STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C **06/21/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CEDAR OAKS	**1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080**

(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 COMPLAINT #: NJ 00143678 CENSUS: 184 SAMPLE SIZE: 38 + 8 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION SURVEY. During a Standard Recertification Survey conducted from 6/8/21 to 6/21/2021, it was determined that effective 4/30/21, the Facility was found to have been in an Immediate Jeopardy for F689. The New Jersey Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 6/15/2021 at 2:14 PM, including the Immediate Jeopardy Template. The Facility failed to ensure the safety of its residents, when one resident who had a physician's order for Executive Order 26, 4.b. was identified to be Executive Order 26, 4.b. on Executive Order 26, 4.b. Executive Order 26, 4.b., Executive Order 26, 4.b., and Executive Order 26, 4.b. On 6/16/21, the New Jersey Department of Health received an acceptable allegation for the Removal of the Immediate Jeopardy. On 6/16/21, the New Jersey Department of Health continued the onsite survey and determined that the Immediacy of the Jeopardy	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/16/2021

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 000	Continued From page 1 could be removed effective 6/16/21. The Facility continues to remain out of compliance for F689 at a Scope/Severity of (F); No actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) accurately sign for the accountability of Executive Order 26, 4.b., b.) discontinue a physician's order for a Executive Order 26, 4.b. and accurately sign for the accountability of the Executive Order 26, 4.b. and, c.) follow a physician's order designating a pain scale for the administration of as-needed pain medication, (Executive Order 26, 4). This deficient practice was identified for Exe (three) of Executi residents reviewed for professional standards of nursing practice (Resident Executive, Resident Executive O, and Resident #Executive). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching,	F 658	Corrective Action: Resident Executive Order 26, 4.b. order was discontinued Resident Executive Ord order for a chair alarm has been discontinued Resident Executive Ord has been discharged. Potential to Affect: All residents and staff have the potential to be affected. Systemic change: Licensed staff were educated on the proper documentation of Executive Order 26 use, Executive Order 26, 4.b. use and adhering to physician orders as prescribed. Licensed staff were educated regarding documentation including how to appropriately document medications, treatments and safety interventions not in use. Licensed staff were educated to discuss during clinical rounds physician orders that may no	8/3/21

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F 658

Continued From page 2

health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."

Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case-finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

The evidence was as follows:

1. On 6/8/21, during the initial tour of the facility, the surveyor interviewed Resident Executive Ord at 11:33 AM in their room. The surveyor observed an Executive Order 26, 4.b. (Executive Order 26, 4.b.) in the room, and it was turned off. The resident had no roommate at the time. The resident stated that they used the Executive Order 26, 4.b.."

On 6/11/21 at 9:29 AM and 6/14/21 at 11:21 AM, the surveyor observed that Resident Executive O was Executive Order 26, 4.b..

The surveyor reviewed the medical record for Resident Executive O.

A review of the Face Sheet (an admission summary) revealed that Resident Executive Ord was

F 658

longer be warranted, such as Executive Order 2 and alarms. Residents with bed and chair alarms will be re-assessed quarterly to determine continued need. If Interdisciplinary Team determines items such as, but not limited to; a bed/chair alarm are no longer warranted, physician will be notified for a potential order to discontinue intervention. Licensed staff were educated on Pain medication orders, reading and following orders as prescribed and on medications being administered within the acceptable parameters. Licensed Staff will administer pain medication as ordered for the appropriate pain level. If the resident does not have an order, the licensed staff will contact the physician for further instruction.

Monitoring:
The Unit Manager/Nursing Supervisor will conduct random sample audits on residents with Executive Order 2 orders, residents with orders for Executive Order 26, 4.b. and residents with Executive medication orders weekly x 4 weeks and monthly x3 months. The results of these audits will be reviewed at the monthly Quality Assurance Steering Committee. Following the four months, the committee will determine the future need/ frequency of the audit.

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F 658	Continued From page 3 admitted with diagnoses that included: Executive Order 26, 4.b. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated Executive Order reflected that the resident had a Executive Order 26, Executive Order 26, 4.b. on the Brief Interview for Mental Status (BIMS). This score indicated that the resident was Executive Order 26, 4.b.. A review of the resident's electronic medical record revealed that there was a physician order dated Executive Order 26, 4.b. continuous every shift for Executive Order 26, 4.b. Executive Order." The surveyor reviewed the electronic Medication Administration Records (EMAR) for Resident #Executive for Executive Order 26, 4.b., and Executive Order 26, 4.b. The EMAR indicated that Executive was administered to Resident #Executive continuously on every shift from Executive Order until the evening shift of Executive Order 26. The surveyor had not observed Resident Executive Ord using Executive during the course of the survey. On 6/15/21 at 1:01 PM, the surveyor interviewed the Registered Nurse (RN), who stated that Resident Executive O used Executive Order 26, 4.b. Executi when in the facility's lobby. She noted that the resident "Executive Order 26, 4.b." uses the Executive Executive Order 26, 4.b. in their room. On 6/16/21 at 12:02 PM, the surveyor and the Licensed Practical Nurse/Unit Manager (LPN/UM) reviewed the current June 2021 EMAR regarding	F 658		

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F 658	Continued From page 4 the nurse's signatures for the physician's order for [Executive Order 26, 4.b.]. The LPN/UM stated that the nurses were recording Executive Order 26, 4.b. a measure of the [Executive Order 26, 4.b.] levels carried in the resident's blood) on the EMAR. Further review of the EMAR had indicated that the [Executive Order 26, 4.b.] Sats corresponded with the physician's order for "[Executive Order 26, 4.b.] via N/C (nasal cannula) Continuous every shift for SOB [Shortness of Breath]." The LPN/UM added that he thought the nurses were signing for the [Executive Order 26, 4.b.] Sats and that they were not signing that they had administered [Executive Order 26, 4.b.] continuously to Resident [Executive Order 26, 4.b.] On 6/16/21 at 12:03 PM, the surveyor interviewed LPN #1, whose signature appeared numerous times on the EMAR. LPN #1 stated that she had documented the [Executive Order 26, 4.b.] saturation levels on the dates indicated on the EMAR. LPN #1 added that she did not think that she was signing for continuous [Executive Order 26, 4.b.] administration for Resident [Executive Order 26, 4.b.] On 6/16/21 at 1:13 PM, the surveyor, with the Director of Nursing (DON), reviewed the current June 2021 EMAR regarding the physician's order for [Executive Order 26, 4.b.] for the resident. The DON stated that the nurses' signatures indicated that the resident's [Executive Order 26, 4.b.] was being administered continuously. The DON added that the [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] were also documented on the EMAR. On 6/16/21 at 2:01 PM, the survey team met with the administrative team. The DON presented to the surveyor documentation of a "Summary Report of Meeting/In-service," which was conducted on [Executive Order 26, 4.b.] at 1:25 PM after the surveyor inquiry. The DON stated that she had inserviced the nurses regarding proper documentation of [Executive Order 26, 4.b.] use.	F 658		

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F 658	Continued From page 5 2. On 6/8/21 at 11:24 AM, the surveyor, observed Resident [Executive Order 26, 4.b.] standing up from their wheelchair in front of their bed. The resident was straightening out the bedsheets on the bed. The surveyor did not observe a chair alarm on the back of the wheelchair or hear a chair alarm sounding. At that time, the surveyor attempted but could not interview the resident due to a language barrier. On 6/9/21 at 1:34 PM, the surveyor observed Resident [Executive Order 26, 4.b.] in a wheelchair, self-propelling in the hallway, and stopped to talk to a nurse. The surveyor did not observe a [Executive Order 26, 4.b.] on the [Executive Order 26, 4.b.] of the wheelchair. The surveyor reviewed the medical record for Resident [Executive Order 26, 4.b.]. A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted with diagnoses that included but Executive Order 26, 4.b. A review of the resident's June 2021 EMAR included a physician's order (PO), with a start date of [Executive Order 26, 4.b.], for [Executive Order 26, 4.b.] and check placement every shift for monitoring. Each shift for each day of June indicated that the order was administered (done) except for [Executive Order 26, 4.b.] evening shift which indicated the resident refused. On 6/15/21 at 11:18 AM, in the presence of LPN #2, the surveyor observed Resident [Executive Order 26, 4.b.] sitting in their bed. The wheelchair was positioned next to the resident's bed. The surveyor did not observe	F 658		

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F 658	Continued From page 6 a chair alarm on the wheelchair or hear a chair alarm sounding. The surveyor asked LPN #2 to confirm that Resident Executive did not have a Executive Or Executive Ord on their Executive Order 26, 4.b. LPN #2 stated that she did not see a Executive Order 26, 4.b. on the resident's Executive Order 26, 4.b. She then stated that she would look in the computer to see if there was an order and check with the Unit Manager (UM #2). She further noted that if the resident still needed the chair alarm, she would put it on, and if the resident did not need the chair alarm, she would call the physician to get an order to discontinue it. At 11:26 AM, during the surveyor interview, UM #2 stated that the resident did not have or require a Executive Order 26, 4.b. and that it had been resolved in the care plan. She further noted that the resident did not want the Executive Order 26, 4.b. and that the family also did not want the Executive Order 26, 4.b. On 6/16/21 at 8:52 AM, during the surveyor interview, LPN #2 stated that Resident Executive had fallen in the past and that they had put on a Executive Ord Executive Ord for a short time. She further noted that the order was not deleted when the Executive Order 26, 4.b. was taken off the Executive Order 26, 4.b. and resolved in the care plan. A review of Resident Executive Or comprehensive care plan indicated a focus area that resident was at Executive Order 26, 4.b. The resident had an intervention that included applying a Executive Order 26, 4.b. and re-evaluate for effectiveness as needed, which was initiated on Executive Orde. The intervention was resolved Executive Order 26, 4.b. At 12:17 PM, during the surveyor interview, UM #2 stated that the staff should not have been signing the eMAR that they were checking the	F 658		

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F 658	Continued From page 7 Executive Order 26, 4.b. if there was no Executive Order 26, 4.b. on the resident's Executive Order 26, 4.b. On 6/21/21 at 11:03 AM, during the surveyor interview, the DON stated that the staff should not have been signing the EMAR that they were checking the Executive Order 26, 4.b. if there was no Executive O on the resident's Executive Order 26, 4.b.r. She further stated that the staff should have contacted the physician to have the Executive Order 26, 4.b. discontinued. The surveyor asked the DON to provide the facility policy for wheelchair alarms. The DON stated that the facility did not have a policy for wheelchair alarms. 3. On 6/8/21 at 1:32 PM, the surveyor, observed Resident Executive O lying in bed. The resident stated that they had pain in their Executive Order 26, 4.b. and Executive O and that they requested pain medication when needed, and the pain medication provided relief. The surveyor reviewed the medical record for Resident Executive O. A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. A review of the quarterly MDS, dated Executive Order 26 indicated that the resident had a brief interview for mental status (BIMS) Executive Order 26, 4.b., indicating the resident had an Executive Order 26, 4.b.. It further included that the resident had received Executive Order 26, 4.b.. A review of the resident's Physician Order Sheet (POS) dated Executive Order 26, included a physician's order	F 658		

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F 658	Continued From page 8 (PO) dated [Executive Order] for "[Executive Order 26, 4.b.] MG ([Executive Order 26, 4.b.] m [Executive]) give [Executive Order 26, 4.b.]ery 6 hours as needed for moderate pain 4-6." A review of Resident [Executive Order 26, 4.b.] care plan indicated a focus area that resident had an alteration in comfort due to pain evidenced verbally due to [Executive Order 26, 4.b.] The resident had an intervention that included [Executive Order 26, 4.b.] medication ([Executive Order 26, 4.b.]) as ordered. A review of the resident's [Executive Order 26, 4.b.] EMAR included the following dates and times of administrations that were not followed in accordance with the physician's order for the parameter of a pain level to be between [Executive Ord] for the administration of [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] administered for [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] administered for [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] administered for [Executive Order 26, 4.b.] [Executive Order 26, 4.b.]8 administered for [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] administered for [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] administered for [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] administered for [Executive Order 26, 4.b.] On 6/16/21 at 8:30 AM, during the surveyor interview, LPN #3 stated that the pain level number listed on the EMAR is the pain level of the resident prior to administering the [Executive] [Executive Order 26, 4.b.] She further noted that the [Executive] listed on the EMAR indicated that the [Executive Order 26, 4.b.] was effective, and the corresponding pain level after receiving the [Executive Order 26, 4.b.]n would be documented in a progress note. The surveyor then asked LPN #3 what the process was for administering a [Executive Order 26, 4.b.] that was ordered	F 658		

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F 658	Continued From page 9	F 658		

with a specific pain level parameter. LPN #3 stated that if a [Executive Order 26, 4.b.] was ordered for a pain level of [Execu...] and a resident had a [Executive Order 26, 4.b.] of [Exe...], then she would administer that medication. She then stated that if the resident had a [Executive ...] [Executive O...] that was lower than a [Exe...] that she would offer the medication that was ordered for that pain level, probably [Executive Order 2...]. If the resident did not have another order or did not want the other medication, she would tell the charge nurse or call the physician for a one-time order.

At 8:43 AM, during the surveyor interview, UM #3 stated that if a resident's pain level is not within the parameters of the medication order, then the staff should offer another medication that is ordered. She further stated that if the resident did not have an order for another medication that the staff would call the physician. UM, #3 could not speak to why the nurses had administered and documented the administration of the [Executive Order 26, 4...] not in accordance with the physician's order.

On 6/21/21, during the surveyor interview, the DON stated that staff should follow a physician's order and not administer a pain medication outside the physician's ordered parameters. She then added that the staff should administer the pain medication ordered for the appropriate pain level. If the resident did not have an order, the staff should contact the physician and obtain another order.

A review of the undated facility-provided policy titled "Administering Pain Medications" included "Follow the medication administration per physician order." The policy did not include information regarding administering pain medication if the pain level was outside the

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F 658	Continued From page 10 parameter of the physician's order. NJAC: 8:39-11.2(b), 29.2(d)	F 658		
F 689 SS=L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident (Resident #Executive Order 26, 4.b. who had a physician's order for Executive Order 26, 4.b. was properly identified, assessed, re-assessed, and monitored for Executive Order 26, 4 after the resident was noted to be Executive Order 26, Executive Order 26, 4.b. on Executive Ord separate occasions on Executive Order 26, Executive Order 26, and Executive Order 2. Further, the facility failed to address the Executive Order 26, 4 violations in accordance with their Executive Order 26, 4 policy and revise the resident's care plan to ensure safe Executive Order 26, 4 practices. The facility's failure to revise and implement a care plan to avoid a Executive Order 26, 4 accident while the resident had a physician's order for continuous Executive Order 2 and was found to be Executive Order 26, 4.b. Executive Order 26, 4.b. created an unsafe environment for serious injury, combustion, and fire.	F 689	Corrective Action: Resident R Executive was educated on the facility s revised Executive Order 26, 4 policy. Reeducation was also provided to R Executive by the nursing department regarding the dangers of Executive Order 26, 4 with or near Executive Order 26 Resident R Executive s Executive Order 26, 4.b. was changed to PRN. Resident R Executive is aware that searches will be completed upon returning from Executive Order 2 appointments and random room check audits will be completed daily related to Executive Order 26, 4 materials/violation of the Executive Order 26, 4 policy. Resident R Executive verbalized understanding and is in agreement. Any deliveries including food will be checked by the Receptionist/front desk staff upon receipt at the front desk. Potential to Affect: All residents and staff have the potential	8/3/21

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(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 689	Continued From page 11 This posed a serious and immediate threat to the safety and well-being of all the residents in the facility residing on [Ex] of [Ex] resident care units (Executive Order 26, 4.b. unit) which resulted in an Immediate Jeopardy (IJ) situation. The facility Administration was notified of the Immediate Jeopardy situation on 6/15/21 at 2:14 PM. The IJ began on [Executive Order 26] upon the [Executive Order 26] [Executive Order 26] violation incident and continued until 6/16/21, when the facility alleged complete implementation of the elements in their IJ Removal Plan, accepted on 6/16/21 at 4:00 PM and verified by the survey team on 6/16/21 and throughout the remainder of the Recertification Survey. The evidence was as follows: On 6/8/21, between 10:27 AM, the surveyor conducted an Entrance Conference with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator, and the Director of Nursing (DON). Included as part of the Entrance Conference, the surveyor requested a copy of a list of residents who smoked at the facility. The surveyor reviewed the list of residents identified to be smokers provided by the LNHA. The list of smokers did not include Resident #[Executive]. On 6/8/21 at 11:33 AM, during the initial tour of the facility, the surveyor observed Resident [Executive Or] in their semi-private room with no assigned roommate. The surveyor observed an [Executive Order 2] Executive Order 26, 4.b. [redacted] use) in the room, and it was turned to the off position. The surveyor interviewed	F 689	to be affected. Systemic change: The facility revised the [Executive Order 26] policy to include updates on violations, labeling of [Executive Order 26] materials, and additional [Executive Order 26] times. The residents who [Executive Order], including R[Executive] were educated on the revised [Executive Order 26] policy and signed the [Executive Order 26] assessment contract. All residents including R[Executive] verbalized understanding of what the violations are and the consequences of these violations. Staff education was completed on the [Executive Order 26] policy including proper notifications when a resident violates the policy. Families were notified via the facility newsletter regarding the updated [Executive Order 26] policy and protocol for delivery of [Executive Order 26] materials. Education was completed with the direct care staff of R[Executive] to include expectations of random room checks related to [Executive Order 26] materials/ violation of [Executive Order 26] policy. The department heads that complete weekly non-clinical rounds for the identified [Executive Order 26, 4] residents will complete an audit of the person/ property and document on the rounds sheet. Any violations will be reported and addressed with resident per the [Executive Order 26] policy. Monitoring: The Unit Manager/Nursing Supervisor will conduct random room check audits for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 689	Continued From page 12 Resident #[Executive Order 26, 4.b.] who stated that they used the [Executive Order 26, 4.b.] "once in a while." On 6/11/21 at 9:29 AM and 6/14/21 at 11:21 AM, the surveyor observed that Resident #[Executive Order 26, 4.b.] was not using the supplemental [Executive Order 26, 4.b.], and the Executive Order 26, 4.b. was turned to the off position. The surveyor reviewed the medical record for Resident #[Executive Order 26, 4.b.] A review of the Admission Record face sheet (an admission summary) revealed that Resident #[Executive Order 26, 4.b.] was admitted Executive Order 26, 4.b. A review of an initial [Executive Order 26, 4.b.] Safety Screen dated [Executive Order 26, 4.b.] reflected that the resident smoked Executive Order 26, 4.b. but could not Executive Order 26, 4.b. and required [Executive Order 26, 4.b.] Executive Order 26, 4.b.. The note on the [Executive Order 26, 4.b.] screen indicated that the resident had subsequently, [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] A review of the admission comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [Executive Order 26, 4.b.] reflected that the resident had a Brief Interview for Mental Status (BIMS) [Executive Order 26, 4.b.] ndicating that the resident had an Executive Order 26, 4.b.. The MDS assessment further revealed that the section used to assess if the resident was a	F 689	R169 daily related to [Executive Order 26, 4.b.] materials/violation of the [Executive Order 26, 4.b.] policy. This audit will be completed daily x 4 weeks and then weekly for three months. The results of these audits will be reviewed at the monthly Quality Assurance Steering Committee. Following the four months, the committee will determine the future need/ frequency of the audit.	

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F 689	Continued From page 13 smoker reflected that they were not a current tobacco user. A review of the most recent MDS dated Executive Order reflected that the resident had BIMS Executive Order 26, 4.b. Executive Order 26, 4, indicating the resident had a fully intact cognition. A review of the resident's individualized comprehensive care plan initiated on Executive Order 26, reflected that Resident #Executive was a Executive Order 26 smoker and not interested in Executive Order 26, 4 at this time." It further reflected that the resident had Executive Order 26, 4.b.." The goal indicated that the resident would be Executive Order 26, 4.b. through the next review date, with a single intervention to provide check-in visits to see how they were doing. The care plan further reflected that the resident was on Executive Order 26, 4.b. related to a Executive Order 26, 4.b. of Executive Order 26, 4.b.. Interventions included to administer the Executive Order 26, 4.b. . A review of the physician's order sheet (POS) reflected that the resident had a physician's order (PO) dated Executive Order 26 for a Executive Order 26, 4.b. Executive Order 26, 4.b.. The Executive Order 26, 4.b. was re-ordered by the physician on Executive Order 26 and Executive Order 26, 4.b. There were no other subsequent physician orders for a Executive Order 26, 4.b. Further review of the POS reflected a physician order dated Executive Order 26 to administer Executive Order 26, 4.b. Executive Order 26, 4.b. continuously every shift via the nares using a Executive Order 26, 4.b. for Executive Order 26, 4.b.). The surveyor reviewed the electronic Progress	F 689		

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F 689	Continued From page 14	F 689		

Notes (ePN) for Executive Order 26, 4.b. which reflected that the resident had Executive Order 26, 4.b. of Executive Order 26, 4.b. The Behavior Notes written within the ePN reflected the following:

An ePN dated Executive Order 26, 4.b. included that the Executive Order 26, 4.b. ." The Licensed Practical Nurse (LPN) documented that she asked the resident why they were Executive Order 26, 4.b. in the Executive Order 26, 4.b. , but the resident denied doing it. No other details were documented in the ePN regarding the Executive Order 26, 4.b. paraphernalia, notification to the physician or chain of command, and the resident's use of Executive Order 26 during the alleged incident.

A review of the electronic Medication Administration Record (eMAR) for Executive Order 26, 4.b. reflected the PO dated Executive Order 26, 4.b. to continuously administer Executive Order 26, 4.b. at Executive Order per minute. The eMAR was signed to reflect that the resident received the Executive Order 26, 4.b. continuously via Executive every shift on Executive Order 26 .

A review of the comprehensive individualized care plan initiated Executive Order 26 reflected that the care plan for Executive Order 26, 4.b. was not updated after the alleged Executive Order 26, 4. violation incident on Executive Order 26 until nine days later on Executive Order 1, which indicated to "educate resident as needed on the dangers of Executive Order 26, 4. while being on Executive Order 26, 4.b.]."

There was no documented evidence in the medical record that reflected that the resident received the education on the dangers of Executive Order 26, 4. while being on Executive Order 2 and how they responded to the education since the first alleged incident on Executive Order 26 .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING _______ B. WING _______	C 06/21/2021

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F 689	Continued From page 15	F 689		

The surveyor reviewed the [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] incident documented in the ePN dated [Executive Order 26, 4.b.] at 2:21 PM. The note indicated that the same LPN wrote the following Behavior Note: "Resident was [Executive Order 26, 4.b.] in the room, [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] resident denied, social worker, informed."

There was no subsequent re-assessment for [Executive Order 26, 4.b.] for Resident #[Executive Order 26, 4.b.] after the first [Executive Order 26, 4.b.] violation.

A review of the ePN dated 4/30/21 at 3:08 PM, reflected that the Social Worker (SW) wrote that two social workers "performed a room search and confiscated a [Executive Order 26, 4.b.] of [Executive Order 26, 4.b.] [Executive Order 26, 4.b.]." The Behavior Note indicated that the resident denied [Executive Order 26, 4.b.] in the room and stated they go outside to smoke. The SW continued, "Writer re-educated the resident on the [Executive Order 26, 4.b.] policy, and at this time, there is no [Executive Order 26, 4.b.]." The SW concluded the note by documenting that the resident was "aware of all the above."

A review of the eMAR for [Executive Order 26, 4.b.] reflected the PO dated [Executive Order 26, 4.b.] to continuously administer [Executive Order 26, 4.b.]. The eMAR was signed to reflect that the resident received the [Executive Order 26, 4.b.] continuously via [Executive Order 26, 4.b.] every shift on [Executive Order 26, 4.b.]

A review of the comprehensive individualized care plan initiated on [Executive Order 26, 4.b.] reflected that the care plan for [Executive Order 26, 4.b.] was not updated after the alleged [Executive Order 26, 4.b.] incident on [Executive Order 26, 4.b.] until nearly a month later on [Executive Order 26, 4.b.], which indicated a new intervention to offer the resident a [Executive Order 26, 4.b.] [Executive Order 26, 4.b.].

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 689	Continued From page 16 The eMAR for April 2021 and May 2021 was signed every shift that the resident continued on Executive Order 26, 4.b. continuously on Executive Order 26. There was no documented evidence that the resident had a physician's order or received a Nicotine Patch. A review of a Care Plan Meeting Note within the ePN dated Executive Order 26 and authored by the Activities Director (AD) reflected that the "Resident was unable to attend care planning meeting as [Resident #Executive was in the shower." The AD also documented in this progress note that, "Resident is a Executive Order r, has not Executive Order 26 the last few months d/t [due to] Covid -19 restrictions and guidelines. The resident had one violation of Executive Order 26, 4 in [their] room and was educated. Resident is non-compliant with medical advice." The surveyor reviewed that a Executive Order 26, 4.b. Executive Order 26, 4 incident occurred on Executive Order 26, 4.b. when an SW wrote a Behavior Note in the ePN timed at 4:09 PM for Resident #Executive. The note reflected: "Writer received a call Executive Order 26, 4.b. coming from room. Myself and Admin [Administrator] conducted a room search with resident present." The SW quoted the resident, who stated, Executive Order 26 Executive Order 26, 4.b." The Behavior Note concluded that the resident "handed over a Executive Order 26, 4.b. No other Executive Order 26, 4 materials found after search completed." The eMAR for Executive Order 26, 4.b. was signed every shift that the resident continued to receive Executive Order 26, 4.b. Executive Order 26, 4.b. continuously in accordance with the physician's order, including on the date of the Executive Order 26, 4.b. Executive Order 26	F 689		

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 17 A review of an ePN Behavior Note dated 6/11/2021 at 4:51 PM reflected that the Director of Nursing (DON) documented that "Daily room checks will be done over the weekend to ensure no Executive Order 26, 4.b. is found." A review of the comprehensive individualized care plan initiated on Executive Order 26, reflected that the care plan for Executive Order 26, 4 was not updated until Executive Order 26, after the alleged Executive Order 26, 4.b. on Executive Order 26, The surveyor continued to conduct interviews with facility staff. The following was revealed: On 6/14/21 at 1:49 PM, two surveyors interviewed the SW regarding her responsibility with residents who Executive Order 2. The SW stated that her only involvement regarding residents who Executive Order was to provide Executive Order 26, 4 counseling and conduct a room search. The SW added that she would offer counseling regarding issues with Executive Order 26, 4 and reiterate to the resident the facility's rules and Executive Order 26, 4 requirements. The surveyor inquired if incident reports or any type of investigation were conducted for any Executive Order 26, 4 violations. She replied that the incident report would be filled out if needed if there was a Executive Order 26, 4 violation. She stated that she completed incident reports within the electronic medical record, specifically in the electronic Progress Note section. The SW said that the ePN would get attached to a 24-hour report (a shift-to-shift nursing report to communicate incidents or changes in resident condition). The SW continued that nursing staff would then know by reading the 24-hour report that they would have to go by the resident's room to make sure they didn't smell anything unusual like smoke. She stated that they would conduct a	F 689		

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

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 689	Continued From page 18	F 689		

room search if necessary. The SW added that the [Executive Order 26] privileges would be taken away for 24 hours after the first offense. After the second offense, they would lose their privileges for a few days. The SW further stated that the consequences were spelled out in the [Executive Order 26] policy, which was given to all residents who [Executive Order]. She then stated, "We all know what the rules are." She explained that the Recreation Department was in charge of the [Executive Order 26] program. The SW explained that the Activities Director (AD) distributed the list of [Executive Order 26] to all the nursing units. Resident #[Executive] was taken off the list because he/she was on continuous [Executive Order 26]. The SW clarified that as of recently, the resident no longer needed continuous [Executive Order 26], and therefore they were allowed to [Executive Order]. She stated that the resident's name was subsequently put back on the facility list of residents who [Executive Order 26]

On 6/14/21 at 2:11 PM, the surveyor interviewed the AD, who indicated that Resident #[Executive] was not on the [Executive Order 26, 4.b] because they weren't cleared to [Executive Order] until today (upon surveyor inquiry). She stated that they just reached out to the Attending Physician to add Resident #[Executive] to the [Executive Order 26] list because they were cleared to [Executive Order]. When asked if there had been any violations during [Executive Order 26], the AD was unaware whether-or-not Resident #[Executive] had violated any [Executive Order 26] rules. The AD stated that nursing did an initial [Executive Order 26] screen upon admission and that the resident would need a further [Executive Order 26, 4] assessment before being placed on the [Executive Order 26] program. She further stated that Physical Therapist would complete a safety screen for residents who qualified and wanted to [Executive Order]. She stated that she also did an initial assessment that was

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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ARISTACARE AT CEDAR OAKS	**1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080**

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F 689	Continued From page 19 "activity-based." The AD added that residents would sign their names in a book outside when [Executive Order 26, 4.b.] in addition to signing a [Executive Order 26, 4.b.] contract. The AD stated that Resident #[Executive Order 26, 4.b.] was not in the [Executive Order 26, 4.b.] program because he/she did not qualify. She explained that the resident kept saying that they did not [Executive Order 26, 4.b.], and so he/she was not on the [Executive Order 26, 4.b.] list. The AD stated that Resident #[Executive Order 26, 4.b.] always stated to her that he/she previously quit but had now just re-started [Executive Order 26, 4.b.] When asked about [Executive Order 26, 4.b.] violations and consequences, the AD explained that the first violation would result in resident education and warning. She stated that if the resident was not on the [Executive Order 26, 4.b.] list and had a [Executive Order 26, 4.b.] violation anyway, the resident could still get consequences if necessary. The AD continued that for the second violation, the resident would lose privileges for one day, and for the third violation, privileges would be lost for three days. The AD concluded that Resident #[Executive Order 26, 4.b.] now "has a [Executive Order 26, 4.b.] contract." She stated that the resident was Executive Order 26, 4.b. and had "just started [[Executive Order 26, 4.b.]] today," on [Executive Order 26, 4.b.] On 6/15/21 at 9:02 AM, a second surveyor observed five residents with the Recreation Aide (RA) outside on the patio area where [Executive Order 26, 4.b.] was permitted. The surveyor interviewed the RA, who stated that he had a binder with [Executive Order 26, 4.b.] instructions for each resident, and each resident signed a [Executive Order 26, 4.b.] Sign Off Sheet" when taking a cigarette for the date and time. The RA added that [Executive Order 26, 4.b.] times were only at 9:00 AM and 1:00 PM because several activity programs were	F 689		

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F 689	Continued From page 20	F 689		

being done in the afternoon. The surveyor interviewed a resident (Resident #[Executive]) who was present [Executive Order 26, 4] and stated that there had been additional [Executive Order 26, 4] times in the past, but now the times were only 9:00 AM and 1:00 PM daily.

On 6/15/21 at 9:30 AM, the surveyor conducted a second interview with the AD, who stated that she thought that the facility had stopped the [Executive Order 26, 4] program in Executive Order 26, 4.b. She said that if staff smelled [Executive Order 26] in a resident room in a location not approved for [Executive Order 26, 4], they would contact the SW, who would counsel the resident and conduct a room search. When asked if she had any [Executive Order 26, 4] violations on Resident #[Executive], the AD just stated that the social worker would do a room search and an investigation. The AD did not answer the question regarding if Resident #[Executive] had any [Executive Order 26, 4] violations.

The AD provided a copy of the facility's undated Smoking Policy which included the following:

"Due to the safety-related to non-compliance with the smoking policy, the following consequences will be enforced. Violations will include but are not limited to: Smoking in areas not designated for smoking, maintaining supplies/lighting materials that should be locked up, and/or smoking without supervision when assessment indicates otherwise.

1st violation-resident will be educated and given a warning.

2nd violation-resident will lose smoking privileges for one day.

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 689		F 689		

Continued From page 21

3rd violation-resident will lose smoking privileges for three days.

4th violation-resident will lose smoking privileges for seven days.

5th violation-resident will lose smoking privileges in this facility.

6th violation-resident will have possible discharge from the facility."

The surveyor reviewed that the Executive Order 26, 4.b Policy was signed by Resident #Executive on Executive Order 26. There was no documentation provided that revealed that Resident #Executive signed a Executive Order 26, 4.b. or other Executive Order 26, 4.b. prior to Executive Order 26, 4.

On 6/15/21 at 10:11 AM, two surveyors interviewed the DON and the LNHA. The DON explained that a Executive Order 26, 4 assessment was performed and documented on the Nursing Admission Summary. She stated that if the resident answered "yes" that they were a smoker, the facility would initiate screening, and a Executive Order 26, 4 assessment would be done, and the AD would further complete the Executive Order 26, 4 assessment. The DON also stated that the Therapy department would be incorporated into the assessment to determine if the resident could safely hold a cigarette.

At that time, the LNHA stated, "There was a period of time that we weren't allowing Executive Order 26, 4" due to the COVID-19 pandemic and the risk for the spread of infection, and instead were offering Executive Order 26, 4.b.. The LNHA elaborated that some residents had a desire to quit Executive Order 26, 4

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F 689	Continued From page 22	F 689		

When asked specifically about Resident [Executive Order] the DON stated that he/she [Executive Order 26, 4.b.] [Executive Order 26, 4.b.]" She continued that the resident denied [Executive Order 26, 4.b.] on the Nurse's Assessment. The DON then referenced the incident that occurred on [Executive Order 26]: "The incident last Friday. I physically smelled the cigarette. [Resident #[Executive Order] lit it quickly and threw it away... This is why we're trying to get to the bottom of this."

The LNHA concluded that they spoke to the nurse who wrote the note on [Executive Order 26, 4.b.] and that the nurse did not see the resident [Executive Order 26, 4.b.] that day. He stated that his understanding was that [Executive Order 26, 4.b.] were only found and confiscated. The LNHA said, "I was not aware that [Resident #[Executive Order] was [Executive Order 26, 4.b.] in the room. We're trying to find out now." He then stated that as far as physically seeing the resident [Executive Order 26, 4.b.]..."No one saw."

On 6/15/21 at 10:30 AM, the DON presented the facility's investigations for Resident #[Executive Order] since [Executive Order]; The surveyor had requested these files on [Executive Order 26, 4.b.]. There was no investigation or report related to the Behavior Note dated [Executive Order 26] regarding the resident [Executive Order 26, 4.b.] [Executive Order 26, 4.b.]. One new Interdisciplinary Care Plan Intervention was added on [Executive Order 26] to "Educate resident as needed on the dangers of [Executive Order 26, 4.b.] while being on [Executive Order] This intervention was added nine days after the actual, alleged incident.

The folder provided regarding the [Executive Order 26] incident contained two papers: one was a copy of the Behavior Note from the medical record written by the SW on that date. The other was an "Employee Concern Report" completed by the Assistant Administrator and signed by the LNHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CEDAR OAKS	**1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080**

(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 689	Continued From page 23 on Executive Order 26. The "Detail of Concern" was that Executive Order 26, 4.b. were found in Resident # Executive Or room. "Findings and Disposition: Removed Executive Order 26, 4 materials and complete room check done. Follow Up/If Applicable: Resident verbally educated that residents cannot have Executive Order 26, 4 materials in room as per our Executive Order 26, 4 policy." There were no other details provided within the investigation. There were no written statements from the LPN who discovered the resident Executive Order 26, 4 in the room while Executive Order 26, 4.b. was in use or statements from any potential witnesses, including the resident. There was no investigation regarding where the resident may have obtained the Executive Order 26, 4 materials. The only intervention added to the resident's Care Plan was to Executive Orde Executive Order 26, 4.b. This intervention was not initiated until Executive Order 26, 26 days after the incident occurred. The only evidence in the medical record that the nicotine patch was offered to Resident Executive Ord was dated ten months prior, on Executive Order 26. The Care Plan Meeting Note dated Executive Order 26 authored by the AD did not address that the resident was offered or refused a Nicotine Patch. It reflected that the resident was a smoker and "has not smoked the last few months d/t [due to] Covid -19 restrictions and guidelines." The investigation of the Executive Order 26, 4.b. violation incident on Executive Order 2, which occurred within the dates of the Recertification Survey, included statements from witnesses including the DON, LNHA, SW, and AD. The resident's Interdisciplinary Plan of Care was revised regarding Executive Order 26, 4 on Executive Order 26. There was a signed daily check of the resident's room for lighters, dated Executive Order 26, Executive Order 26, 4 and Executive Order 26. There was a Executive Order 26, 4.b policy signed by the resident, dated Executive Order 26. The "Executive Order 26, 4 Violation	F 689		

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F 689	Continued From page 24	F 689		

Review," dated 6/11/21, revealed that the facility considered this incident as the resident's "Level 1: First Offense," requiring a "Warning with education." There was no documentation that a first or second offense was issued for either the Executive Order 26 or Executive Order 26 incidents.

On 6/15/21 at 11:10 AM, the surveyor attempted to conduct a phone interview with the LPN who wrote the Behavior Notes regarding Resident #Executive Order 26, Executive Order 26, 4.b. on Executive Order 26 and Executive Order 26. A message was left on the LPN's phone to contact the surveyor at the facility, but the LPN did not respond.

On 6/15/21 at 11:15 AM, the LNHA presented a timeline regarding Resident Executive Order 26, which included the following information:

Executive Order 26, 4.b. Executive Order 26, 4.b. - Safety Screen completed. "Resident Executive Order 26, 4.b.

Executive Order 26, 4.b. Nurse Practitioner (NP) Progress Note: "History of Executive Order 26, 4.b. not current [sic] Executive Order 26, 4.b. due to medical condition."

Executive Order 26, 4.b.: "Resident told recreation that [he/she] had quit Executive Order 26, 4.b. and donated [his/her] Executive Order 26, 4.b... to another resident."

Executive Order 26, 4.b.: "Resident went outside during Executive Order 26 times to Executive Order 26 a Executive Order 26, 4.b.. Recreation staff spoke with resident about Executive Order 26, 4.b.. Clinically Executive Order 26, 4.b. is not recommended. Resident agreed to Executive Order 26, 4.b.

Executive Order 26, 4.b.: "NP Note: Discussed Executive Order 26, 4.b. Executive Order 26, 4.b. program."

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 689	Continued From page 25 Executive Order 26, 4.b. "NP Note: No current Executive Order 26, 4.b. Executive Order 26, 4.b.: "Covid outbreak-Executive Order 26, 4 put on hold." Executive Order 26, 4.b.: "Reviewed Executive Order 26, 4 changes due to Covid- Resident states [he/she] does not have Executive Order 26, 4.b. and does not ask for any." Executive Order 26, 4.b.: "Resident found Executive Order 26, 4 Executive Ord Executive Order 26, 4.b. Resident denied." Executive Order 26, 4.b. "Resident found Executive Order 26, 4 in room -social worker informed." Executive Order 26, 4.b.: "Social worker performed room search and confiscated Executive Order 26, 4.b. and matches. [Resident Executive Order] denied Executive Order 26, 4 in the room and states [he/she] goes outside when [he/she] wants to Executive Order 26 Resident was re-educated on policy." Executive Order 26, 4.b.: "Resident Council - Discussed re-implementing Executive Order 26, 4.b." Executive Order 26, 4.b.: "Recreation note summarizing Executive Order 26, 4.b. Executive Order 26, 4." Executive Order 26, 4.b.: "Smelled Executive Order from room. Room search completed. Resident educated. Daily checks put into place for residents [sic] room for Executive Order 26, 4.b.." Executive Order 26, 4.b.: "Restarted Executive Order 26, 4" and Executive Order 26, 4 -Safety Screen updated. On 6/15/21 at 1:00 PM, the LNHA provided a written statement regarding a phone interview with the LPN who wrote the Behavior Notes for	F 689		

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 26 Resident [Executive O]. The statement revealed the following conversation that the LNHA had with the LPN: In the 4/18/21 [Executive Order 26, 4.b] Note statement, the LPN stated that she had smelled a strong air freshener smell and possibly [Executive Order 2] when in the resident's room. She asked the resident if they were [Executive Order 26, 4] Resident #[Executive] denied [Executive Order 26, 4] at the time. The statement did not indicate that a chain of command at the facility was made aware of the incident. In the statement for the [Executive Order 26. Executive Order 26, 4] Note, the LPN stated that she smelled [Executive Order] from the resident's room. She found the resident [Executive Orde] [Executive Order 26, 4.b.] where she believed Resident [Executive O] might have been [Executive Order 26, 4]. The resident denied [Executive Order 26, 4] The Executive Order 26, 4.b. was on in the room away from the [Executive Order 26, 4.b.] The Supervisor and Social Services were made aware. On 6/15/21 at 1:01 PM, the surveyor interviewed the Registered Nurse (RN), who stated that Resident [Executive Ord] used Executive Order 26, 4.b. when in the facility's lobby. She noted that the resident "sometimes" used the Executive Order 26, 4.b. when in their room. On 6/15/21 at 1:10 PM, the surveyor interviewed Resident [Executive O], who was observed [Executive Order 26, 4] in the courtyard. The resident was not receiving Executive Order 26, 4.b. at that time. The resident stated that he/she was offered a [Executive Order 26, 4.b.] in the past and that he/she refused it, because it didn't work. The facility was notified of the Immediate Jeopardy (IJ) situation on 6/15/21 at 2:14 PM.	F 689		

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 689	Continued From page 27	F 689		

The facility's LNHA and DON were informed that the facility's failure to ensure Resident Executive O, who had a physician's order for Executive Order 26, 4.b., was properly identified, assessed, re-assessed, and monitored for Executive Order 26, 4 after the resident was allegedly noted to be Executive Order 26, 4.b. on Executive Order 26, 4.b. occasions on Executive Order 2, Executive Order 2 and Executive Order 2. Further, the failure to address each of the Executive Order 26, 4 violations in accordance with their Executive Order 26, 4 policy, and revise the resident's care plan in a timely manner to ensure safe Executive Order 26, 4 practices, posed a serious and immediate threat to the safety and wellbeing of all the residents in the facility. The Removal Plan was accepted on 6/16/21 at 4:00 PM. The immediacy was removed on 6/16/21 based on the accepted implemented elements of the Removal Plan verified by the survey team on 6/16/21.

The plan included the following:

Removal Plan and Completion Date 6/16/21

On Executive Order 2, members of the Interdisciplinary Team met with Resident #Executive to review the Executive Order 26, 4 violation and conduct a room search. With the resident's permission, measures were initiated on Executive Order 2 and documented on a log sheet. The Unit Manager/Nursing Supervisor was charged with overseeing the log for compliance.

During the public health emergency, the Executive Order 26, 4 program was put on hold. Residents were offered Executive Order 26, 4.b.. Executive Order 26, 4.b. Executive Order 26, 4.b.

The nursing department increased random room checks to three times per day on Executive Order 26 for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 28	F 689		

resident. In-service was initiated for all front desk receptionists regarding checking packages delivered to Resident #Executive . A new Executive Order 26, 4. evaluation was conducted, revealing that Resident Executive Ord was safe to Executive Order with supervision. Executive Order 26, 4 times were increased from Executive Order 26, 4.b.. The Executive Order 2 Executive Order and Executive Order 26, 4.b. company were notified that they should not provide Executive Order 26, 4 materials to Resident Executive O or any of the residents from the facility.

Staff were interviewed regarding the resident's Executive Order 26, 4 events since Executive Order 26, 4.b.. Resident #Executive was made aware that he/she would be searched upon return from all medical appointments. The resident was re-educated regarding the dangers of Executive Order 26, 4 with or near Executive Order 2. All Executive Order 2 supplies were removed from the resident's room and chair, as the physician's order for the supplemental Executive Order 2 was changed from continuous to as needed.

The facility held a Executive Order 26, 4 program meeting on 6/15/21 with all residents who Executive Order 26. The facility revised the Executive Order 26, 4 evaluation and completed a new Executive Order 26, 4. evaluation on each resident that currently Executive Order 26 or who formerly Executive Order 26 within the past six months. An individualized care plan was completed for these residents.

The facility revised the Executive Order 26, 4 policy to include updates on violations.

Education was initiated with the direct care staff of Resident #Executive to include expectations of random room checks related to Executive Order 26, 4 materials/violation of the Executive Order 26, 4 policy.

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 689	Continued From page 29 The survey team verified the Removal Plan from 6/16/21 to 6/21/21 during the remainder of this Recertification Survey. The surveyors continued to interview facility staff and review pertinent facility documents regarding the three Executive Order 26, 4.b. violations. The following was revealed: On 6/16/21 at 11:59 AM, the surveyor interviewed Executive Order 26, 4.b. /21 and 4/30/21. The LPN stated that regarding the Executive Order 26, 4.b. incident that occurred on Executive Order 26, 4.b., she had walked into the resident's room and asked if he/she was okay. The resident was in the Executive Order 26, 4.b., and as soon as they came out, the LPN stated that she could smell Executive Order 26, 4.b.. Even though she could smell the Executive Order 26, 4.b., she asked the resident, and Resident Executive Order 26, 4.b. denied Executive Order 26, 4.b. Executive Order 26, 4.b. was on in [his/her] room. I went to the desk to report it. Staff came upstairs right away and searched [Resident Executive Order 26, 4.b. room and found Executive Order 26, 4.b. and a Executive Order 26, 4.b.." The surveyor reviewed the "Statement Forms" provided by the LNHA regarding Resident Executive Order 26, 4.b. in response to the surveyor's inquiry. There were two forms signed on Executive Order 26, 4.b. completed by a Certified Nursing Aide (CNA #1). CNA #1 wrote on one form that on Executive Order 26, 4.b. she smelled a special spray in the resident's Executive Order 26, 4.b. and she notified the nurse. The second Statement Form reflected that CNA #1 witnessed Resident #Executive Order 26, 4.b. with a cigarette and called the nurse on Executive Order 26, 4.b.. The surveyor reviewed the eMARs for Resident	F 689		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CEDAR OAKS	1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080

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F 689	Continued From page 30	F 689		

#[Executive Order 26, 4.b.] for April, May, and June 2021. The eMARs indicated that [Executive Order 26, 4.b.] was administered to Resident [Executive Order 26, 4.b.] continuously on every shift from [Executive Order 26, 4.b.] with the exception of [Executive Order 26, 4.b.] during the day shift, which documented that the resident "refused" the [Executive Order 26, 4.b.] that shift.

The three [Executive Order 26, 4.b.] violations and subsequent investigative reports provided to the surveyor did not include an examination of the eMAR and a determination if Resident [Executive Order 26, 4.b.] may have been using [Executive Order 26, 4.b.] on [Executive Order 26, 4.b.], [Executive Order 26, 4.b.], and [Executive Order 26, 4.b.] when the eMAR had been signed to reflect the resident was receiving the [Executive Order 26, 4.b.] every shift on those dates.

On 6/16/21 at 12:02 PM, the surveyor and the Licensed Practical Nurse/Unit Manager (LPN/UM) reviewed the current June 2021 eMAR regarding nurses' signatures for the physician's order for [Executive Order 26, 4.b.]. The LPN/UM stated that the nurses were recording [Executive Order 26, 4.b.] on the eMAR. Further review of the eMAR had indicated that the [Executive Order 26, 4.b.] corresponded with the physician's order for "[Executive Order 26, 4.b.] via [Executive Order 26, 4.b.] Continuous every shift for SOB." The LPN/UM added that he thought the nurses were signing for the [Executive Order 26, 4.b.] and that they were not signing that they had administered [Executive Order 26, 4.b.] to Resident [Executive Order 26, 4.b.]

On 6/16/21 at 12:03 PM, the surveyor interviewed LPN #1, whose signature appeared numerous times on the eMAR. LPN #1 stated that she had documented the [Executive Order 26, 4.b.] on the dates indicated on the eMAR. LPN #1 added that she did not think that she was signing

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	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 689	Continued From page 31 for continuous Executive Order 26, 4.b. for Resident # Executive Order 26, 4.b. On 6/16/21 at 1:13 PM, the surveyor interviewed the DON regarding the resident's eMAR. She stated that her understanding of the nurses signing and checking the eMAR for an order on the Executive Order 26, 4.b. stating Executive Order 26, 4.b. every shift for SOB" meant that the Executive Order 26, 4.b. was administered as ordered. The surveyor reviewed the Facility Assessment dated April 2021. This document included that "Services and Care [are] Offered Based on our Resident's Needs." Within this section of the Assessment, the document reflected that the facility would "Provide person-centered/directed care," including "Identify hazards and risks for residents." A review of the undated Smoking Policy provided upon the Entrance Conference on 6/8/21 included that the facility shall establish and maintain safe smoking practices. Supervised smokers will smoke only during the following scheduled times: 9:00 AM - 9:15 AM; 1:00 PM-1:15 PM. "There is No Smoking after 1:15 PM until 9 AM." "Smoking is only permitted in the area that is designated as a smoking section. ...Smoking restrictions shall be strictly enforced in all nonsmoking areas...[The Facility] may check periodically to determine if residents have any smoking articles in violation of our smoking policies. Staff shall confiscate any such articles, and shall notify the charge nurse/supervisor that they have done so." NJAC 8:39-27.1 (a); 31.4 (a)	F 689		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std	F 836		8/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

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F 836	Continued From page 32 CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and facility document review, the facility failed to ensure staffing ratios were met for 66 of 84 shifts reviewed. There was no	F 836	Corrective Action: The facility will continue to recruit for permanent staff aggressively. These	

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F 836	Continued From page 33 increase in the resident census for a period of nine consecutive shifts. This deficient practice has the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every ten residents for the evening shift provided that no fewer than half of all staff members shall be CNAs and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. On 6/21/21, the surveyor reviewed the facility provided Nursing Home Resident Care Staffing Reports from 5/25/21 to 6/21/21 which included the following staff to resident ratio for each shift: 5/26/21-(Census-187) Day shift 1CNA:8.9 residents 5/27/21-(Census-185) Day shift 1 CNA:8.8	F 836	recruitment efforts include but not limited to: • Recruiting a new staffing coordinator • Working directly with the newly hired corporate recruiter • Add additional staffing agency contracts • Offer bonuses when applicable • Advertise our newly approved increased rates • Send brochures /recruitment flyers to the nurse and C.N.A. zip code list • Recruit for non certified aids • Social media recruitment campaign • Creative recruitment efforts by incorporating line staff for videos and also placing the flyers in their neighborhoods • Working with the Councilman of South Plainfield to add a bus stop at the facility to increase accessibility for staff Potential to Affect: All residents and staff have the potential to be affected. Systemic change: The facility will document the responses to call outs with the daily worked staffing sheets. Weekly the facility will have a staffing meeting where one of the tasks is to review staffing needs/ schedule. Monitoring: The Director of Nursing/Designee will conduct random audits of nursing time schedules weekly x 4 weeks and monthly x 3 months. The results of these audits will be reviewed at the monthly Quality Assurance Steering Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CEDAR OAKS	1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080

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F 836	Continued From page 34 residents 5/28/21-(Census-187) Day shift 1 CNA:9.8 residents 5/29/21-(Census-186) Day shift 1 CNA:10.9 residents 5/30/21-(Census-188) Day shift 1 CNA:12.5 residents 5/31/21-(Census-188) Day shift 1 CNA:9 residents 6/1/21-(Census-188) Day shift 1 CNA:9.4 residents 6/3/21-(Census-187) Day shift 1 CNA:11 residents 6/4/21-(Census-187) Day shift 1 CNA:9.3 residents 6/5/21-(Census-185) Day shift 1 CNA:10.9 residents 6/6/21-(Census-183) Day shift 1 CNA:12.2 residents 6/7/21-(Census-183) Day shift 1 CNA:9.2 residents 6/8/21-(Census-184) Day shift 1 CNA:9.7 residents 6/9/21-(Census-186) Day shift 1 CNA:9.8 residents 6/11/21-(Census-188) Day shift 1 CNA:9.4 residents 6/12/21-(Census-191) Day shift 1 CNA:11.2 residents 6/13/21-(Census-191) Day shift 1 CNA:10.6 residents 6/14/21-(Census-191) Day shift 1 CNA:10.6 residents 6/17/21-(Census-192) Day shift 1 CNA:10.1 residents 6/18/21-(Census-193) Day shift 1 CNA:9.7 residents 6/19/21-(Census-190) Day shift 1 CNA:11.2 residents	F 836	Following the four months, the committee will determine the future need/ frequency of the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 836	Continued From page 35 6/20/21-(Census-190) Day shift 1 CNA:11.9 residents 6/21/21-(Census-190) Day shift 1 CNA:9.5 residents 23 of 28-day shifts did not meet the minimum required ratio of 1 CNA to 8 residents: 5/29/21-Evening shift 1 CNA:10.9 residents 5/30/21-Evening shift 1 CNA:12.5 residents 5/31/21-Evening shift 1 CNA:11.1 residents 6/1/21-Evening shift 1 CNA:11.1 residents 6/6/21-Evening shift 1 CNA:11.4 residents 6/12/21-Evening shift 1 CNA:11.2 residents 6/13/21-Evening shift 1 CNA:11.2 residents 6/14/21-Evening shift 1 CNA:11.2 residents 6/15/21-(Census-191) Evening shift 1 CNA:11.2 residents 6/16/21-(Census-194) Evening shift 1 CNA:10.8 residents 6/17/21-Evening shift 1 CNA:10.7 residents 6/18/21-Evening shift 1 CNA:12.1 residents 6/19/21-Evening shift 1 CNA:12.7 residents 6/20/21-Evening shift 1 CNA:14.6 residents 6/21/21-Evening shift 1 CNA:10.6 residents 15 of 28 evening shifts did not meet the minimum required ratio of 1 CNA to 10 residents: 5/25/21-(Census-184) Night shift 1 CNA:15.3 residents 5/26/21-Night shift 1 CNA:17 residents 5/27/21-Night shift 1 CNA:15.4 residents 5/28/21-Night shift 1 CNA:15.6 residents 5/29/21-Night shift 1 CNA:18.6 residents 5/30/21-Night shift 1 CNA:17.1 residents 5/31/21-Night shift 1 CNA:15.7 residents 6/1/21-Nightshift 1 CNA:15.7 residents 6/2/21-(Census-186) Night shift 1 CNA:15.5 residents 6/3/21-Nightshift 1 CNA:17 residents	F 836		

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F 836	Continued From page 36	F 836		

6/4/21-Nightshift 1 CNA:15.6 residents
6/5/21-Nightshift 1 CNA:18.5 residents
6/6/21-Nightshift 1 CNA:15.3 residents
6/7/21-Nightshift 1 CNA:15.3 residents
6/8/21-Nightshift 1 CNA:15.3 residents
6/9/21-Nightshift 1 CNA:15.5 residents
6/10/21-(Census-186) Night shift 1 CNA:15.5 residents
6/11/21-Night shift 1 CNA:17.1 residents
6/12/21-Night shift 1 CNA:21.2 residents
6/13/21-Night shift 1 CNA:15.9 residents
6/14/21-Night shift 1 CNA:15.9 residents
6/15/21-Night shift 1 CNA:15.9 residents
6/16/21-Night shift 1 CNA:16.2 residents
6/17/21-Night shift 1 CNA:16 residents
6/18/21-Night shift 1 CNA:16.1 residents
6/19/21-Night shift 1 CNA:17.3 residents
6/20/21-Night shift 1 CNA:17.3 residents
6/21/21-Night shift 1 CNA:15.8 residents

28 of 28-night shifts did not meet the minimum required ratio of 1 CNA to 14 residents.

On 6/21/21 at 10:28 AM, during the surveyor interview, the Director of Nursing (DON) stated that the facility did not currently have a staffing coordinator. She added that she was performing the duties of staffing the facility. The surveyor then asked if she was aware of the minimum direct care staff to resident ratio, which became effective 2/1/21, in which she stated that she was aware. She then said that she sends an email twice a day to staffing agencies to acquire staff to meet the ratio.

At 10:39 AM, during the surveyor interview, the Administrator stated that the facility utilizes a few different staffing agencies but that sometimes there are last-minute call-outs from the agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING ______ B. WING ______	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 836	Continued From page 37 He further noted the facility was doing everything they could and that the nursing supervisors would provide additional support to staff and would be given an assignment if needed. The facility did not provide documentation as to which dates and shifts a nursing supervisor was designated an assignment of residents to provide care. A review of the facility provided document titled "Facility Assessment Tool," updated April 2021, included the following: Under "Staffing Plan. This chart describes our approach to ensure sufficient staffing based on our resident population and their needs for care. Average Staffing for 7-3 Shift: Position-Nurse aides. Total Number Needed or Average or Range-1:8." NJAC: 8:39-5.1(a)	F 836		

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
315214 (Y1)	A. Building B. Wing (Y2)	8/11/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CEDAR OAKS	1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 08/03/2021	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 08/03/2021	ID Prefix F0836 Reg. # 483.70(a)-(c) LSC	Correction Completed 08/03/2021
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	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

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	
6/21/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO