practice for the disposal of soiled dressings. There was now a designated room on each unit with receptacles for soiled materials and biohazard waste. During an 11/14/19 (9:26 AM) interview with the ADON, she stated that the facility updated the Executive Order treatment policy and created a room designated for soiled dressings/biohazard	F 880		

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F 880	Continued From page 7 materials. She further stated that the old treatment policy instructed that the soiled dressing be disposed of in the garbage. A review of the facility's Wound Ulcer Treatment Policy reviewed on 3/28/18 failed to address the disinfection of the treatment cart prior to placing clean supplies on top of it. It also failed to address sanitizing the over bed table after the treatment was completed. The policy instructed staff to dispose of the soiled dressing and used materials in an unspecified garbage can. On 11/14/19 at 12:08 PM, the survey team met with the Administrator and Director of Nursing to discuss the above observations and concerns. No further information was provided by the facility. NJAC 8:39-19.4 (a) 1	F 880		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/13/19, it was determined that the facility failed to provide 80 square feet of living space in multi-bedded resident rooms. This deficient practice was evidenced as follows: During a tour of the building in the presence of	F 912	F458 Rooms Executive Order 26, 4.b. are only occupied by one resident.Room Execu is only occupied by two residents. no other residents will be admitted to the rooms unless they meet the measurement	11/29/19

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

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F 912	Continued From page 8 the facility's Administrator and Corporate Regional Administrator from 11:25 AM to 1:00 PM, the surveyor observed the following conditions: 1. Room [Executive Order] was a 3-bedded room that measured 229.5 square feet instead of 240 square feet. 2. Rooms [Executive Order 26, 4.b.], and [Executive Order] were 2-bedded rooms that measured 150 square feet instead of 160 square feet. Also, rooms [Executive Order] were 2-bedded rooms that measured 140 square feet instead of 180 square feet. This condition was confirmed in an interview with the facility's Administrator and Corporate Regional Administrator during the tour. The surveyor noted that residents occupied the rooms noted above. The surveyor verbally informed the facility's Administrator, and Corporate Regional Administrator of the findings noted above during the Life Safety Code exit conference at 1:30 PM. NJAC 8:39-31.1(d)	F 912	requirements Administrator and staff will give these rooms priority in ensuring that residents are comfortable, and rooms are free of all hazard and danger. This would be performed on a daily basis.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315390 (Y1)	A. Building B. Wing (Y2)	5/23/2022 (Y3)

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

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 12/09/2019	ID Prefix F0912 Reg. # 483.90(e)(1)(ii) LSC	Correction Completed 11/29/2019	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
11/15/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO